| CONTENTS |
|----------|---|
| 1. Executive Summary | 3 |
| 2. Background to the project | 4 |
| 2.1 Research findings | 6 |
| 2.2 Research conclusions | 7 |
| 2.3 Research recommendations | 8 |
| 3. Introduction to the project | 9 |
| 4. Progress of the project | 10 |
| 4.1 Establishment of the National Mental Health Advisory Committee | 10 |
| 4.2 Meetings of the National Mental Health Advisory Committee | 10 |
| 4.3 Endorsement of the project plan and methodology | 11 |
| 4.4 Assessment of existing mental health legislation and other related legislation | 11 |
| 4.5 Findings of the assessment | 11 |
| 4.6 Endorsement of the need for a new Mental Health Bill | 12 |
| 4.7 Development of drafting instructions for a new Mental Health Bill | 13 |
| 4.8 Finalisation of phase 1 of the project | 14 |
| 5. Achievements of the project | 14 |
| 5.1 Engagement and support of government | 14 |
| 5.2 Establishment of a National Mental Health Advisory Committee | 14 |
| 5.3 Consensus on the need for a new Mental Health Bill | 15 |
| 5.4 Development of draft instructions for a new Mental Health Bill | 15 |
| 5.5 Commitment to continuation of the project | 15 |
| 6. Lessons learned | 15 |
| 6.1 Need for a dedicated in-country project manager | 15 |
| 6.2 Need for scheduled and formal in-country meetings of the NMHAC | 16 |
| 6.3 More effective implementation of the communication strategy | 16 |
| 6.4 Impact of external political factors | 17 |
| 6.5 Potential for streamlining the project | 17 |
| 6.6 Potential for replicating in other countries | 17 |
| 7. Next steps | 17 |
| 8. Attachments | 18 |
| 8.1 Reasons for the review of the Seychelles Mental Health Act 2006 | 18 |
| 8.2 Membership of the Seychelles National Mental Health Advisory Committee | 19 |
| 8.3 Project responsibilities and expectations | 20 |
| 8.4 Report of the review of Seychelles mental health and related legislation | 21 |
| 8.5 Stakeholder consultation feedback | 28 |
| 8.6 Drafting instructions for a new Mental Health Bill for Seychelles | 30 |
1. EXECUTIVE SUMMARY

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

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

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

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

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

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

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

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

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

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

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

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

The World Health Organisation report that:

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

There is huge inequity in the distribution of skilled human resources for mental health across the world. Shortages of psychiatrists, psychiatric nurses, psychologists and social workers are one of the main barriers to providing treatment and care in low and middle income countries. Low income countries have 0.05 psychiatrists and 0.42 mental health nurses per 100,000 people. The rate of psychiatrists in high income countries is 170 times greater and for nurses is 70 times greater.

Stigma about mental disorders and discrimination against patients and families prevent people from seeking mental health care.

On average about 800,000 people commit suicide every year, 86% of them in low and middle income countries. Mental disorders are one of the most prominent and treatable causes of suicide.

War and other major disasters have a large impact on mental health and psychosocial wellbeing. Rates of mental disorder tend to double after emergencies.

Few countries have a legal framework that adequately protects the rights of people with mental disorders.

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

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

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

---

In 2013, the 25\textsuperscript{th} Commonwealth Health Ministers meeting (CHMM), which is held the day prior to the opening of the World Health Assembly, took mental health as its theme. In preparation for the CHMM, research into mental health legislation in Commonwealth countries was commissioned by the Commonwealth Health Professions Alliance and funded by the Commonwealth Foundation. The research was conducted by a team from the Indian Centre for Mental Health Law and Policy (ICMHL) led by Dr Soumitra Pathare.

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

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

Table 1: CRPD status Commonwealth countries.

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>Low to middle</th>
<th>Upper middle</th>
<th>High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratified</td>
<td>5</td>
<td>11</td>
<td>6</td>
<td>6</td>
<td>28</td>
</tr>
<tr>
<td>Signed</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Neither</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

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

2.1 Research findings

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

6. Mental health legislation in only four Commonwealth member states had provisions for supported decision making including the provision of Advance Directives in their mental health legislation.

7. Mental health laws in all Commonwealth member states allow involuntary admission to a mental health facility. Only half (51 per cent) of country mental health laws require the person to be discharged as soon as they do not meet the criteria for involuntary admission. 80 per cent of mental health legislation in Commonwealth countries does not apply the principle of least restrictive alternative to involuntary admission.

8. More than two-thirds of the mental health laws do not have a judicial/quasi-judicial body to review involuntary admissions and treatment.

9. Provisions for protection from cruel, inhuman and degrading treatment are included in the legislation in only 23 (51 per cent) countries.

10. The informed consent of persons with mental disorders for participating in clinical and experimental research is specifically mandated in mental health legislation in only five (11 per cent) countries.

11. Mental health laws in only nine (20 per cent) countries include a provision on the protection of confidentiality and only eight (18 per cent) countries include a provision on privacy for persons with mental disorders.

12. Legislation in only three (7 per cent) countries specifically outlaws forced or inadequately remunerated labour within mental health facilities.

13. Very few laws have specific provisions for the involvement of families and care-givers. Legislation in 12 (27 per cent) countries provides for information to be given to families and caregivers; in 10 (22 per cent) countries families and care-givers are encouraged to participate in the formulation of treatment plans.

14. Mental health laws in most Commonwealth countries provide very little protection to minors and children. Laws in only two (4 per cent) countries restrict involuntary admission of minors with mental health problems, and laws in only three (7 per cent) countries ban any irreversible treatments on children with mental health problems.

15. The word “lunatic” is used in the mental health laws of 12 countries; the term “insane” is used in the mental health laws in 11 countries; the term “idiot” is used in the mental health laws in 10 countries; two mental health laws use the term “imbecile”; and two mental health laws use the term “mentally defective”. Overall 21 (47 per cent) laws use one of the above terms.

16. The law in only one Commonwealth country mandates that users of mental health services are involved in mental health policy, legislation development and service planning.

2.2 Research conclusions:

1. Mental health legislation in many Commonwealth member states is out-dated and does not fulfil member states’ international human rights obligations toward persons with mental disorders.

2. Mental health legislation in many Commonwealth member states is not compliant with the Convention on Rights of Persons with Disabilities. Substantive and procedural provisions related to guardianship in mental health laws are particularly problematic in this regard.
3. Many mental health laws reviewed in the report treat persons with mental disorders as needing protection rather than as subjects with rights. As a result, mental health legislation, instead of protecting the rights of persons with mental disorders, is likely to lead to violation of rights.

4. Mental health legislation in many countries is based on an out-dated understanding of mental disorders; ignores advances in the care and treatment of mental disorders and denies the capacity of persons with mental disorders to manage their lives.

5. Provisions in and the language of mental health laws in many instances adds to negative perceptions and further stigmatisation of persons with mental disorders.

6. Most mental health laws pay little attention to protecting the rights of vulnerable groups with mental health problems such as minors, women, and minorities and the special needs of such vulnerable groups.

7. Many mental health laws in Commonwealth countries do not address the issue of (lack of) access to mental health care, in particular, making care and treatment easily available; provided in a manner which enhances the capacities of individuals and protects and promotes their rights; and enables them to live and participate in their communities.

8. There is little participation of persons with mental disorders and their families and care-givers in the development and implementation of legislation.

2.3 Research recommendations:

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

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

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

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

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

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

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

Seychelles Mental Health Act was enacted in 2006 prior to the Seychelles signing (March 2007) and ratifying (October 2009) the CRPD. The CRPD was developed December 2006 and came into force May 2008. The Consultant to the project, Dr Soumitra Pathare, from the Indian Centre for Mental Health Law and Policy prepared a preliminary assessment of the Seychelles Mental Health Act 2006 (see Attachment 1) and found:

- The 2006 Act has never been fully implemented.
- There is a lack of recognition in the 2006 Act of legal capacity (Article 12) and right to community living (Article 19).
- There is no mention of protection of any of the rights of persons with mental illness in the Act as protected in the UN CRPD which was ratified by Seychelles in 2009.
The Act is primarily written from an administrative perspective rather than protecting and promoting the rights, health care and treatment of persons with mental illness.

The Act presupposes that almost all people with mental illness will not be able to consent. In all provisions where consent is required, there is a provision for consent to be obtained from the person with mental illness or their next of kin with no qualification of when such proxy consent may be obtained.

The involuntary admission criteria are extremely vague and make poor law. There is no time limitation for involuntary admission (it is indefinite), there is no provision for regular review of involuntary admission at timely intervals and there is no possibility of appeal against involuntary admission.

There is no provision for community based treatment of persons with mental illness.

It is penal in character and sees mental illness as a law and order problem rather than a health issue;

No amount of amending this law will change this fundamental character of the Act; and

The Act does not take into account the advances in medical treatment of mental illness that have happened in the last 60 years.

The Seychelles Government recognised that their current mental health legislation did not meet the requirements of the international conventions they were a party to, including the CRPD. Their 2006 Act had not been implemented. They welcomed the opportunity to participate in the project and made a formal commitment, by exchange of letters, to endorse, participate in, and support the project.

4. PROGRESS OF THE PROJECT: SEYCHELLES

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

The Seychelles Ministry of Health appointed members of the NMHAC including the Chairperson (see Attachment 2 for membership). The NMHAC included a user of mental health services and a carer of a person with mental health problems. A preparatory meeting was held with Ministry of Health and mental health officials on 8 September 2014. At this meeting, the background to the project was shared together with the overall aim and objectives of the project. The Seychelles Ministry of Health undertook to provide financial support for meetings and activities of the NMHAC, freeing up project funds for other activities. A list of responsibilities and expectations of each partner in the project was developed and agreed (see Attachment 3).

4.2: Meetings of the NMHAC

The NMHAC met formally as part of the project on seven occasions however met informally to progress activities much more frequently. Formal project meetings were held:

- 13 November 2014
- 20 April 2015
- 7 September 2015
- 30 September 2015
- 12 February 2016
- 18 July 2016
- 5 December 2016
4.3: Endorsement of the project plan and methodology
At the first meeting of the NMHAC which was held on 13 November 2014 at which the project plan, methodology, and timelines were endorsed. Members of the NMHAC undertook to provide information about the project in their workplaces and to their networks. A power point presentation was developed so that information shared was consistent.

4.4: Assessment of existing mental health and other relevant legislation
The second meeting of the NMHAC was held on 20 April 2015. At this meeting a list of relevant legislation for assessment was developed and the NMHAC committed to obtaining soft copies of the legislation for the research team from the Indian Centre for Mental Health Law and Policy. The third meeting of the NMHAC was held on 7 September 2015. The meeting was advised that the Cabinet Memorandum authorising the review of the legislation and action on the recommendations of the review had been approved by Cabinet. The meeting also prepared the agenda for the visit of the consultant, Dr Soumitra Pathare, at the end of the month when the assessment results and recommendations would be shared with the NMHAC and a broader stakeholder meeting.

4.5: Findings of the assessment
The fourth meeting of the NMHAC was held on 30 September 2015. This meeting was attended by the consultant, Dr Soumitra Pathare, who shared with the NMHAC the result of the assessment of the legislation against the CRPD and his recommendations.
Documents which were included in the assessment were:

1. Mental Health Act (Act 8 of 2006) consolidated up to 2012
2. Draft National Mental Health Policy for Seychelles 2014
3. Civil Code of Seychelles Act
5. WHO Country Co-operation Strategy 2008-2013
6. WHO Country Co-operation Strategy updated May 2014
8. National Policy and Plan of Action on Disability

The consultant noted that the Seychelles has ratified the following International Treaties and Conventions which have relevance to mental health legislation and policies:

1. International Covenant on Civil and Political Rights and the Optional Protocol (ICCPR)
2. International Covenant on Economic, Social and Cultural Rights (ICESCR)
3. International Convention on the elimination of all forms of racial discrimination (ICERD)
4. Convention on the elimination of all forms of discrimination against women (CEDAW) and Optional Protocol
5. Convention against torture (CAT)
6. Convention on the rights of the child (CRC) and Optional Protocols
7. CRPD (ratified the Convention and signed the Optional Protocol)

Seychelles therefore has an obligation to ensure its domestic legislation, including mental health legislation, is in compliance with the obligations under the International Conventions and Treaties ratified by Seychelles. In particular, mental health legislation needs to meet Republic of Seychelles’ obligations under the Convention on Rights of Persons with Disabilities. The full report of the legislation assessment and the conclusions and recommendations of the consultant can be found at Attachment 4.

The recommendation of the consultant was that amending the existing legislation would be very difficult because (a) nearly every clause required amendment and (b) the approach taken in the existing legislation was protection of the public from people with mental disorders rather than upholding the human rights of people with mental disorders which is the approach taken by the CRPD. Following lengthy discussion, the NMHAC unanimously endorsed the development of a new Mental Health Bill.

4.6: Endorsement of the need for a new Mental Health Bill
On 1 October 2015 a meeting of broader stakeholders was held where once again, the consultant shared the results of his assessment of the existing mental health legislation and other related legislation. The consultant also provided an overview of the CRPD. Stakeholders were given the opportunity to ask questions, respond to the consultant’s presentations, and voice agreement or concerns. The recommendation from the NMHAC to draft a new Mental Health Bill was unanimously endorsed by the stakeholders at the meeting. Feedback from the stakeholder consultation is outlined in Attachment 5.
On 2 October, the NMHAC reconvened to discuss the feedback from the stakeholder meeting and plan for the next steps which were to submit the NMHAC recommendations to the Ministry of Health, and meet with the staff at the Attorney General’s Chambers to brief them on the results of the assessment. Members of the NMHAC and the consultant subsequently met with the Minister for Health and the Permanent Secretary for Health to share the results of the assessment of the legislation and the recommendation of the NMHAC, endorsed by the stakeholder meeting. The Minister for Health agreed that the project should move to develop drafting instructions for a new Mental Health Bill. A further meeting was held with staff at the Attorney General’s Chambers where the results of the assessment of the existing legislation was shared as well as the recommendation to draft a new Bill. The process for the development of a new Bill was discussed and it was agreed that, in consultation with the NMHAC, the consultant would develop the initial drafting instructions.

4.7: Development of drafting instructions for the new Mental Health Bill
The fifth meeting of the NMHAC was held 12 February 2016. The major focus of the meeting was preparing for stakeholder consultations once the drafting instructions were available. On 18 July 2016, at the sixth formal meeting of the NMHAC, the consultant, Dr Pathare, met with the NMHAC to share the first draft of the drafting instructions. The document was discussed in great detail to ensure that it was relevant to the Seychelles context and that it met the CRPD standard as far as was possible. Representatives from the Attorney General’s Office were not available to work with the consultant to begin drafting the new Mental Health Bill however the consultant met with the Seychelles Minister for Health who reiterated support for the project and also reaffirmed the request for the consultant to work with the NMHAC to finalise the National Mental Health Policy. Further minor amendments to the drafting instructions were made by the NMHAC and the consultant to prepare them for submission to the Attorney General’s Office through the Minister of Health (see Attachment 6).
4.8: Finalisation of phase 1 of the project
The final meeting of the NMHAC was held on 5 December 2016. At this meeting, the NMHAC reviewed the progress of the project. The Chair of the NMHAC confirmed that the drafting instructions for the new Mental Health Bill, together with the original Cabinet Memorandum and a covering letter from the Principal Secretary, Ministry of Health, had been sent to the Attorney General’s Office. The NMHAC had recommended they continue as a Standing Committee to drive mental health reform, not only the legislation, but the implementation of the legislation into policy and practice. This recommendation had the support of the Ministry of Health. The Minister for Health had provided direction to the NMHAC to revise the National Mental Health Policy in line with the drafting instructions for the new Mental Health Bill which would be developed as quickly as possible and prior to the development and enactment of the new Mental Health Bill. The Minister recommended that support from the Consultant to the project be sought in finalising the National Mental Health Policy. Two TV sessions had been organised: the first on 15 April 2016 on mental health and addiction, and the second on 18 May 2016 on mental health. The sessions took the form of a televised forum followed next day by general phone in, plus texting, plus audience participation. The sessions were considered to be very popular.

5. ACHIEVEMENTS OF THE PROJECT

5.1: Engagement and support of government
The engagement and support of the Seychelles Ministry of Health and Minister for Health through the former and current Permanent Secretary for Health was essential to the successful establishment and implementation of the project. This ongoing support and accessibility for encouragement and direction has been a critical factor for the project.

5.2: Establishment of a National Mental Health Advisory Committee
The establishment of a representative National Mental Health Advisory Committee with an excellent Chair was another critical success factor. The members of the NMHAC, including the service user and the carer representatives, remained committed and enthusiastic throughout the project. The NMHAC was a small committee which facilitated positive discussion and consensual decision making. Attendance at meetings of the NMHAC by all members was excellent. Over the life of the project, members of the NMHAC saw significant advantages in having such a committee and have recommended that the committee become
a standing committee to oversee the implementation of the new mental health legislation and its
translation into policy and practice. It has been a very positive experience for both the external project
manager and the consultant in working with such a dedicated group of people.

5.3:  Consensus on the need for a new Mental Health Bill
The recommendations from the consultant following the assessment of the existing mental health and
other related legislation were unanimously endorsed by both the NMHAC and at the external stakeholder
consultation. While individuals raised particular issues of concern related to perception of mental illness;
adaptation to the Seychelles culture and context; and translation of the tenants of a new Bill into practice;
the need for a new Mental Health Bill was unanimously endorsed.

5.4:  Development of drafting instructions for a new Mental Health Bill
The consultant spent four days in the Seychelles and sat with members of the NMHAC to develop drafting
instructions for a new Mental Health Bill. This was a very effective strategy. The consultant had the
knowledge and expertise of the CRPD and other reformed mental health legislation and the NMHAC
members had the knowledge and expertise of the Seychelles culture and context. Having a first draft gave
a sense of accomplishment and time for both the consultant and the NMHAC to reflect on what had been
produced, consult further, and make necessary amendments. On reflection, there could have been a
much shorter time interval between endorsement of the need for a new Mental Health Bill and
development of the drafting instructions.

5.5:  Commitment to continuing the project
The Seychelles Minister for Health and members of the NMHAC have made clear their ongoing
commitment to the project and to seeing the drafting instructions become a new Mental Health Bill
enacted by the Seychelles Parliament. This commitment, among all the other responsibilities of their
respective positions, is commendable and will see a transformation of the way care is provided to people
with mental illness in the future in the Seychelles.

6.  LESSONS LEARNED

6.1:  Need for a dedicated in-country project manager
The most important lesson is the need for the appointment of a dedicated in-country project manager
either full-time or part-time to drive the project forward. The work commitments of members of the
NMHAC, particularly the Chairperson and the Secretary to the NMHAC, made it very difficult for them to
give the project the time required to achieve project timelines and activities and as a consequence
timelines and some activities were routinely not met, particularly in relation to implementation of the
communication strategy. In-country activities of the NMHAC tended to occur around the time of a
scheduled formal meeting called by the external project manager from the CNMF however the interval
between formal meetings of the NMHAC were often delayed due to the work commitments of the
external project manager. The appointment of a dedicated in-country project manager (either full-time
or part-time) would assist in ensuring scheduled activities were undertaken and timelines met. A
dedicated in-country project manager could also organise external stakeholder consultants in a timelier
manner. It has been estimated that the appointment of a dedicated in-country project manager would
reduce the time required for completion of the project to from 24-30 months to 12 months.
6.2: Need for scheduled and formal regular in-country meetings of the NMHAC

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

6.3: More effective implementation of communication strategy

The NMHAC endorsed a communication strategy which had a number of elements, none of which worked as effectively as they were envisaged by the project, if at all.

- A communiqué was developed for circulation after each meeting, however it is unclear whether the communiqué was always circulated or to whom it was circulated as communication needed to go through the official channels of the Ministry of Health.
- A series of education leaflets were to be prepared as part of the project for the education of health professionals, the media, and the public however as there was already a dedicated education section in the mental health team responsible for education, this aspect of the project was devolved to this team with suggestions from the NMHAC as to what topics would be most supportive to the project. As a consequence however, it was doubtful whether education about the need for reform of the mental health legislation, and information about the CRPD and its basis in upholding the individual human rights of people with mental disorders, ever reached the intended audience.
- The project communication strategy recommended briefing ‘champions’ for the project, however the NMHAC, while including ‘champions’ in their communication strategy, felt that this strategy would be more effective once a new Mental Health Bill was submitted to Parliament. The project
- A data base was developed as part of the project for dissemination of communiqués and educational material however, despite requests to the NMHAC for names to be included on the data base, this facility was underused and could have been more effective. Originally it was envisaged that all health professionals working within mental health both in-patient and in the community and in government and non-government facilities could be part of the data base to receive regular updates about the project.
- A website was also developed for the project with a secure section for the NMHAC. Website statistics demonstrated that it not as effectively used as it could be or was intended both within the country and by the NMHAC.

6.4 Impact of external political factors

National Assembly elections were held in the Seychelles 8-10 September 2016. After thirty five years in power, the People’s Party was replaced by the opposition, the Linyon Demokratik Seselwa Alliance (LDS), which won 19 of the 33 seats. This meant significant changes for the Seychelles which affected both government and bureaucracy. A new Minister for Health was appointed and for the following three months, the focus was very much on adjusting to the new government rather than pursuing current projects. To complicate matters, on 27 September 2016, the President, James Michel who had been President for the past 12 years, resigned as from 16 October, being succeeded by his deputy, Mr Danny Faure.
Changes in government cannot be predicted, however the impact for the project has been positive as the new Minister for Health is very committed and will champion the new Bill through the Parliamentary process. The new Permanent Secretary for Health is also committed to supporting the work of the National Mental Health Advisory Committee.

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

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

7. NEXT STEPS
The Seychelles Minister for Health and the National Mental Health Advisory Committee are committed to seeing the project to its logical conclusion: development of a new Mental Health Bill and submission to Parliament for enactment. They are further committed to review of the current National Mental Health Policy so it is consistent with the provisions in the new Mental Health Bill. The Commonwealth Nurses and Midwives Federation has submitted to the Commonwealth Foundation for funding for an extension to the project to facilitate the development of the new Bill and its submission to Parliament including extensive stakeholder consultation for input and support. The existing National Mental Health Policy will be reviewed as part of this process. The CNMF is quietly confident of the continued support of the Commonwealth Foundation to follow the project to a successful conclusion.
ATTACHMENT 1

REASONS FOR REVIEW OF THE SEYCHELLES MENTAL HEALTH ACT

Brief summary from Dr Soumitra Pathare
September 2014

The UN Convention on the Rights of Persons with Disabilities is the gold standard for mental health legislation. The Convention was adopted by the UN on the 13 December 2006 at the 61st session of the UN General Assembly by resolution A/RES/61/106. The convention was made available for signature on 30 March 2007. Seychelles signed the convention on 30 March 2007 and the Optional Protocol on the same date. Seychelles ratified the convention on 2 October 2009. The Optional Protocol has not been ratified by Seychelles.

Seychelles’ current mental health Act overall is non-compliant with the UN Convention on Rights of Persons with Disabilities (CRPD) in many aspects. Some of the immediate issues are listed below from a very brief examination of the act by Dr Soumitra Pathare, Coordinator of the Indian Centre for Mental Health Law and Policy.

- Particularly problematic are the lack of recognition of legal capacity (Article 12) and right to community living (Article 19).
- There is no mention of protection of any of the rights of persons with mental illness in the Act as protected in the UN CRPD which was ratified by Seychelles in 2009.
- The Act is primarily written from an administrative perspective rather than protecting and promoting the rights, health care and treatment of persons with mental illness.
- The Act presupposes that almost all people with mental illness will not be able to consent. In all provisions where consent is required, there is a provision for consent to be obtained from the person with mental illness or their next of kin with no qualification of when such proxy consent may be obtained.
- The involuntary admission criteria are extremely vague and make poor law. There is no time limitation for involuntary admission (it is indefinite), there is no provision for regular review of involuntary admission at timely intervals and there is no possibility of appeal against involuntary admission.
- There is no provision for community based treatment of persons with mental illness.

The 2006 Seychelles Mental Health Act was drafted prior to the endorsement of the CRPD and prior to Seychelles ratifying the convention. As the Act has never been fully implemented, it is therefore better to replace the Act rather than try to amend it because:

a. it is penal in character and sees mental illness as a law and order problem rather than a health issue;
b. no amount of amending this law will change this fundamental character of the Act; and
c. the Act does not take into account the advances in medical treatment of mental illness that have happened in the last 60 years.

The mental health legislation project of the Commonwealth Nurses and Midwives Federation and funded by the Commonwealth Foundation provides an opportune time for a review of the Seychelles mental health Act to bring it into line with the UN Convention.
ATTACHMENT 2
SEYCHELLES NATIONAL MENTAL HEALTH ADVISORY COMMITTEE

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Representation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Susan Fock Tave</td>
<td>Chairperson NMHAC</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td></td>
<td>Principal Medical Officer, Seychelles Hospital</td>
<td></td>
</tr>
<tr>
<td>Mrs Bella Henderson</td>
<td>Principal Policy Analyst</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Mrs Gina Michel</td>
<td>Program Manager: Cancer and other NCDs</td>
<td>Public Health Services</td>
</tr>
<tr>
<td>Dr Daniella Malulu</td>
<td>Psychiatrist CIC Wellness Centre</td>
<td>Mental Health Services</td>
</tr>
<tr>
<td>Allen Gervais Comettant</td>
<td>Artist / Staff member, Ministry of Environment and Energy</td>
<td>Service consumer</td>
</tr>
<tr>
<td>Mrs Mariola Betsy</td>
<td>Customer Service Manager</td>
<td>Carer of person with mental health problems</td>
</tr>
<tr>
<td>Anna-Lisa Labiche</td>
<td>Senior Clinical Psychologist</td>
<td>Mental Health Services</td>
</tr>
<tr>
<td>Dr Conrad Shamlaye</td>
<td>Health Policy Adviser</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Anselmine Cafrine</td>
<td>Principal Nursing Officer, Training and Nursing Development</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Ms Jacqueline Cupidon</td>
<td>Occupational Therapist</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Dr Soumitra Pathare</td>
<td>Consultant</td>
<td>Indian Centre for Mental Health Law and Policy</td>
</tr>
<tr>
<td>Ms Jill Iliffe</td>
<td>Project Manager</td>
<td>Commonwealth Nurses and Midwives Federation</td>
</tr>
</tbody>
</table>
**ATTACHMENT 3**

**PROJECT RESPONSIBILITIES AND EXPECTATIONS**

<table>
<thead>
<tr>
<th>Commonwealth Foundation</th>
<th>Funding for project</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commonwealth Nurses and Midwives Federation</strong></td>
<td>Manage project and project budget</td>
</tr>
<tr>
<td></td>
<td>Ensure all project deliverables</td>
</tr>
<tr>
<td></td>
<td>Liaison with researcher and Chairperson of NMHAC</td>
</tr>
<tr>
<td></td>
<td>Secretariat support to NMHAC</td>
</tr>
<tr>
<td><strong>Seychelles Ministry of Health</strong></td>
<td>Nominating members of NMHAC and appointing Chairperson</td>
</tr>
<tr>
<td></td>
<td>Providing venue and sustenance for anticipated meetings x 6</td>
</tr>
<tr>
<td></td>
<td>Identifying and facilitating access to soft copies of mental health and other relevant legislation</td>
</tr>
<tr>
<td><strong>Researcher</strong></td>
<td>Analysing Seychelles mental health and other relevant legislation against UN Convention on Rights of Persons with Disabilities</td>
</tr>
<tr>
<td></td>
<td>Preparing draft report with recommendations</td>
</tr>
<tr>
<td></td>
<td>Preparing technical drafting instructions to NMHAC instructions</td>
</tr>
<tr>
<td><strong>NMHAC</strong></td>
<td>Endorsing project plan and communication strategy</td>
</tr>
<tr>
<td></td>
<td>Endorsing communication materials</td>
</tr>
<tr>
<td></td>
<td>Assisting with identification and obtaining soft copies of mental health and other relevant legislation</td>
</tr>
<tr>
<td></td>
<td>Participating in implementation of communication strategy</td>
</tr>
<tr>
<td></td>
<td>Providing comment on report of researcher and recommendations</td>
</tr>
<tr>
<td></td>
<td>Providing researcher with Bill drafting instructions for Seychelles context</td>
</tr>
<tr>
<td></td>
<td>Endorsing technical instructions and submitting to Ministry of Health</td>
</tr>
<tr>
<td></td>
<td>Lobbying for passage of Bill through Parliament</td>
</tr>
<tr>
<td></td>
<td>Lobbying for implementation of Bill and subsequent translation to policy and practice.</td>
</tr>
</tbody>
</table>
ATTACHMENT 4

REPORT OF THE REVIEW OF SEYCHELLES MENTAL HEALTH AND RELATED LEGISLATION

Seychelles Ministry of Health in partnership with the Commonwealth Nurses and Midwives Federation, the Commonwealth Foundation, and the Indian Centre for Mental Health Law and Policy

Review of Mental Health Act, 2006

Prepared by: Dr Soumitra Pathare, Consultant to the Project
30 September 2015

I. Introduction

The following documents were reviewed for preparing this report:

9. Mental Health Act (Act 8 of 2006) consolidated up to 2012
10. Draft National Mental Health Policy for Seychelles 2014
11. Civil Code of Seychelles Act
12. Mental Health Atlas Country Profile Seychelles 2011
14. WHO Country Co-operation Strategy updated May 2014
16. National Policy and Plan of Action on Disability

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

a) International Covenant on Civil and Political Rights and the Optional Protocol (ICCPR)
b) International Covenant on Economic, Social and Cultural Rights (ICESCR)
c) International Convention on the elimination of all forms of racial discrimination (ICERD)
d) Convention on the elimination of all forms of discrimination against women (CEDAW) and Optional Protocol
e) Convention against torture (CAT)
f) Convention on the rights of the child (CRC) and Optional Protocols
g) CRPD (ratified the Convention and signed the Optional Protocol)

As Seychelles has ratified the Optional Protocol for the ICCPR, CEDAW and CRC, the inhabitants of Seychelles and their representatives are able to invoke their human rights through the treaty monitoring bodies.

Seychelles has an obligation to ensure its domestic legislation including mental health legislation, is in compliance with the obligations under the International Conventions and Treaties ratified by Seychelles. In particular, mental health legislation needs to meet Republic of Seychelles’ obligations under the Convention on Rights of Persons with Disabilities.
The National Policy and Plan of Action on Disability has the following specific objectives:

- Enact appropriate legislations to domesticate the Convention on the Rights of Persons with Disabilities.
- Promote the participation of women and men with disabilities in decision-making.
- Ensure the mainstreaming of disability rights into all policies, structures, systems, programmes and activities in order for them to contribute effectively to national development.
- Improve service delivery for persons with disabilities

There is a National Council for Disabled Persons which was set up through the National Council for Disabled Persons Act, 1994.

“The National Council for Disabled Persons is the key government point of contact for the disability sector and one of its roles is to remain in regular contact with the NGO platform through the Social and Health Commission of LUNGOS and the associations for persons with disabilities. Two persons with disabilities sat on the council’s board out of 10 members. This has however been reduced to 1 for the newly nominated council from the 1st February 2012.” (Para 1.1 CRPD/C/SYC/1 Report)

II. Analysis of Mental Health Legislation and Policy with respect to the Convention on Rights of Persons with Disabilities & Specific Objectives of the National Policy on Disability

1. Article 12 of CRPD: Equal recognition before Law

The current mental health act (MHA 2006) violates Article 12. The Civil Code provisions on Interdiction of persons with mental illness also violates Article 12 of the CRPD.

The Committee on Rights of Persons with Disabilities has published General Comment 1 to help with interpretation of Article 12. Article 12 requires countries to move their legislation from a system of substitute decision making to a supported decision making model.

MHA, 2006 uses a substitute decision making model which does not meet standards of Article 12 of the CRPD. Although there is recognition of the right of persons with mental illness to make their own decisions, the wording of the Act also allows other substitute decision makers to make decisions on their behalf. For example see Section 29(1) and Section 29(2) of MHA 2006. Section 29(1) implies that even when the person has capacity to give consent, this can be either ignored or over-ridden by the next of kin who can either withhold or give consent on behalf of the person. The MHA 2006 is also unclear whose consent has primacy in case there is a difference of opinion between the person and their next of kin and the treating psychiatrist. The wording of Section 29(2) suggests that a psychiatrist can over-ride treatment refusal by the person and/or their next of kin.

Other sections of the MHA, 2006 which also violate Article 12 include:

Section 15(1) – “if that person or the person’s next of kin consents to the examination”. Does not specify what is to be done if there is a disagreement between the person and their next of kin.

Section 16(2) – “is incapable of expressing consent to receive treatment may be admitted as an involuntary patient to a mental health facility on the application of the person’s next of kin.” Does not specify what “incapable of expressing consent to receive treatment” means. It could be taken to mean that any refusal of consent by a person will be regarded as “incapable of expressing consent”. For any consent process to be valid, the person should have the right to either consent or refuse consent.

Section 29(3) – “No treatment by way of psychosurgery or electroconvulsive therapy or any non-psychiatric treatment shall be administered to any patient without the consent of the patient or the
patient's next of kin and the advice of the treating psychiatrist:” – This section effectively means that the person has no right to refuse consent.

Section 30(2): “The patient or the patient’s next of kin may participate in the formulation of the treatment plan”. A plain reading of this section means that the patient with mental illness can be kept out of any participation in the formulation of a treatment plan.

Section 31(1) (c), Section 32: give powers to the psychiatrist and the Minister to move persons with mental illness without having to assign any reason for this movement and thus suffers from arbitrariness.

Section 50(2): “Where a patient repeatedly frustrates the purposes of the patient's admission by unreasonably withholding consent to, or refusing to follow, treatment or by repeatedly being violent, the consultant-in-charge shall submit a report on the case to the Director of Health Services who may, after considering the matter, discharge the patient or order that he be detained in a unit for the mentally ill in a prison or in any high security facility as deemed fit.”

This is particularly problematic as it puts pressure on all patients to give consent to whatever is being proposed as treatment.

2. Article 14 of CRPD: Liberty and Security of Person

The language of the MHA implies that it is ‘detention’ in the mental hospital, for example see wording of Sections 33(1) 34(1) and 35(3). However this detention is neither time limited, nor is there a provision for appeal against the detention by the person who is being detained. The only provision for discharge is in Section 35(1) which is at the discretion of the psychiatrist and this read with Section 50(1)(c) (“be of good behaviour”) makes the entire process rather arbitrary.

Section 16(2) also provides for involuntary admission to a mental health facility based on an application made by the next of kin. Section 16(4) also talks about “preventive confinement” based on a recommendation by the psychiatrist.

The Committee on Rights of Persons with Disabilities has recently published Guidelines on interpretation of Article 14 and above provisions of the MHA 2006 clearly violate these Guidelines.

3. Article 13: Access to Justice

As mentioned above, MHA 2006, there is no provision for appeal against involuntary detention nor is the detention time limited. There is no provision for the patient to seek discharge from hospital and discharge is only at the discretion of the psychiatrist (Section 35(1)). In view of the above, MHA 2006 violates Article 13 of the CRPD.

4. Article 15: Freedom from torture and cruel inhuman and degrading treatment

Article 15 of the CRPD states that no one shall be subjected without his or her free consent to medical or scientific experimentation. Section 25 violates this right in the CRPD by allowing next of kin to consent on behalf of the person with mental illness to exercise the right to “treatment or experimentation”.
5. Article 17: Protecting the integrity of the person

Article 17 of the CRPD states “Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others”. This right is violated by provisions of Section 29(1), (2) and (3) and Section 25 of the MHA 2006.

6. Article 19: Living independently and being included in the community

There are no provisions in the MHA, 2006 which protect the right to independent community living.

Section 35(1) by stipulating that the person “shall remain admitted until the patient is granted temporary leave of absence or is removed, released or discharged in accordance with this Act” and

Section 35(3) by stipulating “A patient who has escaped or disappeared may be apprehended and conveyed back to the mental health facility” actually violate rights under Article 19.

Section 36(1) also says that consultant in charge of a mental health facility shall discharge a person “as soon as reasonably practicable”. However this is not defined.

All the provisions of the MHA 2006 are written with the express purpose of retaining persons with mental illness in institutions rather than facilitating their discharge and community inclusion.

The National Mental Health Policy also provides lukewarm support to the provision of independent community living. The Policy states

“Every person with a mental illness shall have the right to live and work, as far as possible, in the community.

Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives”.

The words “as far as possible” in the Policy above, means this right can be withheld by the service providers on arbitrary basis. The term “as far as possible” also means that health services can deny making provisions for community based care without having to provide any reasons other than to say that it is not possible at the current time. Thus there is no time-limited responsibility on the mental health services to enable persons with mental illness to exercise their right to community living.

7. Article 22 of CRPD: Respect for Privacy

Article 22(1) states “No person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence or other types of communication or to unlawful attacks on his or her honour and reputation” and Article 22(2) states “States Parties shall protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others”

MHA 2006 does not have any explicit provision on protection of confidentiality as required under Article 22(2). On the other hand, Section 25 violates confidentiality by allowing next of kin to exercise the “the right to confidentiality or access to records” on behalf of the person.

Section 18(3) gives Police officers the right to use reasonable force to “to gain entry into any premises or to apprehend the person concerned” and thus violates Article 22(1) which requires that privacy and home is to be protected on an equal basis with others.
8. **Article 26 of CRPD: Habilitation and Rehabilitation**

MHA, 2006 has no provisions for rehabilitation of persons with mental illness. The National Mental Health Policy mentions establishing a rehabilitation village under the heading of “Strategies” but this is not elaborated in the document. Under the heading of “Targets” the Policy also talks about providing rehabilitative services to “those in need” but no clear targets and timelines are mentioned in the policy.

9. **General Principles of CRPD: Participation**

The CRPD requires State Parties to ensure that persons with disabilities fully participate in all decisions regarding their care, treatment and rehabilitation. Seychelles National Policy and Plan of Action on Disability also speaks of promoting “the participation of women and men with disabilities in decision-making”.

MHA 2006 does not have any participation of persons with mental illness or their representative organizations in any of the regulatory bodies created under the Act, namely the Commission or the Board.

There is also no participation of persons with mental illness or their representative organizations in the drafting of the National Mental Health Policy.

10. **Miscellaneous:**

Section 10 of the Act is contradictory to the admission provisions. Whereas the Act allows for involuntary admissions, Sec 10 says “Where the Commission receives a complaint that a person has been admitted to or kept at a mental health facility against the person’s will the Commission shall enquire into the complaint immediately”. By definition, all involuntary admissions are admissions against a person’s will. So if the patient who is admitted involuntarily complains to the Commission does that lead to an inquiry by the Commission?

**III. Recommendations**

1. It will be extremely difficult to amend the MHA 2006 to make it compliant with the CRPD because the fundamental premise of the MHA 2006 is completely at odds with the CRPD. It will be easier to draft new legislation which complies with the requirements of the CRPD.

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

3. It is important that those drafting the new law take General Comment 1 and the Guidelines on Article 14 by the Committee on Rights of Persons with Disabilities into account when drafting new legislation. 4. Civil Code provisions on plenary guardianship violate Article 12 of the CRPD and will need to be amended.

4. A comprehensive mental health legislation will need to address issues of access to mental health care, prevention, care, treatment and rehabilitation. Quality of care and protection of CRPD rights needs to be specifically addressed in legislation.
5. Other non-health areas of importance to persons with mental illness such as discrimination in employment, education and housing to name a few, will need to be addressed either in legislation dealing with these subject areas or in the mental health legislation itself.

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

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

IV. Supported decision making

The Committee on Rights of Persons with Disabilities (the Committee) defines substitute decision making systems where:

i. legal capacity is removed from a person, even if this is in respect of a single decision;

ii. a substitute decision-maker can be appointed by someone other than the person concerned, and this can be done against his or her will; and

iii. 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

From item (iii) above, it is clear that the Committee does not regard the appointment of a substitute decision maker as non-compliant with the CRPD. Rather the Committee is concerned with how the substitute decision maker is appointed (by whom) and how decisions are made by the substitute decision maker.

In paragraph 21 of the General Comment the Committee also says “Where, after significant efforts have been made, it is not practicable to determine the will and preferences of an individual, the “best interpretation of will and preferences” must replace the “best interests” determinations.

The above leads to the interpretation that the following are NOT substitute decision making systems:

i. If a substitute decision maker is appointed by the person concerned (eg. through an Advance Directive, or a nominated representative, or through an enduring power of attorney).

ii. A substitute decision maker makes decisions based on the ‘will and preferences’ of the individual and not on the basis of the ‘best interests’ principle.

iii. After significant efforts if it is not possible to discern the will and preferences of the person, a substitute decision maker makes the decision based on the substitute decision maker’s “best interpretation of the will and preferences” of the person concerned.

Bach and Kerzner (Report for the Law Commission of Canada, Oct 2010) have designed a model of decision making which particularly takes into account the difficulties experienced in decision making by persons with mental illness. This model complies with the CRPD’s requirement for providing supported decision making structures in law.

In summary, it provides for three different decision making status:

a) legally independent decision making where the person makes the decision herself

b) Supported decision making where a significant other who knows the person well can interpret the person’s will and preferences and convey the person’s decision to service providers
c) Facilitated decision making where a significant other is not available eg: someone who is homeless and/or a significant other is available, but are unable to discern the person’s will and preferences and hence the significant other makes the decision based on their ‘best interpretation of the person’s will and preferences’.

This model also envisages a dynamic process by which people may move up and down the decision making status at different points in time and with respect to different decisions.

The Bach and Kerzner model of decision making can be operationalized in law even in countries with limited resources. A law which is based on the above model of decision making would be compliant with the CRPD.

This can be graphically represented as follows:
ATTACHMENT 5

STAKEHOLDER CONSULTATION FEEDBACK
2 October 2015

- If the 2006 Act was not fully implemented, what are the chances that a new Act would be fully implemented?
  Different environment; ratification of CRPD; developing a national health strategy and mental health will be a part of that; development of a national mental health policy; need to pay attention to mental health because of future cost to health system; there are things you can do to facilitate implementation such as take the public, media and other stakeholders with you; law does not act on its own so you need policy and program strategy.

- Redrafting or revision of the law is usually done by legal people so how close will be the relationship between the legal people and the health people in the process to make sure the Act reflects the CRPD?
  The intent is to work closely with AGs during the process of drafting amendments or a new Act and also to submit technical recommendations; also to invite a representative from AGS to be a part of the NMHAC.

- The CRPD has a clear paradigm shift from medical or social which will require a paradigm shift also for the public, families, media, government, bureaucrats. Is there any plan to do that?
  The project has a communication strategy which includes educational leaflets and champions for the project.

- I support the review of legislation because of the discrepancies identified particularly the power it gives in the Act the psychiatrist to override the person and their next of kin. The person with mental illness should be at the centre but may not have 100% capacity to consent but the next of kin and the psychiatrist should also not have 100% decision making powers.
  It is not a matter of not taking power away or giving power to but sharing of power. The important question is how can we support people with mental illness to give their own consent - supported decision making rather than substitute decision making? Not always binary decisions but deciding amongst a range of choices.

- Were mental health consumers involved in the development of the National Mental Health Policy?
  Yes, groups of patients and families were consulted, also other areas such as education, police, and social welfare. There is a consumer and carer represented on the NMHAC.

- Will the draft Mental Health Policy be endorsed or will it wait until the Act is replaced or amended?
  This is a question the NMHAC will need to make a recommendation about although there are some changes that can be made to the Policy right now to improve it.
Dr Pathare was asked to explain preventive confinement. Dr Pathare responded that to confine someone BEFORE they had committed an offence was not something that any person with or without a physical disability would allow; that is should not be allowed for people with a mental disability; and that it grossly infringed their human rights. It also removed the emphasis from developing other less confronting management strategies. Dr Pathare briefly referred to the possibility of people with a mental illness developing an ‘advance directive’ which allows them to have a say in how their illness should be managed if they are temporarily unable to consent on their own behalf.

What statistics are available in relation to mental health?
Some statistics are available but not all. Some practices have changed even though they are still possible in the Act. Practice has moved but the Act needs to change to reflect and support the change in practice.

How is society to be protected by people with mental illness who are violent?
People with mental illness are three times more likely to be victims of violence than perpetrators of violence. Violence is usually the end point of a chain of events that lead to the violence so just focusing on the violence is not resolving the issue.

People with mental illness are non-compliant with their medication which precipitates violence.
Non-compliance is not an effect of mental illness. The statistics demonstrate that the same percentage of people with diabetes and hypertension are not compliant.

What about decision making if one parent has a mental illness. Should they be allowed to participate in decision making about their child?
A parent with a mental illness should be held to same standard of any other parent and be given support and empowerment in decision making. The main importance is the wellbeing and safety of the child which must come first.

Should we amend the existing Act or write a new Act?
There was unanimous support for new Act or at least no opposition to the idea and no suggestion for amending existing Act.
ATTACHMENT 6

DRAFTING INSTRUCTIONS FOR A NEW MENTAL HEALTH LAW

1. Definition of mental illness and treatment

“Mental illness” means a substantial disorder of thinking, mood, perception, orientation or memory that impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life including mental conditions associated with alcohol and drugs but excludes intellectual disability.

Personality disorder by itself, is not regarded as a mental illness under this Act.

“Treatment” under this Act includes biological, psychological treatments and social care for mental illness and also includes curative and rehabilitation care provided either in a health or mental health facility or in the community.

2. Determination of mental illness

a) Mental illness shall be determined in accordance with such nationally or internationally accepted medical standards (including the latest edition of the International Classification of Disease of the World Health Organisation) as may be notified by the Ministry of Health.

b) Mental illness of a person shall not be determined on the basis of (i) political, economic or social status or membership of a cultural, racial or religious group, or for any other reason not directly relevant to mental health status of the person; (ii) non-conformity with moral, social, cultural, work or political values or religious beliefs prevailing in a person’s community.

c) Past treatment or hospitalisation in a mental health facility though relevant, shall not by itself justify any present or future determination of the person’s mental illness.

d) Mental illness shall only be determined by a person qualified to do so for that purpose under this Act.

e) A determination of mental illness under this Act shall not be taken to mean that the person is or has been declared to be of unsound mind for the purposes of the law.

3. Mental Health Professional for the purpose of this Act means

Qualified and licensed psychiatric social workers (under the Social Workers’ council), psychiatric nurses (nurses and Midwives Council), psychologists (Allied Health Professional council) and psychiatrists (Medical and Dental Council).

4. Capacity to make decisions

Mental illness is not equivalent to loss of capacity to make decisions and both issues (illness and decision making capacity) need to be independently determined.

a) There is a presumption of capacity – that is persons with mental illness have capacity to make decisions unless proved otherwise.
b) Capacity is task specific – so a loss of capacity in one area of life should not lead to loss of capacity in other areas of life.

c) Any loss of capacity is regarded as temporary and time limited and fresh assessment should be done at intervals of time. In the event that a person is presumed to have incapacity in a particular area, their right to make decisions in that area of life should be regarded as temporarily suspended and not to permanently take away the person’s right to make decisions.

d) Different procedures for determining lack of capacity for different tasks eg: for making mental health treatment decisions, property, testamentary capacity.

e) Provide an opportunity for the person to be able to appeal the mental health professionals or court’s decision on the incapacity to make decisions.

f) The capacity or incapacity to make a decision can only be made based on the assessment confirmation of the person’s ability or inability to make decisions. This means the person should be subjected to some tests that will verify if indeed the person has or does not have the capacity to can make a decision. The assessment procedures should be different for different areas.

g) The suspension of the capacity in one area should not be regarded as incapacity in other areas.

h) Since there is a presumption of capacity for persons with mental illness, the onus of proving lack of capacity is on the person alleging the lack of capacity of a person with mental illness.

5. Advance Directives (AD)

Noted that the Health Charter being drafted and also the ‘Patient centred care’ policy refers to Advance Directives. Hence there is a need to incorporate Advance Directives in mental health legislation.

An advance directive is only restricted to mental health care.

An advance directive cannot contain provisions which are contrary to the law or Constitution of Seychelles.

Through an AD the following can be done:

a) Appoint a representative to make decisions about mental health care and treatment for them when they are not in a position to make decisions themselves. The representative so appointed should be an adult and should consent to act as a representative.

AND/OR

b) Specify how they want to be treated or not treated for a future mental illness.

The person making an AD shall be presumed to have capacity to do so, unless proved otherwise.

Procedure: The AD can be made on a plain paper and should also be signed by two witnesses of whom one shall be a registered medical practitioner.

The person making the AD has the right to change/revoke/cancel the AD at any time.

The procedure for cancellation/revoking/changing shall be the same as it is for making an AD.

AD shall not include any emergency treatment given by a registered medical practitioner.
Doctors need to be indemnified from the negative outcomes of following an AD.

It is the responsibility of the person who made the AD to ensure that the mental health professionals have access to the advance directive.

6. Rights of persons with mental illness

a) **All rights available under the Constitution:** It is important to reiterate in the mental health law that persons with mental illness enjoy all rights available under the Constitution of Seychelles on an equal basis with other citizens.

b) **Parity** for treatment and care of mental illness with treatment for physical illness.

Every person with mental illness shall be treated as equal to persons with physical illness in the provision of all health care.

Persons with mental illness being treated in mental health facilities enjoy the same rights as patients receiving treatment any other health facility.

c) **Right to live in the community:** persons with mental illness have a right to live in, be part of, and not segregated from the community. Hence Government shall develop appropriate community based programs and facilities for care and treatment of persons with mental illness.

7. Care and Treatment of Persons with mental illness

a) As far as is possible, people should be treated in the community, at their home or near to their home without requiring care and treatment in a mental health facility.

b) If care and treatment is required in a mental health facility, as far as it is possible, it should be provided on a voluntary basis and only in exceptional circumstances (outlined below) should the person be cared for and treated on a facilitated basis.

c) Facilitated care and treatment should be restricted to conditions when a person lacks capacity to make decisions for their mental health care (see details below).

d) **Voluntary Admission**

All persons with mental illness desiring of taking treatment in a mental health facility shall apply to the mental health facility for admission. They will be examined by a registered medical practitioner or a psychiatrist who will certify that they have a mental illness and will benefit from admission to a mental health facility and only then will they be admitted.

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

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

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

ii) An application for facilitated admission has to be made by:
A person nominated under an Advance Directive, if any, or
Next of Kin if any, or
A Social Worker in public service.

Next of Kin is defined in the following descending order:
(a) A person who is living with the person with mental illness in the same household if any, or
(b) Adult children of the person with mental illness if any, or
(c) Parent of the person with mental illness if any, or
(d) Adult siblings of person with mental illness if any.

iii) Once the application is made, the person should be independently examined by two health professionals and certify the following:
The person lacks capacity to make mental health decisions and;
The person has a mental illness as defined under the Act and;
The person has one of the following:

- They have recently threatened or attempted or threatening or attempting to cause bodily harm to himself/herself or
- Has recently behaved violently or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him/her
- Has recently shown or is showing an inability to care for himself/herself to such a degree that places the individual at risk of harm to himself/herself.

iv) Of the two health professionals, one has to be a psychiatrist and the other health professional can be a mental health professional or a registered medical practitioner.

The above professionals should have examined the alleged person with mental illness in a period not exceeding 7 days preceding the day when they certify (iii) above.

v) the admission of a person with mental illness as a facilitated patient is limited to a period of 20 days in the first instance.

vi) The head of the mental health facility has the duty to discharge the person from the facilitated admission before the end of the 20-day period if they believe that the person no longer meets the conditions for facilitated admission.
vii) Any person who is admitted as a facilitated admission shall receive treatment as prescribed by the mental health professional, with the consent of the person making the application for facilitated admission.

vii) At the end of the 20-day period, the following may happen:

a) If the conditions for a facilitated admission continue to be met, the mental health professional in charge of the mental health facility shall apply to the Tribunal for an order to continue the admission (see below).

b) If the conditions for a facilitated admission are no longer met, the person with mental illness may either continue to remain admitted as a voluntary patient if necessary or may be discharged from the facility.

viii) All persons admitted under as facilitated admission order have the right to appeal to the Tribunal against this order at any time during their admission and they shall be informed of this right when they are admitted to the mental health facility.

ix) the Social Worker or the Mental Health Professionals or the Registered Medical Practitioner should not have a conflict of interest or be a relative of the person being examined for a supported admission.

xi) When an application is made to the Tribunal for continuation of the facilitated admission after 20 days or an appeal against the facilitated admission:

a) The Tribunal shall hold a hearing

b) The person shall be represented at the hearing

c) The Tribunal shall also hear evidence from the mental health professionals

d) The Tribunal may decide to either discharge the patient or extend the facilitated admission.

All extensions in the first instance shall be up to a maximum of 90 days, while subsequent extensions shall be up to a maximum of 120 days.

Psychiatrist treating the person should have the duty to discharge the person earlier if the conditions for facilitated admission are no longer met. No need to go back to the Tribunal to ask for a discharge.

Person with mental illness shall have the right to appeal to the Tribunal at any time during the extension of their facilitated admission and they shall be informed of this right when the facilitated admission has been extended by the Tribunal.

f) Admission of Minors

Minors lack legal capacity to make decisions so the procedure for their admission will be similar to the procedure for facilitated admission, except that the application for admission in this instance shall be made either by the parent if present or a legal guardian.

Minors should not be admitted in an adult ward of a mental health facility and should be admitted separately from adults.

Parent or legal guardian should stay with the minor in the mental health facility during their admission.

Minors should be treated only with the consent of their parents or legal guardian.

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

i) Request assistance at the nearest health facility

ii) A health care worker from the health facility shall visit the alleged person with mental illness and make an assessment

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

h) Persons with mental illness found wandering on the street

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

i) A person with mental illness at any health facility

Any person at a health facility, who has come either through (g) or (h) above or has voluntarily attended the health facility and after examination, the health care staff at the facility are satisfied the person has a mental illness which requires assessment at a mental health facility, they shall arrange for the said person to be transported to the mental health facility. If necessary, the health workers shall be entitled to ask Police to provide assistance in such a transfer if the patient is violent or at risk of harming themselves or others and to also seek assistance of Police to keep the person in a place of safety while transport is being arranged. This transfer shall take place within a maximum of 24 hours and the Police can hold the persons in a place of safety up to a period of 24 hours until transfer to the mental health facility.

8. Emergency Treatment of Mental Illness

Emergency treatment can be given by any registered medical practitioner to a person with mental illness either in the community, home or in a mental health facility with or without consent from the person with mental illness if it is immediately necessary to prevent:

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

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

Emergency treatment shall be limited to a period of 24 hours.

9. Seclusion and restraints
a) done as a matter of last resort, in exceptional cases to prevent immediate or imminent harm to self or others.

b) Regulations will be issued by Ministry of Health notifying the standards for use of seclusion and/or restraint.

c) can only be done in an accredited mental health facility.

d) should be authorised by a psychiatrist.

e) that the reasons and duration of each incident be recorded in a database and made available to the Commission on a regular basis.

f) should never be used and a means of punishment or for the convenience of staff.

g) Seclusion on each instance is restricted to a maximum of 2 hrs continuously and restraints on each instance is restricted to a maximum of 8 hours continuously.

h) family members/care-giver and personal representatives should be immediately informed when the patient is subject to seclusion and/or restraint.

i) encourage the development of appropriate structural and human resource requirements that minimize the need to use seclusion and restraints in mental health facilities.

10. Rights of care-givers and relatives

(a) Families and care-givers have a right to be involved in setting treatment goals, treatment planning, planning discharge from hospital and care and treatment after discharge from the mental health facility. In the case of voluntary patients, this should be done with the consent of the patient concerned, but in case of facilitated patients, this will be done with the person who made the application for admission.

(b) Right to visit the person with mental illness admitted to a mental health facility.

(c) They have the right to provide feedback including complaints about any deficiency in services.

(d) They have a right to support by health services to enable them to effectively perform their caregiving role.

(e) They have the right to all social assistance on par with any such support provided to care-givers of persons with physical illness.

11. Bodies created under the Act

A regulatory Body called National Mental Health Commission

One quasi-judicial Body called the Mental Health Tribunal

a) National Mental Health Commission

i) To be appointed by the Minister of Health

ii) Shall consist of the following members:
Principal Secretary, Ministry of Health as Chairperson (ex-officio)

Chief Medical Officer, (ex-officio)

Consultant in charge of Mental Health in Health Care Agency (ex-officio)

Representative from Public Health Authority (ex-officio)

Representative from Ministry of Social Affairs (ex-officio)

A representative from the National Council of Disabled

Chief Nursing Officer (ex-officio)

Chief Allied Health Officer (ex-officio)

A user of mental health services

A family member or care-giver to a person with mental illness

Two (2) civil society representatives with special interest or knowledge of mental health issues.

iii) Functions:

To plan and manage mental health care in Seychelles;

To promote standards of good practice and the efficiency of mental health services;

Setting standards for accreditation of mental health facilities and Accreditation of mental health facilities

Setting criteria and standards for specific mental health services, interventions, treatments as necessary

To inspect with sufficient frequency every mental health facility to ensure that the conditions, treatment and care of patients comply with the provisions of this Act;

Review use of seclusion and restraints in mental health facilities

Any other matters related to mental health in Seychelles

iv) Meetings

The Commission shall meet at least 4 times a year

5 members shall constitute a quorum

The Commission shall keep a record of its proceedings and decisions.

The Commission shall furnish a report of its decisions to the Minister every year and such other information as the Minister may require from time to time.

The decisions of the Commission shall be taken by a majority of votes of all the members present and voting at any meeting and, in the event of an equality of votes, the chairperson or the member presiding in the absence of the chairperson shall have a casting vote.
No member of the Commission shall vote on any matter in relation to any patient who has been treated by that member.

The members of the Commission shall be paid such fees or allowances as determined by the Minister.

The non-official members of the Commission shall be appointed by the Minister to hold office for a period of 3 years and shall be eligible for reappointment.

b) Mental Health Tribunal

To check whether this meets with standards of Tribunals in Seychelles in consultation with AG’s Office

i) To be appointed by the **Minister of Health/Chief Justice**

ii) Shall consist of the following members:

   - Judge of the High Court (or Magistrate?) nominated by the Chief Justice (Chairperson)
   - Consultant Psychiatrist with at least 10 years’ experience
   - A representative from the Attorney General’s Office
   - A representative from the Ministry of Health
   - A civil society representative with an interest in or special expertise in mental health

iii) Functions

   - Hearing appeals by persons with mental illness against facilitated admission
   - Deciding on renewal/extension of facilitated admission
   - Hearing any complaints regarding violation of rights of persons with mental illness in mental health facilities
   - Refer any suspected criminal offence under this Act to the police
   - Ask the Commission to inquire into any problems relating to the living conditions and the standard of care at any mental health facility and submit a report to the Tribunal
   - Review periodically all persons held under Section 196A of Penal Code at the President’s pleasure and if appropriate, make recommendations for discharge of such persons.

iv) Meetings

   - Three (3) members of the Tribunal, of whom one shall be the judicial member, shall constitute a quorum.

   - The Tribunal shall function as a quasi-judicial body and may regulate its meetings and proceedings in such manner as it thinks fit.

   - The members of the Tribunal, except the nominated member, shall be appointed by the Minister to hold office for a period of 3 years and shall be eligible for reappointment.

   - The members of the Tribunal shall be paid such fees or allowances as may be determined by the Minister.
The Tribunal shall meet as frequently as required to ensure that reviews and renewals of facilitated admission are completed within the stipulated time and complaints are heard within a period of 15 days.

12. Leave for persons admitted as facilitated admission to mental health facility

The health professional in charge of a mental health facility may grant leave to a person with mental illness for a period not exceeding 7 days at a time.

The mental health professional recommending leave has the right to revoke the leave at any time if the mental health professional is satisfied that it is necessary for improvement or prevent deterioration of the mental health of the person concerned.

If the person refuses to come back to the mental health facility either on revocation of the leave or end of the leave period, the mental health professional shall inform the nearest health facility of the same and the subsequent process shall be similar to the procedure for “Persons with mental illness who are at their home and unwilling to attend for an assessment” (see 7 (g) above).

13. Absence without leave of facilitated patients admitted to a mental health facility

Any person who has been admitted as a facilitated admission and goes missing from the mental health facility without either being granted leave or discharge, the mental health professional in charge of the mental health facility shall inform the Police and the person who had made the application for admission of the person.

14. Prisoners with mental illness

If it appears to a prison officer that a prisoner is likely to have a mental illness, the officer in charge of the prison shall make an application to the mental health facility to transfer the prisoner to the mental health facility for assessment and admission to the mental health facility if necessary.

On assessment, the psychiatrist may recommend either:

- Outpatient treatment and send the prisoner back to the prison or
- Recommend admission to the mental health facility either as a voluntary admission or facilitated admission depending on the criteria being met

Time spent at the mental health facility will be counted towards the term of the prison sentence.

On discharge from the mental health facility the prisoner shall be sent back to the prison.

15. Persons who are not citizens but currently resident in Seychelles

Provisions of this Act shall apply in the same manner to persons who are not citizens but are currently resident in Seychelles.

Only when a non-citizen is admitted as a facilitated admission, the Embassy of the person’s country of citizenship shall be informed of the admission.

16. Offences and penalties