



**REPUBLIC OF NAMIBIA**

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**LAW REFORM AND DEVELOPMENT COMMISSION**

**REPORT ON THE  
MENTAL HEALTH BILL**

**In partnership with the**

**MINISTRY OF HEALTH AND SOCIAL SERVICES**

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Windhoek, Namibia  
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## **LAW REFORM AND DEVELOPMENT COMMISSION**

The Namibian Law Reform and Development Commission (the LRDC) is a creature of statute established by section 2 of the Law Reform and Development Commission Act, 1991 (Act No. 29 of 1991).

The core mandate of the Commission is to review and undertake research in connection with all branches of law and to make recommendations for the reform and development, where necessary. The current Commission members are—:

Vacant	Chairperson
Mr. E. Josua	Deputy Chairperson (Acting Chairperson)
Mr. B. Dyakugha	On behalf of the secretariat
Mr. H. Gerdes	Law Society of Namibia
Ms. F. Owoses	Chief Legislative Drafter
Mrs. A. Zender	Faculty of Law, UNAM
Mr. J. Walters	Ombudsman
Mrs. S. Mezui Engo	An appointment under s 3(f) as a member with special expertise.

Under section 3 of the Law Reform and Development Commission Act, 1991, Commissioners are appointed by the President. Previous Commissioners ceased to hold their office when their term of three (3) years lapsed in August 2018. They were —:

Ms. Y Dausab,	Chairperson
Adv. J Walters,	Ombudsman
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Ms. L Usebiu,	Faculty of Law, UNAM
Mrs. A Van der Merwe,	Law Society of Namibia

The Directorate of Law Reform serves as Secretariat to the Commission, assisting the Commission in the exercise of its powers and the performance of its duties and functions under the Law Reform and Development Commission Act, 1991. The Commission and Secretariat are housed on the 8<sup>th</sup> Floor, Sanlam Building, Windhoek. The working committee on this project consisted of the project officer Ms. R Ntinda; the Ministry of Health and Social Services supported by the former Chairperson of the Commission Ms. Yvonne Dausab and Commissioner A. Zender.

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**29 July 2020**

Mr Ben Nangombe  
Executive Director  
Ministry of Health and Social Services  
Private Bag 13198  
Windhoek

Dear Mr. Nangombe,

**RE: SUBMISSION OF THE REPORT ON THE MENTAL HEALTH BILL**

1. We are pleased to submit to your Ministry, the attached Report on the Mental Health Bill, which was approved by the Law Reform and Development Commission (LRDC) on the 15<sup>th</sup> of July 2020, for your attention.
2. The LRDC is aware of the urgency and importance of the Mental Health Bill, however the delay in finalizing the report was due to the nature and pace of law reform and development process which is admittedly frustratingly slow although it is important to ensure that full and effective consultations are conducted. The report incorporates input from public consultations and further targeted consultations with selected stakeholders. These included the Namibian Police, Office of the Prosecutor-General, the Judiciary, the Master of the High Court, and the Namibian Correctional Services.
3. We would like to thank you, the Executive Director and your team for the draft Bill and the valuable information provided by your Ministry during the process.
4. Please be assured that the Law Reform and Development Commission values the work of your Ministry and looks forward to continue to cooperate on this project and others in the future.

All official correspondence must be addressed to The Secretary

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## INTRODUCTION

The Law Reform and Development Commission (LRDC) is a statutory body established under section 2 of the Law Reform and Development Commission Act of 1991,<sup>1</sup> with the mandate to review all existing policy, legislation and institutions of Namibia, undertake research both domestically and in comparable jurisdictions and make recommendations for the repeal, amendment and development, where necessary. Law Reform involves an in-depth consultation process involving legal and social-legal research, which must reflect the views expressed and shared by the relevant stakeholders and the communities we consult. What processes the LRDC follows and how it conducts its research, the consultation and quality of reports it publishes is very important for law reform in this country.

Thus the process of law reform is long and vigorous. This is to ensure a quality report that will accompany a specific Bill. The normal stages of the law reform process involve stages such as the drafting of the Project Initiative Document. This document sets out the stages of the project, time frame, possible stakeholders, the business case, the financial and human resources. This is to be followed by the drafting of the Issues Paper and consultations with the relevant stakeholders are held. The comments and inputs collected during the consultations will inform the drafting of the Discussion/Working Paper. Further consultations may be held where necessary leading to the development of the final report.<sup>2</sup>

The LRDC undertook the Mental Health Bill Project upon the request of the Cabinet Committee on Legislation (CCL) in August 2018 to assist the Ministry of Health and Social Services with public consultations and to prepare a report, incorporating the views and lessons learned during the consultations. The issue to be interrogated by this project is a question of law. As a result of continued discrimination and stigmatisation due to out-dated mental health laws. The LRDC is suited to carry out this project in line with section 6 of the Law Reform and Development Commission Act that provides for the objects of the Commission.<sup>3</sup> The obstacle envisaged by the LRDC in undertaking this project within a limited timeframe is a possible conflict of views among stakeholders.

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<sup>1</sup> Law Reform and Development Commission Act, 1991 (Act No.29 of 1991).

<sup>2</sup> See the Law Reform and Developmental Commission Operations Manual for Law Reform.

<sup>3</sup> These include:

*(b) The consolidation or the codification of any branch of the law or the introduction of other measures aimed at making the law more readily accessible;*

*(dA) the enactment of laws to enhance respect for human rights as enshrined in the Namibian Constitution or to ensure compliance with international legal obligations;*

*(e) To advise the Minister in regard to any matter which the Minister may refer to it.*

Despite the policy, legal and institutional limitations and defects the number of persons with mental health-related disabilities is on the rise and will continue to grow. According to the Namibian Statistics Agency (NSA) Disability Report, a total of 636 persons were recorded in the first census of 1991. This number then drastically increased to 2571 in the 2001 national census, only to sky-rocket to 12 731 in the 2011 national census.<sup>4</sup> Out of the 12 731 persons, 6 772 are males and 5 959 are female.<sup>5</sup> About 27.9% are found in urban areas and 72.1% are found in rural areas all over Namibia, often far away from health services. Omusati region has the highest number of persons with mental health disabilities at 16.3%, while //karas has the lowest at 2.4%.<sup>6</sup> Arguably this may be a result of the general population sizes within the respective regions, as Omusati is home to a population of over 243 166 people and //karas is home to a population of only 77 421.<sup>7</sup>

furthermore, over 33.6% never attended schools and 44.2% had to leave school due to several circumstances.<sup>8</sup> The majority of persons with mental health issues and disabilities are unemployed and are often seen as a burden to others, as only 2 269 out of 12 731 are in some form of employment.<sup>9</sup> This leads to human rights violations<sup>10</sup> and abandonment by family members who in some cases just drop them at the mental health institutions. It is, however, not clear how many persons with mental health-related issues and disabilities have access to health care services. The proposed Bill seeks to ensure the protection of the rights and provision of mental health care to all Namibians with mental and intellectual disabilities.

## **SCOPE, METHODOLOGY AND LIMITATIONS**

The report focuses on the consultations held with the relevant stakeholders on the Mental Health Bill. The Bill specifically provides for the admission, care and treatment of persons who are suffering from mental or intellectual disorders; it sets out the procedures for admission to health facilities of persons who are mentally ill and for their discharge from such facilities; provides for the establishment of review boards to supervise the functions of mental health services and mental health facilities; provides for the powers and functions of review boards;

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<sup>4</sup> Namibia 2011 census disability report p13.

<sup>5</sup> Namibia 2011 census disability report p96.

<sup>6</sup> Namibia 2011 census disability report p14.

<sup>7</sup> Namibia 2011 population and housing census main report p26.

<sup>8</sup> Namibia 2011 census disability report p28.

<sup>9</sup> Namibia 2011 census disability report p42.

<sup>10</sup> In *Gawanas V Government of the Republic of Namibia* 2012 (2) NR 401 (SC) it was held that a person compulsorily detained in a mental institution was physically restrained and his or her right to freedom of movement had been taken away. He or she was subject to certain discipline enforced by the institution where he or she was detained. Therefore, compulsory incarceration in a mental institution where a person was mentally fit, did impair the liberty and dignity of a person. Accordingly, article 7 of the Constitution which protected individual liberty had to be broadly interpreted.

promotes and protects the rights of people with mental disabilities and provides for the care and administration of the property of mentally ill persons.<sup>11</sup>

The report will critically analyse, examine and research the stakeholder's comments and inputs gathered during consultations on the Mental Health Bill. It is intended to ensure language and text that is more inclusive and human rights-oriented and meets Namibia's international obligations in terms of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and other supporting international and regional legal instruments. The Bill shall not cover aspects covered by or falling under other pieces of legislation or administered by other institutions other than the Ministry of Health and Social Services. This is to avoid encroaching on the mandate of other Offices, Ministries and Agencies (OMAs). The Bill will however indicate and provide possible amendments to any other affected laws to ensure overall compliance and support for the objectives of the Bill.

The law reform process outlined above could not be fully complied with, as the Bill was referred to LRDC from CCL in its final stages. The Project Initiative Document (PID) was simply prepared as a guiding document on the route to be taken in the completion of the project. This was then followed by a request for written submissions from interested persons and stakeholder consultations were held at the Protea Hotel Conference Room on 17 – 18 October and 06 November 2018 at the Ministry of Health and Social Services Boardroom. The consultations were poorly attended and no apologies were received.<sup>12</sup> This could be attributed to various factors, however, the main factor is the fact that mental health is not an issue people are comfortable discussing but also there isn't sufficient awareness of the scope of its meaning. For instance, most people think of mental health issues limited to people that would otherwise be considered "crazy" whereas the variations affect many people including those in so-called important or well off positions.

The consultative workshop was opened officially by Ms. Juliet Kavetuna, Deputy Minister of Health and Social Services, followed by remarks by Ms. Yvonne Dausab, Chairperson of the Law Reform and Development Commission. In her address, the Chairperson welcomed all the stakeholders and pointed out the importance of public consultations as they are the channel through which the public can get fully involved in the law-making and reforming process. She further pointed out the importance of a mentally healthy workforce. Depression is one of the most common mental health issues, however as a result of continued discrimination and stigmatization associated with mental health issues, persons often avoid

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<sup>11</sup> See long title of the Bill.

<sup>12</sup> Annexure 1: Attendance Register.

seeking help. The Bill intends to bring about a paradigm shift that is human rights-based and will ensure the respect, promotion and protection of the rights of persons with mental health issues as provided for in the CRPD.

The Keynote address was delivered by Mrs. Alexia Manombe-Ncube, the Deputy Minister Office of the Vice President Disability Affairs. She stated that persons with mental health and psychosocial disabilities have long been side-lined and not afforded the same accessibility and participation in public affairs as a result of their limited legal capacity. They continue to face numerous challenges in accessing mental health services, education, employment, social protection and access to justice. The continued stigmatisation and discrimination lead to violations of economic, social and other rights and the denial of autonomy and legal capacity.

Consultations minutes were compiled and presented to the LRDC Commission and the Minister of Health and Social Services. A PowerPoint presentation was also prepared and presented to the Minister to brief him on the project leading to the drafting of this report. The Mental Health Bill process runs from 2008 to date. The responsible ministry cannot afford any more delays. Thus, the decision to proceed to the final report. During the compilation of the report, a few critical issues were identified. Such issues necessitated further targeted consultations with a few targeted stakeholders. Particularly with the Namibian Police,<sup>13</sup> the Correctional Service,<sup>14</sup> the Master of the High Court,<sup>15</sup> the Office of the Judiciary<sup>16</sup> and the Office of the Prosecutor-General.<sup>17</sup>

The report's introduction lays out the mandate and the role of the Law Reform and Development Commission, the project's terms of reference, the scope and limitations of the project and the methodology used to manage the Mental Health Bill Project. The historical context and the current position of mental health are discussed under the contextual framework of the report as it affects disability issues in the country. The report then clearly explains the issues that the proposed Bill addresses, the submissions on the specific content of the draft Bill, the recommendations on issues identified as contentious or requires improvement or addition and the discussions of the Bill made by the relevant stakeholders.

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<sup>13</sup> Targeted stakeholder consultation held on the 11<sup>th</sup> November 2019 with Commissioner George Mhoney at the Namibian Police Head Quarters. Written comments received 22 July 2020.

<sup>14</sup> Targeted stakeholder consultation held on the 5<sup>th</sup> November 2019 with Commissioner Mirjam Nampweya at her office.

<sup>15</sup> Targeted stakeholder consultation held on the 4<sup>th</sup> November 2019 at the Office of the Master of the High Court. Attendance Annexed at the end of the Report.

<sup>16</sup> Targeted stakeholder consultation held on the 24 October 2019 at the Office of the Judiciary. Attendance Annexed at the end of the Report.

<sup>17</sup> Targeted stakeholder consultation held on the 8<sup>th</sup> November 2019 with Prosecutor General Martha Imalwa at her office. Written comments were received on the 14 July 2020.

The international, regional and national law including other comparable foreign jurisdictions shall also be consulted during the discussion of the stakeholder's submissions. This exercise provides scope for learning from best international practice, identify the challenges of implementation, and ensure policy, legal or institutional frameworks relevant to mental health in Namibia to produce a Bill which is the best to promote, protect and fulfil the rights of persons with mental health issues. Finally, the proposed options for law reform, along with the main arguments for and against those options, as well as the LRDC's findings as informed by the stakeholder inputs are considered, concluding with the overall recommendations derived from those inputs and a clear distinction and discussion of laws that may be affected by the proposed law reform.

## **CONTEXTUAL FRAMEWORK**

The contextual framework shall provide a synopsis of the historical background on how Namibia has been governed through the Mental Health Act, 1973 (Act No. 18 of 1973) which the proposed Bill seeks to repeal. The current position shall provide an in-depth analysis of the current legal and institutional position relevant to the project.

### **i. Historical Context**

In 1884, Namibia became a German protectorate and a British Crown Colony to be known as South West Africa in 1890. Namibia then became a South African protectorate under the Peace Treaty of Versailles in 1919. In terms of the Treaty of Peace and the South West African Mandate Act<sup>18</sup> and the mandate and administration of South West Africa, the Governor-General of South Africa had legislative and executive powers over the South West Africa territory.<sup>19</sup> These two pieces of law coupled with the Proclamation of 1921<sup>20</sup> granted the Governor-General and the Administrator-General of South West Africa the power to apply South African legislation to South West Africa, and make new laws for the territory and its inhabitants. The Mental Health Act of 1973 was thus inherited in terms of section 1<sup>21</sup> and 78<sup>22</sup> of the same Act. Such existing pieces of legislation remained in force after Independence in terms of Article 140(1) of the Namibian Constitution<sup>23</sup> which provides that existing laws shall remain in force until repealed or amended by an Act of Parliament or declared unconstitutional

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<sup>18</sup> (Act No. 49 of 1919).

<sup>19</sup> Namibian Law Reform and Development Commission: LRDC 32; Discussion Paper on issues relating to Insolvency Act, 1936 (Act No 24 of 1936) February 2015 Windhoek at 8.

<sup>20</sup> (Proclamation 1 of 1921).

<sup>21</sup> Section 1 of the Mental Health Act of 1973 states that "Republic" to include "the territory of South West Africa".

<sup>22</sup> Section 78 of the Mental Health Act of 1973 states that "This Act and any amendment thereof shall apply also in the territory of South West Africa, including the Eastern Caprivi Zipfel."

<sup>23</sup> The Constitution of Namibia, 1990.

by a court of law. Article 140(2) further goes on to terminate any legislative or executive powers vested in the South African Government, such powers are deemed to be vested in the Republic of Namibia as a sovereign and independent state in terms of section 2(1) of the Recognition of Independence of Namibia Act, 1990 (Act No. 34 of 1990). The proposed Mental Health Bill seeks to address this out-dated remnant of the South African colonial regime to ensure the protection and promotion of the rights of persons with mental health-related disabilities in line with the letter and spirit of the Namibian Constitution and the current international human rights standards.

## **ii. The Current Position**

The Mental Health Act of 1973 which is currently operational is supported by the Mental Health Policy of 2005. The policy aims to attain a high standard of mental health and wellbeing of the Namibian population through comprehensive community-based services decentralised and integrated into the general health service. The Act and the Policy are further supported by the national disability and health care legal frameworks.

On the face of it, the policy and legislation could be seen as fairly comprehensive but it does not concern itself with individual rights. It is more focused on patient control, treatment and the welfare and safety of the society. This could be attributed to the fact that the Act is a product of the apartheid era where human rights were not the driving force behind actions. The interest of the patient was marginalised whereas there was a tendency to abuse the process of restraint, with no regard for the overall well-being of the person in a rehabilitative and caring manner.

The language, text and intention of the Act have been criticized for several issues. For example, these may include the fact that the Act only required a reasonable degree of suspicion to be institutionalized, leading to the denial of a person's freedom of movement and liberty due to institutionalization based on prejudice or vendetta as the patients do not have a significant right of appeal or representation. In this manner, mental disability was criminalised without due regard to the rights of persons. The Act does not promote personal autonomy, dignity or justice for individuals with mental health-related disabilities. Instead, it continues to ensure a paternalistic principle that allowed mentally ill persons to be alienated, stigmatised and discriminated against, segregated and disempowered.<sup>24</sup> Thus, there is a need for a new

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<sup>24</sup> Natalie Latoya McCrea 2010. An Analysis of South Africa's Mental Health Legislation <https://www.natlawreview.com/article/analysis-south-africa-s-mental-health-legislation> Accessed 19 June 2019.

human rights-based legislation, which ensures greater health care, promotion and protection of the rights of persons with mental health-related disabilities.

## STAKEHOLDER SUBMISSIONS

Undertaking public consultations is a constitutional requirement<sup>25</sup> which is an important part of our law-making process in general and the law reform process in particular. The stakeholders' inputs and comments collected through written submissions and during the stakeholders' consultative workshop on the proposed Mental Health Bill are discussed below.

### 1. The Long title

The Bill is based on the South African Mental Health Act No. 17 of 2002 with some amendments. In general, the Bill has a lot of inconsistency with the use of singular and plural in some headings. The long title needs to be re-worked. It should ensure that the language focuses on the person and not the disabilities, condition or illness. The term "living with disabilities" needs to be removed and replaced with "persons with disabilities" or "persons with mental illness". The term "persons with disabilities" is preferred first, because it is in line with current terminological preferences by the World Health Organisation (WHO)<sup>26</sup> and second, it focuses on the persons rather than the disability.<sup>27</sup> A distinction should be made between "intellectual disabilities" and "mental illness" and awareness should be raised across the board to prevent stigmatizing of mental health issues. In addition, stakeholders thought that the word 'or' should be replaced with 'and' to allow for more inclusivity.

### 2. Clause 1

2.1. Clause 1 of the Bill provides for definitions. The definition of the "age group" is confusing. If a person is 6, 12 or 18 years of age, they will fall into 2 categories. The overlapping of the age group should be changed. For this Bill, persons aged 18 and

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<sup>25</sup> See article 1(2) of the Namibian Constitution, which states that "All power shall vest in the people of Namibia who shall exercise their sovereignty through the democratic institutions of the State." This can be read with Article 95(k) that requires the state to encouragement of the mass of the population through education and other activities and through their organisations to influence Government policy by debating its decisions.

<sup>26</sup> Protecting the right to legal capacity in mental health and related services WHO Quality Rights training to act, unite and empower for mental health (pilot version). Geneva: World Health Organization; 2017 (WHO/MSD/MHP/17.5). Licence: CC BY-NC-SA 3.0 IGO. <https://apps.who.int/iris/bitstream/handle/10665/254805/WHO-MSD-MHP-17.5-eng.pdf;jsessionid=1BD15C8B8C86D1E4F5A5908F1BF40539?sequence=1> accessed 8 July 2019.

<sup>27</sup> See 2012. Human Rights. Yes 'Action and Advocacy on the Rights of Persons with Disabilities' Lord *et al*, page 14-16, University of Minnesota HRC.

older are considered an adult in line with the Child Care and Protection Act, 2015 (Act No. 3 of 2015).<sup>28</sup>

- 2.2. The definition of “**authorized prescriber**” allows general practitioners to prescribe medication to mental health patients which is a specialised practice and reserved for psychiatrists. This may be as a result of the lack of psychiatrists in Namibia and logistical implications. The type of medication that general practitioners may be allowed to prescribe should be provided for in regulations, the Bill or the Medicines and Related Substance Control Act, 2003 (Act No. 13 of 2003).
- 2.3. The “**community custodian**” and in particular, the functions of such a person, are not clearly defined. It is unclear if the functions listed in clause 43(3) are their only functions. Clarity is therefore required. Also, the word “**facility**” “**community-based mental health care**”; “**community-based healthcare facility**”; “**halfway house**” and “**Day-care**” should not be limiting. It was cautioned, however, that the word ‘facilities’ should also not be exhaustive. Clause 6<sup>29</sup> of the Bill is vague and is rendered unworkable if the criteria and requirements for licensing and monitoring are not provided for in the regulations in terms of clause 79(1)(j) of the Bill as community-based healthcare facility”; “halfway house” and “day-care” are not listed in Schedule 1 of the Hospital and Health Facilities Act No. 36 of 1994. The definition of a “community-based healthcare facility” already seems fairly open. Perhaps, the drafters<sup>30</sup> should include the phrase “or similar facility providing community-based mental health care” or borrow from other comparable jurisdictions. Zambia, for instance, defines “community mental health service” as mental health service within a community in terms of section 2 of the Mental Health Act 2019 (No. 6 of 2019).<sup>31</sup> The management of Bel Esprit believes<sup>32</sup> that the definition of **health facility** which includes private hospital/health facility is good and well, but the current status is that the grading of facilities is not indicated. They found that the Namibian Association of Medical Aid Funds (NAMAF) has no grading for health facilities. They are all regarded and graded the same, whether or

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<sup>28</sup> See section 10(1).

<sup>29</sup> Section 6 of the bill provides for Primary and community mental health care

(1) Organs of the State responsible for health services must ensure and regulate the provision of comprehensive, decentralised and community-based mental health care services, integrated into the existing health care system with emphasis on a primary health care approach that is accessible, equitable and affordable.

(2) Preference must be given to the least restrictive and intrusive form of mental health care if that is appropriate and possible.

<sup>30</sup> With reference to the drafting consultant.

<sup>31</sup> Zambian Mental Health Act 2019 (No. 6 of 2019).

<sup>32</sup> Input on the new Mental Health Bill from Bel Esprit Hospital received from verona@belesprit.com.na <verona@belesprit.com.na> Thu, Nov 22, 2018 at 12:55 PM.

not the facility function as a center or hospital. The current Bill clearly defined different facilities from day-care to halfway house and as such, each license holder will have to operate within its scope. However for a mental health hospital to admit voluntary and involuntary patients, it needs more nurses per patient, security services, isolation rooms, full psychiatric teams and more. Perhaps this should be improved in the Bill or its Regulations. Sections 2(1);<sup>33</sup> 2(3);<sup>34</sup> 3;<sup>35</sup> 23<sup>36</sup> and 25<sup>37</sup> of the Hospital and Health Facilities Act should be consulted.

- 2.4. The definition of “**court**” is problematic. It refers to the High Court in terms of section 1 of the High Court Act 16 of 1990, excluding magistrate courts. Most of the sections in the Bill relates to the lower courts. It is therefore recommended that the Bill follows the South African Mental Health Act that defines court as a court of law. This will include all courts applicable. Where the High Court is exclusively referred to, it should be covered with the definition of High Court in section 1 of the High Court Act 16 of 1990.
- 2.5. The definition of the **Namibian Constitution** does not make sense. The ‘Namibian Constitution’ is the proper name of the Constitution as provided in the Constitution itself. Article 148 that provides for the Short Title, states that the Constitution shall be called the Namibian Constitution. The phrase “the Constitution of the Republic of Namibia” does not appear at any place in the Namibian Constitution. This definition should, therefore, be deleted.

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<sup>33</sup> Section 2. (1) Of the Act states that the Minister may by notice in the Gazette, establish or close down a state hospital.

<sup>34</sup> Section 2 (3) of the Act provides that the Minister may -  
(a) establish state health facilities and related services in order to promote efficient health services;  
(b) prescribe the categories into which state health facilities shall be classified;  
(c) enter into an agreement with any Government or person for the supply of health services; and  
(d) determine the terms and conditions on which persons may make use of such state health facilities and related services.

<sup>35</sup> Section 3 of the Act provides for the taking over of private hospitals as state hospitals  
(1) The Minister may in the public interest, take over, acquire, purchase, lease or otherwise procure a private hospital as a state hospital subject to the payment of just compensation and to such terms and conditions as may be mutually agreed upon between the Minister and the owner of the hospital, and may thereafter conduct such hospital as a state hospital.  
(2) Where the owner of a private hospital gives written notice under subsection (2) of section 26 of his or her intention to close down a private hospital or part thereof or any service therein, the Minister may for such period as he or she may deem necessary and upon such terms and conditions as may be mutually agreed upon between the Minister and the owner of the hospital, take over such hospital, part thereof or service, as the case may be, and conduct it as a state hospital or service.  
(3) Where the terms and conditions referred to in subsection (1) and (2) cannot be mutually agreed upon, they shall be determined by arbitration under the Arbitration Act, 1965 (Act 42 of 1965).

<sup>36</sup> Section 23 of the Act makes provision for the registration of private hospitals.

<sup>37</sup> Section 25 of the Act provides for the register of private hospitals and private health facilities.

2.6. It was noted under the definition of “**curator**” that the Bill seems to establish and promote guardianship or allows for substituted decision-making<sup>38</sup> which is at odds with the CRPD that advocates for supported decision making.<sup>39</sup> If so, this will require not just a language reframing, but reconsideration about how legal capacity is enabled and supported instead of allowing for third parties to make decisions on someone’s behalf.<sup>40</sup> The Canadian Association for Community Living proposes the following provisions, as alternatives to put in laws like this instead of guardianship provisions:

- A legal right to support in decision-making and a corresponding obligation on the government to establish these supports;
- A legal prohibition on findings of ‘incapacity’, the imposition of substitute decision-making measures and detention, with a focus instead on human rights-compliant alternatives;
- A legal obligation to explore alternatives to substituted decision-making;
- A duty on ‘third parties’ (doctors, banks, coffee shops) to make accommodations (adjustments) to ensure that the person with a disability can exercise their autonomy, and have their decisions made with support as legally valid;
- A right to advocacy in the mental health system, and access to free and quality legal representation and
- A duty on Government to engage people with disabilities, their representative organisations and communities in developing and delivering supports.<sup>41</sup> Perhaps these alternatives can be interrogated on how they can be included in the Bill instead of a clear-cut curator provision.

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<sup>38</sup> Substitute decision making means that someone “stands in the shoes” of the person with the mental incapacity and tries to make the decision that the person would have made for themselves if they could still make that decision. See Making Decisions for Others > Substitute Decision Making. [http://www.opa.sa.gov.au/making\\_decisions\\_for\\_others/substitute\\_decision\\_making](http://www.opa.sa.gov.au/making_decisions_for_others/substitute_decision_making). Accessed 01 May 2020.

<sup>39</sup> Supported Decision-Making (SDM) is a series of relationships, practices, arrangements and agreements designed to assist an individual with a disability to make and communicate to others decisions about their life. See Support My Decision: A project of Disability Rights Maine. <http://supportmydecision.org/>. Accessed 30 April 2020.

<sup>40</sup> Realising supported decision making and advance planning - WHO Quality Rights training to act, unite and empower for mental health (pilot version). Geneva: World Health Organization; 2017 (WHO/MSD/MHP/17.8). Licence: CC BY-NC-SA 3.0 IGO. <https://apps.who.int/iris/bitstream/handle/10665/254808/WHO-MSD-MHP-17.8-eng.pdf?sequence=1> Accessed 8 July 2019.

<sup>41</sup> Michael Bach, March 26, 2014. Supported Decision Making Evolution of an idea and Canadian experience Canadian Association for Community Living. [http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=2ahUKEwjWqdOH1qfjAhXirHEKHf9ABdcQFjABegQIAxAC&url=http%3A%2F%2Fwww.bbi syr.edu%2Fnews\\_events%2Fnews%2F2014%2F03%2FBach.ppt&usq=AOvVaw1nanlIDYLKxRTh7Fz\\_5dzK](http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=2ahUKEwjWqdOH1qfjAhXirHEKHf9ABdcQFjABegQIAxAC&url=http%3A%2F%2Fwww.bbi syr.edu%2Fnews_events%2Fnews%2F2014%2F03%2FBach.ppt&usq=AOvVaw1nanlIDYLKxRTh7Fz_5dzK) Accessed 4 July 2019.

- 2.7. Regarding the definition of a **family member**,<sup>42</sup> the term 'lifetime partner' should be removed. It has been argued, however, that the term should be kept in the Bill to be inclusive of unmarried couples but could be defined within certain parameters (e.g., partner of more than 10 years). The term Life partner is politically controversial and is better left to the Cabinet Committee on Legislation to decide on. Paragraph (d) under this definition should be qualified for when such persons listed may provide consent. The term "guardian" or "Legal guardian" should be included in the definition of a family member. This is a result of the fact that the definition failed to include guardian to ensure the inclusivity of legal guardians of a child or person with psycho-social disabilities. Also, the drafters should additionally insert or include in paragraph (d) 'who has guardianship responsibilities of the person'. The definition also fails to make provision for the person's "major children" as they often have a responsibility for their parents and are part of the family unit. It is not clear as to what amounts to a 'significant relationship' in terms of this Bill. Finally, forms should be included in the regulations to be able to assess the nature of the relationship of the person to the patient as well as the ability to provide the necessary care to the patient. Similarly, all concerns raised with regards to the term family member should apply to the definition of the term "**interested party**".
- 2.8. The definition of "**free and informed consent**"<sup>43</sup> amounts to consent which was not coerced but voluntarily provided and that the patient was given sufficient information to make a decision. It was cautioned by the stakeholders that it should be clear as to whether free and informed consent applies to both voluntary patients and involuntary

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<sup>42</sup> The Child Care And Protection Act of 2015 (Act No. 3, 2015) defines "**family member**" in section 1 in relation to a child to mean -

- (a) a parent of the child;
- (b) any other person who has parental responsibilities and rights in respect of the child;
- (c) a grandparent, step-parent, brother, sister, uncle, aunt or cousin of the child; or
- (d) any other person with whom the child has developed a significant relationship, based on psychological or emotional attachment, which resembles a family relationship;

<sup>43</sup> It is not clear as to why "free" was added to informed consent. A comparative analysis indicates that most states only use "informed consent". For instance, Zambia in section 2 of the Mental Health Act (No. 6 of 2019) defines "informed consent" to mean consent obtained freely, without threats or improper inducements, after appropriate disclosure to the mental patient of adequate and clear information in a form and language understood by the mental patient on—(a) the diagnostic assessment; (b) the purpose, method, likely duration and expected benefit of the proposed treatment; (c) alternative modes of treatment, including those less intrusive; and (d) possible pain or discomfort, risks and side effects of the proposed treatment. In addition, Zambia goes on to further provide for "informed decision" which amounts to a decision by a mental health services user about a diagnostic or therapeutic procedure, based on choice, which requires the decision to be voluntary and that the mental patient has the capacity for choice, which rests on the following key elements: (a) possession of a set of values and goals for which the mental patient need to make a decision; (b) ability to understand information and communicate decisions; and (c) ability to reason and deliberate".

patients. It could be assumed that the debate between the stakeholders was on whether “involuntary patients” enjoy the same right to informed consent and is it possible? If all persons have the right to freedom from coercive treatment, would involuntary treatment without free and informed consent reach the threshold of torture?<sup>44</sup> Further research may be required to provide answers to these questions. The Bill should therefore not remove the common law’s presumption that all persons can consent until proven otherwise.<sup>45</sup> The onus is on the person asserting incapacity. And the fact of institutionalization should not alter the presumption of capacity. There should be NO blanket exceptions or exclusions from the right to informed consent. This at a minimum would prevent Namibia violating the duty of non-retrogression<sup>46</sup> in terms of the CRPD even if a fully-CRPD-compliant law is not finally enacted.

- 2.9. **“Intellectual disability’s”** definition should be compatible with international definitions of the same term. The reference to “various barriers” does not provide sufficient clarity of the meaning. For instance, the World Health Organisation International Statistical Classification of Diseases and Related Health Problems defines “mental retardation” (intellectual disability) as: “*A condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities.*”<sup>47</sup> While the WHO Regional Office for Europe says: *Intellectual disability means a significantly reduced ability to understand new or complex information and to learn and apply new skills (impaired intelligence).*

<sup>44</sup> Report: Office of the High Commissioner for Human Rights convened an expert meeting on “Freedom from torture, cruel, inhuman or degrading treatment or punishment and persons with disabilities” 2007. <https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=2ahUKEwit2bj29KfjAhV4URUIHRSawUQFjAAegQIAxAC&url=https%3A%2F%2Fwww2.ohchr.org%2Fenglish%2Fissues%2Fdisability%2Fdocs%2Ftorture%2Fseminartorturereportfinal.doc&usq=AOvVaw19d4ohSNJBifNoS4UO9Kw9> accessed 1 July 2019.

<sup>45</sup> Re T (An adult: Consent to Medical Treatment) [1992] 4 All ER 649

<sup>46</sup> The principle of non-retrogression prohibits measures that directly or indirectly lead to backward steps in the enjoyment of rights. The CRPD in Article 19 prohibits non-retrogression requires that States do not allocate any additional resources towards forms of residence or service provision that violate Article 19 and, specifically, do not create new institutions or increase investment in existing institutions, for example, through refurbishment. The principle of non-retrogression is immediately binding on States on ratification. See Mental Disability Advocacy Centre – OHCHR Comments on the draft General Comment on the right of persons with disabilities to live independently and be included in the community (article 19). 7 July 2017. [https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=2ahUKEwiC7dKcVp7IAhXpShUIHd1SAPYQFjAAegQIBBAC&url=https%3A%2F%2Fwww.ohchr.org%2FDocuments%2FHRBodies%2FCRPD%2FDGCArticle19%2FMentalDisabilityAdvocacyCentre.docx&usq=AOvVaw25lhovp-rJWCITqmeBu7Z\\_](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=2ahUKEwiC7dKcVp7IAhXpShUIHd1SAPYQFjAAegQIBBAC&url=https%3A%2F%2Fwww.ohchr.org%2FDocuments%2FHRBodies%2FCRPD%2FDGCArticle19%2FMentalDisabilityAdvocacyCentre.docx&usq=AOvVaw25lhovp-rJWCITqmeBu7Z_) Accessed 13 October 2019.

<sup>47</sup> International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10), 2016.

*This results in a reduced ability to cope independently (impaired social functioning), and begins before adulthood, with a lasting effect on development.* While societal barriers certainly add to the impact of intellectual disabilities, it is not clear that this should be part of the definition of the concept. Therefore, the definition of “**intellectual disability**” should be changed to mean “a condition involving a significant impairment”. This definition should focus on the systems and not the process leading to the condition as intellectual disability is linked to a developmental process.<sup>48</sup> It differs from other neuro-cognitive disorders. Finally, it was further suggested that the terms “**Profound**”, “**severe**” or “**moderate**” **intellectual disability**” should be removed from the definition and the Bill as a whole. The suggestion may not be advisable unless it is determined that this distinction assists with the provision of the nature and scope of services and interventions concerning the severity of the intellectual disability. This is drawn from the Western Cape Forum judgment<sup>49</sup> which unequivocally challenged the South African government on its apathy towards the need to protect the right to education of children with profound and severe intellectual disabilities as their needs may require. Removal of such distinction may not cater to the specific needs of all persons with intellectual disabilities.

- 2.10. The legal guardian referred to under the definition of “**interested party**” should also include legal guardians appointed by any court order, such as under section 101 of the Child Care and Protection Act of 2015. Clarity was provided by the Mental Health Unit on “**involuntary mental health care**” as a patient who, because of his or her condition is unable to make a decision and who is a threat to himself or herself and therefore urgently requires mental health care.<sup>50</sup> The criteria to identify such patients are provided in clause 29 of the Bill. The language and text of the Bill must support the general principles that are set out in the CRPD and other supportive international and regional instruments on the rights of persons with disabilities. The letter and spirit of the Bill should not deprive any person of rights the person would otherwise have based on a person’s actual or perceived impairment. This is prohibited under human rights

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<sup>48</sup> Definition: intellectual disability. WHO Europe: <http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/news/news/2010/15/childrens-right-tofamily-life/definition-intellectual-disability> Accessed 21 June 2019.

<sup>49</sup> Western Cape Forum for Intellectual Disability v Government of the Republic of South Africa 2011 5 SA 87 (WCC) (Western Cape Forum).

<sup>50</sup> This definition is somewhat similar to the definition of “involuntary admission” under section 2 of the Zambian Mental Health Act (No. 6 of 2019) which amounts to the detention and provision of mental health services to a mental patient who (a) is incapable of making an informed decision due to their mental health status; or (b) unreasonably withholds or refuses to give informed consent but requires those services for that person’s own protection or for the protection of others”.

law and is considered arbitrary detention because it is discriminatory.<sup>51</sup> The UN Special Rapporteur on Torture stated that “deprivation of liberty” encompasses “any form of detention, imprisonment, institutionalization or custody of a person in a public or private institution which that person is not permitted to leave at will. This category of persons includes those persons who are under the custody and supervision of certain institutions, such as psychiatric hospitals and any other similar institutions, the purpose of which is to deprive persons of their liberty”.<sup>52</sup> The Ministry of Health and Social Services should, therefore, be able to provide reasons to defend involuntary mental health care in terms of this Bill as it will be later questioned during Namibia’s Universal Peer Review or by any treaty body as a violation.

2.11. The definition of “**judge**” should specifically indicate a judge of the High Court. The term “**mental disability**” as in the case of “intellectual disability”, should be examined for consistency with the latest international definitions. UNICEF, in its correspondence with the LRDC, indicated that the current definition places too much emphasis on the condition and does not conform to current international standards. Stakeholders agreed to remove the second part of this definition from “...*person suffers from a disability...*” onward. At the national level, the concept of ‘disability’ has so many definitions, depending on what the specific law is addressing. It was suggested that the Guidelines on the Disability Grant, which is currently being developed by the Ministry of Health and Social Services, provide for different levels of disability and establish what disability is to aid in the prevention of abuse of the protection afforded to a person with a mental disability which is currently left to the discretion of a medical practitioner. The drafter should consult the WHO Quality Rights Initiative discussion on terminology.<sup>53</sup>

2.12. Referring to “**mental health care**” it was suggested that other definitions for “intellectual disability” in the Bill should be considered to avoid inadvertently removing protection afforded to such persons when changing the definition of “mental disability”

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<sup>51</sup> Committee on the Rights of Persons with Disabilities. Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities. The right to liberty and security of persons with disabilities. Adopted during the Committee’s 14th session, held in September 2015. <http://www.ohchr.org/Documents/HRBodies/CRPD/GC/GuidelinesArticle14.doc>. Accessed 27 June 2019.

<sup>52</sup> UN General Assembly, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez (A/68/295), August 9, 2013, para 27.

<sup>53</sup> Protecting the right to legal capacity in mental health and related services WHO Quality Rights training to act, unite and empower for mental health (pilot version). Geneva: World Health Organization; 2017 (WHO/MSD/MHP/17.5). Licence: CC BY-NC-SA 3.0 IGO. <https://apps.who.int/iris/bitstream/handle/10665/254805/WHO-MSD-MHP-17.5-eng.pdf;jsessionid=1BD15C8B8C86D1E4F5A5908F1BF40539?sequence=1> Accessed 8 July 2019.

as suggested. A distinction should be made between persons with mental illness and persons with intellectual disabilities as receiving different but equal treatment. However, it is not clear how protection of persons with intellectual disabilities would be removed from other definitions for “intellectual disability” in the Bill.

- 2.13. The definition of a “**mental health facility**” should mean a health facility. The drafter should use this term for consistency. Health facility is defined above as “any State hospital, State health facility, private hospital, private health facility or a health facility as defined in section 1 of the Hospitals and Health Facilities Act.<sup>54</sup> It is not clear if there will be criteria in regulations for such approvals as pointed out in Part (b) of the definition. This should be provided for. The words severe or profound should be removed from the definition of “**mental health status**”. It seems not necessary in this definition.
- 2.14. As stated above, the latest international criteria for **mental illness** should be compared. This definition should also clarify whether this Bill will include persons with drug and alcohol dependencies, especially if such dependencies lead to some form of disability. Compare para (c) of the definition of “patient” within the same Bill. Zambia’s definition of mental illness does not include persons with drug and alcohol dependencies. It merely focuses on a mental impairment or disability with evidence of an organic etiology.<sup>55</sup> The current definition of mental illness should perhaps avoid the inclusion of persons with drug and alcohol dependencies if such dependencies lead to some form of disability as there is no evidence of an organic etiology.
- 2.15. The definition of “**Minister**” should be included in the definitions clause and refer to the Minister of Health and Social Services. Reference to other Ministers should be specifically indicated in the relevant clauses with respect to their specific functions and mandates to avoid confusion. The stakeholders suggested that the definitions of “**inpatient**” and “**out-patient**” are confusing and are overlapping. A distinction is relevant where fees are charged, as outpatient fees are lower than inpatient fees. Also, outpatient needs to be changed to read “...for a continuous period of time as defined in the regulations or definition of the Bill.” The time period should also be provided in the regulations. In addition, the wording “four hours or less” must be altered to less than four hours. Otherwise in 4 hours, one is both an in-patient and an out-patient. As “in-patient” may mean a person who receives mental health care at a mental health facility for a continuous period of four hours or more. Guidance should be taken from

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<sup>54</sup> Hospitals and Health Facilities Act of 1994 (No. 36 of 1994).

<sup>55</sup> Section 2 of the Zambian Mental Health Act (No. 6 of 2019).

the Hospital and Health Facilities Act.<sup>56</sup> However, the Bill provides that in the event of any conflict arising between the provisions of this Act and any law other than the Constitution of the Republic of Namibia, the provisions of this Act prevail. This far-reaching provision makes it difficult for the nation to rely on the definition in the Hospital and Health Facilities Act.

- 2.16. The definition of “**primary mental health care**” was identified as too broad. Instead, this definition should indicate the care as a first point of contact which is consequently followed up with an assessment.
- 2.17. The definition for “**psychiatrist**” is very limited problematic. This definition, however, is derived from the Medical and Dental Act, 2004 (Act No.10 of 2004). Even if the Bill may amend the current definition, it is advised that it should remain in line with the section 31(1)(b) of the Medical and Dental Act read with regulation 4 annexure A issued in terms of that act unless such limited definition is inconsistent with international law. The 1973 Act requires a registered psychiatrist in terms of the relevant health laws. Section 79(12) of the Criminal Procedure Act No. 51 of 1977 refers to a registered psychiatrist. Thus the courts require a registered psychiatrist in terms of section 77(1) and 78(2) of the Criminal Procedure Act. Other professions also referred to under the Bill need to be registered in terms of their relevant laws. Such as the social workers and psychology in terms of section 1 Social Workers and Psychology Act (Act No 6 of 2004).
- 2.18. The definition of “**State Patient**” should be reconsidered as the same term is used to refer to people who receive ordinary medical care at state-funded facilities (as opposed to private patients). It is advisable to follow the South African Mental Health Act definition that defines it “as a person so classified in an order by any court of law in terms of section 77(6) and 78(6) of the Criminal Procedure Act.<sup>57</sup> The current term is “State President’s decision patient”,<sup>58</sup> or “President’s patient” in terms of section 77(6) and 78(6) of the Criminal Procedure Act.<sup>59</sup> The Mental Health Bill does not refer to the

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<sup>56</sup> The Act in section 1 defines “in-patient” to mean a person who receives treatment at a hospital or health facility for a continuous period of longer than four hours; and “out-patient” to mean a person who receives treatment at a hospital or health facility for a continuous period of four hours or less.

<sup>57</sup> Hereinafter referred to as CPA.

<sup>58</sup> The term is not defined in the Correctional Service Act, 2012. (Act No. 9 of 2012):

<sup>59</sup> In *Gawanas V Government of the Republic of Namibia* 2012 (2) NR 401 (SC), the appellant had been detained as a President’s patient in terms of s 77(6) of the Criminal Procedure Act 51 of 1977, read with chapter 3 of the Mental Health Act 18 of 1973. In 2002, the hospital board recommended that she be released. She was temporarily released for three months, but on her return she was not as well as when she had left the hospital. Later during 2002 she was again temporarily released. She returned in January 2003 and the resident psychiatrist recommended

wording in section 77(6) and 78(6) of the Criminal Procedure Act in its definition. Currently, to declare a patient as a State President's decision patient signification of the president is required in terms of section 77(6) and 78(6) of the Criminal Procedure Act. The Registrar of the High Court questioned as to the last time if ever that the State President visited the forensic patients and had personal interactions with his patients or attended to the personal needs of the SPDs. Some stakeholders echoed the same sentiments and pointed out that this term is not appropriate to the new approach. Perhaps they could be referred to as "Government patient", "Justice System patient". Zambia's approach could be of some guidance. Zambia refers to such a patient as "forensic mental patient" and defines it to mean a "person who is referred to a mental health facility by a court for assessment in order to determine whether or not that person is mentally fit to stand trial, or to be held criminally responsible for an offence".<sup>60</sup> The Judiciary pointed out that the term forensic patients' covers two types of patients. These are the observation patients sent in terms of section 79 of the CPA and the SPD patients that has been declared in terms of section 77(6) and 78(6) of the CPA. The National Correctional Service (NCS)<sup>61</sup> however believes that the term "State President Decision Patient (SPD) should only be used if the release is by the Head of State<sup>62</sup> and Forensic Mental Patient should only refer to those released by the Board.

- 2.19. It is not clear why the Bill does not contain a definition of the term "**this Act**" as contained in the 1973 Act.<sup>63</sup> Finally, the definition of "**treatment**" is vague and very wide leaving room for abuse. Stakeholders wondered whether 'combating' was an appropriate word to use. It was further suggested that a more apposite terminology such as "alleviating" should be used instead. The word "any medicine" and "health practitioner" contained in this definition are not defined in the Bill. some of the services

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her release. The hospital board made a recommendation which eventually reached the Minister of Justice on 24 June 2003. The minister averred that it was only the President who could order the release of the appellant, since that power had not been delegated to the minister. The appellant's release was ordered in December 2003.

<sup>60</sup> Section 2 of the Zambian Mental Health (No. 6 of 2019).

<sup>61</sup> Hereinafter referred to as NCS.

<sup>62</sup> According to *Jurgens V Prokureur-Generaal, Transvaal, En Andere* 1978 (1) Sa 556 (T), a President's patient can only be released in accordance with the provisions of section 29 of Act 18 of 1973 which deals fully with the procedure to be followed in regard to the release of a President's patient or his further detention as such. In accordance with this section a patient as contemplated by sub-section (1) cannot be released except on the authority of the State President after a recommendation of a Judge has been placed before him. Such recommendation can in turn only be made upon a written application which must be addressed to a Judge in Chambers by the official curator ad litem. The application is accompanied by the reports referred to in sub-section (1) (b), which must comply with the requirements of sub-section (1) (c). In terms of sub-section (1) (d) a Judge may call for such further information as he may consider necessary and may summon any psychiatrist to his assistance.

<sup>63</sup> Which states that "this Act" includes the regulations.

included under (c) and (h) of this definition are a copy from “treatment” in the context of general hospitals<sup>64</sup> in terms of the Hospital and Health Facilities Act. Finally, the term ‘**least restrictive form of treatment**’ under this Bill should perhaps be included and defined in clause 1 of the Bill.

### 3. Clause 2 and 4

- 3.1. The main objectives and application of the Bill are provided for in clause 2. The issue of family members and interested persons discussed under clause 1 above must be considered under clause 2(1) (b). The term “relatives” referred to in clause 2(1) (a) (iii) should be replaced with “family member” which is defined in the Bill. The meaning of property in clause 2(1) (d) should be clarified in relation to the definition of “property” for purposes of Part 8 of the Bill. The Prosecutor-General argued that clause 2(3) will severely affect a lot of laws. Other stakeholders, however, suggested that, instead, this provision should state “whichever law is most favourable to the patient”.
- 3.2. Clause 4 ensures the provision of mental health care at health facilities. The clause is highly confusing since the sub-clauses seem to be a mixture of provisions about health facilities, mental health facilities and general rules that apply to mental health services at any facility. Clause 4(1) is noble but ambitious. While (a) includes the *caveat* of “insofar as reasonably possible”, (b) indicates that the entire list of services “must” be satisfied by referrals if they cannot be provided by the health facility itself. This may not be practically feasible given the distances to the nearest mental health facilities in Namibia. The Prosecutor-General recommends that the services<sup>65</sup> listed under clause 4(1)(a) must be addressed in the regulations and not in the Bill as they are too wide. Clause 4(2)(e) should read “person referred by any court” and not “person referred by the court of any court”.
- 3.3. Clause 4(4) is not clear, making it difficult to enforce compliance. The discussion of ‘who amounts to a family member and interested party’ under clause 1 similarly applies to clause 4(5). The inclusion of “voluntary patients” in the process itself was considered a good thing by some stakeholders. However, some thought that this may seem to be inappropriate as voluntary patients have the capacity to make their own decisions. Mandatory involvement of others would be appropriate only for assisted and involuntary patients. Concerning clause 4(7), it was agreed that the institutionalisation

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<sup>64</sup> Not mental health hospitals.

<sup>65</sup> Such as educational activities, vocational training, leisure and recreational activities, housing, after care and reintegration, social welfare, social development services, services addressing religious and cultural needs in the least restrictive environment.

of children with mental disabilities should be a last resort after all other alternatives have been exhausted. This complies with section 9<sup>66</sup> of the Child Care and Protection Act, which makes provision for children with disabilities.

- 3.4. In addition, article 23 of the CRPD says that in cases where the immediate family is unable to care for a child with a disability, governments are required to “undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting.” This should, therefore, be considered before the “institutionalisation” of the child. The Committee on the Rights of the Child also recommends for de-institutionalisation. It called on State parties to establish programs to de-institutionalize children with disabilities and return them to their biological or extended families or place them in foster care, (guardianship) and to provide children’s families with the systematic support they may need to include children into their homes.<sup>67</sup>
- 3.5. The phrase “persons suffering from” in section 4(8) should be changed to “persons with” instead. It is preferred that focus is first directed to a person as a human being before their conditions. Practical problems could arise concerning clause 4(9) (b) should more women than men require beds or *vice versa*. Perhaps change to “space available per patient”. Stakeholders also questioned if interested parties themselves should care for the mental health care user in the community-based facility as stated in clause 4(10), or can they arrange for care by another person? No response was provided and no similar position could be determined upon further comparative research with other jurisdictions.

#### 4. Clause 5

- 4.1. Clause 5 of the Bill makes provisions for “the powers and scope of functions of a mental health facility other than State hospital or State health facility relating to mental health care.” It is not clear as to what the purpose of clause 5 is. It seems to give powers to

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<sup>66</sup> Section 9 provides that:  
(1) Every person, authority, institution or body must treat a child with disabilities in a manner which respects the child’s dignity.  
(2) A child with disabilities is entitled to appropriate care and protection and must have effective access, insofar as reasonably possible and in the best interests of the child, to inclusive and non-discriminatory education, training, health care services, support services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to enabling the child to achieve the fullest possible social integration and individual development, ensuring his or her dignity and promoting his or her self-reliance and active participation in the community.

<sup>67</sup> Convention on the Rights of the Child. General Comment No. 9: The rights of children with disabilities. Geneva: United Nations Committee on the Rights of the Child; 2006; para 49.

certain institutions to keep patients, such as private institutions for civil patients and involuntary patients if authorised by a court. The minister only has a statutory duty in terms of clause 39 of the Bill to designate a health facility that may admit, observe and provide mental health care to state patients and accused referred in terms of section 77(1) and 78(2) of the Criminal Procedure Act. If read with clause 5, the minister's statutory duty is vague as no specific time period is stipulated within which the minister should make such designation.<sup>68</sup> The Prosecutor-General pointed out that nothing is stated in clause 39 regarding any duty on the minister to designate a state hospital or other health facilities for the “dangerous mentally ill persons”. Section 5 and 41 of the South African Mental Health Act may be of some guidance.

- 4.2. It was advised by the Judiciary that forensic patients in terms of section 77-78 of the CPA should be excluded. Also, it may be ambiguous to put the courts in clause 5 as the Bill seems to do away with the powers of the court. In terms of clause 5(c) read with clause 30, authorisation is not made by the court but by the Head of the health facility who is a medical doctor. The distinction was made between State facilities deriving their mandate from the Bill, which authorizes the head of such a facility to discharge an involuntary patient, and private facilities requiring a court order to ensure that they comply with the prescribed manner” which is not defined in the Bill. To ensure that an institution is conforming to the ‘prescribed manner’, the license<sup>69</sup> obtained by the hospitals should indicate whether they can provide for mental health services. These licenses are issued by the Minister of Health under the Health Facilities Act of 1994. An issue was also raised with the phrase “registered for that purpose”. It is thus advised that such “registration for that purpose” should be in line with the Health Facilities Act.
- 4.3. Stakeholders were referred to clause 1 on definitions on the distinction between “assisted patients” and “voluntary patients” as per the required clarification. The distinction between patients and their attached consequences may depend on the given circumstances of a country. This is particularly given that the Committee on the Rights of Persons with Disabilities has been very explicit in calling for the prohibition of disability-based detention. The Committee’s position is that community living, with support should no longer only be seen as a favourable policy development but an internationally recognized right. In this regard, the CRPDs approach is to forbid

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<sup>68</sup> The South African Mental Health Act states that such designation must be done within 120 days of the coming into operation of the Act.

<sup>69</sup> The Bill does not indicate what type of license it would be.

deprivation of liberty based on the existence of any disability, including mental or intellectual, as discriminatory.”<sup>70</sup>

## 5. Clause 6

- 5.1. The Bill provides for primary and community-based mental health care under clause 6. Clause 6(1)<sup>71</sup> is a noble goal. It is however very vague as a legal requirement and may lead to different interpretations. The stakeholders enquired as to what amounts to “least restrictive and intrusive” in clause 6(2). It was suggested that the drafters use the term “non-intrusive” instead. However, no definition of “non-intrusive” was provided.
- 5.2. It is assumed that the use of “intrusive or restrictive treatments” is done based on being non-consensual. This is contrary to human rights standards set out for mental health service users and persons with mental and psychosocial disabilities. Article 25(d) of the CRPD requires healthcare services to make provision for the care of the same quality to persons with disabilities as it does to everyone else based on free and informed consent. The UN Special Rapporteur on Health reaffirms this view and stated that guaranteeing informed consent is a fundamental feature of respecting an individual’s autonomy, self-determination and human dignity in an appropriate continuum of voluntary health care services.<sup>72</sup> Similarly, the UN Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment also stated that it is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions, as it may lead to other non-consensual treatment.<sup>73</sup> The provision for involuntary patients is therefore potentially problematic and should be subjected to further discussion, perhaps at the level of the responsible line ministry and the Cabinet Committee on Legislation.

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<sup>70</sup> UN Human Rights Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 1 February 2013, A/HRC/22/53, available at: <https://www.refworld.org/docid/51136ae62.html> [accessed 2 July 2019] para 68

<sup>71</sup> Clause 6.(1) provides for “Organs of the State responsible for health services must ensure and regulate the provision of comprehensive, decentralised and community-based mental health care services, integrated into the existing health care system with emphasis on a primary health care approach that is accessible, equitable and affordable.”

<sup>72</sup> Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Rep. to the General Assembly (Main Focus: Right to Health and Informed Consent), para. 9, U.N. Doc. A/64/272 (Aug. 10, 2009).

<sup>73</sup> UN Human Rights Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 1 February 2013, A/HRC/22/53, available at: <https://www.refworld.org/docid/51136ae62.html> [accessed 2 July 2019] para 63

- 5.3. During the consultations on the Bill, it was proposed that “appropriate and possible” be removed from clause 6(2) as patients may risk not obtaining the necessary health care. In its defence, the Mental Health Care Unit considered the vastness of Namibia and the fact that mental health patients are generally accompanied by someone. This would result in the need for both such patients and accompanying persons to travel long distances to obtain the necessary care. It was further suggested that perhaps the word “possible” be removed and the word “appropriate” be retained. Although the section provides for the least restrictive and intrusive form of mental health care, the treatment provided must also be appropriate depending on the mental condition concerned.
- 5.4. Finally, community-based mental health facilities should be treated equivalent to those under part 5 of the Child Care and Protection Act 2015, to ensure that they are fully capable of housing, caring for and dealing with persons with mental health issues. This must be provided for either in the Bill or the regulations. Strict requirements are required to ensure that these vulnerable persons are protected from sexual abuse, human trafficking, etc. These community-based care institutions should be regulated and registered with a body that will monitor their compliance.

## **6. Clause 7 and 8**

- 6.1. The promotion of mental health is recognized and provided for in clause 7 of the Bill. Stakeholders suggested that this clause be more specific to identify persons such as the police who as part of their statutory and operational mandate may deal with persons with mental health issues. This may occur when they are called to respond to a public disturbance or domestic issue. In this regard, there is a need to identify areas where there is a lack of understanding of mental health issues. Furthermore, instead of leaving the promotion of mental health in the hands of policymakers, it would be more effective if hardwired into the law.
- 6.2. The counter-argument to 6.1 above was that it would be unwise to fully provide for the promotion of mental health in the Bill, but rather keep it as is and let it be further provided for in the directive or internal policy of the Ministry of Health and Social Services to ensure that relevant persons are trained. It was further pointed out that the use of the word “must” in this clause would still accomplish that goal since it would be an obligation of all health facilities and can otherwise be challenged.
- 6.3. Instead of medical staff, it is proposed that the term ‘Mental health care practitioners’ which includes social workers, psychologists, medical officers, nurses with mental

health training or background, Occupational therapists, etc. should be used where appropriate in the entire Bill.

- 6.4. Clause 8 makes provision for the respect for personal integrity, human dignity and privacy of mental health patients. Clarity was sought on the limits of doctor-patient confidentiality particularly as it relates to a subpoena of the doctor to testify in court. The response was that, as a general rule, doctor-patient confidentiality<sup>74</sup> applies except in very exceptional circumstances.<sup>75</sup> The exception to this rule is, for example in terms of section 77 of the Criminal Procedure Act No. 51 of 1977, where a doctor may be requested to testify as to whether an accused is fit to stand trial.
- 6.5. In *Bernstein v Bester*<sup>76</sup> the court held that the right to privacy extends to only those aspects where a legitimate expectation of privacy can be harboured. It is not clear how one balances institutionalisation and the right to privacy". Perhaps, since mental health patients are placed in a ward with other people, their privacy infringed upon. In that case, the same could be said for general admissions. It should be noted, however, that any differential guarantee of patient confidentiality in the context of mental healthcare services would likely amount to discrimination based on disability. The only permissible exceptions should be those applied to all persons without distinction based on mental or psychosocial disability.
- 6.6. According to the Mental Health Unit the purpose of requesting patients to meet visitors in a common area, as opposed to a private area, is to protect the patient or visitor from the patients who may be naked, behave aggressively and may cause harm. This is also to protect the identity of other patients. The issue of privacy is not only confined to the number of beds in a room but also extends to the right to own private property. It was pointed out that clothes provided to patients are marked as belonging to a specific ward and not to individual patients whose private belongings are returned to

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<sup>74</sup> Justice Boreham summarized the common law duty to respect confidentiality in *Hunter v Mann* [1974] QB 767 that 'the doctor is under a duty not to disclose, without the consent of his [or her] patient, information which he [or she], the doctor, has gained in his professional capacity, save in very exceptional circumstances'.

<sup>75</sup> In *W v Edgell* [1990] a paranoid schizophrenic, had been detained in a secure hospital for shooting and killing five people. Following refusal of his application for release his solicitors commissioned a report from Dr Edgell, an independent psychiatrist. Dr Edgell found that W had a long-standing and continued interest in home-made bombs, and concluded that W remained a threat to the public. Dr Edgell gave the medical director of the secure hospital and the Secretary of State a copy of his report, to facilitate W's continued treatment. W issued a writ against Dr Edgell seeking damages for breach of confidence. His claim was dismissed: 'A consultant psychiatrist who becomes aware, even during the course of a confidential relationship, of information which leads him to fear that [the decision to release W] may be made on the basis of inadequate information and with a real risk of consequent danger to the public is entitled to communicate his concerns to the responsible authorities.'

<sup>76</sup> *Bernstein v Bester* NO 1996 (2) SA 751 (CC).

the person that accompanied the patient. There is no scholarly consensus on whether it is possible or even desirable to define a universal right to privacy.<sup>77</sup> Privacy under Article 13 of the Namibian Constitution<sup>78</sup> is restricted to the home, correspondence and communication and does not seem to apply to admission wards.

## 7. Clause 9

- 7.1. Consent to mental health care and admission to health facilities is provided for under clause 9 of the Bill. Stakeholders suggested that clause 9(1) (a) should state “and/or to the admission” in the event that consent for both is required. This was clarified, however, by pointing out that the provision applies only to patients who are admitted either voluntarily, as the case in clause 9(1) (a) or with assistance or involuntarily as per clause 9(1) (d). A concern was raised that therapy should also be provided to persons on whom a patient has inflicted harm. Especially health care providers. Nurses are attacked daily and no counselling or therapy is provided.
- 7.2. With regard to clause 9(2)(b), a question on clarity was raised as to what would happen in the interim where an application for mental health care in terms of Part 5 of the Bill is made? Are patients released immediately? The response from the Mental Health Care Unit was that patients remain in the care of the health facility pending the outcomes of the application.

## 8. Clause 10

- 8.1. The Prosecutor-General is of the view that Clause 10(1) that provides that “a patient may not be discriminated against on the grounds of his or her mental health status”, is overbroad, unfair and unconstitutional. The clause further ventures in the field of medical schemes by referring to the Medical Aid Funds Act, 1995 (Act No. 23 of 1995) under 10(3) which deals with private medical aid funds. It is not clear whether NAMFISA was consulted before this provision was included in the Bill. The Bill fails to

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<sup>77</sup> Anna Jonsson Cornell Right to Privacy. Oxford Constitutional Law September 2016 <https://oxcon.oup.com/view/10.1093/law:mpeccol/law-mpeccol-e156>. Accessed 07 May 2020.

<sup>78</sup> Article 13 of the Namibian Constitution provides that:  
(1) *No persons shall be subject to interference with the privacy of their homes, correspondence or communications save as in accordance with law and as is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the protection of health or morals, for the prevention of disorder or crime or for the protection of the rights or freedoms of others.*  
(2) *Searches of the person or the homes of individuals shall only be justified:*  
(a) *where these are authorised by a competent judicial officer;*  
(b) *in cases where delay in obtaining such judicial authority carries with it the danger of prejudicing the objects of the search or the public interest, and such procedures as are prescribed by Act of Parliament to preclude abuse are properly satisfied.*

point out in its preamble, objectives of the Bill under clause 2 or in the definition of “interested party” that private medical aids are included under it. As such, matters pertaining to medical aid schemes should not be part of the Bill.<sup>79</sup> The wording contained in section 10 of the South African Mental Health act should serve as a better guide in drafting this clause.

- 8.2. On the other hand, most of the stakeholders felt that clause 10(3) is especially progressive as it prevents insurance companies from using mental health illness against persons with mental health and intellectual disability-related issues.<sup>80</sup> Regardless of how much Namibia wants to comply with international standards on mental health and human rights,<sup>81</sup> it can be expected that the insurance sector will contest this clause in courts. Especially, since they were not represented at the consultative workshop. Perhaps this should be addressed by CCL or brought before the Attorney-General for further guidance.
- 8.3. Stakeholders also questioned whether the amount of N\$ 200, 000 was a realistic reflection of the fine of what private persons and insurance companies could pay. The fine should be lower for an individual and higher for a medical aid fund or other institution. The suggestion was thus made to maintain the fee of N\$ 200, 000 for purposes of clause 10(4) relating to individuals and to change the fine amount in clause 10(5), relating to medical aid fund and other institutions, to N\$ 500,000.

## 9. Clause 11

- 9.1. The exploitation and abuse of persons with mental health and intellectual disability is prohibited in terms of clause 11. Stakeholders pointed out that clause 11(1) should be clear in that it is possible for a patient or someone acting on behalf of a patient unable to make decisions may give informed consent to medical or scientific experimentation such as trying a new drug or treatment which could help the patient. The Legal Assistance Centre suggested the following optional wording. Option 1: “A *patient may*

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<sup>79</sup> See section 44(1) Medical Aid Funds Act.

<sup>80</sup> The Supreme Court rejected an appeal in *Gibbs v. Battlefords and Dist. Co-operative Ltd.* (1996), 27 C.H.R.R. D/87 (S.C.C.) and found that “It is not fatal to a finding of discrimination that not all persons in the group bearing the relevant characteristic have been discriminated against. Discrimination against a sub-set of the group, in this case those with a mental disability, can be considered discrimination against persons with disabilities”.

<sup>81</sup> Article 12(5) of the CRPD would require Namibia to take “*appropriate and effective measures to ensure the equal rights of persons with disabilities to have equal access to other forms of financial credit*” which may include insurance services. Even if similar prohibitions have been accommodated in many countries in the context of conditions like HIV/AIDS, a prohibition on unfair discrimination does not preclude an insurer from considering someone’s health status per se but prohibits unfair discrimination on that basis.

*not be subjected to any torture or cruel, inhuman or degrading treatment or punishment, including but not limited to medical or scientific experimentation regarding a mental health problem or intellectual disability". And option 2: "Notwithstanding subsection (1)), a patient may provide free and informed consent for participation in appropriate experimental treatment or research, where such medical or scientific experimentation does not amount to torture or cruel, inhuman or degrading treatment or punishment".*

- 9.2. Clarity was sought on the distinction between the fine stated in clause 11(5) and 11(6). The distinction is that clause 11(5) refers to someone who subjects a patient to torture, cruel or inhuman treatment or who exploits such patient, subjects' patients to forced labour or uses mental health care to punish a patient or for the convenience of another person. While clause 11(6) refers to situations where a patient is subjected to unsafe and unsanitary conditions or where persons providing mental health care fail to report a suspicion of abuse against a patient.
- 9.3. Clause 11(5) may work for private facilities but not for State facilities as the State cannot bring a legal case against itself. Perhaps Namibia can borrow from the Canadian approach, where there is an independent commission that would bring legal actions against the State. Several facilities have a pre-screening process of persons providing mental health care as a preventative measure. It is however not clear whether, subject to availability of resources, the Bill could make such a pre-screening process a requirement at all State and private health facilities. Or, the Bill could establish a review board to oversee such employees at State facilities, with powers to receive complaints and take disciplinary action. This is especially important as Namibia does not have a register of sexual offenders. This could be a policy issue as it also applies to foreign persons who enter Namibia and provide mental health care. It was suggested that the standards of mental health facilities as well as the requirements of persons providing mental health care be incorporated into the regulations even if these issues are somewhat covered under clause 67.

## **10. Clause 12**

- 10.1. Clause 12 provides for the use of seclusion and restraint.<sup>82</sup> There is no definition in clause 1 of the Bill as to what constitutes "seclusion" and 'restraint". Stakeholders wanted to know whether the seclusion and restraint of a patient should be qualified in clause 12(2). This was also the concern of the WHO, as it even views chemical

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<sup>82</sup> It can be read with clause 79(1)(f).

restrains as a form of torture and is not an acceptable alternative.<sup>83</sup> However, according to the 1973 Mental Health Act, restraint referred to “mechanical restraint” and the use of restraint jackets. Restraint jackets are no longer used but the term restraint is retained since patients are required to be calm to administer medication on authorisation by a medical doctor. It was argued that, should any liberties be taken away, it should only be for the shortest period possible.

- 10.2. According to the UN Special Rapporteur on Torture, however, “any restraint on people with mental disabilities, even for a short period may constitute torture and ill-treatment.”<sup>84</sup> The UN Special Rapporteur on Torture further pointed out that “It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions. The environment of patient powerlessness and abusive treatment of persons with disabilities in which restraint and seclusion are used can lead to other non-consensual treatment, such as forced medication and electroshock procedures.”<sup>85</sup> It is therefore imperative that the term “restraint” is clear. Strict regulations, as well as the duration, manner and circumstances under which restraints may be used, should be hardwired in the Bill or regulations.
- 10.3. Referring to the methodology of restraint in clause 12(1) (b) as being “appropriate or proportionate”, it was noted that this provision may leave room for abuse. This suggests that a very violent patient would be met with equally violent restraint resulting in injury to the patient. It was suggested to rephrase the clause to state “where there is a need for restraint”. It must be conducted in a manner that is not harmful to the patient”. The restraint used should not be confused with the restraint used by the police who may have a different interpretation of “minimum force”.
- 10.4. Although the suggestion was made to include provisions in the Bill that pertain to the police in dealing with mental health patients, it was pointed out that it is unlikely that the police would not be able to distinguish between mental health and intellectual disability. Any training afforded to the police in this regard should become an inside directive between the Ministry of Health and Social Services and the Police. It was

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<sup>83</sup> WHO Quality Rights Initiative <https://apps.who.int/iris/bitstream/handle/10665/254809/WHO-MSD-MHP-17.9-eng.pdf?sequence=1> Accessed 5 May 2019.

<sup>84</sup> CAT/C/CAN/CO/6, para. 19 (d); ECHR, Bures v. Czech Republic, Application No. 37679/08 (2012), para. 132.

<sup>85</sup> UN Human Rights Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 1 February 2013, A/HRC/22/53, available at: <https://www.refworld.org/docid/51136ae62.html> para 63. Accessed 12 April 2019.

further suggested that female health practitioners should apply restraint on female patients and the same should apply to males. In practice, however, this suggested approach is not always possible.

## 11. Clause 13

- 11.1. The Bill prohibits sterilisation under clause 13. According to Article 23 of the CRPD, patients have the right to have a family as guaranteed under Article 14 of the Namibian Constitution and that the provision of clause 13 be deleted from the Bill. Clause 13 provides that sterilisation is not a treatment for mental illness or mental disability and involuntarily sterilisation of a patient may only be carried out under the Abortion and Sterilisation Act.<sup>86</sup> The stakeholders' disagreed on this point.
- 11.2. Some stakeholders pointed out that the relevant sections in the Abortion and Sterilisation Act that deal with, *inter alia*, sterilisation applicable to mental health patients should further be researched. The Abortion and Sterilisation Act is a contentious law, especially where disability and abortion are concerned. Section 3(1) of the Act allows for abortion when there is a risk that the child will be born with a physical or '*mental defect; seriously handicapped*'<sup>87</sup> or when the mother is unable to handle parental responsibilities as a result of a mental disability.<sup>88</sup> It violates article 10 of the CRPD on the right to life of persons with disabilities by making disability as a ground to allow abortion that places the negative duty on the State not to take someone's life<sup>89</sup> and a positive duty to protect someone's life<sup>90</sup> to respect, promote, protect and fulfil the right to life.<sup>91</sup> The right to life coupled with the right to dignity forms the bases upon which all the other rights can be claimed. Naldi argues that "maybe" the Namibian Constitution does not intend to protect unborn foetus unconditionally<sup>92</sup> it can perhaps be argued that Article 6 of the Namibian Constitution does not apply to unborn children. But who decides that a child's life, disability or not is unworthy to live?
- 11.3. Other stakeholders questioned whether referencing of the clause to the Abortion and Sterilisation Act, 1975 may not be abused. Both the UN Committee on the Rights of

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<sup>86</sup> 1975 (Act No. 2 of 1975).

<sup>87</sup> Abortion and Sterilisation Act, s3(1)(c).

<sup>88</sup> Abortion and Sterilization Act s3(1)(e). See Namibia. The Abortion and Sterilization Act (1975), as amended through Act 48 of 1982. <http://www.hsph.harvard.edu/population/abortion/NAMIBIA.abo.htm> (accessed 23 October 2013).

<sup>89</sup> S v Makwanyane 1995 (3) SA 391 (CC).

<sup>90</sup> Carmichele v Ministry of safety and security 2001 (4) SA 938 (CC).

<sup>91</sup> Ian C and De Waal J. 2009. The bill of rights handbook. Fifth edition. Juta, 285.

<sup>92</sup> Naldi, G. (1995). Constitutional Rights in Namibia: A Comparative Analysis with International Human Rights, Kenwyn, Juta & Co Ltd, 40.

Persons with Disabilities and the Special Rapporteur on torture stated that forced or non-consensual sterilization of persons with psychosocial or mental disabilities violates the prohibition clause of the Convention against Torture and Inhuman and Degrading Treatment.<sup>93</sup> The African Commission on Human and Peoples' Rights in its General Comment No. 4 also confirmed that forced sterilization is an act of sexual or gender-based violence that may amount to torture or inhuman treatment.<sup>94</sup> What is being proposed in clause 13 may not be forced sterilization per se, but it may not be consensual if the person with mental health issues may not understand the content of the document they sign in accordance with the Abortion and Sterilisation Act.

## 12. Clause 14

- 12.1. This clause provides for circumstances where it is necessary for the mental health practitioner to disclose information. The issue of disclosure was raised most prominently in labour issues. It was clarified that section 5(1) (e) of the Labour Act<sup>95</sup> provides for the protection of employees against discrimination on grounds of mental illness. This may be contradicted by sections in numerous laws that provide for termination of employment on mental and physical incapacity.<sup>96</sup> The same applies in the instance of, for example, application for sick leave where failure to keep such information confidential amounts to a breach of confidentiality of the doctor-patient relationship which falls primarily under the common-law, as supplemented by specific rules issued under the laws which govern doctors and other members of the health professions. In this respect, awareness should be raised.
- 12.2. It was pointed out that in the private sector, policies provide for the functionality of the duties of the employee and require disclosure of information which may affect the ability to perform such functions. This issue should be addressed as it is often used

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<sup>93</sup> UN Human Rights Council, The Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 1 February 2013, A/HRC/22/53, available at: <https://www.refworld.org/docid/51136ae62.html> [accessed 2 July 2019] see also See CRPD, General comment No. 3 on women and girls with disabilities (2016), para. 32; Report of the Special Rapporteur on torture and other cruel, inhumane or degrading treatment or punishment, 5 January 2016, UN Doc. A/HRC/ 31/57, para. 45.

<sup>94</sup> ACommHPR, General Comment No. 4 on the African Charter on Human and Peoples' Rights: The Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment (Article 5) (2017), para. 58.

<sup>95</sup> Labour Act (Act No. 15 of 2007).

<sup>96</sup> Such as the Namibia University of Science and Technology Act 7 of 2015. Section 10(3) provides that "the Minister may, on the recommendation of the Council, remove a member from office if the Minister is satisfied, after the member having been heard, that such member -  
(a) is incapacitated by physical or mental illness; or  
(b) is for whatever other valid reason incapable of efficiently performing his or her functions as member of the Council."

against persons even if they are capable of carrying out their duties. It was also pointed out that, although the Labour Act prohibits discrimination based on mental illness, it does not distinguish between mental illness and intellectual disability. The Bill should make provision for when a patient is considered not to be “of sound mind” and therefore unfit to perform his or her duties. The mental health practitioners agreed that for as long as patients are taking their medication, then they are considered to be of sound mind.

- 12.3. Also, stakeholders questioned whether or not clause 14(4) will apply or make provision for disclosure to persons making decisions on behalf of patients who are unable to make decisions for themselves. Finally, criminalising a breach of doctor-patient confidentiality is worrisome in a country where mental health workers are limited. A three-year prison sentence seems too excessive for such an offense. For comparison, in the United States of America, the law generally just gives the aggrieved patient a cause of action against the doctor which allows them to sue for damages, as is currently done in Namibia.

### **13. Clause 15, 16, and 18**

- 13.1. The Bill limits intimate adult relationships under clause 15 as far as it is relevant to the objectives of this Bill. The aspirations of this clause are good, but its application may be problematic. The stakeholders suggested that the term “may” should be changed to “must”. However, this may also put a massive amount of responsibility on the health facility. Including something along the lines of “if it comes to the attention of the facility” would help curb any unwanted negative consequences from using “must.” Furthermore, the word “ability” in the last sentence of this clause should maybe be replaced with the term “capacity”.
- 13.2. The Judiciary pointed out that in terms of clause 16, most persons with mental health may not afford legal representation. The Legal Aid Act (Act No. 29 of 1990) should be amended to compel legal aid services to provide legal aid for persons with psychosocial disabilities on a mandatory basis with no minimum contribution required.<sup>97</sup> This will ensure compliance with Article 12(3) of the CRPD which provides that “*States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity*” and equal

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<sup>97</sup> In *Purohit and Moore v The Gambia* (2003) AHRLR 96 (ACHPR 2003) it was held that persons with mental disabilities were vulnerable and without legal aid they could not access justice to defend their rights and hence the state must take all necessary measures to ensure that their decisions made on their behalf go through checks and balances and where they have issues legal aid is availed to them.

recognition before the law.<sup>98</sup> Clause 18(1) (a) should be amended to read “patients who are” or “a patient who is”. Finally, clause 19 makes provisions for the determinations concerning mental health status. The clause should contain a provision as to the required contents of the psychiatric report to be compiled in terms of section 79 of the Criminal Procedure Act. Such requirements are listed in the Regulations of the 1973 Act.

#### **14. Clause 20**

- 14.1. Clause 20 provides for the establishment and constitution of the Review Boards. There was a concern raised during the consultations on the phrase “medical practitioner with interest in mental health”. It was suggested that this clause refers to a psychiatrist to prevent the specialization from being watered down. This would uphold a standard and provide value addition. Only where a psychiatrist does not exist should reference be made to “medical practitioner with interest in mental health”. It is however not advisable to delegate powers or allocate duties to a person who does not hold the same qualification. If it is a psychiatrist, only delegate to or use a psychiatrist. The state should plan on how to address such a lack of required skill set. It is also not clear as to why the Bill is placing so many obligations and functions on the head of the facility or the psychiatrist if it may not be possible to control the amount of personnel available.
- 14.2. A proposal was made to change sub-clause 1 and 3(b) from “three members” to “seven members” to reflect the different professions, namely: a lawyer, a doctor, a nurse, a psychologist and a social worker. The two other members, who would be alternative members to the Review Board, should be a representative from the National Disability Council of Namibia (NDCN) or a community leader and someone from the National Correctional Service (NCS). Care should be taken not to create a group that is too large as it may lead to quorum issues.
- 14.3. The Prosecutor-General recommended that all members of the Review Board should be Namibian under clause 20(2). Furthermore, the conditions of the removal of a member of the review board should be stricter. Regarding sub-clause 7(b), a proposal was made to distinguish between “temporary” and “permanent” medical illnesses of a board member. A question was raised by several stakeholders as to whether the Review Board would not slowing down progress. The response was that the Minister may establish a Review Board at each mental facility and, therefore, this would not slow down progress. However, if the Ministry must implement what is insinuated in

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<sup>98</sup> See Article 12 of the CRPD which provides for equal recognition before the law.

clause 4, then there will be a situation where every facility in the country would need a Review Board. This may not be practically feasible. Finally, the term '*suitably-qualified*' should be added to "any person" under clause 20(8).

## 15. Clause 21

- 15.1. Clause 21 makes provision for the powers and functions of the Review Board. This clause is not linked to other sections of the Bill which refer to Review Boards such as clause 9(2) (a) on notification of certain admissions and clause 12(5) on seclusions or restraints. The Legal Assistance Centre (LAC)<sup>99</sup> therefore proposes that these clauses should both be incorporated in this clause, to clarify the Review Board's role when it is notified of such admissions and seclusions or restraints.
- 15.2. A proposal was made to have more than one unannounced visit by the Review Board. In response, it was pointed out that the Bill at clause 21(1) states "at least" thereby making provision for more than one visit. In terms of clause 21(1) (e), one of the functions of the review board is to considers complaints from the patients. It is the Prosecutor-General's opinion that the review board must inform the official curator ad litem of such complaints and the outcomes of their internal investigations. Also, there should be provisions to enable the review board to impose sanctions<sup>100</sup> and to report a crime or suspicion of a crime to the Namibian police.
- 15.3. Currently, in terms of the Correctional Service Act (Act No 9 of 2012),<sup>101</sup> a judge of the High Court needs to visit correctional facilities at regular intervals and compile a report

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<sup>99</sup> Hereafter referred to as LAC.

<sup>100</sup> Such as withdrawing accreditation, imposing penalties or closing facilities that persistently violate human rights.

<sup>101</sup> See Correctional Service Act (Act No 9 of 2012)

"Section 122. (1) For the purposes of this Act, the following persons are visiting justices ex-officio, namely -

(a) a Judge of the Supreme Court of Namibia or Judge of the High Court of Namibia, in respect of all correctional facilities in Namibia;

(g) a magistrate, in respect of all correctional facilities within his or her area of magisterial jurisdiction.

Section 123. (1) A visiting justice may at any time visit a correctional facility in respect of which he or she is a visiting justice, and may –

(a) subject to being at all times escorted by an appropriate correctional officer, inspect every part of the correctional facility and visit every offender in solitary confinement or in a separate cell;

(b) inspect and test the quality and quantity of food ordinarily served to offenders;

(c) inquire into any complaint or request made by an offender;

(d) ascertain as far as possible, whether the rules, standing orders and administrative directives issued under section 5(3) for such correctional facility are being observed;

(e) inspect any book, document, or record relating to the management, discipline and treatment of offenders; and

(f) perform such other functions as may be prescribed.

on what is going on there. The forensic mental health facilities in Windhoek and Oshakati seems to be excluded from the Correctional Service Act, which means the judges do not have the authority or the mandate to visit them. The Bill should, therefore, provide authorisation for the judges to inspect all mental health centers that keep forensic patients and any involuntary admissions including all institutions under clause 5 of the Bill. Some stakeholders questioned whether this will infringe the powers of the executor. In response, the Registrar argued that it has nothing to do with administration, it is merely a judicial oversight as the institutions are dealing with the status of a person.

- 15.4. In distinguishing between the role of the Prosecutor-General and Judiciary, it was indicated that the Review Board makes recommendations following which, either the Prosecutor-General's office discharges the inmates or the Judiciary discharges the State patients. Regarding clause 21(6), investigation of misconduct at private mental health facilities are made in terms of the Hospital and Health Facilities Act and the National Welfare Act (Act No. 79 of 1965). The term "or interested party" should be inserted immediately after the term "patient". Concerning clause 21(3), it was questioned as to why there is no definition of "health care facility", only "health facility"<sup>102</sup> or "mental health care facility". It is not clear which one applies. Since the Review Board visits the Windhoek State Mental Health Center, it is not clear if the Review Board will also be required to visit from time to time all other centers and the "community-based healthcare facilities" that receive patients from the health facility it is responsible for.
- 15.5. It is also not clear whether clause 21(6) (b) will apply if the complaint concerns someone who is neither a member of the public service nor a mental health care practitioner. For example a member of a contracted cleaning, security service, a maintenance person or a member of the public who was present at the facility. Perhaps the Bill should make provision for this.

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(2) On the completion of each visit, a visiting justice must enter in the visiting justices' book, to be kept by the officer in charge for that purpose, such remarks, suggestions and recommendations about his or her findings, as he or she may consider necessary for the attention of the Commissioner-General.

(3) The officer in charge must, as soon as is practicable, in writing notify the Commissioner-General of all remarks, suggestions and recommendations entered into the visiting justices' book by a visiting justice.

<sup>102</sup> Also defined in section 1 of the Hospitals and Health Facilities Act 36 of 1994 to mean a health facility referred to in section 30 and includes a state health facility and a private health facility.

## 16. Clause 25 and 26

- 16.1. The discharge of voluntary patients is provided for in clause 25. The 72 hours in clause 25(1) seems to be long for a voluntary patient to be released. Perhaps the wording of 'discharged without delay' in clause 28(3) could also be used here. Any voluntary patient mature enough to make the request should be able to do so in line with clause 25(3). The Bill, especially clause 26(1) (c) (ii)) should comply with section 220 of the Child Care and Protection Act.<sup>103</sup>
- 16.2. Also, the term "valid reasons" should be replaced with "medical evidence" which is more objective, the same applies to clause 26. A comparison of clause 30(13)-(14) and clause 26 is needed to ensure clarity, as it is not clear as to the application of these sub clauses. Clause 26(2) seems misplaced since sub clause (1) does not refer to discharge. It repeats clause 25(4) and should be deleted.
- 16.3. It should be cautioned that the procedure for admission into health facilities is open for abuse. Especially since the person who decides on the application for admission need not be medically trained.<sup>104</sup> There is no requirement that the applicant must have seen the assisted patient within a short stipulated time before making the application.<sup>105</sup> There is no requirement that the head of the health facility must upon receipt of the application for admission cause the assisted patient to be examined by a medical practitioner before deciding whether to admit the patient.<sup>106</sup> There is no appeal procedure in the Bill to appeal against the decision of the head of the health facility on assisted mental health care. There is no statutory duty on the Review Board to review the decision of the head of the facility to admit or not admit the assisted patient. There is no requirement for compulsory periodic review and annual reports to be provided to the review board to monitor the detention and treatment of assisted patients. As such, there is practically no checks and balances.<sup>107</sup>

## 17. Clause 27, 28 and 29

- 17.1. Clause 27(1) refers to an application made in terms of clause 26(1). Both clauses do not refer to the courts and the application will be made to the head of the mental health

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<sup>103</sup> Section 220 makes provision for consent to medical intervention and surgical operations Child Care and Protection Act No. 3 of 2015.

<sup>104</sup> See definition of a "head of a health facility" as a person who manages a health facility or any employee of any facility who is authorised by that person to perform or carry out any power or function of the person. This would have been different had the bill followed the definition in section 1 of the Hospital and Health faculties Act of 1994.

<sup>105</sup> See section 27(1)(b) of the South African Mental Health Act of 2002.

<sup>106</sup> See section 27(4)(a) of the South African Mental Health Act of 2002.

<sup>107</sup> See section 28-31 of the South African Mental Health Act of 2002.

institution. The Bill seems to suggest that everything that is now being done by the magistrates in terms of the 1973 Mental Health Act, will be done by the head of the mental institution under the Bill. This will be troublesome, especially as to the binding nature of such decisions.

- 17.2. Comparing clause 27 with the procedure for appeals under clause 33, it would be sensible to harmonize the two provisions, as the provision on appeals appears to apply only to involuntary care. The rights of appeal, and appeals procedure, for decisions on assisted patients, need to be clarified. Since an assisted patient is someone who is not refusing care, appeals would presumably be required only concerning treatment decisions or the classification of the patient as an assisted patient. Also, replace the term “reason” with “evidence in clause 28.
- 17.3. The phrase “*and the head of the health facility is satisfied that the patient has recovered and has the capacity to make informed decisions*” in clause 28(3) is inconsistent with the definition of “assisted mental health care”.<sup>108</sup> It seems that the proper procedure in such circumstances would be either to discharge the patient or to use the procedure for involuntary mental health care.
- 17.4. With necessary modification, the changes applicable to clause 25 also apply to clause 28(4) and 29. Harmonise clause 29(d) or any other provision in the Bill with similar wording with section 220 of the Child Care and Protection Act. Also, the procedure for the admission of involuntary patients could be open for abuse. Finally, discussions on involuntary mental health care under clause 1 above apply fully to clause 29.

## **18. Clause 30 and 31**

- 18.1. Clause 30 provides for an application to obtain involuntary mental health care. The Bill gives the head of a health facility who needs not be medically or psychiatrically trained a choice or discretion in clause 30(5) and (6) whether to have the patient examined by 2 medical practitioners within 72 hours after receipt of the application for admission. Stakeholders requested that when a patient is involuntarily committed, that should be done by a psychiatrist. Referring to a mental health care practitioner may be good for the system, but may not be good for the rights of the patient. Also, the term “opinion” in clause 30(6), should be “medical opinion”.
- 18.2. The Bill must make provision to ensure that there is no conflict of interest pertaining to the medical practitioners who examine the involuntary patients before their admission.

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<sup>108</sup> Clause 1 Mental Health Bill.

The written findings that the two medical practitioners must provide to the head of a health facility in terms of clause 30(8), must certify that such medical practitioners are not prohibited law from providing the written findings. Clause 30(7) only provides for one instance of conflict of interest where a medical practitioner may not examine an involuntary patient. This is not enough and all circumstances must be listed in the Bill to avoid abuse of the law.<sup>109</sup>

- 18.3. The Police failed to see why clause 30(15)(b) apply to them and suggests that this clause be reworked. Also, no court is involved in clause 30. No healthcare worker should ever be entitled to make decisions about whether or not a human being has human rights.<sup>110</sup> The CRPD Committee stated that article 14 of the Convention<sup>111</sup> does not permit any exceptions whereby persons may be detained on the grounds of their actual or perceived impairment.<sup>112</sup>
- 18.4. Preliminary assessment and subsequent provision of further involuntary mental health care is provided for under clause 31 of the Bill. Clause 31(1)(b) refers to “within one week of admission”, however, the same section later refers to a ‘72 hours assessment period’ which is a copy of section 34 of the South African Mental Health Act of 2002. The justification for the “one week” period in clause 31(1) (b) was provided as a provision where a particular health facility does not have a psychiatrist available and patients are required to wait for a psychiatrist to travel to that health facility. Psychiatrists see patients twice a week, on Tuesdays and Thursdays, although a general period of one week is provided, the medical health practitioner could still see the patient within a shorter period. The one week period, which refers to seven calendar days at which point an assessment of the patient’s condition has to be conducted, was deemed reasonable.
- 18.5. The discrepancy of the period of “72 hour assessment period” in clause 31(3) (b) (i) and “24 hour assessment period” in clause 31(2) was further identified. The Mental Health Care Unit pointed out that the assessment period forms part of the “one week” in clause 31(1)(b) and “seven days” in clause 31(3)(b)(i). The Unit further pointed out that the “prescribed period” in clause 31(1) (b) referring to the 24 hours according to

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<sup>109</sup> See section 23 of the 1973 Act.

<sup>110</sup> See discussions under “involuntary institutionalization” in clause 1 as a human rights violation. Liberty and security of person.

<sup>111</sup> Liberty and security of person.

<sup>112</sup> Committee on the Rights of Persons with Disabilities Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities. The right to liberty and security of persons with disabilities Adopted during the Committee’s 14th session, held in September 2015.

<https://www.ohchr.org/Documents/HRBodies/CRPD/14thsession/GuidelinesOnArticle14.doc>  
Accessed 18 April 2018.

the regulations is confusing and must be rectified. Clause 31(8) must provide that if the Review Board decides to grants the heads request, it must submit the documents for consideration by a judge in chambers. There is no indication in the Bill as to the powers of the judges in chambers or the orders they may make in consideration of the decision of the Review Board.<sup>113</sup> Finally, the phrase “and/or interested party” should be inserted immediately after “applicant” throughout clause 31.

## **19. Clause 32 and 33**

- 19.1. Concerning periodic review and reports on involuntary patients under clause 32, stakeholders felt that three months, in terms of clause 32(1), is too long. A shorter period would be better. Unreasonable delay by a Review Board amounts to the infringement of the rights of the patient. In response, the Mental Health Care Unit argued that patients are not kept for three months but return home and are required to return three months periodically for a review. This is not clear in the Bill. It certainly reads that patients are kept for the whole three months.
- 19.2. It was further pointed out that the function of the Review Board under clause 32(6) may not be appropriate given that the review procedure does not require direct examination of the patient by anyone on the Review Board, aside from the authorisation to receive “information” from the patient under sub clause (4)(a).
- 19.3. It is not clear whether clause 33 on appeal against decisions of the head of a health facility on involuntary care, treatment and rehabilitation also applies to assisted care. Clause 27(4) on assisted care speaks about appeals but does not contain a procedure for appeals. If this procedure in clause 33 is applicable, it would seem more than what is required for an assisted patient, who can leave treatment voluntarily at any time.
- 19.4. It was further suggested that the “patient” should also be included in the list under clause 33(2) (b), as the patient may not be the appellant or the applicant. Regarding clause 33(4) (b) and clause 32(6), “without delay” is very vague and needs to be more specific. Also, the word “High” must be included before the word “Court” In clause 33(5). Finally, the Judiciary pointed out that clause 33(5) refers to “a review by a judge in chambers”. But nowhere in the Bill is reference made as to what the consideration of this review should be. Such considerations should be clearly stated in the Bill as in the current Act.

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<sup>113</sup> See also clause 33(5) of where the bill is also silent. The bill should contain a provisions similar to section 19(2) and (3) of Act 18 of 1973.

## 20. Clause 34, 35 and 36

- 20.1. Clause 34 provides for the need for further involuntary mental health care. The time period of 15 days to obtain a judge's decision was pointed out as potentially difficult by the Mental Health Care Unit. However, others argued that this should not be too difficult since the process does not require obtaining a slot on the court's roll. The 15 days in clause 34 should refer to "court days". It is however not clear whether involuntary care continues while the judge's decision is pending and why. Clarity may be required as this could be a possible legal issue that the courts may be faced with should the Bill become operational.
- 20.2. When viewed from a human rights perspective, from the point of application to the Review Board, the period afforded to the Review Board and then to the High Court can be anti-therapeutic and patients may suffer from anxiety due to long waiting periods. It would be ideal if patients awaiting a response to their application from the Review Board or High Court be moved to a separate ward. It should be noted that the Courts have their own directives.<sup>114</sup> Also, in human rights matters, there will always be competing interests and rights. It is therefore not advisable to rush a judge to make a decision that may end up being wrong and letting that patient to be a risk to society.
- 20.3. The phrase "further hospitalisation or confinement" in clause 34(c) (i) should be replaced with the phrase "in-patient care" for clarity. In terms of clause 35(1) (c), it is not clear as to what happens if a patient with recovered capacity consents to further care. Discharge should not be the only option. According to the LAC, if the involuntary mental health care user consents to further care, treatment and rehabilitation services under clause 24 applies. If the involuntary mental health care user is unwilling to continue with care, treatment and rehabilitation services, then discharge should be required.
- 20.4. Clause 35(2): states that "*notify the registrar of the court in writing of a discharge made in terms of this section.*" The Registrar of the High Court questioned<sup>115</sup> as to what she is expected to do with such notification. It is not clear what the purpose of this sub-clause is. Also, the phrase "reason to believe" in clause 36(2) should not substitute proactive monitoring of discharge conditions. While sub clause (1) should establish that the leave may include conditions. Clarity is required when comparing this clause

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<sup>114</sup> Guidelines for the submission of application to a judge in chambers in respect of President's patients in terms of section 29 of the Mental Health Act No. 18 of 1973.

<sup>115</sup> During the targeted stakeholders consultation with the Office of the Judiciary held 24 October 2019.

with clause 43(4) of the Bill, which makes provision for leave of absence from a designated health facility.

## **21. Clause 37 and 38**

- 21.1. Intervention by members of the Namibian Police Force is provided for in clause 37 of the Bill. A concern was raised that the police may misuse their powers as there are no time requirements in the Bill as to how long after their apprehension should the person be taken to a health facility or mental health facility for assessments. In practice, such a person may languish in a police cell for days before a vehicle is available to transport such person to a health facility.<sup>116</sup> Also, the Bill fails to provide the circumstances where a police officer should take a mentally ill person to a health facility.
- 21.2. Safeguards such as a short and strict time period for the assessment should be included, because this clause is potentially a situation that entails an extreme violation of individual rights under clause 37(1). Stakeholders suggested that social workers should be called in response to the public's call to assist persons with mental disability since they may be better qualified to know how much force to use in restraining persons with mental illness. Or, calling upon both a social worker and the police at the same time. However, issues on response time, the mandate of social workers and transportation may arise. Either way, the Bill should require comprehensive mandatory training for the police on handling mental health issues. Stakeholders failed to reach consensus on this, as the police are seen as the authority responsible for this role and not social workers. Stakeholders were reminded of the cross-cutting roles of the Ministry of Health and Social Services and the Police and cautioned that the mandates of these institutions should not be encroached upon. It was suggested that the use of "minimum force" by the police needs to be specific and that continuous awareness-raising was needed.
- 21.3. The phrase "assisted" patient under clause 37(5) is not logical given the definition of assisted care. The police in their submissions cautioned that the request by the head of the mental health facility in clause 37(5)(b) cannot be made to any member of the police, a formal request must be forwarded to the Station Commander within that district, with clear particulars, same apply to clause 37(6). Some stakeholders felt that this could lead to length bureaucracies. The police further submitted that clause 37(7)

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<sup>116</sup> Section 14(2) of the 1973 Act states that such apprehended person shall "forthwith" report the matter to the magistrate. Clause 37 can perhaps state that the apprehended person shall "forthwith" be taken to a health facility.

will depend on the availability of space within its holding cells to accommodate such a person, taking into consideration the person's mental health.

- 21.4. Finally, LAC believes that clause 38 on the balancing of rights is an example of a provision that might be misunderstood at first blush to require that State-funded care should be the same as privately-funded care if the term "State patient" is retained. This will however not be an issue of concern if private care provided by private institutions is similarly provided for in the Bill. Clarity needs to be provided as to who the "the State" is at clause 38(2). The 1973 Act referred to 'the organ of the State'.

## **22. Clause 40**

- 22.1. Clause 40 provides for the admission of State Patients to designated health facilities. According to the judiciary, there is a need for an automatic review of an order declaring someone an SPD under clause 40(1). In their submissions, the Office of the Prosecutor-General pointed out that it seems the curator ad litem in the Bill is the Attorney-General similar to the provisions of 1973 Act. However, in terms of article 141(2)<sup>117</sup> of the Namibian Constitution, this should be deemed to be a reference to the Prosecutor-General. There is no reason why the official curator ad litem should be the Attorney-General who is not even in charge of criminal justice system. As such section 40, 41 and 42 of the Bill requires the involvement of the Prosecutor-General and not the Attorney-General.
- 22.2. It is not clear as to whether the order stated under this clause is the order declaring one an SPD. Judging from the title, it appears to be another order as one would have been declared already for them to be called an SPD. Perhaps a reference to the relevant sections of the Criminal Procedure Act is required to ensure clarity. References to the Correctional Services should also be corrected to "Correctional Service" throughout the entire Bill.
- 22.3. Concern was raised by the Mental Health Care Unit and the LAC regarding the period of 14 days provided for in clause 40(2) and (4). At present, the State mental health facility is already operating at maximum capacity and patients remain at the mental health facility after the 14 days are exceeded. Stakeholders suggested that perhaps

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<sup>117</sup> Article 141(2) of the Namibian Constitution states that "any reference to the Attorney-General in legislation in force immediately prior to the date of Independence shall be deemed to be a reference to the Prosecutor-General, who shall exercise his or her functions in accordance with this Constitution.

patients be transferred to mental health facilities where there is space available on a first-come basis.

- 22.4. The NCS pointed out that it has attempted to appoint two psychologists in 2018. Due to the scarcity of registered Clinical Psychologists in the country, only two candidates amongst 29 applicants who applied met the minimum requirements. Unfortunately, they both turned down the offers for other work opportunities in the private sector. The plan is to re-advertise in the coming financial year pending availability of funds. Even if the NCS had appointed the two psychologists, assistance from the Mental Health Care Center would still be required, especially for psychiatric services.

### **23. Clause 41 and 42**

- 23.1. State Patients who abscond from a designated health facility are covered under clause 41 of the Bill. Stakeholders suggested that the word “opinion” in clause 41(1) should be replaced with “discovered”. The NCS agrees with clause 41. If granted that NCS takes charge of the Forensic Unit, many provisions in the Bill will need to be amended to reflect the changes and the ministries affected by the Bill should first have a consultation to discuss the budgetary cost and personnel involved.
- 23.2. The Police in their submissions pointed out that the request under clause 41(1)(a) cannot be made to just any member of the Namibian Police Force, a formal request must be forwarded to the Station Commander within that district, with clear particulars. Some of the stakeholders felt that this will lead to a lot of length bureaucracies and delays. The Police also stated that they have no capacity or expertise to detain such persons in terms of clause 41(3). Furthermore, the Police cautioned that because some mentally ill persons may have a violent temperament, the members of the Namibian Police Force might have to resort to the use of force in the apprehension of the person concerned in terms of clause 41(4). Clause 41(4) provides that *‘the Namibian Police Force may only use the constraining measures as may be necessary, proportionate, and appropriate in the circumstances when apprehending a State patient or performing any function in terms of this section’*. This provision seems sufficient enough to cover the concern of the Police.
- 23.3. With regards to clause 42(2) the word “those”, should be changed as sub clause (1) articulates only one reason. LAC stated that the previous drafts contained an additional safeguard in clause 42(6) which stated that” *(7) the detention of a State patient at a correctional facility as contemplated in subsection (6) may not exceed six months...*” and it should be considered. At the very least, a review of the patient’s health condition

should be considered periodically after such a transfer, given that the correctional facility may lack the treatment capacity of a designated health facility. Finally, the NCS pointed out that clause 40, 41, 42, 44 exclude accused persons undergoing observation.

## 24. Clause 43

- 24.1. Leave of absence from a designated health facility fall under clause 43 of the Bill. The LAC queried if the crime of culpable homicide is appropriately listed under clause 43(1) and 44(5) (b)-(c). The reason being that all the other listed crimes require “intention” while culpable homicide requires “negligence.” The Prosecutor-General indicated that only the office of the Prosecutor-General can decide whether an offence involves grievous bodily harm or a similar offence based on his or her access to the police docket and the prosecution representatives appearing in court. The Prosecutor-General further argued that the word ‘including’, “assault” and “capable homicide” must be removed.<sup>118</sup> It should be the function of the official curator ad litem to decide whether an offence is a “similar offence”.
- 24.2. With regards to clause 43(1) the Mental Health Care Unit explained that, once a patient is assessed, the head of the mental health facility should make recommendations to the Review Board which is ultimately responsible for granting the leave of absence. Accordingly, the head of the mental health facility grants leaves of absence to mental health patients in general, including patients who are assessed whether they are fit to stand trial. Where a mental health patient has committed a serious crime identified in clause 43(1), the Review Board determines whether to grant leave of absence based on the recommendations of the head of the mental health facility.
- 24.3. A review of previous drafts that contain this provision by the LAC showed that the head of the mental health facility recommended and the Review Board had to give consent. *“The review board concerned must upon receipt of a recommendation referred to in subsection (2) make a final decision thereon and notify the head of the designated health facility thereof, who must then grant the leave concerned if the review board has so consented.”* The previous procedure seems to provide a better safeguard. The purpose of this clause is to have it written in law the practice of gradually integrating mental health patients, who have been released from the mental health facility, back into society.

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<sup>118</sup> This is also applicable to clause 44(5) (b) and (c).

- 24.4. This clause seems to only provide for SPDs kept at a health facility and excludes those kept at correctional facilities. Thus, provision for those housed at correctional facilities should be included in this provision. But, to avoid misuse of this provision or provide some control thereof, it may be best to include maximum leave of absence permitted within a stipulated timeframe, etc. e.g. a maximum of 3 months leave of absence annually.
- 24.5. The NCS agrees with the view that SPDs who have committed minor offences to be granted leave of absence, however, there is a need for measures to ensure proper assessment of the care-taker who will be responsible for supervising and staying with the SPD during that timeframe. Only SPDs that have proven to have had successful treatment/intervention during their stay in the health facility/correctional facility with proper evidence can be granted a leave of absence and conditions that set out clearly what is expected of them.
- 24.6. The NCS is also considering the inclusion of SPDs who committed serious offences in this clause. They indeed pose a high risk to re-offend, but these are also the people that may need systematic reintegration back into society. Therefore, it might be a good idea if they are allowed leave of absence, after a specified adequate period when they have received adequate treatment. A provision can then be made to have a minimal leave of absence as compared to those who committed minor offences. For example, those who committed scheduled/serious offences must first receive adequate treatment/intervention for the first 5 years of their stay in a health facility or correctional facility, thereafter they can qualify for Leave of Absence, for a maximum of 30 days annually. During that period, strict conditions can be set to monitor them during their leave of absence.
- 24.7. Clause 43 provides for a notice to the curator ad litem, by an SPD. The practicality of this clause is still debatable. The Mental Health Care Unit also pointed out that logistically the “weekly basis” provided for in clause 43(3) (a) is not possible. Currently, patients return to the mental health facility monthly to collect medication and also to see a social worker. Since some patients live far from the nearest mental health facility, it would make more sense to require the community custodian to contact the patient monthly.
- 24.8. The NCS suggested that official personnel from the Ministry of Health and Social Services such as a social worker and an official from NCS such as a Community Supervision Officer should be appointed. Their appointment, functions and scope of powers should be set out in the Bill to conduct face-to-face supervision weekly or as

per condition set uniquely on the merit of each case. The idea of weekly contact telephonically and face-to-face sessions monthly should thus be limited to special cases where the likelihood of re-offending or relapsing is next to zero. As much as NCS recommended for SPDs who have committed serious offences to also be allowed to qualify for a leave of absence, again this should be permitted after a thorough assessment and there is evidence that the SPD will not pose a serious threat during the leave of absence. In addition, stricter conditions should be set out for their time away. Generally, leave of absence is a good method to systematically facilitate successful reintegration, but if not managed properly, it may cause unintended consequences and a big threat to society. Thus, a lot of consultation between the main stakeholders is required before this is implemented. Finally, the Judiciary suggested that the curator should be notified of SPD's leave of absence, as they have a parenting role to take care of their affairs.

## **25. Clause 44**

- 25.1. The periodic review of the mental health status of a State patient falls under clause 44. This clause excludes SPDs detained in correctional facilities and should also provide for them. There is a need to indicate how long it should take for the Head of the designated health facility or correctional facility after the review to ensure that the summary review report is submitted to the board and official curator ad litem in terms of section 44 (3).
- 25.2. The six months in clause 44 must be distinguished from the one month in clause 33, in that it refers to the periodic review of the patient at the Mental Health Care Unit. If the recommendation to include the correctional facilities in this provision is accepted, then clause 20 and any other relevant sections should be reviewed to include the establishment of a review board at correctional service or add a member of NCS on the existing review board.
- 25.3. In clause 44(5) (b) and (c) the word "including" must be removed. Furthermore, the phrase in clause 44(5) (c) "*pending a decision by a judge in chambers as contemplated in section 45(6)*" is clumsily worded. It could be understood to mean that, if the patient falls into this category, the review board may make a recommendation for the judge for discharge, but lacks the power to discharge the patient, conditionally or unconditionally, before the judge makes a decision. This seems to be the import of section 44-46 of the 1973 Act. It is recommended by the NCS that all the major /scheduled offences should be included in clause 44 (5) (c) as per the Criminal

Procedure Act or the Correctional Service Act. The Bill should also make provision for feedback to SPDs under consideration.

- 25.4. Finally, clause 44(7) states that “*the review board must without delay inform the official curator ad litem of the decision*”. This will be problematic if the official curator ad litem is the Attorney-General, as the decision whether or not to continue with the prosecution is the sole prerogative of the Prosecutor-General.<sup>119</sup> The clause should also provide that the information must be provided to the official curator ad litem in writing on a prescribed form. The form must contain all the information that the Prosecutor-General will need to trace the court proceedings in which the declaration as a State patient was made to enable the Prosecutor-General to determine if the prosecution against the accused will proceed after his/her discharge as a State patient.

## **26. Clause 45**

- 26.1. Clause 45 on the application for discharge of a State patient is a good idea, as the patient also now has a right to bring an application. The practicality of it may be challenging and may end up like the current prison appeals. Perhaps, re-look at the similar section in the current 1973 Act. The Prosecutor-General proposes that the Bill should make provisions for a statutory mechanism whereby State patients detained for minor crimes; interested parties; the official curator ad litem or the head of the designated health facility can apply to the review board for their discharge. As such, section 45 should only be reserved for State patients accused of crimes involving grievous body harm, murder, rape, etc.
- 26.2. Clause 45 does not provide for the involvement of Correctional Service in the discharge of the SPDs housed at correctional facilities. Currently, section 29 of the 1973 Act requires that the application for recommendation of discharge be accompanied by a report from the head of the institution where the SPD is kept, which then includes the correctional facility. Thus all recommendations of SPDs housed at a correctional facility are accompanied by reports from NCS facilities. If that part is then discarded in the new Bill, then a discussion should be held between the two ministries on how correctional facilities with their limited human resource can be involved in the recommendations of discharge for SPDs in their care. One such recommendation is the establishment of a review board at correctional service or to add a member of NCS

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<sup>119</sup> See Ex parte Attorney General: in the constitutional relationship between the Attorney General and the Prosecutor General 1998 NR 282 SC.

on the existing review board as stated in clause 44 above, to enable the NCS to make recommendations for discharge provided for in clause 45 (2) (ii).

- 26.3. The Judiciary wanted to know what application contemplated in clause 45(1) and (2) will envisage. Will the application be in terms of the Rules of the High Court, if it's been brought to a judge in chambers? Also, the Bill repeatedly makes use of the term "application" randomly, but nowhere in the Bill is it defined. The term application is very wide. What does this application constitute? Is it on notice confirmed by an affidavit? Or is it under oath? It is not sufficient to say it will be dealt with in the regulations. It must specifically say "application on an affidavit" or "application in terms of rule xx of the High Court Rules" or "ex parte application" etc. Caution should, however, be taken if a definition of application is to be included in the Bill. Each part of the Bill that refers to the term application should be carefully considered to determine whether the definition still applies.
- 26.4. The Bill fails to stipulate what the psychiatrist is supposed to address in the report contemplated in clause 45(2) (c) (ii). The current 1973 Act makes provision for a procedure and what the psychiatrist is to address in such a report. It is also not clear if the psychiatrist mentioned in clause 45(2) (c) (iii) is in addition to the psychiatrist mentioned in clause 45(2) (c) (ii), or is it the same person. The judiciary submits that it should be a second to ensure checks and balances.
- 26.5. The LRDC sought clarity on the reason for the "12 months" period provided in clause 45(2) (c) (IV). The Mental Health Care Unit confirmed that in addition to the head of the mental health facility and the Review Board, the patient can also make an application to be discharged. The 12 month provision in clause 45(2) (c) (IV) relates to the application of the patient. The purpose of the 12 months is because there may be reasons such as recovery or unresolved issues why the patient's application cannot be entertained. It is however not clear as to how the 12 months are counted. It is perhaps counted from the period of the judges' determination or counted backward from the date of the current application.
- 26.6. The LRDC further enquired whether 12 months is not unreasonably long. The Mental Health Care Unit responded that, before the 12 months, the head of the health facility would already have evaluated the patient to determine whether such a patient can be discharged. It is possible that such a patient could be discharged earlier. In addition, the process where a patient makes the application for discharge is also cumbersome. This process involves an application by the patient to the head of the health facility, which is then forwarded to the Office of the Prosecutor-General who retrieves the

docket and writes a recommendation to judges who review and determine the application. Despite this explanation, the 12 months were still considered to be too long, and a recommendation was made to change the period to 6 or 8 months.<sup>120</sup>

- 26.7. Clause 45(3) provides for 30 days within which the official curator ad litem should provide the judge in chambers with numerous listed documents. Most of the documents listed are not in the control and custody of the official curator ad litem and it takes time to obtain them from other government agencies. Also, the Guidelines compiled by the Judge President for application for discharge of State patients contains a lot of additional documentation to be provided to the judge in chambers. In addition, the application must be officially indexed and bound. The Prosecutor-General therefore proposes that a period of three months be granted to the official curator ad litem for submission.
- 26.8. Clause 45(3) (a) (i) will need to be amended to include correctional facilities. The judiciary submitted that the psychiatrist in clause 45(3) (a) (ii) and (b) should not be the same person to ensure checks and balances. It seems that since workdays in clause 45(6) relate to court days, it implies that, in addition to the 6- or 12-months period where a patient applies for discharge, such period will further be extended with six weeks. A period of 15 days is recommended so as not to infringe further on the liberties of the patient.
- 26.9. Clause 45(3) (c) provides for a report from a social worker, the Bill is silent on the content of the said report and whether the report is compiled before or after the discharge. Section 17 of the 1973 Act and the current practice should be considered where clause 45(4) (b) is concerned. Clause 45(4) (c) include evidence under oath. It should also state that at the discretion of the judge in chambers, he or she may call for evidence viva voce and not only in the affidavit to satisfy him or herself if he or she deems it necessary. It is not clear why 30 days may be required under clause 45(6). It is also not clear if the order by the judge in chamber is a final order. Currently, under the 1973 Act, it is just a recommendation by the judge to The State President. It is not clear if the Bill is axing this out.

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<sup>120</sup> In *Gawanas V Government of the Republic of Namibia* 2012 (2) NR 401 (SC), the court held, accordingly, that the hospital board did not act reasonably in delaying from January 2003 until 24 June 2003 before they sent their recommendation to the Minister of Justice. The court went on to state that there was no reasonable explanation for the delay to act in order to discharge the appellant as a President's patient, which was a necessary step in the process before a judge could order the release of the appellant.

## 27. Clause 46

- 27.1. The conditional discharge of State Patients, amendments to conditions or revocation of conditional discharge is provided for under clause 46. It might be useful to state outright in clause 44 that the conditional discharge of SPDs falling under clause 44(5) (c) cannot be conditionally discharged except by the decision of a judge in chambers as stipulated in clause 46(4) (i) and clause 46(5). It seems the provision intends that such patients cannot be discharged at all without the decisions of a judge, which seems to be the correct approach. It would be useful to make it clear in clause 44.
- 27.2. Clause 46 (2) should specify who should monitor the SPD. Currently, the social worker appointed by the Ministry of Health and Social Services assesses and monitors the conditional release with the assistance of the Community Supervision division of the NCS. If this still applies in the new Bill, it should be stated as such. Clause 46(3) (b) (ii) and clause 46(4) (i) should refer to the Registrar of the High Court. The Mental Health Care Unit suggested that a sub clause be added under clause 46(3) (b) (iii) stating that the head of a mental health facility should also inform the Review Board of his or her assessment of a patient on conditional discharge.
- 27.3. The provisions of clause 46(5) should include an interested party and the *curator* since the patient may continue to lack full capacity even if he or she is no longer considered dangerous. This may be inconsistent with Article 19<sup>121</sup> of the CRPD on independent living, but it is safe to have some form of a safeguard. With regards to unconditional discharge listed under clause 46(5) the LAC stated that it is possible, albeit unlikely, that the patient or someone acting for him or her, might also want to apply for revocation of a conditional discharge, in a situation where the patient felt that he or she was not coping. This option should be available to the patient.
- 27.4. The judiciary questioned whether it is advisable for unconditional discharge after the 6 months in terms of clause 46(5). A year is advisable as a person may still be taking

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<sup>121</sup> The CRPD in Article 19 on Living independently and being included in the community provides that “States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

- (a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;
- (b) 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;
- (c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

their medication within the 6 months, but it may not be the case after a year. If it was a court that made an order for conditional discharge, it is not clear why the application for unconditional discharge be made to the head of the facility. The Bill deals with the status of a person. It is therefore not clear why the Bill provides for an administrative person to make a decision on the status of a person. The Bill is also silent on how decisions by such administrative person can be reviewed. Furthermore, providing administrative heads with such powers would infringe on the jurisdiction, powers and independence of the court. It is similar to sequestering someone without going to court. The application should be made to a judicial officer from the onset. The phrase “or” in ‘*or a judge in chamber*’ does not make sense. Finally, it is not clear how the allegations described under clause 46(7) be verified.

- 27.5. Over all, the discharge process does not make provision for a State patient to be discharged into the care of a custodian who must see to it that the State patient complies with the conditions of his discharge and report all none compliance or relapse in the mental condition to the head of the mental health facility. It is also not clear how the discharge procedure will work in practice where the state patients are discharged and they do not have family to care for them.

## **28. Clause 48 and 50**

- 28.1. Clause 48 of the Bill makes provision for the enquiry into mental health status of inmate or offenders. The Mental Health Unit raised a concern that NCS does not have persons specialized in mental health care and incorrect information may be relayed. The NCS responded that it has officers with a mental health background who are able to detect and provide basic to moderate mental health intervention. They are referred to as Case Management Officers/ Rehabilitation Coordinators/ Programme Officers/ Mental Health Officers. They have qualifications in Social Work, Psychology and Occupational Therapy. They all work within their scope of practice and refer to the Mental Health Care Unit or State hospitals when a case beyond their scope of practice arises. The NCS has also made provision in its organizational structure for one Registered Clinical Psychologist at the each of the two facilities where SPDs are housed. Therefore, clause 48 (1) should include the word “in charge” that is omitted, to read “... *officer-in-charge*”<sup>122</sup> to make provision for correctional service. In addition, clause 48 (1) (a) is missing, but it is referred to in 48 (2).

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<sup>122</sup> The Officer-in-charge refers incidence of mental health problems to the head of a designated health facility following consultation and reports from officers with a mental health/medical background.

- 28.2. The magistrates were concerned with the transfer to designated health establishments under clause 50 of the Bill. They were of the view that the Bill seems to have removed all the magistrates' powers under the 1973 Act, then suddenly remembered to add magistrates only after the fact in clause 50. Clause 50 is so cumbersome in its reading and not clear as to what it provides for unlike section 30 of the 1973 Act which is clearer. The clause further fails to take cognisance of the fact that the Magistrates' Court is a creature of statute<sup>123</sup> and the closest courts to the people, as such, involuntary orders should remain under the court.
- 28.3. According to the magistrates, reception order applications are made by a family member to place a person under treatment. However, challenges do occur. For instance; the police are often uncooperative to bring such persons before the magistrate to hold the enquiry and satisfy themselves as to whether the situation that is been reported by the report of the two doctors is true. This has led to such persons never making appearances before the magistrate making such reception orders. The Criminal Procedure Act and the 1973 Act fails to provide measures for the magistrate to subpoena the police to bring such persons before it to make a well-informed decision. The Bill should make it mandatory to ensure that the person is brought for an enquiry.
- 28.4. The magistrates further stated that a reception order<sup>124</sup> is directed to the head of the mental health institution to take that person for treatment. They are kept for three-four days under treatment and once the condition stabilises, they are released within two days. Thereafter, the same person often appears before the court again continuously. The magistrates suggested that before such persons are released, the doctors must provide the court with a report as to why they are being released. Without that report, the order remains open-ended. The court order would be meaningless if the institution keeps releasing these persons without valid reasons.
- 28.5. It's on this basis that the Judiciary recommends that the Bill or its Regulations should make provisions for how such persons shall be reintegrated in society after discharge as rehabilitation and reintegration processes are very important for the courts. Finally,

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<sup>123</sup> The Magistrates' Courts Act, 1944 (Act No. 32 of 1944).

<sup>124</sup> Reception orders are granted in terms of s 9 of the Mental Health Act. This section empowers a magistrate to issue a reception order and s 9 (3) stipulates as follow:  
"If the magistrate, upon consideration of all the evidence relating to the mental condition of the person concerned, including his own observations with regard to such condition, is satisfied that such person is mentally ill to such a degree that he should be detained as a patient, he may issue an order in the prescribed form authorizing the patient to be received, detained and treated at an institution specified in the order, or directing that the patient be received and detained as a single patient under section 10(1)."

clause 50(3) (a) should include provision that mental health care can be rendered on an outpatient or inpatient basis.

## **29. Clause 51, 52, 53, 54 and 55**

- 29.1. The procedure to transfer an inmate or offender with mental health problems to designated health facility is provided for under clause 51 of the Bill. Clause 51(1) (b) and (2) should however clarify which Ministers it refers to. Clause 52 on the transfer of offenders with mental illness between designated health facilities may pose practicality issues. Which begs the question as what is the process and practice currently? Would it be better to maintain it, rather than institute the process?
- 29.2. Stakeholders suggested that clause 53 which provides for the periodic reviews of mental health status of inmate or offender with mental health problem, should be compared with Section 30<sup>125</sup> of the current 1973 Act to determine if there is any change. In addition, the word “interred” in clause 53(3) (b) is wrongly used and should be removed as it refers to the burial of a corpse. The Bill should also enable the review board to see the inmate or offender personally, not just to consider the written reports.
- 29.3. A number of stakeholders wanted to know why the recovery of inmates with mental health problems procedures and processes in clause 54 differs from those set out in clause 53. In response, the Mental Health Unit argued that, if the inmate’s condition is discovered to have improved during a periodic review, the Review Board makes the final decision on the way forward in terms of clause 53. While, if the improvement is observed by the head or based on medical information obtained by others, the process will be in terms of clause 54. Stakeholders further argues that, the distinction does not seem to warrant different decision-making processes, since the key factor in either instance is the improvement of the inmate’s condition. The LAC therefore suggested that the procedure involving the review board described in clause 53 should apply equally to the circumstances described in clause 54. In fact, clause 53(1) (b) on early reviews seems to cover the situation described here. LAC therefore suggested that clause 54 be deleted.
- 29.4. Section 33 of the 1973 Act requires two medical practitioners to certify in writing that a patient “has recovered to such an extent that his detention in the institution or prison hospital is no longer necessary.” The Bill only requires certification of the head of the health facility, acting upon medical information from health care practitioners. No

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<sup>125</sup> Section 30 provides for convicted prisoner who is mentally ill.

reasons are provided as to why the Bill only requires certification of the head of the health facility and not the current practice of two medical practitioners.

- 29.5. The stakeholders felt that “personal observation” by the head of the facility in clause 54(a) should be altered to read “medical observations”. Also, “reason to believe” referred to, in clause 54 may be abused by the heads of facilities. Perhaps as an additional safeguard that requires the consent of the Review Board should be added to lessen the possibility of abuse of the “reasonable belief” language.
- 29.6. Finally, in terms of clause 55(1), the word “opinion” should be replaced with “observes”. According to the Police, the request in clause 55(1)(a) cannot be made to just any member of the Namibian Police Force, a formal request must be forwarded to the Station Commander within that district, with clear particulars. The police also pointed out that compliance to clause 55(2) will only be in an event that a proper outlined request procedure is put in place and complied with. They further cautioned that they do not have the capacity or expertise to detain such persons under clause 55(3). It is also not clear as to what happens if the police officer wants to charge the offender or inmate with mental health issues with escaping from lawful custody in terms of clause 55(3).<sup>126</sup>

### **30. Clause 57**

- 30.1. This clause makes provision for the appointment of administrators for care and administration of property of a person suffering from mental health problems or severe or profound intellectual disability. The clause falls under Part 8 which stakeholders identified as the most contentious part of the Bill. It raises the issue of a patient’s right to private property, which was also raised by the World Health Organisation, in particular, the ability of a patient to get back his/her powers from a curator, once mental health care is completed. Part 8 further appears to cement the outdated view of legal capacity of persons with mental and psychosocial disabilities and establishes substituted decision making in guardianship or proxy powers over their property. This is a violation of article 12 of the CRPD. In fact the State should provide support to enable the individual to exercise and enjoy their legal capacity in line with their will and preference through supported decision making.<sup>127</sup>

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<sup>126</sup> Clause 55 provides for inmate or offenders with mental health problem who abscond from designated health facility.

<sup>127</sup> For instance, the Peruvian law is an example for all States to follow. They recognise the legal capacity of people with disabilities, remove restrictions to their rights, and provide support to allow them to take their own decisions”. See Peru: Milestone disability reforms lead the way for other States, says UN expert.

- 30.2. The practicality of this clause 57 is debatable. The Masters of the High Court argued that the term “property” under part 8 of the Bill should be defined even if it is not defined in the current Mental Health Act 18 of 1973. This will make it easy to determine as to whether the term “property” includes both movable, immovable property and financial assets.
- 30.3. The Mental Health Care Unit suggested that the Bill possibly makes room for social workers to be able to access curators. In addition, the ability of the patient to pay curators has also proved to be problematic. It was suggested that the Bill should perhaps make room for the appointment of a public curator who will mainly be responsible for administering the financial affairs and/or inheritance of the mental health patient under the Master of the High Court. It is however not clear as to how such a person shall be held accountable, remunerated and whether they should fall under the Master's Office or be an independent body.
- 30.4. If what is provided for under clause 57 is what would be deemed to amount to supported decision making, it is not in line with international standards. Clause 57 fails to set out which instances supported decision making is to be utilized and the relevant monetary measures. Clear directives need to be set out. In line with Article 12 of the CRPD, the administrator’s role should be reframed to be one of a person who provides support to the person in question to exercise their own will and preference and legal capacity over their property as opposed to what is currently stated which amounts to a removal of the person’s legal capacity in relation to their property entirely. The General Comment on Article 12 of the CRPD at para 21 says that “States must abolish denials of legal capacity that are discriminatory on the basis of disability in purpose or effect.”<sup>128</sup> This includes denials based on “functional tests of mental capacity or outcome-based approaches” that lead to denial of legal capacity if they disproportionately affect persons with disabilities. Therefore, if the role of the administrator was framed in line with Article 12 of the CRPD as a supporter (supporting the person to make and exercise decisions not substituting their will and preferences)

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<https://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=23501&LangID=E>. Accessed 11 April 2020.

<sup>128</sup> A Resolution on Mental Health and Human Rights from the United Nations Human Rights Council calls upon States to ‘abandon all practices that fail to respect the rights, will and preferences of all persons, on an equal basis’ with others and to ‘provide mental health services for persons with mental health conditions or psychosocial disabilities on the same basis as to those without disabilities, including on the basis of free and informed consent’. See Gooding, Piers; McSherry, Bernadette; Roper, Cathy and Grey, Flick (2018) Alternatives to Coercion in Mental Health Settings: A Literature Review, Melbourne: Melbourne Social Equity Institute, University of Melbourne p8.

then the person in question must “have the right to refuse support and terminate or change the support relationship at any time”.<sup>129</sup>

- 30.5. The phrase “*the Master may*” in clause 57(1) (b) may not be applicable if the court has ordered the Master to appoint an administrator, this will not be discretionary on the part of the Master. Furthermore, clause 57(4) (c) provides that an administrator’s order indicates when the appointment as administrator will be reviewed. This is in line with Article 12(4) of the CRPD that requires the State to implement certain safeguards to ensure that support measures are not abused. Assuming this part of the Bill can be framed in line with Article 12, this clause also needs improvement on the nature and regularity of review. Article 12(4) goes on that measures must apply “for the shortest time possible” and be subject to “*regular review by a competent, independent and impartial authority or judicial body*”.
- 30.6. The Bill should therefore set a maximum period for review of the appointment in terms of clause 57(4) (c) to read “*which may not be later than a specific date after the date of such appointment*”. It is not clear whether the phrase “subject to regular review” under clause 57(5) refers to a review by the Master in terms of sub clause (4), and in terms of what process. It is also not clear if an administrator can be replaced if the review identifies irregularities. It would be helpful to refer to the prescribed procedures as set out in clause 80(1) (bb) that makes provision for regulations on the procedures for review. Finally, the Bill also fails to clearly set out as to who makes the decision with regard to the phrase “*and his or her appointment ends forthwith*” in clause 57(5).

### **31. Clause 58**

- 31.1. When the order is made by a court, the standard referred to in clause 57(1) (b) is that the person concerned is “*incapable of managing his or her own property*”. However, this standard is not referred to in clause 57 or 58 in respect of a decision by the Master. As such, the LAC was of the opinion that the standards should be clearly stated in clause 58.<sup>130</sup> The standard should be the same regardless of who makes the decision.
- 31.2. If the provision of clause 58(2)(c) was redrafted in line with Article 12 of the CRPD, the relevance of these kinds of documents would only be in relation to determining the nature of support a person may need to exercise their legal capacity. Using someone’s mental health status to deny legal capacity is a violation of the right to equality before

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<sup>129</sup> See para 25(g) of the General Comment.

<sup>130</sup> Clause 58 makes provision for the application to Master for appointment of administrator.

the law.<sup>131</sup> Clause 58(2) (g) should also require information on joint financial interests with any other person, such as a spouse in community of property or a business partner. If there is such a person, it is suggested that such person must be given an opportunity to make representations by an appropriate addition to clause 58(6), 58(12) (b), clause 59(2) and clause 62(7).

- 31.3. The provisions in clause 58(6) (a) should at least include a requirement that adequate support and reasonable accommodation is provided for the affected person to participate in these proceedings. Clause 58(10) (a) reads “*a written notice of appeal in the prescribed form with the reasons therefor to a judge in chambers*”. It would seem more appropriate for the notice of appeal to be submitted to the Registrar. The appellant should not approach the judge directly. Same applies to clause 62(5) (a).
- 31.4. The language of clause 58(12) (b) must clearly indicate that the affected person must be heard in these proceedings or be afforded an opportunity to be heard. This is not clear in subsection (i). It seems inappropriate for a judge to simply make a “*recommendation*” to the Master in terms of clause 58(12) (c). Especially when the decisions may be in the context of an appeal against the Master’s initial decision. It would be better for the court to “*order*” one of these options. If the order is for appointment of an administrator, then the Master can still be tasked with the selection of that person. Note that clause 57(1) (b) refers to a court “*order*”.
- 31.5. Clause 58(14) (a) could amount to an infringement of human rights. Clause 58(13) (a) should perhaps be rephrased to affirm and alter the administrator’s role to one of a supporter and not a substituted decision maker. This will be in line with Article 12(4) of the CRPD that requires that States have a duty to implement certain safeguards to ensure that supports affirm human rights and are not abused. Paragraph 18 of the General Comment on Article 12 says that “*the purpose of these safeguards should be to ensure the respect of the person’s rights, will and preferences.*”<sup>132</sup> These criteria should be two medical practitioners legally required to be considered in assessing the suitable candidate. If the application is denied, there should at least be no order as to costs. Finally, stakeholders suggested that the term “*life partner*” should be removed from all sections in the Bill until the court pronounces itself on the issue. It is also not clear whether section 58 also applies to persons under the age of 18, as only those

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<sup>131</sup> Guaranteed in Article 10(1) of the Constitution and article 5(1) of the Convention on the Rights of Persons with disabilities.

<sup>132</sup> General comment on Article 12: Equal recognition before the law. Committee on the Rights of Persons with Disabilities Eleventh session 30 March–11 April 2014 Item 10 of the provisional agenda General comments and days of general discussion. [www.ohchr.org](http://www.ohchr.org) accessed 10 January 2020.

over the age 18 are provided for. Perhaps the Child Advocate route should be considered or provide for it in the Child Care and Protection Act.

### 32. Clause 59, 61, 62 and 63

- 32.1. According to the Ministry of Health and Social Services, clause 59 that provides for the recommendation to appoint administrators by court during an enquiry or in the course of legal proceedings may be problematic in practice. Reporting processes and waiting periods are frustrating as responses are often delayed from the Master. Administrator costs are high and unreasonable. The Ministry of Health and Social Services further argued that it also seems unreasonable to charge the patient with the costs of an administrator which the court has independently determined the patient needs. This is therefore deeply abusive to place costs over the individual even if they didn't consent to the administrator's support.<sup>133</sup> Also, the term "*recommend*" should be replaced with "*order*" as the court's decision are binding.
- 32.2. Stakeholders questioned as to whether administrators have a duty to act in the best interest of the patient with regards to clause 61.<sup>134</sup> If they do, this should be provided for in the Bill or the regulations. It was however cautioned that the best interests standards tend to violate human rights principles if not combined with protections of the individual's rights to informed consent, liberty and protection of their legal capacity, will and preferences.
- 32.3. It is not clear what '*regained supported decision-making*' refers to in clause 61(3) (b). It would seem that the person concerned is either "*incapable of managing his or her own property*", or is "*capable*". If there is some intermediate position, it should be clearly set out. Furthermore, if some capacity has been regained, then that would suggest that the person should be involved in decisions that affect their properties.
- 32.4. There are no safeguards in clause 61(4) (a)-(b). At a minimum, the provision must stipulate that the administrator has a duty to support the affected person to express their will and preferences and must administer the estate or property in line with their will and preference. Clause 61 as a whole is not clear, especially clause 61(6). It seems the administrator will not be required to provide security. It would be advisable to require security at the value close to that of the estate being administered. It is also

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<sup>133</sup> Clause 59(5)(a)-(b).

<sup>134</sup> Clause 61 provides for the powers, functions and duties of administrators and miscellaneous provisions relating to appointment of administrators.

not clear as to how the administrator would receive money on behalf of the person in question prior to appointment. Clarification is required.

- 32.5. Clause 62 that provides for the termination of appointment of the administrators is too long. It needs to be revised, refined and shortened. As it may lead to abuse. Insert in clause 62 that “failure of the administrator to report on time will lead to termination of appointed administrator” as a safeguard. It is not clear to whom the term “detained” under clause 63(1) is referring to.
- 32.6. According to the CRPD Committee’s General comment on Article 12, substituted decision-making regimes have the following common characteristics:
- *Legal capacity is removed from the person, even if this is just in respect of a single decision*
  - *A substitute decision maker [in this case, the administrator] can be appointed by someone other than the person concerned and this can be done against the person’s will.*
  - *Any decision made by a substitute decision maker is based on what is believed to be in the objective “best interests” of the person concerned as opposed to being based on the person’s own will and preferences.*<sup>135</sup>
- 32.7. All three of these features are clearly exhibited in the provisions of Part 8 of the Bill. Part 8 therefore violates the rights of persons with psychosocial and mental disabilities. Instead of using the administrator to substitute the capacity of the individual (to make decisions on their behalf) the administrator’s role should be fundamentally reformed to frame their function as rather to support the affected person to exercise their own legal capacity in line with the individual’s will and preferences. Article 12(5) of the CRPD explicitly states that the State must take measures to ensure respect of persons with disabilities’ right to legal capacity in respect of financial and economic affairs. The African Disability Protocol<sup>136</sup> Article 8(f-g) echoes the same sentiments and provides that persons with disabilities have an equal right to own or inherit property and not be arbitrarily dispossessed of their property. Persons with disabilities have equal rights to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit.

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<sup>135</sup> Paragraph 23 of the General comment on Article 12: Equal recognition before the law. Committee on the Rights of Persons with Disabilities Eleventh session 30 March–11 April 2014 Item 10 of the provisional agenda General comments and days of general discussion. [www.ohchr.org](http://www.ohchr.org) accessed 10 January 2020.

<sup>136</sup> Namibia not yet a State party to the African Disability Protocol and is under no obligation to adhere to the Protocol. It is used merely as a reference in this context.

### 33. Master of the High Court overall observations on part 8 of the Bill

- 33.1. According to the Office of the Master of the High Court, their general observation of Part 8, incorporating clause 57-62, will result in the duplication of laws as there are similar procedures, although not entirely comprehensive, set out under Chapter IV section 71-85 of the Administration of Estates Act No. 66 of 1965. The Administration of Estates Act makes provision that a curator may be appointed for a child or for a person who is mentally or physically incapacitated to handle their assets.
- 33.2. Should the Mental Health Bill be passed it will result in there being two procedures and laws that set out to achieve the same objectives. The only difference being that, one is appointed by the Master<sup>137</sup> and the other by the court.<sup>138</sup> This will cause confusion and will lead to a number of questions such as which Act applies? Which procedure should the public follow? What are the consequences of either of the procedures? Another question would be whether both an administrator and curator can be appointed to administer the same person's assets at the same time? Will part 8 of the Mental Health Bill also be administered by the Master of the High Court similarly to the Administration of Estates Act? Who bears the costs? And why is the term Guardian is not defined in the Bill?
- 33.3. It is not clear whether the investigator and administrator in the Bill amounts to a curator bonis. It seems the Bill will not provide for curatorship (especially private curatorship) for persons with mental incapacitation as provided for by the Administration of Estates Act. Should that be the case, who takes care of the person's property? The masters only control the accounts and not the assets. Someone else should be responsible and accountable for the persons asserts.
- 33.4. The Bill fails to make provision for the Master's report in terms of Rule 83 of the High Court rules. In addition, the process set out in the Bill is too long and impractical. If the Master has to take over, it will take a lot of manpower and cost which is not currently available. Furthermore, reference to a judge in chambers in this part of the Bill may not be practical. A similar provision exists under section 96(3)<sup>139</sup> of the Administration of Estates Act for a judge to review administration of estate issues. This section has never

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<sup>137</sup> The Mental Health Bill.

<sup>138</sup> Administration of Estates Act No. 66 of 1965.

<sup>139</sup> Section 96(3) Whenever any difference of opinion upon a question of law arises between the Master and an executor in the distribution of an estate and a minor is interested in the decision of that question, the Master and the executor may state a case in writing for determination by a judge in chambers, and the determination of the judge shall be binding upon the Master and the executor, without prejudice to the rights of other persons interested in the distribution: Provided that the judge may refer the matter to the Court for argument.

been invoked before. Finally, the 1973 Act has a cap that provides that certain estates with a certain amount can go to the magistrates' court. This should be retained in the Bill but the process should be made easier and user friendly through the magistracy based on the size of the estate to bring the service closer to the people in the remote areas.

- 33.5. To avoid the above duplication of laws, it is therefore, recommended that Chapter IV section 71-85 of the Administration of Estates Act be amended to incorporate Part 8 of the Mental Health Bill and remove part 8 wholly from the Bill.

#### **34. Clause 65, 66, 67 and 68**

- 34.1. Clause 65 on the ill-treatment of patient by persons employed at health facilities, fails to make provision for reporting systems by patients. Such reporting systems must ensure confidentiality and protection of the patient. In addition the Bill must make provisions obligating the person who receives the report under clause 65(2) (b) to take prompt action to investigate and take any appropriate steps in response to such a report. If the abuse involves a home or community caregiver, the person who observes it should have a duty to report it to the police or social worker.
- 34.2. Stakeholders sought clarity on the difference between clause 65(1) and (2). The Mental health Unit indicated that the distinction is that, one clause criminalizes mistreatment while the other clause criminalizes indifference to mistreatment. It was suggested that correctional and any other facility be specifically included in clause 65(2). The stakeholders also wanted clarity on whether clause 66 that provides for offences in connection with patients who abscond applied only to State patients/inmates. It was further argued by some stakeholders that it seems very harsh to allow for a prison sentence to punish persons who help a general mental health patient to abscond.
- 34.3. The provisions under clause 66(c) were welcomed by stakeholders. It was however not clear if it's correctly placed in the clause on abscondment and may be overlooked if placed under the current heading. It should be added to clause 68 instead. The screening process of possible employees must be broad and detailed to flush out persons with sexual abuse and other related convictions as Namibia does not have a registered sex-offenders list. Clause 67(2) has a typo, "*this*" should be change to "the". Clause 67(4) is not clear where "such crimes" are prescribed. They should perhaps be specifically listed in the Bill or its regulations.

34.4. Finally, stakeholders argued that clause 68 providing for sexual, indecent or immoral acts with patient is gender-biased and phrased as though only a female patient could be raped.<sup>140</sup> It was argued that this section diminishes protection and is limited to one gender. This also becomes important where minor children are concerned. In this regard it is advisable to follow the approach by the Combating of Rape Act of 2000.

### **35. Clause 69, 70, and 71**

35.1. The Bill in clause 69 prohibits the publication of the patient's sketches, photos and information. The clause is however unclear and needs to be reworked. It is unclear if the clause also applies to labour issues. Or to instances where the medical doctor discloses on the medical leave form the type of health issues (depression) the person suffers from. Even just the medical ward stamp on such forms may lead to unforeseen labour issues. It is also not clear if the clause is only limited to "publications" or may also apply to any other type of "released to, provide to or informs a third party".

35.2. Clause 69 is not clear if consent will be required and in what format. The clause also fails to indicate what may amount to confidentiality and/or confidential information to this regard. Imprisonment seems a bit harsh of a punishment. Creating a cause of action for the patient to sue seems more appropriate. Further research is required with regard to privacy rights and their limitations. A closer look should be directed at the access to information and communication laws. Perhaps something should be added to specify that consent from a patient is valid only where that patient has the capacity to give such consent.

35.3. The stakeholders felt that the sanctions provided for other offences in clause 70 are not justified and are unclear. No response was provided as the consultant who drafted the Bill was not present during the consultations. Finally, stakeholders argued that clause 71 may not be adequate in addressing issues on Namibians with mental health problems imprisoned in foreign countries and jurisdictions. The phrase "*if applicable*" may be limiting as nothing prevents the respective States from agreeing after the fact or based on other existing bilateral agreement on the case to case basis.

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<sup>140</sup> An urgent application was brought by the Legal Assistance Centre in 2010 to transfer a 15-year-old mentally ill boy from Windhoek Central Hospital following his alleged rape. See Rape in Namibia: An assessment of the operation of the Combating of Rape Act 8 of 2000, Windhoek: Legal Assistance Centre, 2006 at 168; R Coomer, Experiences of parents of children with mental disability regarding access to mental health care. Cape Town: University of the Western Cape (thesis), 2011 at 95.

### **36. Clause 72, 73, 74, 75 and 76**

- 36.1. Clause 72 on the examination of patients awaiting prosecution, is not clear. For instance; it is not clear as to the type of examination clause 72 provides for. The clause should be redrafted by deleting the phrase “*any other Act*” and insert “any other law”. Some of the stakeholders were of the opinion that this clause and the Bill in general fails to make clear provisions for rape victims that may be referred to the mental health hospital. However, NCS felt the Bill should not single out one type of trauma, but rather provide for all traumas equally.
- 36.2. The Ministry of Health and Social Services representatives at the consultation workshop requested that the expenses of SPDs be either paid by the Ministry of Justice or judiciary, Parliament or by Correctional Services under clause 73.<sup>141</sup> The question is “who will be responsible for payment?” Especially for the observations in terms of section 77 of the Criminal Procedure Act. NCS agreed with the proposal that those waiting for observation/evaluation should have their financial cost covered by Ministry of Justice or Judiciary, while SPDs in the care of the Forensic Unit should be cared for by the Ministry of Health and Social Services, on the other hand, SPDs in the custody of the correctional service should be covered by the correctional service budget. Consultations should be held between the parties as to the way forward.
- 36.3. If clause 63 that provides for unauthorised detention of patients is read with clause 74 on indemnity, it is not clear as to what will amount to good faith in these instances. It is also not clear why gross negligence specifically, general negligence seem a good enough ground.
- 36.4. The Police felt that ‘*any police officer*’ in clause 75 is too general, perhaps it should be by ‘*an authorised police officer*’. The clause should perhaps also provide for instances where the police do not cooperate, or if cooperation is not done on time. Finally, it is also not clear if the medical certificate in clause 76 is to be provided as evidence in all instances or just in court.

### **37. Clause 77, 78 and 79**

- 37.1. The Judiciary questioned as to whether clause 77 that provides for a review by Court, envisages a rule 76 review in terms of the High Court Rules or a more criminal type of review. This must be specified. Perhaps it should refer to the review of an

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<sup>141</sup> Clause 73 provides for the expenses in connection with detention and treatment of State patients in health facilities.

administrative function in terms of Article 18 of the Namibian Constitution. The judiciary further queried why the High Court cases are not reviewed where mental health cases are concerned. They also questioned as to why there is no automatic review for clause 45 discharge and section 77(6) and 78(6) of the CPA of 1977 related cases. They suggested that an automatic review by the judge of the High Court be worked in as magistrates may not interpret and apply section 77-79 of the CPA of 1977 correctly. A couple of those referrals accidentally slip through the cracks and come to the judges, necessitating judgment.<sup>142</sup> This can be remedied by amending the CPA to subject the decision of the magistrate to an automatic review by a High Court judge and a person's declaration as an SP by a judge in chambers to be subjected to a Supreme Court judge for review. The CPA can be amended through the Bill as this is a human rights concern. Persons are referred and declared as SPDs often with no clear reason why, and they cannot call themselves on a rule 76 review as they don't have the funds and facilities to do so.

- 37.2. With regard to requesting assistance by members of Namibian Police Force in terms of clause 78, it is not clear what amounts to minimum force in this instance and how the Bill ensures that the police keep the rights of the patients in mind when rendering their assistance. The Police also pointed out that the request under clause 78(1) cannot be made to just any member of the Police Force, a formal request must be forwarded to the Station Commander within that district, with clear particulars.
- 37.3. Regulations are provided for in clause 79 of the Bill. Clause 79(1) (a) (i) provides that Electro-Convulsive Therapy<sup>143</sup> may never be used on any child.<sup>144</sup> Parents felt this is not a wise addition, as electroshock therapy can be very useful. Speaking as the parent of an under-18 year old for whom such treatment was life-saving, Mrs. Hubbard pointed out that, this form of treatment has acquired a bad reputation, but if properly applied it is beneficial. She further stated that there should be safeguards for the use of such

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<sup>142</sup> See *Nghivali v S* (CA 42 /2016) NAHCNLD 55 (15 June 2017); the appellant was to be detained in a mental hospital pending the signification of the State President and receive psychiatric treatment, as a civil patient, in terms of s 9 of the Mental Health Act. The Court a quo failed to allow the State the opportunity to investigate options available. This resulted in a miscarriage of justice. Proceedings set aside and remitted back to the court a quo.

<sup>143</sup> Electro-Convulsive Therapy also referred to as ECT or electroshock therapy is a treatment for some mental disorders and severe depression. A brief seizure is induced by giving electrical stimulation to the brain through electrodes placed on the scalp. See Dictionary.com. <https://www.dictionary.com/browse/electroconvulsive-therapy> accessed 20 July 2020.

<sup>144</sup> This is due to the fact that early ECT treatments administered high doses of electricity without anesthesia, leading to memory loss, fractured bones and other serious side effects. The treatment is much safer today with some side effects. ECT now uses electric currents given in a controlled setting to achieve the most benefit with the fewest possible risks. See Electroconvulsive therapy (ECT) <https://www.mayoclinic.org/tests-procedures/electroconvulsive-therapy/about/pac-20393894> accessed 20 July 2020.

therapy, but it should not be completely outlawed for under 18 year olds. In one of the Bill's previous draft, paragraph (y) provided for regulations on "*the parameters for the use of electroshock therapy on adults and children under age 18*". Perhaps this would be a much better option. While it is agreed that community custodians can be covered primarily in regulations, the Bill at present does not really explain this concept at all, or clarify how community custodians fit into the overall picture.

## **PROPOSED LAW REFORM**

The Mental Health Bill as the proposed law has as its main objective to make provisions for the admission, care and treatment of persons with mental or intellectual disorders. It sets out the procedures for admission to health facilities of such persons and for their discharge from such facilities. The Bill establishes the review boards and empowers it to supervise the functions of mental health services and mental health facilities. The Bill seeks to promote and protect the rights of people with mental and intellectual disabilities and goes on to provide for the care and administration of their properties. The Bill introduces a paradigm shift from a sole medical to a more human rights-based approach to mental health care. It seeks to ensure Namibia's compliance to the CRPD and the implementation of its obligations towards persons with mental health issues and intellectual disabilities. The worldwide approach is deinstitutionalisation and scaring down treatment to primary health care settings including community services.

## **RECOMMENDATIONS**

Possible recommendations were interrogated on how to ensure the effective implementation of the Bill. The Bill should be multi-sectorial and include strong involvement of the stakeholders, the public at large and the private sector. More importantly it will require sustained political will, and commitment. The strength of the implementing ministries, the resources available and a coordinated multi-sectoral approach also play a role in the effective implementation of this Bill.

In addition, Namibians should develop and embrace a culture of speaking out, seeking help and viewing mental health as just another disability or health condition. Attitude change is required for Namibia to address and eradicate discrimination and stigmatisation surrounding mental health and intellectual disabilities. This can be done through awareness-raising and public education on the rights of persons with mental and intellectual disabilities.

The proposed Bill is not intended to address issues that fall within the scope of other legislation; issues such as maintenance, disability grants, medical dosage, diagnoses and

marriage regimes among others. The aim of the Bill is not to duplicate the mandate of other organisations, ministries and institutions but rather to bring about uniformity and effective cooperation among intellectual disability and mental health care providers and relevant stakeholders in order to ensure a more progressive and human rights-based mental health care. The specific Acts and other laws that may be affected in some way by the Bill, must be revisited and amended in order to cater for issues that fall within their mandated areas.

## **AFFECTED LAWS**

The proposed Bill stands to affect the following additional legislations.

### **1. Mental Health Act (Act No. 18 of 1973)**

The Bill will repeal the Mental Health Act of 1973. It is noted however that, in the process of repealing the current Act, Namibia may stand to lose some of the good measures and practices that are watered down or not provided for by the proposed Bill. It is advised that certain sections of the 1973 Act be retained and improved on if possible as discussed in this report. Such sections include section 8,<sup>145</sup> 9, 12, 15 and 22.

### **2. Legal Aid Act (Act No. 29 of 1990)**

All persons in Namibia are entitled to be defended by a legal practitioner of their choice in the determination of their civil rights and obligations or any criminal charges against them.<sup>146</sup> However, persons with mental and intellectual disabilities may often not be able to afford legal representation. Therefore, the Legal Aid Act should be amended to provide mandatory legal aid to such persons with no minimum contribution required in accordance with Article 12(3) of the CRPD.

### **3. Correctional Service Act (Act No 9 of 2012)**

If approval is granted for NCS to take over the Forensic Unit as discussed under 22.2 above, a lot in the Bill will need to be amended to reflect the changes. In addition the Correctional Service Act may require amendment to provide NCS with such a mandate. This should only be done upon in depth consultations with the ministries affected to discuss the budgetary cost and personnel involved.

### **4. Administration of Estates Act (Act No. 66 of 1965)**

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<sup>145</sup> In relation to clause 5 of the Bill.

<sup>146</sup> See Article 12 (1) (a) read with Article 12 (1) (e) of the Namibian Constitution.

In order to avoid duplication of laws, it is advised that the Chapter IV section 71-85 of the Administration of Estates Act No. 66 of 1965 be amended to incorporate Part 8 (clause 57-62) of the Mental Health Bill and remove part 8 wholly from the Bill.

### **5. Criminal Procedure Act (Act No. 51 of 1977)**

Should the Bill persist with the use of the term “state Patient” to refer to SPDs, the necessary amendment to the Criminal Procedure Act No. 51 of 1977 may be required. This is a result of the fact that the current term is “State President’s decision patient”, or “President’s patient” in terms of section 77(6) and 78(6) of Criminal Procedure Act. Section 77(6) and 78(6) states ‘pending the signification of the decision of the state president. And the Bill fails to make reference to the wordings in section 77(6) and 78(6) of Criminal Procedure Act. Finally, section 77-79 be amended to subject the decision of the magistrate to an automatic review by a High Court judge and a person’s declaration as an SP by a judge in chambers be subjected to a Supreme Court judge.

### **IN RETROSPECT**

The proposed Bill reflects the values of the Namibian people as reflected in the Namibian Constitution, the National Development Plans and notably the Harambee Prosperity Plan. This, it does through Pillar 1 on Effective governance of firm accountability and adequate transparency, to improve performance and mental health care service delivery. Secondly, it reflects the values provided for in Pillar 2 on Economic advancement to bring about Economic competitiveness by ensuring an effective and mentally healthy workforce and nation at large. The Bill further seeks to place Namibia on a trajectory towards the achievement of the Sustainable Development Goals, goal 1-17 that are all linked to disability. And finally, the Bill ensures Namibia’s standing as a member of the international community in terms of Pillar 5 by complying with its international obligations under the CRPD and others. It is however to clear how the Bill will ensure that community services and mental health facilities are regulated to avoid them becoming money-making rackets similar to the ‘Life Healthcare Esidimeni scandal’. The scandal led to the death of 143 mental patients from neglect, starvation, dehydration, hypothermia etc.<sup>147</sup> The scandal happened under the South African Mental Health Act of 2002 that forms the basis of the proposed Bill. There are many gaps in the South African Mental Health Act of 2002 that lead to the scandal. Such gaps may also exist in the proposed Bill, proper analyses of the final Bill may be required before it is passed into law.

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<sup>147</sup> The Life Esidimeni tragedy: The courts are also to blame  
<http://www.scielo.org.za/pdf/samj/v108n3/06.pdf> accessed 20 July 2020.

## ANNEXURES

### A. STAKEHOLDERS CONSULTATIONS AGENDA



**PUBLIC CONSULTATIVE WORKSHOP ON  
THE MENTAL HEALTH BILL  
By the  
LAW REFORM AND DEVELOPMENT COMMISSION  
In partnership with  
THE MINISTRY OF HEALTH AND SOCIAL SERVICES**

**PROGRAM  
17 & 18 October 2018**

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#### DAY 1

<b>08h00-08h30:</b>	Arrival and Registration
<b>08h30-08h40:</b>	AU Anthem followed by the Namibian National Anthem
<b>08h40-09h00:</b>	Welcome Remarks by Hon. Julieta Kavetuna, Deputy Minister of Health & Social Services
<b>09h00-09h20</b>	Keynote address by Hon. Alexia Manombe-Ncube, Deputy Minister Disability Affairs. Office of the Vice President
<b>09h20-10h00:</b>	Remarks by Ms. Yvonne Dausab Chairperson of the Law Reform and Development Commission
<b>10h00-10h30:</b>	Tea Break
<b>10h30-13h00:</b>	The current situation on mental health in Namibia” (Dr Mthoko, Psychiatrist)
<b>13h00-14h00:</b>	Lunch
<b>14h00-15h00:</b>	Discussion of the Bill by Advocate Denk/ Ms. Ruusa Ntinda
<b>15h00-15h30:</b>	Tea Break
<b>15h30-16h30:</b>	Discussion of the Bill Continues

#### Day 2

<b>08h00-08h30:</b>	Registration
<b>08h30-09h00:</b>	Recapture: Mr. Hermann Nakwatumbah Law Reform and Development Commission
<b>09h40-10h00:</b>	Discussion of the Bill Continues
<b>10h00-10h30:</b>	Tea Break
<b>10h30-13h00:</b>	Discussion of the Bill Continues
<b>13h00-14h00:</b>	Lunch
<b>14h00-15h00:</b>	Discussion of the Bill Continues
<b>15h00-15h30:</b>	Tea Break
<b>15h30-16h30</b>	The Way Forward by Ms. Ruusa Ntinda, Chief Legal Officer Law Reform and Development Commission
<b>16h00-16h30:</b>	Closure and thanks by Ms. Najmia Jantjies Senior Legal Officer. Law Reform and Development Commission.

**B. STAKEHOLDERS CONSULTATIONS ATTENDANCE LIST**



**NAMIBIA MENTAL HEALTH BILL WORKSHOP**

**ATTENDANCE LIST (DAY 1)**

17<sup>TH</sup> TO 18<sup>TH</sup> OF OCTOBER 2018

No.	FULL NAME	ORGANIZATION	E-MAIL ADDRESS	CONTACT DETAILS	SIGNATURE
1	Herbertus Nkumbemph	Legal Reform and Dev. Comm.	Herbertus.Nkumbemph@legreform.gov.na	081 900 114	
2	William Andrew	M. O. H. S. Mental Health	william.andrew@mail.gov.na	081 25 335 5 2 061-2033374	
3	Justice Armin Basson	Community Member	justicearminbasson@gmail.com	081 2911234	
4	Nelke Jacobs	MOH	nelke.jacobs@mo.gov.na	0812003869	
5	Mabambela Mthoko	Community member	mthoko@libim.com	081232599	
6	DAVID HUGHES	NFPDN	davin.hughes@gmail.com	0813643551	
7	Sabine Withing	JUICEF	sabine@juicef.org	08161926	
8	Ismael Fied	UNICEF	ismael.fied@unicef.org	0814536410	
9	Majimela Gantjes	LRDC	mgantjes@mo.gov.na	081 3190191	

10	Joseph S. Siseho	MOHSS	Joseph.Siseho@mhss.gov.tl	0812414199	
11	Dorothy Kambinda	MOHSS	dkambinda@gmail.com	0812553999	
12	Jessica Gamodals	NDCN	greatnag@gmail.com	0811555532	
13	Yerone Dauvas	LRDC	Chairperson lrdc @	081-2262321.	
14	Jackson Nona	MOHSS	Jackson.Nona@mhss.gov.tl	0815614991	
15	Rinaoni Nushuba	ESIT	rinaoni@yepoc.com	0815615191	
16	Thully Davids	MOHSS	Thullydavid@gmail.com	0816332068	
17	Milka Mushimba	MOHSS	Milka.Mushimba@mhss.gov.tl	0812560805	
18	Alexia P. Manawe	Nudge Presidency	alex.manawe@yepoc.com	0811492232	
19	Julietta Kavetum	MOHSS	Julietakavetum@gmail.com	0810831279	
20					
21	Lukas Amakali	Nahya	LukasAmakali@gmail.com	0812116253	
22	Deen Batsako	NAMHAPS/ER/UC/DEEN	DeenBatsako@gmail.com	0914334532	
23	Loide Nampala	NAMHAPS/ER/UC/LOIDE	LoideNampala@gmail.com	0816671401	
24	Mery K Kufung	UPI Disability Affair	MeryKufung@gmail.com	0815392053	
25	Samuele Samuele	G.V.P. Disability Affairs	SamueleSamuele@gmail.com	0813322222	



## NAMIBIA MENTAL HEALTH BILL WORKSHOP

### ATTENDANCE LIST (DAY 2)

17<sup>TH</sup> TO 18<sup>TH</sup> OF OCTOBER 2018

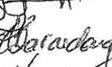
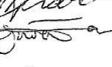
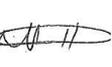
No.	FULL NAME	ORGANIZATION	E-MAIL ADDRESS	CONTACT DETAILS	SIGNATURE
1	Miretha W. Jacobs	MOTHS	miretha1212@gmail.com	0813003885	
2	Malahombelela MTHOM	Community worker	mthom@iwayona.com	0812325909	
3	Nicimbia Gandiza	CRDC	ngandiza@moj.gov.na	0813170191	
4	W. D. Andrew	W.D.H.S.S.	wandrew@gmail.com	0812533332	
5	Joseph S. Siseho	MOTHS	joseph.siseho@amb.gov.na	0112919191	
6	Dorethy N. Kambinda	MOTHS	dkambinda@gmail.com	0812553969	
7	Jackson Noma	MOTHS	Jackson.Noma@moths.gov.na	0815619191	
8	DAVID HUGHES	NFPDN	davin.ston.hughes@gmail.com	0813643357	
9	Leide Namfala	NAMHA		0716672241	



C. BRIEFING OF THE MINISTER OF HEALTH AND SOCIAL SERVICES AND FURTHER CONSULTATIONS ON THE BILL

NAMIBIA MENTAL HEALTH WORKSHOP  
ATTENDANCE LIST

06 Nov 2018

NO	FULL NAME	ORGANISATION	EMAIL ADDRESS	CONTACT NO.	SIGNATURE
1	K. Kouso	LRDC	kouso.kang@gmail.com	0813952058	
2	R Nhinda	LRDC	nhinda.ley@gmail.com	0811472708	
3	Nd. F. Mthoko	—	mthoko@iwa.na	0812324909	
4	J. Gawochob	NDCN	gawochob@gmail.com	0811555550	
5	A. Barandeng	—	abarandeng@gmail.com	0812072193	
6	M. Jacobs	MHU WCH	micha1212@yahoo.com	0813003889	
7	W.P. Andrew	MHC - FORENSIC	wpandrew@gmail.com	0812533350	
8	J. Xlowa	MHC WCH	jsu547644@gmail.com	0815204701	
9	M. Mushimbe	Molles Pite	Mushimbe@gmail.com	081266972	
10	MK Kufuna	OVP; Disability Aff	mkufuna@yahoo.com	0813390057	
11	Samuel E.	OVP; Disability Aff	ssamuel@gmail.com	0813780155	
12	DAVID HUGHES	NFASN	dwinstonhughes@gmail.com	0813643351	

**D. TARGETED STAKEHOLDERS ATTENDANCE LIST**

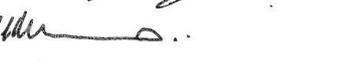
Targeted Stakeholders  
Consultation with Judiciary

24 / 10 / 19

	name	Position	Signatures
1.	P. Christiaan	Chief Magistrate	
2.	I. M. Kondandur	Director Lower Courts	
3.	P. T. Matiyil	Director Judicial Commissions Secretariat	
4.	Hermann Nakwintanda	Legal / Intern	
5.	Tami Iemba	ED's office	
6.	Ebe Schusterling	Chief Registrar	

Targeted  
Consultation Masters

4 / 11 / 19

	name	Position	Signatures
	E. Beukes	Master	
	Juge Koujo	Master	
	E. Haradoko	Deputy Master	
	S. Newaka	Senior legal officer	
	Adrie van der Merwe	FQP. attorney	

## E. PROPOSED MENTAL HEALTH BILL

### BILL

**To regulate mental health care in Namibia in order to promote the dignity, autonomy, human rights and the optimal mental, social and physical wellbeing of persons living with mental disabilities; to provide for the care and treatment of persons who are living with mental or intellectual disabilities; to set out the procedures that must be followed should persons living with mental disabilities require admission to health facilities and for their discharge from such facilities; to establish review boards to supervise the functions of mental health services and mental health facilities; to provide for the powers and functions of review boards; to provide for the care and administration of the property of mentally ill persons; generally to give effect to the provisions of the United Nations Convention on the Rights of Persons with Disabilities; and to provide for incidental matters.**

*(Introduced by the Minister responsible for health)*

**BE IT ENACTED** as passed by the Parliament and assented to by the President of the Republic of Namibia, as follows:

#### ARRANGEMENT OF SECTIONS

##### PART 1

#### INTRODUCTORY PROVISIONS

1. Definitions
2. Objects and application of Act

##### PART 2

#### ESSENTIAL PRINCIPLES OF MENTAL HEALTH CARE

3. Implementation of policies and measures by the State
4. Provision of mental health care at health facilities
5. Powers of health facilities other than State hospitals and State health facilities relating to mental health care
6. Provision of primary and community-based mental health care
7. Promotion of mental health

##### PART 3

#### RIGHTS AND DUTIES RELATING TO PATIENTS

9. Consent to mental health care and admission to health facilities
10. Prohibition of discrimination
11. Prohibition of exploitation or abuse
12. Use of seclusion and restraint
13. Prohibition of sterilisation
14. Disclosure of information
15. Limitation on intimate adult relationships
16. Right to representation

17. Discharge reports
18. Knowledge of rights
19. Determinations concerning mental health status

#### PART 4 REVIEW BOARDS

20. Establishment and constitution of review boards
21. Powers and functions of review board
22. Fees and allowances of members of review board
23. Procedures at meetings of review board

#### PART 5 VOLUNTARY, ASSISTED AND INVOLUNTARY MENTAL HEALTH CARE

24. Voluntary mental health care
25. Discharge of voluntary patients
26. Assisted mental health care for patients incapable of making informed decisions
27. Application for assisted mental health care
28. Recovery of capacity of assisted patients to make informed decisions
29. Involuntary mental health care of patients
30. Application to obtain involuntary mental health care
31. Preliminary assessment and subsequent provision of further involuntary mental health care
32. Periodic review and reports on involuntary patients
33. Appeal against decision of head of health facility on involuntary care, treatment and rehabilitation
34. Review of need for further involuntary mental health care
35. Recovery of capacity of involuntary patients to make informed decisions
36. Leave of absence from designated health facility
37. Intervention by members of Namibian Police Force

#### PART 6 STATE PATIENTS

38. Balancing of rights
39. Designation of health facilities for State Patients and other persons to be examined for their mental status
40. Admission of State Patients to designated health facilities
41. State Patients who abscond from a designated health facility
42. Transfer of State Patients between designated health facilities
43. Leave of absence from a designated health facility
44. Periodic review of mental health status of a State patient
45. Application for discharge of a State patient
46. Conditional discharge of State Patients, amendments to conditions or revocation of conditional discharge

#### PART 7 INMATES OR OFFENDERS WITH MENTAL HEALTH PROBLEM

47. Designation of health facilities for offender with mental illness
48. Enquiry into mental health status of inmate or offender
49. Mental health care of inmate or offender with mental health problem in correctional facility
50. Magisterial enquiry concerning transfer to designated health establishments
51. Procedure to transfer inmate or offender with mental health problems to designated health facility
52. Transfer of offenders with mental illness between designated health facilities
53. Periodic reviews of mental health status of inmate or offender with mental health problem
54. Recovery of inmate or offender with mental health problem
55. Inmate or offenders with mental health problem who abscond from designated health facility
56. Procedure upon expiry of term of imprisonment of inmate or offender with mental health problem

#### PART 8

#### CARE AND ADMINISTRATION OF PROPERTY OF PERSONS SUFFERING FROM MENTAL HEALTH PROBLEM OR SEVERE OR PROFOUND INTELLECTUAL DISABILITY

57. Appointment of administrator for care and administration of property of a person suffering from mental health problem or severe or profound intellectual disability
58. Application to Master for appointment of administrator
59. Recommendation to appoint administrator by court during enquiry or in course of legal proceedings
60. Confirmation of appointment of administrator
61. Powers, functions and duties of administrators and miscellaneous provisions relating to appointment of administrators
62. Termination of appointment of administrator

#### PART 9

#### OFFENCES AND PENALTIES

63. Unauthorised detention of patients
64. False statements, entries and willful obstruction
65. Ill-treatment of patient by persons employed at health facility
66. Offences in connection with patients who abscond
67. Employment of appropriate staff
68. Sexual or indecent or immoral act with patient
69. Prohibition of publication of sketches and photographs and information of patient
70. Other offences

#### PART 11 GENERAL

71. Namibians with mental health problems imprisoned in foreign countries
72. Examination of patient in connection with prosecution under Act
73. Expenses in connection with detention and treatment of State Patients in health facilities
74. Indemnity
75. Execution of court orders under this Act
76. Medical certificate evidence of certain facts
77. Review by Court
78. Requesting of assistance by members of Namibian Police Force
79. Regulations
80. Repeal of laws and transitional provisions
81. Short title and date of commencement

## **PART 1 INTRODUCTORY PROVISIONS**

### **Definitions**

1. In this Act, unless the context otherwise indicates -

“administrator” means a person appointed in terms of **section 57**, and includes an interim administrator if applicable;

“age group” means an age grouping in the following categories-

- (a) birth to 6 years;
- (b) 6 years to 12 years;
- (c) 12 years to 18 years; or
- (d) 18 years and older;

“assisted mental health care” means the provision of mental health care to people who require support to make decisions due to their mental health status and who do not refuse such mental health care;

“assisted patients” means a patient receiving assisted mental health care;

“authorized prescriber” means an authorized prescriber as defined in section 1 of the Medicines and Related Substances Control Act;

“care, treatment and rehabilitation services” means health and related services rendered by a health care practitioner for purposes of the treatment and rehabilitation of a patient requiring such services;

“child” means a person under the age of 18 years;

“Child Care and Protection Act” means the Child Care and Protection Act, 2015 (Act No. 3 of 2015);

“clinical psychologist” means a clinical psychologist as defined in section 1 of the Social Work and Psychology Act;

“community custodian” means a person appointed as a community custodian in terms of **section 43(2)**;

“community-based mental health care” means the provision of mental health care by a community-based healthcare facility to support a patient to become reintegrated in society;

“community-based healthcare facility” means a day care centre, halfway house or similar facility providing community-based mental health care;

“Namibian Constitution” means the Constitution of the Republic of Namibia;

“correctional facility” means a correctional facility as defined in section 1 of the Correctional Service Act;

“Correctional Service Act” means the Correctional Service Act, 2012 (Act No. 9 of 2012);

“Court” means the High Court as defined in section 1 of the High Court Act, 1990 (Act No. 16 of 1990);

“Criminal Procedure Act” means the Criminal Procedure Act, 1977 (Act No. 51 of 1977);

“curator” means a person appointed as a curator of a patient in accordance with the Rules of the High Court made under the High Court Act, 1990 (Act No. 16 of 1990);

“day care centre” means a centre offering daytime mental health care to patients in transition between hospitalization and life at home;

“family member” in relation to a patient, means-

- (a) the spouse or life-time partner of patient;
- (b) a parent of the patient;
- (c) any other person who has parental responsibilities and rights in respect of the patient;
- (d) a grandparent, step-parent, brother, sister, uncle, aunt or cousin of the patient; or
- (e) any other person with whom the patient has developed a significant relationship, based on psychological or emotional attachment, which resembles a family relationship;

“free and informed consent” in relation to mental health care means –

- (a) that such consent has not been influenced by a direct or implied threat of compulsion, seclusion, restraint or action for involuntary mental health care;
- (b) that alternatives to the proposed mental health care have been offered for consideration by the patient;
- (c) that the patient has the right to refuse such mental health care; and
- (d) that the patient has been provided with sufficient and understandable information about the mental health care concerned, including potential benefits and side effects to enable that patient to make informed decisions;

“halfway house” means a residential facility for rehabilitating patients to begin the process of reintegration into society, while providing monitoring and support services;

“head of a health facility” means a person who manages a health facility or any employee of any facility who is authorised by that person to perform or carry out any power or function of the person;

"health care practitioner" means a person registered, enrolled or authorised, as the case may be, under

- (a) the Allied Health Professions Act, 2004 (Act No. 7 of 2004) as an allied or complementary health practitioner defined in section 1 of that Act;
- (b) the Medical and Dental Act as a practitioner mentioned in section 17(1) of that Act;
- (c) the Nursing Act, 2004 (Act No. 8 of 2004) as a practitioner mentioned in section 17(1) of that Act;
- (d) the Pharmacy Act as a practitioner mentioned in section 17(1) of that Act; or
- (e) the Social Work and Psychology Act as a practitioner mentioned in section 17(1) of that Act;

“Health facility” includes any State hospital, State health facility, private hospital, private health facility or a health facility as defined in section 1 of the Hospitals and Health Facilities Act;

“Hospitals and Health Facilities Act” means the Hospitals and Health Facilities Act, 1994 (Act No. 36 of 1994);

“inmate” means an inmate as defined by section 1 of the Correctional Service Act;

“inmate or offender with a mental health problem” means an inmate or offender in respect of whom an order has been issued in terms of **section 50(3)(a)** to enable the provision of mental health care at a health establishment designated in terms of **section 47(1)**;

“in-patient” means a person who receives mental health care at a mental health facility for a continuous period of four hours or more;

"intellectual disability" means a condition diagnosed by a mental health care practitioner in accordance with medically accepted diagnostic criteria manifested during a person's developmental period, which in interaction with various barriers may hinder that person's full and effective participation in society on an equal basis with others;

“interested party” means a person with a substantial or material interest in the well-being of a patient or a person who has substantial contact with such patient, including but not limited to that patient's family member, legal guardian appointed under section 113 of the Child Care and Protection Act or curator;

“involuntary mental health care” means the provision of mental health care to a person who needs support to make decisions due to his or her mental health status and who refuses the mental health care, but who require such care for his or her own protection or for the protection of others;

“involuntary patient” means a person receiving involuntary mental health care;

“judge” or “judge in chambers” means a judge of the Court;

“legal practitioner” means a legal practitioner as defined in section 1 of the Legal Practitioners Act, 1995 (Act No. 15 of 1995);

“Master” means the Master of the High Court and includes a Deputy Master appointed in terms of section 2 of the Administration of Estates Act, 1965 (Act No. 66 of 1965);

“Medical and Dental Act” means the Medical and Dental Act, 2004 (Act No. 10 of 2004);

“medical practitioner” means a person who is registered as such in terms of the Medical and Dental Act, or regarded to be so registered in terms of section 64 of that Act;

“Medicines and Related Substances Control Act” means the Medicines and Related Substances Control Act, 2003 (Act No. 13 of 2003);

“mental disability” means a condition diagnosed by a mental health care practitioner in accordance with medically accepted diagnostic criteria that a person suffers from a disability involving a mental condition that hinder the full or equal participation in society of a person suffering from such disorder;

“mental health care” means the provision of care, treatment and rehabilitation services to a person suffering from a mental health problem or a severe or profound intellectual disability;

“mental health care practitioner” means a health care practitioner who has been trained to provide mental health care;

“mental health facility” means a State hospital, State health facility, private hospital or private health facility which-

- (a) provides mental health care; and
- (b) has been approved by the Minister in writing;

“mental health status” means the level of mental well-being as determined by a mental health practitioner in accordance with medically accepted diagnostic criteria of a person suffering from a mental health problem or a severe or profound intellectual disability;

“mental health problem” means a mental disability or mental illness;

“mental illness” means a mental illness diagnosed as such by a mental health care practitioner in accordance with medically accepted diagnostic criteria;

“offender” means an offender as defined in section 1 of the Correctional Service Act;

“officer-in-charge” means the senior correctional officer appointed under section 18(1) of the Correctional Service Act as the officer-in-charge of a correctional facility, and includes a deputy officer-in-charge if the officer-in-charge is for any reason not able to act as officer in charge;

“official curator *ad litem*” means the Attorney-General of Namibia;

“out-patient” means a patient who receives treatment at a health facility for a continuous period of four hours or less;

“patient” means any person receiving mental health care, and includes –

- (a) a State Patient;
- (b) an inmate or offender with a mental health problem; or

- (c) a person diagnosed in accordance with medically accepted diagnostic criteria by a medical practitioner to be suffering from a severe alcohol or drug dependency:

Provided that where the person receiving mental health care is a child or is incapable of taking decisions, it is deemed that such person includes –

- (i) a person who is an interested party in relation to that person;
- (ii) a person authorised by any other law or any court order to act on that person’s behalf; or
- (iii) an administrator or curator appointed in terms of this Act or any other law;

“Pharmacy Act” means the Pharmacy Act, 2004 (Act No. 9 of 2004);

“prescribe” means to prescribe by regulation;

“primary mental health care” means mental health care rendered by a mental health facility;

“private health facility” means a private health facility as defined in section 1 of the Hospitals and Health Facilities Act;

“private hospital” means a private hospital as defined in section 1 of the Hospitals and Health Facilities Act;

“profound intellectual disability” means an intellectual disability diagnosed as profound by a mental health care practitioner in accordance with medically accepted diagnostic criteria;

“psychiatrist” means a medical practitioner who specialises in psychiatry;

“public authority” means-

- (a) any office, ministry or agency of State or administration in the local or regional sphere of government; or
- (b) any other functionary or institution-
  - (i) exercising a power or performing a function in terms of the Constitution; or
  - (ii) exercising a public power or performing a public function in terms of any law,

but does not include any court or a judicial officer;

“rehabilitation” means health services that facilitate a patient to attain an optimal level of independent functioning and “rehabilitating” has a corresponding meaning;

“review board” means a review board established under **section 20**;

“severe intellectual disability” means an intellectual disability diagnosed as severe by a mental health care practitioner in accordance with medically accepted diagnostic criteria;

“Social Work and Psychology Act” means the Social Work and Psychology Act, 2004 (Act No. 6 of 2004);

“State health facility” means a State health facility as defined in section 1 of the Hospitals and Health Facilities Act;

“State hospital” means a State hospital as defined in section 1 of the Hospitals and Health Facilities Act;

“State Patient” means a person detained by order of any court, including a court contemplated in Chapter 13 of the Criminal Procedure Act or other competent judicial authority at any designated place pending the decision of a judge in chambers as contemplated in this Act;

“treatment” means the management and care of a patient, for the purpose of combating any mental health problem, particularly the provision to such patient of any one or more of the following-

(a) psychiatric services by a psychiatrist;

(b) counselling services by a person mentioned in section 17(1)(a), (d), (e), (f), (g), (i) or (j) of the Social Work Psychology Act, 2004 (Act No. 6 of 2004);

(c) nursing services;

(d) accommodation, food or clothing;

(e) medical, surgical, gynecological, obstetrical, dental, curative, diagnostic or preventative examination, measure or service;

(f) immunisation services;

(g) any dressing, medical apparatus or appliance; or

(h) any other article, examination, measure or service as may be prescribed,

and includes the prescribing of medicine by an authorised prescriber, or the dispensing of such medicine by a pharmacist registered under the Pharmacy Act or the provision of any medicine by a health practitioner, and “treat” has a corresponding meaning;

“voluntary mental health care” means the provision of mental health care to a person who gives consent to such mental health care; and

“voluntary patient” means a person receiving voluntary mental health care.

## **Objects and application of Act**

2. (1) The objects of this Act are to -
  - (a) regulate mental health care and health facilities to –
    - (i) make the best possible mental health care available to patients in an equitable, efficient, affordable and accessible manner in order to promote the capacity and the rights of a person living with a mental health problem to make responsible decisions;
    - (ii) coordinate access to mental health care to various categories of patients; and
    - (ii) implement the provisions of the Namibian Constitution and Namibia's international obligations with respect to patients;
  - (b) regulate access to and provide mental health care in a non-discriminatory manner to -

- (i) voluntary, assisted and involuntary patients;
  - (ii) State Patients; and
  - (iii) inmates with mental illness;
- (c) clarify –
- (i) the rights and obligations of patients;
  - (ii) the obligations of mental health care practitioners; and
  - (iii) the obligations and responsibilities of relatives of patients.
- (d) regulate the manner in which the property of persons requiring mental health care may be dealt with by a court of law.

(2) This Act applies in relation to health facilities, mental health facilities, public authorities responsible for mental health care, patients and interested parties.

(3) In the event of any conflict arising between the provisions of this Act and any law other than the Namibian Constitution, the provisions of this Act prevail.

## **PART 2 ESSENTIAL PRINCIPLES OF MENTAL HEALTH CARE**

### **Implementation of policies and measures by the State**

3. Every public authority responsible for health services must determine and coordinate the implementation of its policies and measures in a manner that-
- (a) ensures the provision of mental health care at primary, secondary and tertiary levels and health facilities;
  - (b) promotes the provision of community-based mental health care;
  - (c) promotes and protects the rights and interests of patients; and
  - (d) promotes and improves the mental health status of people requiring mental health care.

### **Provision of mental health care at health facilities**

4. (1) A health facility–
- (a) must, insofar as reasonably possible, endeavor to provide any person requiring mental health care with the appropriate level of mental health care within its professional scope of practice, including services such as educational activities, vocational training, leisure and recreational activities, reasonable accommodation, after care and reintegration, social welfare, social development services, services addressing religious and cultural needs in the least restrictive environment; and
  - (b) must, if that facility is unable to provide the services referred to in paragraph (a), refer a person requiring mental health care according to established referral and admission routes, to a mental health facility that provides such services.

(2) Subject to the provisions of **section 5**, a mental health facility may only admit, care for, treat and rehabilitate the categories of –

- (a) voluntary patients;
- (b) assisted patients;
- (c) involuntary patients;
- (d) State Patients;
- (a) persons referred by the Court of any other court for psychiatric observation in terms of the Criminal Procedure Act; or
- (b) inmates or offenders with a mental health problem.

(3) A mental health facility must provide mental health care in a manner that facilitates community-based mental health care.

(4) A mental health facility must work together with any relevant public authority or non-governmental organization to facilitate the transition of a patient from receiving mental health care within a mental health facility to being an outpatient.

(5) Subject to the requirements of doctor-patient confidentiality a mental health facility must involve voluntary patients and their family members or interested parties in the treatment plan and rehabilitation of such patients.

(6) Patients in the same age group must-

- (a) be housed in the same wards or areas within a mental health facility; and
- (b) receive mental health care appropriate for their age group.

(7) Subject to the provisions of section 9 of the Child Care and Protection Act, the institutionalisation of children with mental disabilities may only be done if authorised by a mental health care practitioner as a last resort.

(8) Patients suffering from an intellectual disability must be housed in wards or areas separate from patients suffering from a mental health problem.

- (9) Sleeping facilities for males and females in a mental health facility must -
  - (a) be separate from each other; and
  - (b) be equal in terms of quality and space available.

(10) Subject to compliance with its provisions, nothing in this Act prevents an interested party from caring for patients in his or her home or in a community-based health care facility.

#### **Powers of mental health facility other than State hospital or State health facility relating to mental health care**

- 6. Notwithstanding the provisions of **section 4** a mental health facility other than a State hospital or a State health facility may provide mental health care for -

- (a) voluntary patients;
- (b) assisted patients, if registered for that purpose in the prescribed manner;
- (c) involuntary patients, if authorised to do so by a Court order and registered for that purpose in the prescribed manner.

### **Provision of primary and community-based mental health care**

**6.** (1) All health facilities must ensure and regulate the provision of comprehensive, decentralised and community-based mental health care services, integrated into the existing health care system with emphasis on a primary health care approach that is accessible, equitable and affordable.

(2) Preference must be given to the least restrictive and intrusive form of mental health care if that is appropriate and possible.

### **Promotion of mental health**

**7.** All health facilities must adopt policies and utilise public health education to promote mental health in all areas of public life.

## **PART 3 RIGHTS AND DUTIES RELATING TO PATIENTS**

### **Respect for personal integrity, human dignity and privacy of patients**

**8.** (1) All health care practitioners responsible for the mental health care of patient must ensure that the personal integrity, human dignity, privacy and autonomy of every patient is protected.

- (2) Mental health care administered to a patient must –
  - (a) be proportionate to his or her mental health status;
  - (b) endeavour to improve his or her capacity to develop his or her full potential and facilitating his or her independent living and reintegration into society; and
  - (c) support the patient’s human dignity to enhance his or her decision-making abilities.

### **Consent to mental health care and admission to health facilities**

**9.** (1) A health care practitioner or a health facility may provide mental health care to or admit a patient only if -

- (a) that patient has given free and informed consent to the mental health care, or to the admission;
- (b) where that patient is a child or is not able to give consent, that child’s family member or legal guardian has consented to the mental health care or to the admission;

- (c) authorised by an order of any court of law or a review board; or
- (d) due to a mental health problem, any delay in providing mental health care or admitting the patient may result in the patient inflicting serious harm to himself or herself or others:

Provided that such patient may only be admitted for a therapeutic purpose and the mental health care concerned can only be given by admission to a health facility.

- (2) Any person or health facility that admits and provides mental health care to a patient in circumstances referred to in subsection (1)(d) –
  - (a) must report this fact in writing in the prescribed manner to the appropriate review board; and
  - (b) may not continue to provide mental health care to that patient for longer than 48 hours, unless an application in terms of **Part 5** is made within that 48-hour period.

### **Prohibition of discrimination**

- 10.** (1) A patient may not be discriminated against on the grounds of his or her mental health status.
- (2) Every patient must receive appropriate mental health care, regardless of his or her sex, race, colour, ethnic origin, nationality, religion, disability, creed or social or economic status.
- (3) A medical aid fund registered under the Medical Aid Funds Act, 1995 (Act No. 23 of 1995), may not –
- (a) exclude persons with mental health problems including health disorders related to addiction to, or abuse of substances, or exclude such problems or disorders, from that fund's coverage; or
  - (b) impose pre-conditions, treatment limitations, a ceiling on any benefits or other requirements on mental health benefits or benefits for substance use disorders which are less favourable or more restrictive in any way than those imposed for other health benefits offered by that fund.
- (4) Any person who contravenes subsection (1) or (2) commits an offence and is liable on conviction to a fine not exceeding N\$ 200,000 or to imprisonment for a period not exceeding three years or to both such fine and such imprisonment.
- (5) A medical aid fund referred to in subsection (3) which contravenes that subsection commits an offence and is liable on conviction to a fine not exceeding N\$ 200,000.

### **Prohibition of exploitation or abuse**

- 11.** (1) A patient may not be subjected to any torture or to cruel, inhuman or degrading treatment or punishment, including but not limited to medical or scientific experimentation regarding a mental health problem or intellectual disability.

(2) Every person, body, organisation or health facility providing mental health care to a patient must take steps to ensure that -

- (a) such patient is protected from exploitation or abuse, including physical, emotional, sexual, psychological and financial exploitation, abuse and any degrading treatment;
- (b) such patient is not subjected to forced labour; and
- (c) mental health care for such patient is not used as punishment or for the convenience of another person.

(3) A health facility administering mental health care to a patient should insofar as reasonable ensure that no patient is subjected to unsafe or unsanitary conditions.

(4) A person who provides mental health care to patients and who, during the course of providing such care, witnesses anything that gives rise to a reasonable suspicion of any form of abuse against a patient must forthwith report such suspicion to an applicable review board in the prescribed manner.

(5) Any person who contravenes subsection (1) or (2) commits an offence and is liable on conviction to a fine not exceeding N\$ 200,000 or to imprisonment for a period not exceeding three years or to both such fine and such imprisonment.

(6) Any person who contravenes subsection (3) or (4) commits an offence and is liable on conviction to a fine not exceeding N\$ 100,000 or to imprisonment for a period not exceeding two years or to both such fine and such imprisonment.

### **Use of seclusion and restraint**

**12.** (1) Any form of seclusion and restraint -

- (a) may not be used as a means to discipline a patient;
- (b) if used, must be appropriate, proportionate and consistent with the objectives of this Act, the Constitution and relevant international agreements and only in circumstances where there are adequate facilities to undertake the seclusion and restraint safely; and
- (c) may not exceed 4 hours, except if the mental health care practitioner authorising the seclusion and restraint otherwise decides on grounds of safety to the patient or other persons or for the prevention of damage to property.

(2) Any seclusion and restraint of a patient –

- (a) must be authorised by a mental health care practitioner; and
- (b) may only be used to prevent a patient from inflicting harm to himself or herself or others or to property of the health facility concerned.

(3) During any period of seclusion or restraint the health facility must ensure that the patient continues to receive the best possible mental health care.

(4) The –

- (a) reason and duration of seclusion and restraint; and
- (b) treatment given to ensure speedy termination of the seclusion and restraint,

must be entered by the mental health care practitioner authorising the seclusion and restraint in the clinical records of the patient concerned.

(5) The mental health care practitioner in charge of a ward concerned must enter records of all seclusions and restraints in a register, which is accessible to a review board.

(6) The mental health care practitioner in charge of a ward in which a patient is treated who is subjected to seclusion and restraint must immediately inform family members of that patient and any interested party of such seclusion and restraint.

(7) Any person who contravenes subsection (1) commits an offence and is liable on conviction to a fine not exceeding N\$ 200,000 or to imprisonment for a period not exceeding three years or to both such fine and such imprisonment.

### **Prohibition of sterilisation**

**13.** Sterilisation is not a treatment for mental illness or mental disability and involuntarily sterilisation of a patient may only be carried out in accordance with the Abortion and Sterilisation Act, 1975 (Act No. 2 of 1975).

### **Disclosure of information**

**14.** (1) No person or health facility may disclose any information which a patient is entitled to keep confidential in terms of any law.

(2) Despite subsection (1), the head of a health facility may disclose information referred to in that subsection if failure to do so may cause a danger to the life or health of a patient or any other person.

(3) A mental health care practitioner may temporarily deny a patient access to information contained in his or her health records, if disclosure of the information is likely to –

- (a) seriously prejudice that patient; or
- (b) cause the patient to conduct himself or herself in a manner that may seriously prejudice him or her or the health or wellbeing of any other person.

(4) Notwithstanding subsection (3), the interests of a patient or any other person must be balanced with the procedural rights of that patient under **Parts 5, 6, 7, and 8**.

(5) Any person who contravenes subsection (1) commits an offence and is liable on conviction to a fine not exceeding N\$ 200,000 or to imprisonment for a period not exceeding three years or to both such fine and such imprisonment.

### **Limitation on intimate adult relationships**

**15.** Subject to any conditions applicable to providing mental health care in a health facility and in accordance with **section 68**, the head of a health facility may limit intimate relationships of an adult patient if, due to a mental health problem, the ability of that patient to consent is diminished.

## **Right to representation**

**16.** A patient is entitled to a representative of his or her own choice, including a legal representative, when -

- (a) submitting an application under this Act;
- (b) lodging an appeal; or
- (c) appearing before a judge or a review board, subject to the laws governing right of appearance in a court of law,

and no presumption, legal or otherwise, relating to the mental capabilities of that patient will detract from the right.

## **Discharge reports**

**17.** (1) The head of a health facility must in the prescribed form and manner issue a discharge report to a patient who was admitted for purposes of receiving mental health care if the health facility discontinues the mental health care of that patient -

- (a) due to an order to do so by a judge or a review board;
  - (b) due to medical reasons as determined by one or more medical practitioners as contemplated in this Act; or
  - (c) in the case of discharges in terms of **sections 28 and 35**.
- (2) A discharge report referred to in subsection (1) must state –
- (a) the date and time of admission;
  - (b) the diagnosis at the time of admission;
  - (c) the duration of the treatment;
  - (d) the final diagnosis and type of treatment received;
  - (e) the date and time of release;
  - (f) the reasons for release; and
  - (g) whether an aftercare plan as prescribed by a mental healthcare practitioner must be followed.

(3) If the patient is a State Patient, the head of the health facility concerned must provide the Minister responsible for correctional services with a copy of that patient's discharge report.

## **Knowledge of rights**

**18.** (1) Every mental health care practitioner must, before administering any mental health care inform-

- (a) the patient who are to receive such care; and

(b) in the case of an assisted or involuntary patient, any interested party,  
in an appropriate manner of the rights and responsibilities of such patient.

(2) A right referred to in subsection (1) includes the right to be informed how to lodge complaints in the case of any exploitation or abuse.

#### **Determinations concerning mental health status**

**19.** (1) Any determination concerning the mental health status of any patient must be made by a mental health care practitioner based on factors exclusively—

- (a) relevant to that patient’s mental health status;
- (b) for the purposes of giving effect to any applicable provision of the Criminal Procedure Act,

but not for purposes of relaying information on a patient’s socio- political or economic status, cultural or religious background or affinity.

(2) A determination concerning the mental health status of a patient may only be made or referred to for purposes directly relevant to the mental health status of that patient.

### **PART 4 REVIEW BOARDS**

#### **Establishment and constitution of review boards**

**20.** (1) Subject to subsection (9), the Minister must in respect of any health facility providing mental health care establish a review board which must consist of at least three and not more than five members appointed by the Minister.

(2) The Minister must by notice in the *Gazette* publish the establishment of a review board and the names of the members thereof.

(3) A review board consisting of –

- (a) not more than three members, must be composed of a psychiatrist or if not available, a medical practitioner with an interest in mental health, a legal practitioner and a community representative;
- (b) more than three members, must be composed of a psychiatrist or if not available, a medical practitioner with an interest in mental health, a legal practitioner and a community representative and the remaining two members may be selected from any of the aforesaid professions or may be any other healthcare professional.

(4) The term of office of a member of a review board is three years and a member is eligible for reappointment.

(5) If, in the case of a review board consisting of not more than three members, the number of members of the board is increased to four or five during the period of office of the serving

members of the board, the period of office of the additional member or members expires on the same date as that of the serving members.

- (6) A member of a review board must vacate office if that member –
- (a) becomes insolvent or makes an arrangement with his or her creditors;
  - (b) is convicted of an offence and sentenced to imprisonment without the option of a fine;
  - (c) resigns his or her office by giving the Minister one month's notice in writing of his or her intention to resign;
  - (d) is absent from three consecutive meetings of that board without a valid apology; or
  - (e) is removed from office by the Minister under subsection (7).

(7) The Minister may remove, by notice in writing, a member of a review board from office if the Minister, after affording the member a reasonable opportunity to be heard, is satisfied that the member –

- (a) is guilty of neglect of duty or misconduct; or
- (b) is incapable, by reason of physical or mental illness, of performing the duties of his or her office.

(8) The Minister may appoint any person to act as substitute for any member who may be absent on leave.

(9) If the office of a member of a review board becomes vacant, the Minister must within 30 days after the vacancy arose appoint a person to fill the vacancy for the remainder of the period for which the member was appointed, and if the member was appointed by virtue of a qualification referred to in subsection (3), the person appointed by the Minister to fill the vacancy must be likewise qualified.

### **Powers and functions of review board**

- 21.** (1) A review board must -
- (a) consider and decide upon appeals against decisions of the head of a health facility;
  - (b) investigate any reasonable complaint or grievance made to it by a patient;
  - (c) consider and act upon periodic reviews on the mental health status of State Patients;
  - (d) consider and act upon periodic reports on the mental health status of inmates with mental illness;
  - (e) consider complaints from patients in relation to any exploitation, abuse, cruel, inhuman or degrading treatment or punishment or ill-treatment by mental health care practitioners and make decisions on whether a complaint should be further investigated; and

(f) make at least one unannounced visit per year to the health facility under its care.

(2) The review board may, by resolution duly adopted and recorded after proper enquiry, conditionally or unconditionally discharge any patient, other than an inmate or offender with a mental health problem and a State Patient, detained in an institution, whether or not such patient has recovered from his or mental health problem

(3) The review board must visit every healthcare facility in respect of which it has been appointed at least once in every two months, and must afford every patient therein an opportunity of making in person any representations he or she may wish to make to the board.

(4) A review board –

(a) must on each visit –

(i) engage in personal observation of every patient;

(ii) inspect every ward, kitchen and place where patients are ordinarily kept, assessing the standard of service in respect of patients; and

(b) must after each visit provide the Minister with a written report of its findings and any recommendations.

(5) In addition to subsection (1), a review board may consider any other matter which may be prescribed for purposes of this section.

(6) When considering a complaint, the review board must afford the complainant and the mental health care practitioner or any other person against whom the complaint is made an opportunity to be heard, and if the board is of the opinion that a complaint should further be investigated, the board must –

(a) if such mental health care practitioner or person concerned is a staff member in the public service, refer the complaint, together with the particulars thereof and evidence substantiating the complaint, to the Permanent Secretary of the mental health care practitioner;

(b) in all cases concerning a mental health care practitioner refer the complaint, together with the particulars and evidence referred to in paragraph (a), to the Council responsible for the registration of the profession of the practitioner or the employer,

for investigation whether –

(i) a charge of –

(aa) misconduct as contemplated in sections 25 and 26 of the Public Service Act, 1995 (Act No. 13 of 1995);

(bb) unprofessional conduct in terms of the laws governing the registration of the profession of the practitioner,

should be brought against the mental health care practitioner; or

(ii) a charge appropriate to the person in question must be brought against that person.

(7) When exercising or performing its powers and functions in terms of this Part, a review board may consult with or obtain representations from any person.

### **Fees and allowances of members of review board**

**22.** Members of a review board who are not staff members in the public service must be paid out of moneys appropriated by Parliament sitting fees and allowances, as well as the

other benefits, as the Minister, with the concurrence of the Minister responsible for finance, may determine.

### **Procedures at meetings of review board**

**23.** (1) A review board may determine its own procedures for conducting its business and require the head of the health facility concerned to attend its meetings.

(2) A review board must elect one of its members as chairperson to preside at its meetings.

(3) The members of a review board may determine the procedure for appointing an acting chairperson if the chairperson is not able to preside over a meeting of the board.

(4) If a review board is considering a matter that involves a health facility at which one of the members of the board is a mental health care practitioner or has a direct interest in the case such as a personal relationship with the complainant or respondent the practitioner concerned –

- (a) may not be involved in the consideration of the matter; and
- (b) must recuse himself or herself from the meeting.

whereupon the review board may consult another mental health care practitioner which is of the same profession as the first-mentioned practitioner.

(5) The board must meet for the despatch of business whenever it is necessary, but at least once in every two months, and due notice of every meeting must be given by the chairperson thereof.

(6) The board must-

- (a) in writing report to the Minister the result of any visit to a healthcare facility within 30 days after concluding such visit; and
- (b) from time to time comment and make suggestions on the welfare of the patients in any healthcare facility for which the board has been established, as it may deem fit.

(7) At a meeting of a review board –

- (a) a majority of the members of the board form a quorum if the

board consist of three members;

- (b) all questions must be decided by a majority of votes of the members present at that meeting and voting; and
- (c) the member presiding has a deliberative vote and, in the event of any equality of votes, also a casting vote.

(8) A decision taken by a review board is not invalid only by reason of a casual vacancy in the review board when the decision has been taken.

## **PART 5**

### **VOLUNTARY, ASSISTED AND INVOLUNTARY MENTAL HEALTH CARE**

#### **Voluntary mental health care**

**24.** (1) A person who submits voluntarily to a health facility for mental health care must be provided with the appropriate mental health care, or be referred to a health facility equipped to provide such care.

(2) A person may by means of a written or oral application voluntarily submit himself or herself to mental health care at a health facility.

(3) If the head of the health facility concerned is satisfied that the person referred to in subsection (1) –

- (a) understands the meaning and effect of the application contemplated in subsection (2); and
- (b) should receive mental health care,

the head may receive, accommodate and ensure that the person receives mental health care at the health facility concerned.

(4) If a person referred to in subsection (1) does not submit a written application as contemplated in subsection (2), the mental health care practitioner receiving that person must produce an admission report for the person's medical file.

(5) If a patient is a child, the health facility in collaboration with officials from the Ministry responsible for child welfare must make every reasonable effort to accommodate the patient's on-going relationship with his or her parents or guardian.

(6) If a patient is received at a health facility in terms of this section, the head of that health facility must inform that patient –

- (a) of his or her rights under **section 25** relating to his or her discharge from the health facility;
- (b) at the time of admission that he or she may only be denied the right to leave if he or she meet the conditions for assisted or involuntary mental health care.

#### **Discharge of voluntary patients**

**25.** (1) Subject to subsection (4), a patient admitted as an in-patient at a health facility in terms of section 24 must be discharged from that facility within 72 hours after the patient has made such a request to the head of that facility.

(2) If a request referred to in subsection (1) –

- (a) is made in writing, the head of the health facility concerned must keep the written request on the file of the patient;
- (b) is not made in writing, the head of the health facility must document the request in the prescribed manner.

(3) If the patient is a child at the time of filing the request referred to in subsection (1), the patient must be discharged within 72 hours after such request was made by the patient's guardian or at least one parent of the patient.

(4) Subsection (1) does not apply if the head of the health facility certifies in writing, supported by valid reasons, that the patient cannot be discharged in terms of this Act because the patient must be classified as an involuntary patient under **section 30**.

#### **Assisted mental health care for patients incapable of making informed decisions**

**26.** (1) A person may only be provided with assisted mental health care at a health facility as an in-patient or out-patient, if -

- (a) a written application for such mental health care in accordance with **section 27** has been made to the head of that health facility, or the application has been made verbally and has been documented as such by the health facility;
- (b) at the time of deciding on the application, the head of that health facility has a reasonable belief that -

- (i) the person referred to in subsection (1) is suffering from a mental health problem or a moderate, severe or profound intellectual disability, and requires such mental health care for his or her health or safety, or for the health and safety of other people; and
- (ii) the person is incapable of making an informed decision on the need for mental health care; and

- (c) (i) the person concerned is 18 years of age or older; or
- (ii) if that person is a child at least one parent or the guardian of the patient has given written consent for such mental health care.

(2) Subsection (1) does not apply if the head of a health facility certifies in writing, supported by valid reasons, that a patient cannot be discharged under this Act because that patient must be classified as an involuntary patient under **section 30**.

#### **Application for assisted mental health care**

**27.** (1) An application referred to in **section 26(1)** may only be made by an interested party, but if -

- (a) the person in need of mental health care is a child on the date of the application, the interested party making the application must be a parent or guardian of that person;
- (b) there is no interested party who is willing, capable or available to make such application, the application may be made by a health care practitioner;
- (c) there is reasonable grounds to believe that a person -
  - (i) has a mental health problem that may cause that person's mental condition to deteriorate if not treated;
  - (ii) is incapable of making an informed decision on the need for mental health care,

any other person may make the application.

- (2) An application contemplated in subsection (1) must be made in the prescribed manner and must –
  - (a) state the relationship of the applicant to the person referred to in that subsection;
  - (b) if the applicant is a mental health care practitioner, state the reasons why he or she is making the application;
  - (c) state the grounds on which the applicant believes that mental health care in respect of that person is required; and
  - (d) state the date and time when and place where that person was last seen by the applicant.
- (3) An application contemplated in subsection (1) may be withdrawn at any time.

(4) The mental health care practitioner who examined a person referred to in subsection (1) at a health facility must inform that person and any interested party that they may appeal in the manner prescribed to the review board against any decision made by that practitioner concerning the person concerned.

### **Recovery of capacity of assisted patients to make informed decisions**

**28.** (1) If the head of a health facility, at any stage after approving an application for assisted mental health care, has reason to believe -

- (a) from personal observation;
- (b) from medical information obtained by others, including mental health care practitioners; or
- (c) on receipt of representations by a patient, family or guardian,

that the patient has recovered the capacity to make informed decisions, that head must enquire from the patient whether the patient is willing to voluntarily continue with mental health care.

- (2) If the assisted patient consents to further mental health care, **section 24** applies.

(3) If the patient is unwilling to continue with assisted mental health care, and the head of the health facility is satisfied that the patient has recovered and has the capacity to make informed decisions, the head of the health facility concerned must cause the patient to be discharged without delay according to accepted clinical practices and standards.

### **Involuntary mental health care of patients**

**29.** A health facility may, without the consent of a person provide that person with mental health care as an in-patient or an out-patient if -

- (a) a written application for mental health care as contemplated in **section 30** has been made to the head of that health facility or the application has been made verbally and has been documented as such by the health facility;
- (b) at the time of making the decision the head of that health facility, reasonably believes that the person concerned -
  - (i) has a mental health problem of such a nature that he or she is likely to inflict serious harm to himself or herself or others; and
  - (ii) is incapable of making an informed decision on his or her need for mental health care and is unwilling to receive such care;
- (c) that person's condition will deteriorate if left untreated; and
- (d)
  - (i) the person is 18 years of age or older; or
  - (ii) where the person is a child, at least one parent or the guardian of that person has given written consent to the treatment concerned.

### **Application to obtain involuntary mental health care**

**30.** (1) An application for involuntary mental health care for a person may only be made by an interested party, but if -

- (a) that person is a child on the date of the application, the application must be made by at least one parent or the guardian of the person; or
- (b) there is no interested party who is willing, capable or available to make such application, the application may be made by a mental health care practitioner.

(2) Any applicant referred to in subsection (1) must have seen the person referred to in that subsection within seven days before making the application concerned.

(3) An application referred to in subsection (1) must be made in the prescribed manner and must -

- (a) state the relationship of the applicant to the person referred to in that subsection;
- (b) if the applicant is a mental health care practitioner, state -
  - (i) the reasons why the mental health care practitioner is making the application;

and

- (ii) what reasonable steps were taken to locate any interested party in order to determine the capability or availability of an interested party to make the application;
  - (c) state the grounds on which the applicant believes that mental health care in respect of that person is required; and
  - (d) state the date, time and place where the person concerned was last seen by the applicant, which must be within seven days of the date on which the application is made.
- (4) An application referred to in subsection (1) may be withdrawn at any time.
- (5) On receipt of the application referred to in subsection (1), the head of the health facility concerned must without delay review the application to determine whether there are reasonable grounds to examine the person referred to in that subsection.
- (6) If the head of the health facility concerned is of the opinion that there are reasonable grounds to examine the person referred to in subsection (1), the head must subject to subsection (7) cause that person to be examined, by two medical practitioners within 72 hours after receipt of the application referred to in subsection (1).
- (7) The medical practitioners contemplated in subsection (6) may not be the persons making the application.
- (8) On completion of the examination referred to in subsection (6), the medical practitioners concerned must submit to the head of the health facility their written findings on whether -
- (a) the circumstances referred to in **section 29**(b), (c) and (d) are applicable; and
  - (b) the person must receive involuntary mental health care,
- but if one of the two medical practitioners concerned is not a psychiatrist, the head of the health facility concerned must obtain the input of a psychiatrist, unless a psychiatrist is not immediately available for an assessment in an urgent case.
- (9) If the findings of the two medical practitioners referred to in subsection (8) differ, the head of the health facility concerned must cause the person referred to in subsection (1) to be examined by a psychiatrist within 72 hours after receipt of the finding referred to in subsection (8).
- (10) The psychiatrist referred to in subsection (9) must within 72 hours of completing the examination contemplated in that subsection submit a written report on the aspects referred to in subsection (8).
- (11) The head of the health facility may only approve the application referred to in subsection (1) if the findings of the two medical practitioners referred to in subsection (6) or the report of the psychiatrist referred to in subsection (10) indicates that conditions for involuntary mental health care of the person concerned exist.
- (12) If the findings of the two medical practitioners referred to in subsection (6) or the report of the psychiatrist referred to in subsection (10) do not indicate that conditions for involuntary mental health care of the person concerned exist, that person must without delay be discharged, unless the person consents to mental health care in which case **section 24** applies.

(13) The head of the health facility concerned must in writing inform the applicant and give reasons on whether to provide mental health care to the person referred to in subsection (1).

(14) If the head of the health facility concerned approves that involuntary mental health care be provided to the person referred to in subsection (1), the head must inform the applicant as well as that person or an interested party of the person's choice in writing thereof and the reasons therefor without delay, but in any case immediately after the person has been received by the health facility.

(15) If the head of the health facility concerned has approved that involuntary mental health care be provided to a person and that person has not been received by the health facility, the head must without delay inform the Namibian Police Force -

- (a) to cause that person to be admitted to the health facility; or
- (b) to refer the person to another health facility with the appropriate facilities approved by the head.

(16) The head of the health facility concerned must inform the person referred to in subsection (1) and any interested party -

- (a) that they may appeal in writing to the review board against the decision of the head of the health facility referred to in subsection (13); and
- (b) that the head of the health facility must provide them or cause them to be provided with assistance to make the appeal if they so wish.

### **Preliminary assessment and subsequent provision of further involuntary mental health care**

**31.** (1) If the head of a health facility grants the application for involuntary mental health care contemplated by **section 30**, he or she must -

- (a) ensure that the patient is given appropriate mental health care;
- (b) admit the patient and request a medical practitioner and a psychiatrist to assess the physical and mental health status of the patient for a prescribed period and prescribed manner within one week of admission; and
- (c) ensure that the medical practitioner and a psychiatrist also consider whether -
  - (i) the involuntary mental health care in respect of that patient must be continued; and
  - (ii) the mental health care must be provided on an out-patient or in-patient basis.

(2) The head of the health facility must, within 24 hours after the expiry of the prescribed assessment period referred to in subsection (1) make available the findings of the assessment to the applicant.

(3) If, following the assessment, the head of the health facility is of the opinion that the mental health status of the patient -

(a) does not warrant involuntary mental health care, the patient must be discharged immediately, unless the patient consents to mental health care in which event section 24 applies; or

- (b) warrants further involuntary mental health care on an in-patient basis, the head must -
  - (i) within seven days after the expiry of the 72-hour assessment period referred to in subsection (1), submit a written request to the review board to approve further involuntary mental health care on an in-patient basis containing -
    - (aa) a copy of the application referred to in **section 30(1)**;
    - (bb) a copy of the notice given in terms of **section 30(13)**;
    - (cc) a copy of the assessment findings; and
    - (dd) the basis for the request; and
  - (ii) give notice to the applicant of the date on which the request together with any relevant documents were submitted to the review board.

(4) If the patient must receive mental health care as an in-patient and the patient has been admitted to a health facility which is -

- (a) a mental health facility, that facility must provide mental health care to that patient; or
- (b) not a mental health facility, the patient must be transferred to a mental health facility for mental health care,

until the review board makes its decision.

(5) If at any time after the expiry of the 72-hour assessment period referred to in subsection (1), the head of the health facility is of the opinion that the patient who was admitted as an involuntary in-patient is fit to be treated as an out-patient, the head must -

- (a) discharge the patient according to the prescribed conditions or procedures: and
- (b) inform the review board in writing.

(6) The head of the health facility may cancel the discharge and request the patient to return to the health facility as an involuntary in-patient, if the head has reason to believe that the patient fails to comply with the terms and conditions of the discharge.

(7) The review board must, within 7 days of receipt of the documents referred to in subsection (3)(b)(i) -

- (a) consider the request in the prescribed manner, and give the applicant, the mental health care practitioners referred to in **section 30** or an independent mental health care practitioner, if any, and the head of the health facility concerned an opportunity to make oral or written representations on the merits of the request; and
- (b) send a decision in writing supported by reasons to the applicant and the head of the health facility.

(8) If the review board decides to grant the request referred to in subsection (3), it must submit to the Registrar of the Court the documents and the notice referred to in that subsection for consideration by the Court.

(9) If at any stage before taking a decision to provide further involuntary mental health care to a patient on an in-patient basis, an appeal in terms of section 33 is lodged against the decision of the head of the health facility, the review board must stop the review proceedings and consider the appeal.

### **Periodic review and reports on involuntary patients**

**32.** (1) The head of a health facility must no later than three months after the commencement of mental health care in respect of an involuntary patient cause the mental health status of that patient to be reviewed but the head may initiate an earlier review.

(2) A review referred to in subsection (1) must include all relevant medical information available to the health facility, including a medical assessment -

- (a) on the capacity of the patient to express himself or herself on the need for mental health care;
- (b) on whether the patient is likely to inflict serious harm on himself or herself or other people;
- (c) on whether there is other mental health care services that are less restrictive or intrusive on the right of the patient to movement, privacy and dignity; and
- (d) with recommendations regarding a plan for further mental health care if such a plan is required.

(3) The head of the health facility concerned must submit to the review board a summary report of the review contemplated by subsection (1).

(4) Within 30 days after receipt of the summary report referred to in subsection (3), the review board must -

- (a) consider the report and may obtain information from any interested party, including the patient;
- (b) examine all relevant medical and social information;
- (c) make a decision on the matter under review; and
- (d) send a written notice of its decision and the reasons therefore to the patient, an interested party or a legal representative of the patient's choice and the head of the health facility where the patient is admitted.

(5) The patient or an interested party has the right to participate in the hearing of the review.

(6) If the review board decides that the involuntary patient be discharged, the patient must without delay be discharged by the health facility concerned, unless the patient consents to voluntary mental health care in which case **section 24** applies.

(7) The head of the health facility concerned must forthwith comply with the decision of the review board.

### **Appeal against decision of head of health facility on involuntary care, treatment and rehabilitation**

- 33.** (1) An appeal referred to in **section 30(16)** must be made in the prescribed manner within 30 days of the date of the written notice issued in terms of **section 30(13)**.
- (2) An appeal referred to in subsection (1) must contain the grounds on which the appeal is based.
- (3) Within 15 days after receipt of the appeal, the review board must –
- (a) obtain from the head of the health facility concerned, a copy of -
    - (i) the application made in terms of **section 30(1)**;
    - (ii) the notice given in terms of **section 30(13)**; and
    - (iii) copies of the findings of the medical assessments conducted in terms of **section 30(8)** and if applicable, in terms of **section 30(9) and (10)**;
  - (b) afford the appellant, the applicant, the relevant mental health care practitioners referred to in **section 30**, an independent mental health care practitioner, if any, the head of the health facility concerned and any other interested party, an opportunity to make written or oral representations on the merits of the appeal;
  - (c) consider the appeal in the prescribed manner; and
  - (d) send a written notice of its decision and the reasons therefor to the appellant, the applicant, the relevant mental health care practitioners, the head of the health facility concerned and any other interested party.
- (4) If the review board upholds the appeal, the head of the health facility concerned must-
- (a) terminate all mental health care services administered to the patient in accordance with accepted clinical practices and standards; and
  - (b) discharge the patient without delay,

unless the patient consents to voluntary mental health care in which case **section 24** applies.

- (5) If the review board does not uphold the appeal, it must submit the documents referred to in subsection (3)(a) and (d) immediately to the Registrar of the Court for review by a judge in chambers.

#### **Review of need for further involuntary mental health care**

- 34.** Within 15 days after receipt of the documents submitted by the review board as contemplated in **section 33(5)**, the judge in chambers referred to in that section -
- (a) must consider the documents submitted and any other representations made by any person referred to in **section 33(3)**;
  - (b) may obtain information from any interested party; and
  - (c) must thereafter order -

- (i) further hospitalisation or confinement of the patient in order to receive mental health care; and
- (ii) if necessary, that the financial affairs of the patient be managed and administered in accordance with **Part 8**; or
- (iii) the immediate discharge of the patient.

### **Recovery of capacity of involuntary patients to make informed decisions**

**35.** (1) If the head of a health facility has reason to believe -

- (a) from personal observation;
- (b) from medical observation obtained by others, including, but not limited to mental health care practitioners; or
- (c) on receipt of representations by a patient,

that the patient has recovered the capacity to make informed decisions, the head of the health facility concerned must cause the patient to be discharged in accordance with accepted clinical practices and standards.

(2) The Registrar of the Court must be notified in writing of a discharge made in terms of this section.

### **Leave of absence from designated health facility**

**36.** (1) The head of a health facility may, subject to such conditions as the head may determine in writing, grant leave of absence to an in-patient receiving assisted or involuntary mental health care from that health facility.

(2) If the head referred to in subsection (1) has reason to believe that an assisted or involuntary patient does not comply with the conditions applicable to the leave referred to in that subsection, the head may cancel the leave and direct that the patient must return to the health facility at a date and time specified by the head.

(3) If a patient who has been on leave as contemplated in subsection (1) fails to return to the health facility concerned on the return date, the patient is deemed to have absconded in which case **section 37** applies.

### **Intervention by members of Namibian Police Force**

**37.** (1) If a member of the Namibian Police Force has reliable information, including, but not limited to information from a mental health facility, that a person might, due to his or her mental health problem or severe or profound intellectual disability inflict physical bodily harm to himself or herself or to others or to cause damage to property, that member must apprehend the person and cause that person to be -

- (a) taken to a health facility or a mental health facility for assessment of the mental health status of that person in accordance with the provisions of this Act; and
- (b) handed over into custody of the head of a State hospital, or a State mental health facility or any other person designated by the head to receive the person.

- (2) If, after an assessment of a person referred to in subsection (1), a mental health care practitioner is of the opinion that the person -
- (a) might, due to his or her mental health problem or severe or profound intellectual disability inflict harm to himself or herself or to others or to cause damage to property the practitioner must without delay submit his or her findings together with an application under **section 30** to the head of the health facility; or
  - (b) is unlikely to cause harm to himself or herself or to others or to property, the practitioner must without delay release the person in accordance with accepted clinical practices and standards.
- (3) If the mental health care practitioner concerned is of the opinion that the apprehended person requires mental health care referred to in **section 24**, the practitioner must advise the patient to be admitted to a healthcare facility as a voluntary patient.
- (4) If an application referred to in subsection (2)(a) is not made within 48 hours, the apprehended person must be discharged without further delay.
- (5) If an assisted or involuntary patient -
- (a) has absconded or is deemed to have absconded; or
  - (b) has to be taken or transferred to a health facility in terms of **section 30(15)**,

the head of the health facility concerned may request assistance from any member of the Namibian Police Force -

- (i) to locate, apprehend and return the patient to the health facility concerned; or
  - (ii) to transfer the patient in the prescribed manner.
- (6) A member of the Namibian Police Force must forthwith comply with a request referred to in subsection (5).
- (7) A person apprehended in terms of subsection (5) may be held in custody at a police station for a period not exceeding 72 hours to ensure his or her return or transfer in the prescribed manner only if there is no other means to immediately transfer the person to the relevant health facility.
- (8) A member of the Namibian Police Force may only use constraining measures as may be necessary, proportionate and appropriate in the circumstances when apprehending a person or performing any function in terms of this section.

## **PART 6 STATE PATIENTS**

### **Balancing of rights**

- 38.** (1) A State patient has the right -
- (a) to the same standard of mental health care as any other patient; and

(b) subject to subsection (3) and any other relevant sections of this Part, to be released if the reasons for his or her detention cease to exist.

(2) The State has the obligation to balance the rights of State Patients contemplated in subsection (1) with the rights of the general public when determining the proper treatment and conditions, if applicable, under which the treatment of a State patient may be terminated and a State patient be discharged.

(3) When balancing the different rights contemplated in subsection (3), the State must take into account -

- (a) the likelihood of the State patient to violate laws and the invasion of individual rights of others in future;
- (b) the severity of potential violations of any law, should they in fact occur; and
- (c) the severity of any restrictions and intrusions on the rights of a State patient to movement, privacy and dignity.

(4) Any kind of restriction to the rights of a State patient must be limited to a minimum.

#### **Designation of health facilities for State Patients and other persons to be examined for their mental status**

**39.** (1) The Minister must designate a health facility which may admit, observe and provide mental health care to -

- (a) State Patients; or
- (b) any accused who -
  - (i) appears to any court of law in accordance with the provisions of section 77(1) of the Criminal Procedure Act to be incapable because of a mental health problem of understanding criminal proceedings against him or her so as to make a proper defence by reason of mental health problem; and
  - (ii) in accordance with section 78(2) of the Criminal Procedure Act, appears to be or is allegedly not criminally responsible for a criminal offence because of a mental health problem, and who a court of law may commit to a mental hospital or to any other place designated by the court as contemplated in section 79(2) thereof.

(2) For purposes of this Part, a “designated health facility” means a health facility designated in terms of subsection (1).

#### **Admission of State Patients to designated health facilities**

**40.** (1) If a court of law issues an order in terms of the Criminal Procedure Act for a State patient to be admitted for mental health care, the Registrar or the Clerk of that court, as the case may be, must send a copy of the order to the -

- (a) official *curator ad litem*; and

- (b) officer-in-charge of the correctional facility where the State patient is detained, if applicable.

(2) If a State patient is in custody at a correctional facility, the Minister responsible for correctional services must within 14 days after receipt of an order referred to in subsection (1) forward a copy of that order to the Minister, requesting that the State patient be transferred to a designated health facility.

(3) The Minister must immediately after receipt of the order referred to in subsection (2) -

- (a) determine the designated health facility to which the State patient must be transferred;
- (b) ensure that the necessary arrangements are made with the appropriate correctional facility to effect the transfer of the State patient to the designated health facility; and
- (c) in writing notify -
  - (i) the official *curator ad litem*; and
  - (ii) the Minister responsible for correctional services,of the details of the transfer including the location of the designated health facility.

(4) Within 14 days of being notified of the details of the transfer as contemplated in subsection (3), the Minister responsible for correctional services must cause the State patient to be transferred to the designated health facility specified in the notice.

### **State Patients who abscond from a designated health facility**

**41.** (1) If the head of a designated health facility is of the opinion that a State patient has absconded, that head must in writing -

- (a) immediately notify and request any member of the Namibian Police Force to locate, apprehend and return the State patient to that health facility; and
- (b) immediately notify the Registrar or the Clerk of a court, as the case may be and the official *curator ad litem* thereof.

(2) A member of the Namibian Police Force must forthwith comply with a request referred to in subsection (1)(a).

(3) A State patient who has been apprehended by the Namibian Police Force in terms of subsection (1) may be held in custody for a period not exceeding 72 hours to effect the return of the State patient to the designated health facility concerned.

(4) A member of the Namibian Police Force may only use the constraining measures as may be necessary, proportionate, and appropriate in the circumstances when apprehending a State patient or performing any function in terms of this section.

### **Transfer of State Patients between designated health facilities**

**42.** (1) Subject to subsection (2), the transfer of a State patient from one designated health facility to another designated health facility may only be done if it is necessary for the mental health care of the State patient concerned, unless otherwise stipulated in this Act.

(2) A review board may order a State patient to be transferred to another designated health facility for a reason other than those contemplated in subsection (1) -

- (a) if the State patient has or is likely to inflict serious harm to himself or herself or on others; and
- (b) on receipt of a written application from the head of the designated health facility at which the State patient is detained, setting out the facts on which the request is based.

(3) When issuing an order referred to in subsection (2), the review board must forward a copy of that order to the Minister.

(4) The Minister must within 14 days after receipt of the order referred to in subsection (3) -

- (a) determine the designated health facility to which the State patient must be transferred; and
- (b) ensure that the necessary arrangements are made with the appropriate health facility to perform the transfer as ordered.

(5) If the conduct of a State patient has or is likely to give rise to an emergency, the head of a designated health facility may effect, with the consent of the head of a health facility with appropriate facilities, the immediate transfer of that State patient to the latter facility, pending the decision of the review board in terms of subsection (2).

(6) If subsection (2) applies and no health facility with appropriate facilities is able to receive a State patient as contemplated in that subsection, the review board may order the State patient to be transferred to and detained at a correctional facility.

(7) The person responsible for performing a transfer in terms of this section must in writing notify the official *curator ad litem* of the transfer of the State patient concerned.

#### **Leave of absence from a designated health facility**

**43.** (1) Unless a State patient has been accused of a crime involving grievous bodily harm, including murder, culpable homicide, rape, assault or a similar offence, the head of a designated health facility may in writing grant leave of absence to a State patient from that facility.

(2) The Minister -

- (a) may appoint a staff member in the Ministry responsible for health as the community custodian for a State patient referred to in subsection (1); and
- (b) must notify the review board for the health facility concerned of such an appointment.

(3) A community custodian referred to in subsection (2) must -

- (a) on a weekly basis contact -

- (i) the State patient for which he or she has been appointed;
- (ii) any mental health care practitioner involved with that patient;
- (iii) the head of the health facility where the patient is admitted; and
- (iv) any other interested party,

regarding the well-being of such patient; and

- (b) report any relevant information relating to the well-being of the State patient to the head of the health facility concerned.
- (4) Any written notice of leave of absence in respect of a State patient must -
  - (a) state the commencement date of the leave and the return date of that State patient to the designated health facility where he or she is admitted;
  - (b) be submitted to the Minister responsible for correctional services and the official curator ad litem at least 15 days prior to the commencement of the leave of absence;
  - (c) state the terms and conditions to be complied with during the period of leave; and
  - (d) state the name of the community custodian, if any, referred to in subsection (3) which has been appointed in respect of that State Patient.

(5) If the head of a designated health facility has during a period of leave of a State patient reason to believe that such patient does not comply with the terms and conditions applicable to the leave, the head may by notice in writing cancel the leave and direct in that notice the return date that the State patient must return to the health facility.

- (6) If a State patient whose leave -
  - (a) has expired as contemplated in subsection (4)(a); or
  - (b) has been cancelled as contemplated in subsection (5),

fails to return on the return date to the designated health facility where he or she is admitted, the State patient is deemed to have absconded from that facility.

**Periodic review of mental health status of a State Patient**

**44.** (1) The head of a designated health facility where a State patient is admitted must cause the mental health status of that patient to be reviewed -

- (a) no later than six months after the commencement of mental health care for that patient; and
- (b) every 6 months thereafter,

but nothing in this Act prevents the head from initiating an earlier review.

- (2) A review referred to in subsection (1) must-

- (a) include all relevant medical documentation required for an application under **section 45(2)** by the official *curator ad litem* for the discharge of a State Patient; and
- (b) make recommendations on -
  - (i) a treatment plan for further mental health care to the State Patient;
  - (ii) the merits of granting leave of absence to the State Patient; and
  - (iii) the discharge of the State Patient.
- (3) The head of the designated health facility referred to in subsection (1) must submit a summary report of the review with a recommendation referred to in subsection (2), to the -
  - (a) review board for that health facility; and
  - (b) official *curator ad litem*.
- (4) Within 30 days after receipt of the summary report referred to in subsection (3), the review board must -
  - (a) consider the report and may consult with any person who has information concerning the mental health status of the State patient concerned;
  - (b) make a written decision regarding the issues referred to in subsection (2); and
  - (c) send its decision and reasons to the head of the designated health facility where the State patient is admitted, the Ministers responsible for health and for correctional services, the official *curator ad litem* and the State Patient.
- (5) The review board may decide that the State patient -
  - (a) remains a State Patient;
  - (b) if the State patient was not accused of a crime involving grievous bodily harm, including murder, culpable homicide, rape, assault or a similar offence, be -
    - (i) reclassified and dealt with as a voluntary, assisted or involuntary patient in terms of **Part 5**; or
    - (ii) be discharged, whether conditionally or unconditionally;
  - (c) if the State patient was accused of a crime involving grievous bodily harm, including murder, culpable homicide, rape, assault or a similar offence, may not be recommended for discharge, pending a decision by a judge in chambers as contemplated in **section 45(6)**.
- (6) A decision by a review board under paragraph (b)(ii) of subsection (5) must specify the terms and conditions and the period of the conditional discharge.
- (7) If a review board has made a decision under subsection (5)(b)(ii) and the State patient concerned is an accused who is by reason of a mental health problem not capable of understanding criminal proceedings so as to make a proper defense, as contemplated in section 77 of the Criminal

Procedure Act, the review board must without delay inform the official curator ad litem of the decision.

(8) The head of the designated health facility must forthwith comply with the decision of a review board in terms of this section concerning a State patient admitted at that facility.

### **Application for discharge of a State patient**

**45.** (1) Notwithstanding **section 44**, a State Patient, an interested party, the head of the designated health facility or the official *curator ad litem* may apply to a judge in chambers for the discharge of a State Patient.

- (2) An application referred to in subsection (1) must -
  - (a) be in the prescribed form;
  - (b) be submitted to the Registrar of the Court; and
  - (c) contain -
    - (i) the reasons for the application;
    - (ii) a report by a psychiatrist;
    - (iii) if the applicant is the official curator ad litem, a report containing a history and a prognosis of the mental health status of the State patient from -
      - (aa) the head of the designated health facility where the State patient is admitted; and
      - (bb) two mental health care practitioners, one of whom must be a psychiatrist;
    - (iv) details of any application made for the discharge of the State patient within 12 months before the application in question;
    - (v) if the applicant is not the official *curator ad litem*, proof that a copy of the application has been given to the official *curator ad litem*; and
    - (vi) any information relevant to the application.
- (3) The official *curator ad litem* must within 30 days after receipt of the copy of the application as contemplated in subsection (2)(c)(v), submit a written report to the judge in chambers which must -
  - (a) contain a history and a prognosis of the mental health status of the State patient from -
    - (i) the head of the designated health facility at which the State patient has been admitted; and
    - (ii) two mental health care practitioners, one of whom must be a psychiatrist;
  - (b) contain a report from -

- (i) a clinical psychologist or a psychiatrist; and
- (ii) an occupational therapist.

if the State patient has been assessed by such persons;

- (c) contain a report from a social worker;
- (d) indicate whether another application was made for the discharge of the State patient within a period of 12 months prior to the first-mentioned application and the status of the application, if any; and
- (e) make recommendations on whether the application should be granted and the basis for the recommendation.

(4) When considering an application referred to in subsection (1), the judge in chambers -

- (a) must establish whether another application for the discharge of the State patient concerned is pending or has been considered within a period of 6 months prior to the application referred to in subsection (1), in which case the latter application must be dismissed;
- (b) must establish whether the official *curator ad litem* has a conflict of interest with the State Patient, and if so, must appoint a legal practitioner from the office of the Attorney-General to assist in the processing of the application referred to in subsection (1); and
- (c) may call for further information and assistance from the applicant, a mental health care practitioner, the head of the designated health facility or a relevant curator ad litem, as may be necessary to process the application.

(5) The legal practitioner appointed in terms of subsection (4)(b) must -

- (a) adduce any available evidence relevant to the application; and
- (b) perform the functions and duties as required by the judge in chambers to process the application.

(6) When finally considering an application referred to in subsection (1), the judge in chambers may within 30 days of such consideration order that the State patient -

- (a) remains a State Patient;
- (b) be reclassified and dealt with as a voluntary, assisted or involuntary patient in terms of Part 5;
- (c) be discharged, whether conditionally or unconditionally.

(7) If a judge in chambers has in terms of subsection (6)(c) ordered that a State Patient be discharged conditionally, the judge's order must specify the terms and conditions and period of the conditional discharge.

## **Conditional discharge of State Patients, amendments to conditions or revocation of conditional discharge**

**46.** (1) The head of a designated health facility from which a State patient has been conditionally discharged as contemplated in **section 44(5)(b)(ii)** or **section 45(6)(c)** must-

- (a) cause the mental health status of the State patient to be monitored at that health facility; or
- (b) arrange for another health facility to monitor the State Patient,

if the conditional discharge order requires that the State patient must present himself or herself at that health facility for mental health care.

(2) The person monitoring the State patient in terms of subsection (1) must submit a written report to the head of the designated health facility from which the State patient was discharged -

- (a) relating to any terms and conditions applicable to the discharge;
- (b) at the end of every six months from the date on which the conditional discharge order was made; and
- (c) at the end of the conditional discharge period.

(3) If at the end of the conditional discharge period concerned the head of the designated health facility where the State patient concerned is admitted, is satisfied -

- (a) that the State patient has fully complied with the terms and conditions applicable to the conditional discharge; and
- (b) that the mental health status of the State patient has not deteriorated,

the head of that facility must -

- (i) in writing inform the State patient thereof and immediately discharge the State patient unconditionally; and
- (ii) in writing inform the Registrar of the Court and the official curator ad litem of the discharge.

(4) If after considering any report submitted in terms of subsection (2), the head of the designated health facility has reason to believe that -

- (a) the State patient has not fully complied with the terms and conditions applicable to the discharge; or
- (b) the mental health status of the State patient has deteriorated or has not improved to a point where the State patient can be discharged unconditionally,

the head of that facility -

- (i) may apply to the review board for that facility or the Registrar of the Court, as the case may be, for a decision or an order amending the conditions or revoking the conditional discharge; and

(ii) must forward a copy of the application to the official *curator ad litem*.

(5) A State patient who has been discharged conditionally may at any time after six months from the date on which the order was made, and thereafter, at not less than six months intervals, apply in the prescribed manner to the review board for the designated health facility where he or she was admitted or a judge in chambers, as the case may be, for an -

(a) amendment of any condition applicable to the discharge; or

(b) unconditional discharge.

(6) An application referred to in subsection (5) must state -

(a) the condition to be amended;

(b) the duration of the amendment; and

(c) the reasons for the amendment or revocation of the conditional discharge.

(7) When considering the application, the review board or the judge in chambers, as the case may be, may decide or order that -

(a) the conditional discharge be revoked and the State patient be returned to the designated health facility where he or she was admitted;

(b) any condition applicable to the discharge be amended or revoked;

(c) the State patient be reclassified and dealt with as a voluntary, assisted or involuntary patient in terms of Part 5; or

(d) the State patient be unconditionally discharged.

## **PART 7 INMATES OR OFFENDERS WITH MENTAL HEALTH PROBLEM**

### **Designation of health facilities for inmate or offender with mental illness**

**47.** (1) The Minister must designate a health facility that may admit or provide mental health care to an inmate or offender with a mental health problem.

(2) For purposes of this Part, a “designated health facility” means a health facility designated in terms of subsection (1).

### **Enquiry into mental health status of inmate or offender**

**48.** (1) If it appears to the officer-in-charge of a correctional facility through personal observation or from information provided that an inmate or an offender may have a mental health problem, that officer must arrange with the head of a designated health facility that a mental health care practitioner be appointed to conduct an assessment of that inmate or offender.

(2) The mental health care practitioner referred to in subsection (1)(a) must-

- (a) submit, within 48 hours after the assessment, a written report to the officer-in-charge and to the head of that health facility referred to in that subsection; and
- (b) specify in the report -
  - (i) the mental health status of the inmate or offender; and
  - (ii) a plan for the mental health care of the inmate or offender, if necessary.

**Mental health care of inmate or offender with mental health problem in correctional facility**

**49.** (1) If the mental health care practitioner conducting an assessment in terms of **section 48** finds that the mental health problem of an inmate or offender is of such a nature that the inmate or offender could appropriately receive mental health care in the correctional facility, the officer-in-charge of the facility in consultation with the head of a designated health facility must take the necessary steps to ensure that the required levels of mental health care are provided to the inmate or the offender.

(2) The mental health care practitioner referred to in subsection (1) may after an assessment carried out in terms of that subsection recommend to the head of a designated health facility that an inmate or an offender be classified and dealt with as a voluntary, assisted or involuntary patient in terms of Part 5.

**Magisterial enquiry concerning transfer to designated health establishments**

**50.** (1) If the person conducting the enquiry referred to in **section 49**, makes a recommendation contemplated in subsection (2) the officer-in-charge of the correctional facility where the inmate or offender referred to in that subsection is interred must request a magistrate to cause a subsequent enquiry to be conducted into the mental health status of the inmate or offender as to whether a transfer to a designated health facility designated would be appropriate.

(2) The magistrate must commission two mental health care practitioners of whom at least one must be a psychiatrist, a psychologist or a medical practitioner with special training in mental health to enquire into the mental health status of the inmate or offender referred to in subsection (1) and to make recommendations on whether that inmate or offender should be transferred to a designated health facility.

(3) If the mental health care practitioners referred to in subsection (2) recommend that-

- (a) the inmate or offender referred to in that subsection must receive mental health care at a designated health facility, the magistrate must issue a written order to the officer-in-charge of the correctional facility concerned to transfer that inmate or offender to that health facility in accordance with the procedure set out in **section 51**; or
- (b) the inmate or offender need not receive mental health care at a designated health facility, but instead could receive mental health care at the correctional facility in which the inmate or offender is interred, the magistrate must issue a written order to the officer-in-charge of the correctional facility concerned to take the necessary steps to ensure that the required levels of mental health care are provided to that inmate or prisoner.

**Procedure to transfer inmate or offender with mental health problems to designated health facility**

**51.** (1) On receipt of a written order referred to in section 50(3)(a), the officer-in-charge of the correctional facility referred to in that section must forward a copy of the order to -

- (a) the administrator of the inmate or offender, if appointed; and
  - (b) the Minister, together with a request that the inmate or offender with a mental health problem be transferred to a designated health facility.
- (2) The Minister must forthwith-
- (a) determine the health facility to which the inmate or offender referred to in subsection (1) must be transferred; and
  - (b) ensure that arrangements are made to effect the transfer of that inmate or offender to a designated health facility.
- (3) If a transfer is approved in terms of this section -
- (a) the Minister must in writing within 14 days of the transfer, notify the officer-in-charge of the correctional facility where the inmate or offender referred to in subsection (1) is detained, of the details of the transfer; and
  - (b) the officer-in-charge of that correctional facility continues to have lawful custody of that inmate or offender in accordance with section 29 of the Correctional Service Act, and must secure the custody of the inmate or offender while he or she is undergoing treatment in a designated health facility.

(4) The officer-in-charge of the correctional facility must, within 14 days of receipt of the notice of the details of the transfer, cause the inmate or offender referred to in subsection (1) to be transferred to the designated health facility.

#### **Transfer of offenders with mental illness between designated health facilities**

**52.** (1) Upon the recommendation of the head of a designated health facility, the Minister responsible for correctional services may after consultation with the Minister approve the transfer of an inmate or offender with a mental health problem from one designated health facility to another if it is necessary for the mental health care of that inmate or offender.

(2) The Minister must within seven days after the approval contemplated in subsection (1) -

- (a) determine the designated health facility to which the inmate or offender referred to in that subsection must be transferred;
- (b) ensure that the necessary arrangements are made with the designated health facility referred to in paragraph (a) to effect the transfer; and
- (c) notify the officer-in-charge of the correctional facility where that inmate or offender is detained of the details of the transfer.

(3) If a transfer is effected in terms of this section, the officer-in-charge of the correctional facility where the inmate or offender is interred continues to have lawful custody of that inmate or offender in accordance with section 29 of the Correctional Service Act, and must secure the

custody of the inmate or offender while he or she is transferred from one designated health facility to another.

**Periodic reviews of mental health status of inmate or offender with mental health problem**

**53.** (1) The head of a designated health facility where an inmate or offender with a mental health problem is admitted -

- (a) must cause the mental health status of that inmate or offender to be reviewed in the prescribed form within three months from the date on which that inmate or offender was admitted at that facility;
- (b) may cause an early review in the form referred to in paragraph (a) if the head has reason to believe, either from personal observation or from information obtained by medical staff, that the required mental health care provided to that inmate or offender can be appropriately provided at a correctional facility or may be discontinued.

(2) A review referred to in subsection (1) must -

- (a) include an examination of the inmate or offender referred to in that subsection;
- (b) be conducted by a psychiatrist;
- (c) specify the mental health status of the inmate or offender; and
- (d) state recommendations regarding -
  - (i) a plan for further mental health care to that inmate or offender; and
  - (ii) the merits of returning that inmate or offender to the correctional facility from which he or she was initially transferred.

(3) The head of the health facility must submit a summary report of the review to the -

- (a) review board for that health facility ; and
- (b) the officer-in-charge of the correctional facility where the inmate or offender is interred.

(4) Within 30 days after receipt of the summary report referred to in subsection (3), the review board referred to in that subsection must -

- (a) consider the report and may consult with any person who may have information concerning the mental health status of the inmate or offender referred to in that subsection;
- (b) make a written decision regarding -
  - (i) a plan for further mental health care to that inmate or offender if such a plan is required; and
  - (ii) the return of that inmate or offender to the correctional facility from which he or she was initially transferred; and

- (c) send its decision and reasons to that inmate or offender, the head of that designated health facility and the officer-in-charge of the correctional facility referred to in subsection(3)(b).

#### **Recovery of inmate or offender with mental health problem**

- 54. If the head of a health facility has reason to believe -
  - (a) from personal observation; or
  - (b) from medical information obtained by others, including, but not limited to mental health care practitioners,

that an inmate or offender with a mental health problem has recovered to such an extent that the inmate or offender no longer requires mental health care or that the required care can be appropriately given at a correctional facility, the head of that health facility must -

- (i) compile an appropriate discharge report; and
- (ii) inform the officer-in-charge of that correctional facility that the inmate or offender is ready for discharge and transfer to that facility.

#### **Inmate or offenders with mental health problem who abscond from designated health facility**

**55.** (1) If the head of a designated health facility is of the opinion that an inmate or offender with a mental health problem has absconded, the head must in writing -

- (a) immediately notify and request any member of the Namibian Police Force to locate, apprehend and return that inmate or offender to that health facility; and
- (b) immediately notify the officer-in-charge of the correctional facility where that inmate or offender has been detained.

(2) A member of the Namibian Police Force must forthwith comply with a request referred to in subsection (1)(a).

(3) An inmate or offender with a mental health problem who has been apprehended by the Namibian Police Force in terms of subsection (1) may be held in custody for a period not exceeding 72 hours to effect the return of that inmate or offender to the designated health facility from which he or she absconded.

(4) A member of the Namibian Police Force may only use the constraining measures as may be necessary, proportionate and appropriate in the circumstances when apprehending a person or performing any function in terms of this section.

(5) The head of the designated health facility must forthwith notify the officer-in-charge of the correctional referred to in subsection (1)(b) when an inmate or offender referred to in that subsection was apprehended and returned to that health facility.

#### **Procedure upon expiry of term of imprisonment of inmate or offender with mental health problem**

**56.** The provisions of section 27(3) of the Correctional Service Act apply with the changes necessitated by the context to an inmate or offender with a mental health problem who is

detained at a designated health facility upon the expiry of the term of imprisonment of that inmate or offender.

**PART 8**  
**CARE AND ADMINISTRATION OF PROPERTY OF PERSONS SUFFERING FROM**  
**MENTAL HEALTH PROBLEM OR SEVERE OR PROFOUND INTELLECTUAL**  
**DISABILITY**

**Appointment of administrator for care and administration of property of a person suffering from mental health problem or severe or profound intellectual disability**

- 57.** (1) After consideration and processing of -
- (a) an application submitted in terms of **section 58**; or
  - (b) an order made by the Court after an appeal referred to in **section 58(10)**, a referral by the Master referred to in **section 58(11)** or an enquiry referred to in **section 59** stating that a person suffering from a mental health problem or a severe or profound intellectual disability is incapable of managing his or her own property and that an administrator must be appointed,

the Master may subject to subsections (2) and (3) appoint an administrator to care for and administer the property of that person.

(2) An administrator may only be appointed in respect of the property of a person suffering from a mental health problem or a severe or profound intellectual disability if the procedures stated in **section 58 or 59** have been complied with.

(3) The Master must issue to the administrator referred to in subsection (2) an administration order to the effect that he or she has been appointed as such and that he or she is authorized to have the custody and administration of the property of the person referred to in that subsection.

(4) An administration order referred to in subsection (3) must -

- (a) set out the duties and responsibilities and the extent of the scope and powers of the administrator;
- (b) specify the duration of the appointment as administrator, if applicable; and
- (c) indicate when the appointment as administrator will be reviewed.

(5) An administrator appointed in terms of this section is subject to regular review and his or her appointment ends forthwith if the person in respect of who he or she has been appointed no longer suffers from a mental health problem or a severe or profound intellectual disability.

**Application to Master for appointment of administrator**

**58.** (1) Any person over the age of 18 years, including but not limited to a mental health care practitioner, may apply to the Master for the appointment of an administrator for a person suffering from a mental health problem or a severe or profound intellectual disability.

(2) An application referred to in subsection (1) must -

- (a) be made in writing under oath or solemn affirmation;
- (b) state the relationship of the applicant to the person suffering from a mental health problem or a severe or profound intellectual disability, and -
  - (i) if the applicant is not a spouse, life partner or next of kin of that person, the reason why the spouse, life partner or next of kin did not make the application; and
  - (ii) if the spouse, life partner or a next of kin of that person is not available to make the application, what steps were taken to establish their whereabouts before making the application;
- (c) include all available mental health related medical certificates or reports relevant to the mental health status of that person, including any other information relating to the incapability of the person to manage his or her own property;
- (d) state the grounds on which the applicant believes that that person is incapable of managing his or her own property;
- (e) state that, within seven days immediately before submitting the application, the applicant had seen that person;
- (f) state the particulars of that person and his or her estimated property value and annual income;
- (g) state any specifiable joint financial interest involving the applicant and that person; and
- (h) give the particulars and contact details of persons who may provide further information relating to the mental health status of that person.

(3) An applicant referred to in subsection (1) must attach to the application proof that a copy of the application has been submitted to the person referred to in subsection (1) in respect of whom the application is made.

(4) The Master may appoint, after considering the application, an interim administrator pending the outcome of the investigation referred to in subsection (5).

(5) The Master must, within 30 days after receipt of the application referred to in subsection (1), cause an investigation to be conducted by a suitably qualified person into the merits of the application if -

- (a) certain allegations in the application require confirmation; or
  - (b) further information is required to support the application.
- (6) The person conducting an investigation referred to in subsection (5) -
- (a) must confirm all allegations and facts contained in the application and call on the person referred to in subsection (1) who is allegedly incapable of managing his or her own property or his or her legal representative to respond to the application;
  - (b) may -

- (i) summon any person to appear before him or her to provide information and documents relevant to the application; and
  - (ii) enquire into the financial position of the person referred to in subsection (1) who is allegedly incapable of managing his or her own property; and
  - (c) must submit a report on his or her findings to the Master.
- (7) The investigation referred to in subsection (5) must be finalised within 60 days of being instituted or the extended periods as may be granted by the Master.
- (8) The Master must, within 14 days after considering the report referred to in subsection (6)(c) -
- (a) appoint an administrator;
  - (b) decline to appoint an administrator; or
  - (c) refer the matter for consideration by a judge in chambers.
- (9) The Master must in writing provide his or her decision and the reasons supporting such decision to the applicant and the person referred to in subsection (1) who is allegedly incapable of managing his or her own property.
- (10) The applicant or the person allegedly incapable of managing his or her own property may, within 30 days after receipt of the decision and reasons of the Master, appeal against the decision of the Master by submitting -
- (a) a written notice of appeal in the prescribed form with the reasons therefor to a judge in chambers; and
  - (b) a copy thereof to the Master setting out the grounds of the appeal.
- (11) If the Master refers the application for consideration by a judge in chambers or receives a copy of the written notice of appeal in terms of subsection (10)(b), the Master must submit, within 14 days, to the judge in chambers a copy of -
- (a) the application;
  - (b) a written summary of the Master's findings;
  - (c) a report on the investigation referred to in subsection (5), if conducted;
  - (d) the reasons for declining the application or for referring the application to the judge in chambers; and
  - (e) in the case of an appeal, the notice of appeal.
- (12) Within 30 days after receipt of the documents referred to in subsection (11) the judge in chambers must -
- (a) consider the application or appeal, as the case may be;
  - (b) afford -

- (i) the applicant, or appellant, as the case may be;
- (ii) independent mental health care practitioners, if any; and
- (iii) the head of the designated health facility concerned,  
with the opportunity to make oral or written representations on the merits of the application or appeal;
- (c) make a recommendation on the application or appeal that –
  - (i) an administrator be appointed for the person referred to in subsection (1); or
  - (ii) no administrator should be appointed for that person;
- (d) send a written notice of the recommendation to the Master and the persons referred to in paragraph (b).
- (13) The Master must -
  - (a) cause, within 60 days of being notified of the recommendation by the judge in chambers in terms of subsection (12)(c)(i), an investigation to be conducted to determine a suitable candidate to be appointed as administrator for the person allegedly incapable of managing his or her own property; and
  - (b) appoint the administrator.
- (14) The costs relating to the conducting of an investigation referred to in subsections (5) and (13) must -
  - (a) be paid out of the estate of the person suffering from a mental health problem or a severe or profound intellectual disability or, if the Master or the judge in chambers is of the opinion that the application was frivolous or vexatious, out of the property of the applicant; and
  - (b) be determined by the Master after consultation with the person conducting the investigation.

**Recommendation to appoint administrator by court during enquiry or in course of legal proceedings**

**59.** (1) If any court of law, when conducting an enquiry in terms of this Act or during any legal proceedings, has reason to believe that a person in respect of whom the enquiry or proceedings is held or conducted, may be incapable of managing his or her own property, the court must, as part of the enquiry or proceedings, conduct an investigation into the mental health status of the person and his or her capacity to manage his or her own property.

(2) The court may, when conducting an investigation referred to in subsection (1), request further information from any other person as may be necessary for purposes of establishing the mental health status of the person concerned and the capacity of the person to manage his or her own property.

(3) If, on completion of an investigation referred to in subsection (2), the court finds that the mental health status of the person concerned is of such a nature that the person is incapable of managing his or her own property, the court -

- (a) may recommend that an administrator be appointed in respect of the person; and
  - (b) must in writing notify the person and the Master of the finding and recommendation and the reasons therefore.
- (4) Within 60 days after receipt of the notice referred to in subsection (3)(b) the Master must cause an investigation to be conducted -
- (a) into the estimated property value and annual income of the person concerned; and
  - (b) to determine a suitable candidate to be appointed as administrator for that person.
- (5) The costs relating to the conducting of an investigation referred to in subsection (4) must be -
- (a) paid out of the estate of the person incapable of managing his or her own property; and
  - (b) determined by the Master after consultation with the person conducting the investigation.

#### **Confirmation of appointment of administrator**

**60.** An appointment of an administrator is effective from the date on which the Master signs the prescribed administrator order.

#### **Powers, functions and duties of administrators and miscellaneous provisions relating to appointment of administrators**

**61.** (1) Before the Master signs an administration order referred to in **section 60**, the administrator must, subject to subsection (2), lodge security with the Master of an amount to be determined by the Master.

(2) On good cause shown by the administrator the Master may -

- (a) reduce the amount of security; or
- (b) dispense with the lodging of security,

required in terms of subsection (1).

(3) If the Master at any stage -

- (a) becomes aware that sequestration proceedings against the administrator have commenced or are likely to be instituted; or
- (b) has reason to believe that the person in respect of whom the administrator has been appointed has regained supported decision-making, the Master may -
  - (i) increase the amount of security lodged or to be lodged by the administrator, or

- (ii) appoint a co-administrator, and in such a case all acts relating to the property of the person concerned must be done with the consent of both administrators.
- 4) An administrator may -
- (a) take care of and administer the property of the person in respect of whom he or she has been appointed and perform all functions incidental thereto; and
  - (b) subject to any other law, carry on any business or undertaking of the person concerned.
- (5) Unless -
- (a) authorised to do so by a court order, an administrator may not alienate or mortgage any immovable property of the person in respect of whom he or she has been appointed; and
  - (b)
    - (i) a purchase or acquisition was, in writing, legally authorised by the person concerned before the administrator was appointed in respect of the person; and
    - (ii) the Master has consented thereto,
 a spouse, child, parent, partner, associate or agent of an administrator may not purchase or otherwise acquire any property of the person in respect of whom the administrator has been appointed.
- (6) Immediately after his or her appointment, the administrator must pay to the Master all moneys received on behalf of the person in respect of whom he or she has been appointed, unless -
- (a) the Master directs otherwise;
  - (b) a legal document of the person made before the administrator was appointed, authorises otherwise; or
  - (c) the money is required to -
    - (i) repay any debt;
    - (ii) pay expenses relating to the safe custody of the property of the person;
    - (iii) maintain or educate the person or his or her dependants; or
    - (iv) pay for the current expenditure of the business or any undertaking of the person.

### **Termination of appointment of administrator**

**62.** (1) Except where the duration of an appointment as administrator has been specified as contemplated in **section 57(4)(b)**, the appointment as administrator in terms of this Act may only be terminated after consideration of an application made by -

- (a) the person in respect of whom the administrator has been appointed if the person has regained his or her capacity to make informed decisions concerning his or her property;
  - (b) the administrator; or
  - (c) the person who made an application for the appointment of the administrator concerned or any other interested party.
- (2) An application referred to in subsection (1) must -
- (a) be made by way of a written affidavit;
  - (b) be submitted to the Master; and
  - (c) contain -
    - (i) the grounds on which the application is based;
    - (ii) all medical certificates or reports relevant to the mental health status of the person concerned issued subsequent to the appointment of the administrator; and
    - (iii) the estimated property value of the person at the time of submitting the application.
- (3) The Master must, within 14 days after receipt of the application concerned -
- (a) terminate the appointment of the administrator;
  - (b) decline the application; or
  - (c) refer the matter to a judge in chambers for consideration.
- (4) If the Master -
- (a) terminates the appointment of an administrator;
  - (b) declines the application to terminate the appointment concerned; or
  - (c) refer the matter to a judge in chambers for consideration,

the Master must in writing, notify the applicant of the decision and the reasons therefor.

(5) If the Master declines the application to terminate the appointment of an administrator or refuses to refer the application to a judge in chambers for consideration as contemplated in subsection (3), the applicant may appeal, within 30 days after receipt of the notice referred to therein, against the decision of the Master by submitting -

- (a) a written notice setting out the grounds of appeal to a judge in chambers; and
- (b) a copy thereof to the Master.

(6) The Master must, within 14 days after receipt of an appeal in terms of subsection (5) or after referring an application to a judge in chambers for consideration in terms of subsection (3), submit to the judge a copy of -

- (a) the application concerned;
- (b) a written summary of his or her findings;
- (c) the reasons for refusing the application or for referring the application to the judge, as the case may be; and
- (d) in the case of an appeal, the notice of appeal.

(7) Within 30 days after receipt of the relevant documents referred to in subsection (6) the judge in chambers must -

- (a) consider the application or appeal, as the case may be, in the prescribed manner;
- (b) afford -
  - (i) the appellant;
  - (ii) the administrator concerned;
  - (iii) independent mental health care practitioners, if any; and
  - (iv) the head of the health facility concerned,

the opportunity to make oral or written representations on the merits of the application or appeal, as the case may be; and

- (c) in writing, notify the appellant, administrator and head of the health facility concerned of his or her decision and the reasons therefore.

## **PART 9 OFFENCES AND PENALTIES**

### **Unauthorised detention of patients**

**63.** (1) A patient may only be detained in accordance with this Act.

(2) Any person who contravenes subsection (1) commits an offence and is liable on conviction to a fine not exceeding N\$ 100 000 or to imprisonment for a period not exceeding five years or to both such fine and such imprisonment.

(3) The head of a health facility commits an offence if the head, without having authorisation to do so by the Minister, receives, detains or permits to be received or detained in that health facility a greater number of patients than he or she is authorised to receive or detain therein and is on conviction liable to a fine not exceeding N\$ 50 000 or to imprisonment for a period not exceeding two years or to both the fine and the imprisonment.

### **False statements, entries and wilful obstruction**

**64.** A person commits an offence if the person -

- (a) makes a statement that is false or believing it not to be true in respect of any material fact in any application, statement of particulars, report or order under this Act, or when being examined at any enquiry held under this Act;
- (b) makes a statement that is false or believing it not to be true in respect of any material fact in any medical certificate or other certificate or in any statement or report on the physical or mental health condition of any person under this Act;
- (c) knowingly makes in any book, statement or return, any false entry as to any matter with regard to which he or she is by this Act required to make an entry;
- (d) wilfully obstructs the Minister and the Minister responsible for correctional services or any official *curator ad litem*, administrator, member of a review board, medical practitioner, member of the Namibian Police Force or any person specially authorised by those Ministers or under any order of court, in the exercise of any power under this Act,

and is on conviction liable to a fine not exceeding N\$ 50 000 or to imprisonment for a period not exceeding two years or to both such fine and such imprisonment.

### **Ill-treatment of patient by persons employed at health facility**

**65.** (1) Any person employed in a health facility or community-based healthcare facility or other place at which a patient is being detained or any person having the care or charge of a patient who ill-treats or wilfully neglects the patient, commits an offence and is liable on conviction to a fine not exceeding N\$ 100 000 or to imprisonment for a period not exceeding five years or to both such fine and such imprisonment.

(2) Any mental health care practitioner, any person employed by a health facility or any person having the care or charge of a patient -

- (a) who witnesses any abuse referred to in subsection (1) against a patient; and
- (b) who fails to report the abuse to the Permanent Secretary of the Ministry responsible for health or his or her employer and, if applicable, to the appropriate professional council responsible for the registration of the profession of the person perpetrating the abuse,

commits an offence and is liable on conviction to a fine not exceeding N\$ 50 000 or to imprisonment for a period not exceeding two years or to both such fine and such imprisonment.

### **Offences in connection with patients who abscond**

**66.** Any person who-

- (a) incites any patient to absconds or entices any patient from a place where the patient is detained under this Act;
- (b) assists the patient in absconding or attempting to abscond from such place or who permits any patient to abscond or attempt to abscond from such place or who conspires with the abscondment or attempt to abscond; or
- (c) exposes or provides pornographic materials to any patient,

commits an offence and is liable on conviction to a fine not exceeding N\$ 50 000 or to imprisonment for a period not exceeding two years or to both such fine and such imprisonment.

### **Employment of appropriate staff**

**67.** (1) No -

a) male person may, subject to subsection (2), be employed in a health facility including a community-based healthcare facility to take personal custody of any female patient or to restrain personally any female patient, except -

(i) under the continual supervision of a female person; and

(ii) only on the instructions of the head of the health facility where that person is admitted;

(b) female person may, subject to subsection (2), be employed in any health facility including a community-based healthcare facility to take personal custody of any male patient or to restrain personally any male patient, except -

(i) under the continual supervision of a male person; and

(ii) only on the instructions of the head of the health facility where that person is admitted.

(2) This provisions of subsection (1) do not apply in respect of the employment of a male or a female person in any case of urgency which, in the opinion of the head of the health facility concerned, makes such employment necessary.

(3) The head of a health facility who employs a male or a female person under the circumstances referred to in subsection (2) must report it immediately to the Minister.

(4) Staff members in a mental health facility who have direct contact with patients must in the prescribed manner and at the prescribed times provide to the head of that facility a police conduct certificate showing that they have no convictions in respect of the prescribed crimes.

(5) Any person who contravenes or fails to comply with subsection (1), (3) or (4) commits an offence and is liable on conviction to fine not exceeding N\$ 50 000 or to imprisonment for a period not exceeding two years or to both such fine and such imprisonment.

### **Sexual or indecent or immoral act with patient**

**68.** (1) Notwithstanding the provision of any law, a mental health care practitioner or any person employed at a health facility who-

(a) commits a sexual act with a patient who is detained under this Act; or

(b) performs any indecent or immoral act with any patient,

commits an offence and is liable on conviction to direct imprisonment without the option of a fine.

(2) For the purposes of -

(a) subsection (1), “sexual act” means -

- (i) the insertion (to even the slightest degree) of the penis of a person into the vagina, anus or mouth of another person;
  - (ii) the insertion of any other part of the body of a person or of any part of the body of an animal or of any object into the vagina or anus of another person, except where the insertion of any part of the body (other than the penis) of a person or of any object into the vagina or anus of another person is, consistent with sound medical practices, carried out for proper medical purposes; or
  - (iii) cunnilingus or any other form of genital stimulation;
- (b) paragraph (a), “vagina” includes any part of the female genital organ.

### **Prohibition of publication of sketches and photographs and information of patient**

**69.** Any person who, without the written permission of a patient or his or her legal representative, publishes or causes to be published in any manner whatsoever -

- (a) any sketch or photograph of any patient or group of patients depicting the patient or patients within or outside any health facility; or
- (b) the name of, or other information identifying, a patient,

commits an offence and is liable on conviction to a fine not exceeding N\$ 20 000 or to imprisonment for a period not exceeding one year or to both the fine and the imprisonment.

### **Other offences**

**70.** Any person who contravenes or fails to comply with section 32(7), 37(6), 41(2), 48(8) or 55(2) commits an offence and is liable on conviction to a fine not exceeding N\$ 20 000 or to imprisonment for a period not exceeding one year or to both the fine and the imprisonment.

## **PART 11 GENERAL**

### **Namibians with mental health problems imprisoned in foreign countries**

**71.** A Namibian citizen with mental health problems who has been convicted or imprisoned in a country other than Namibia must be cared for in accordance with the provisions of the Transfer of Convicted Offenders Act, 2005 (Act No. 9 of 2005), if applicable.

### **Examination of patient in connection with prosecution under Act**

**72.** If it is necessary that a patient be examined in connection with the prosecution of any other person under this Act or any other Act, the examination and enquiry must, if practicable, take place at the health facility where the patient is admitted.

### **Expenses in connection with detention and treatment of State Patients in health facilities**

**73.** The maintenance and other expenses necessarily incurred in connection with the detention and treatment of any State patient detained in any health facility under this Act must be defrayed from moneys appropriated by Parliament for that purpose.

## **Indemnity**

**74.** A person is not personally liable for any damage or loss arising out of any act done or omitted by himself or herself in good faith and in the course of his or her powers, functions and duties in terms of or under this Act, unless the loss or damage is due to his or her wilful misconduct, dishonesty or gross negligence.

## **Execution of court orders under this Act**

**75.** Any order by any court of law for the detention or removal of a patient may be executed by the person to whom it is addressed or by any member of the Namibian Police Force.

## **Medical certificate evidence of certain facts**

**76.** Any medical certificate given or medical report made under or for the purposes of this Act -

- (a) is *prima facie* proof of the facts stated therein, in so far as the facts are within the knowledge of the person giving the certificate or making the report, and
- (c) is also proof of the opinion expressed therein by the person giving the certificate or making the report the facts concerned, to the same extent as if the matters appearing therein had been verified on oath.

## **Review by Court**

**77.** Nothing in this Act must be construed to detract from the jurisdiction of the Court to review any decision made in terms of or under this Act.

## **Requesting of assistance by members of Namibian Police Force**

**78.** (1) Any mental health care practitioner, family member of a patient, interested party or member of the public may request assistance from any member of the Namibian Police Force if a patient is aggressive or unmanageable.

- (2) A member of the Namibian Police Force -
  - (a) must forthwith comply with a request referred to in subsection (1);
  - (b) may only use the constraining measures as may be necessary, proportionate and appropriate in the circumstances when apprehending a patient or performing any function in terms of this section;
  - (c) may assist with transportation of the patient to a health facility.

## **Regulations**

**79.** (1) The Minister may make regulations not inconsistent with this Act in respect of the following matters -

- (a) the control of any operation or medical or therapeutic treatment of patients in a health facility, including the parameters for the use of electroshock therapy on adults, subject thereto –
  - (i) that electro-convulsive therapy should not be used in its unmodified form and that informed consent from those adults is always sought; and

- (ii) that electro-convulsive therapy may never be used on any child;
- (b) the powers, functions and duties of voluntary organisations relating to mental health services;
- (c) the collaboration of a mental health facility with health organisations facilitating the transition of patients from an in-patient status to an out-patient status;
- (d) the establishment of a mental health facility for State Patients;
- (e) the setting of quality standards and the norms for the mental health care of patients at a health facility;
- (f) the seclusion and restraints of patients and the use of mechanical means of restraint;
- (g) the observation, detention and treatment of cases referred to a health facility by any court of law;
- (h) the establishment of a health facility for the observation and treatment of alcoholics and drug dependants;
- (i) the establishment of child mental health guidance clinics, child a mental health facility and the mental health care, treatment and rehabilitation of children;
- (j) the regulation of community-based health facilities, including minimum standards to which such facilities must comply with;
- (k) the provision of community-based mental health services, after-care and follow-up services;
- (l) the powers, functions and duties of employees in a health facility;
- (m) additional powers, functions and duties of review boards not stipulated in Part 4;
- (n) the discharge of patients;
- (o) the removal or transfer of patients under this Act, including the temporary transfer of patients to any specified place for the period as may be deemed appropriate;
- (p) the -
  - (i) registers which must be kept in a health facility or otherwise with reference to any patient;
  - (ii) entries which must be made therein; and
  - (ii) accounts, returns, reports, extracts, copies, statements, notices, documents and information which must be sent to the Minister;
- (q) the persons by whom, the times when and the manner in which -
  - (i) entries referred to in paragraph (p)(ii) must be made;

- (ii) accounts, returns, reports, extracts, copies, statements, notices, documents and information referred to in paragraph (p)(iii) must be sent in regard to any health facility or patient;
- (r) the payment of maintenance and expenses incurred in connection with the detention, treatment and rehabilitation of any person in a State health facility;
- (s) the visitation of a State mental health facility where patients are detained;
- (t) the care and comfort of patients in a State mental health facility;
- (u) the appointment process and removal process for members of review boards, including professional and ethical standards for board members;
- (v) the promotion of mental health in all areas of public life;
- (w) the order of precedence or other rules for dealing with conflicts of opinion between multiple interested parties in respect of a single patient;
- (x) the provision of educational activities, vocational training, leisure and recreational activities, and provision for the religious or cultural needs of people with mental illness or mental disabilities;
- (y) the requirements and procedures for registration and de-registration of facilities as a mental health facility, including which categories of mental health facilities may treat which categories of patients;
- (z) the requirements and procedures pertaining to police clearance certificates, including the period of validity of the certificates, the renewal thereof and the crimes in respect whereof the certificates may not be issued;
- (aa) the forms to be used for the purposes of this Act;
- (bb) the powers, duties and functions of community custodians and the procedure relating to the appointment of community custodians;
- (cc) the procedures relating to the review of an administratorship; and
- (dd) any matter which may or is required to be prescribed under this Act or which is necessary or expedient for the better administration and achievement of the purposes of this Act.

(2) A regulation made in terms of subsection (1) may prescribe penalties for any contravention thereof or failure to comply therewith, of a fine not exceeding N\$ 150 000 or to imprisonment for a period not exceeding five years or to both such fine and such imprisonment.

### **Repeal of laws and transitional provisions**

- 80.** (1) The following laws are repealed -
- (a) sections 27, 28, 29 and 29*bis* of the Mental Disorders Act, 1916 (Act No. 38 of 1916);
  - (b) the Mental Health Act, 1973 (Act No. 18 of 1973);

- (c) the Mental Health Amendment Act, 1976 (Act No. 48 of 1976); and
- (d) sections 2 and 3 of the Health Laws Amendment Act, 1977 (Act No. 36 of 1977).
- (2) Any -
  - (a) regulation, application, report, enquiry, finding, request, return, direction, examination or appointment made, held or given;
  - (b) medical certificate or other certificate, order under this Act, summons, warrant or authority issued, made or given;
  - (c) condition imposed;
  - (d) any board established; or
  - (e) any other act done,

under any provision of any law repealed by this Act and which was in force immediately prior to the commencement of this Act is deemed to have been made, held, issued, given, imposed, established or done, as the case may be, under the corresponding provision of this Act.

#### **Short title and date of commencement**

**81.** (1) This Act is called the Mental Health Act, 2018, and comes into operation on a date to be determined by the Minister responsible for health by notice in the *Gazette*.

(2) Different dates may be determined under subsection (1) for different provisions of this Act.