REFORM OF MENTAL HEALTH LEGISLATION ACROSS THE COMMONWEALTH

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

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I. Introduction

The following documents were reviewed for preparing this report:

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
4. Mental Health Atlas Country Profile Seychelles 2011
5. WHO Country Co-operation Strategy 2008-2013
6. WHO Country Co-operation Strategy updated May 2014
7. Seychelles Initial Report on the Implementation of the Convention on Rights of Persons with Disabilities – submitted by the Republic of Seychelles to the Committee on Rights of Persons with Disabilities (CRPD/C/SYC/1)
8. 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: