

Assistant Professor Psychiatry/
Consultant Psychiatrist,
Department of Medical Sciences,
Fiji National University, email
odille.chang@fnu.ac.fj

Fiji's Mental Treatment Act 1940 had become outdated, in part because it concentrated on treatment within a psychiatric hospital. The Mental Health Decree 2010 covers not only in-patient treatment but also the promotion of mental health, the prevention of mental illness, and the community-based and rehabilitative aspects of mental healthcare, as well as human rights issues.

- to facilitate the development of community-based services
- to integrate mental healthcare into the general healthcare systems.

These objectives are to be achieved in accordance with international principles, standards and agreements relating to the care of persons with mental disorders.

Fiji is an upper-middle-income island nation located in the South Pacific Ocean. It comprises approximately 300 islands, but 80% of the total population of some 827 000 people live on the two main islands of Viti Levu and Vanua Levu (Singh *et al.*, 2013). Fiji, a former British colony, gained independence in 1970. Since 1987, Fiji has had three military coups and one civilian coup (World Health Organization, 2008). From 2006 to September 2014, Fiji was governed by an interim administration, when a democratically elected government came to power.

The Mental Health Decree 2010

The Mental Health Decree 2010 was endorsed by the Fiji government on 15 October 2010 and, unlike its predecessor, focuses on more than just treatment in a psychiatric hospital. The Decree states that it is 'a decree to provide for the administration of mental health in Fiji' and it provides a framework for the prevention, treatment, care and management of mental disorders that focuses on: the rights of patients; treatment in the least restrictive environment; community-based care and rehabilitation; and adherence to international laws and conventions.

The Mental Health Decree 2010 is composed of 11 parts, each of which has several sections. This paper describes the significant changes that have been instituted and the challenges faced in the implementation of the Decree. Below, the contents of each part are briefly summarised.

Part 1. Preliminary

Part 1 concentrates on the operational definitions of terms, principles and objectives, the responsibilities of persons dealing with mental health issues, and protection from discrimination of persons with mental disorders. It also includes a definition of who should not be considered to have a mental disorder.

The objectives of the Decree are:

- to provide for, regulate and coordinate access to mental healthcare, treatment and rehabilitation

Part 2. Administration

Part 2 refers to the provision of mental health facilities (MHFs) within general public hospitals as well as the psychiatric hospital. It also allows the establishment of MHFs within prisons, health centres and nursing stations, and in the private sector.

The establishment of the MHF in the general hospital in the capital city was met with much resistance, especially as the only psychiatric hospital was nearby and the general hospital did not see the need for such a unit. There were two other MHFs established in the other main divisional hospitals but without adequate infrastructure or staffing and with minimal discussion or awareness of the new Decree.

Part 2 also provides for the appointment, membership and functions of the National Mental Health Advisory Council (NMHAC), which is responsible for advising the Minister of Health on the administration and operation of the Decree. Another new appointment is the National Mental Health Advisor (NMHA), who is the national focal contact for the development of mental health services nationally.

Parts 3 and 4. Voluntary admission and assessment, and detention and involuntary assessment

Parts 3 and 4 describe the conditions for voluntary and involuntary assessment and admission to an MHF. The Decree allows for a 72-hour assessment period, after which a decision must be made as to whether the person still requires treatment within an MHF. For a voluntary patient this would mean that the person cannot be cared for, supported or treated within the family or community or that the safety of others requires otherwise.

Conditions for involuntary assessment of patients are:

- the person appears to have a mental disorder
- the person is unwilling or unable to be assessed voluntarily

- the person appears to require care, support and treatment for the protection of their own safety, welfare and health, or those of others.

A person may be referred for involuntary assessment upon the recommendation of a medical practitioner, a police officer or ambulance crew, or by the court.

Part 5. Principles for care and treatment

Part 5 states that, as far as is practicable, people should be provided with timely, appropriate, high-quality mental healthcare by authorised healthcare professionals (AHCPs) in the least restrictive environment that meets the cultural and religious needs of the individual.

Respect for the rights of patients is emphasised, including the rights to access to an interpreter and their own records, to confidentiality and to have a statement and explanation of their rights as in-patients. Part 5 also explicitly states limitations on actions that would impinge on patients' rights, such as seclusion or restraint, and prohibits medical treatments such as psychosurgery, insulin coma and deep-sleep therapies. It also requires the regular review of medications, to ensure doses are not excessive and that medications are not inappropriately utilised.

Part 5 also allows for advance directives, whereby patients can indicate the means by which they would prefer to be treated for future episodes of in-patient care. The Decree explicitly states that it is an offence to ill-treat patients that can result in imprisonment or a fine. Unfortunately, many patients are not aware of the provisions of this part of the Decree.

Part 6. Types of treatment

Part 6 covers community treatment and in-patient treatment orders and outlines the processes for the issuance, compliance with and review of such orders. It also outlines the processes to be followed for the administration of electroconvulsive therapy (ECT) and for emergency and elective surgical procedures as well as sterilisation. In all cases, the patient must be capable of giving informed consent. If the patient is unable to provide informed consent for emergency surgery, an AHCP or authorised medical practitioner may give consent on the patient's behalf if the surgery is deemed to be life-saving or able to prevent further serious harm to the patient's health. For elective surgery and sterilisation, if the patient is unable to provide informed consent, the case must be reviewed by the Mental Health Review Board (MHRB).

Part 7. Children and young persons

Part 7 describes specific procedures to be followed with regard to the admission of children and young persons to MHFs, including their separation from the adult population and their continued education and regular access to their families. Treatment should be appropriate to the individual's age, stage of development and condition, and should include

their participation and decisions in the management process.

Part 8. Persons in custody and prisoners

This part allows for the investigation by AHCPs of the mental well-being of persons in custody and convicted prisoners, who are subject to the principles of care and treatment outlined above.

Part 9. Review mechanisms

Part 9 discusses the establishment, membership, procedures, powers and functions of two main review bodies: the MHRB and the Board of Mental Health Visitors (BMHV). Detailed information and training on the roles of these Boards has not yet been provided, which has made their operationalisation difficult.

Patients now have a means of appealing decisions for involuntary in-patient or out-patient care through the MHRB. However, many are still not aware of this and only a handful of patients have exercised these rights.

The BMHV's main role is the maintenance of the welfare of people admitted to MHFs through the receipt of complaints, regular inspections and monitoring of the facilities. However, only the psychiatric hospital and not other MHFs have an active BMHV, and that Board does not regularly monitor or inspect the facility.

Part 10. Management of the estate and affairs of persons with a mental disorder

This part allows for the appointment of managers for those deemed incapable of administering their estate or affairs due to mental incapacity.

Part 11. Miscellaneous provisions

This part summarises the procedures for international transfers; allocation of official visiting hours for MHFs; segregation of male and female patients; and the maintenance of registers for each MHF detailing patient care. It also describes transitional provisions; the possibility of additional regulations, orders and forms; the repeal of the previous laws; and the establishment of MHFs.

Implementation

Implementation of the Mental Health Decree 2010 was commenced in 2011 and is still ongoing. Difficulties have been faced in relation to the lack of planning, information, training and funding for this important activity. This has also contributed to some resistance from health workers, especially those not in mental health. The need to have standard operating procedures, forms and regulations in place has also been a great oversight. The use of a 'top down', non-consultative approach was not beneficial. Revisions will be needed to make it more practical for daily use.

Conclusion

The Decree provides a comprehensive framework not only for the treatment and care of people with mental illness but also for the development of Fiji's

mental health services, especially with regard to community-based and rehabilitative services, as well as preventive and promotional strategies.

Its focus on human rights issues and the delivery of timely, appropriate and quality treatment sees Fiji entering a new and progressive era of mental healthcare. The implementation of the Decree has provided valuable lessons regarding the need for

consultation, awareness and training beforehand, as well as the need to plan, fund and resource this important process.

References

Singh, S., Chang, O., Funk, M., et al (2013) *WHO Profile on Mental Health in Development: Fiji*. World Health Organization.

World Health Organization (2008) *Western Pacific County Health Information Profiles 2008 Revision*. WHO.



Mental health law in New Zealand

Ian Soosay¹ and Rob Kydd²

¹Senior Lecturer, Department of Psychological Medicine, University of Auckland, New Zealand, email i.soosay@auckland.ac.nz

²Professor, Department of Psychological Medicine, University of Auckland, New Zealand, email r.kydd@auckland.ac.nz

New Zealand has an established history of mental health legislation that sits within a framework of human rights, disability and constitutional protections. We outline a brief history of mental health legislation in New Zealand since its inception as a modern state in 1840. The current legislation, the Mental Health (Compulsory Assessment and Treatment) Act 1992, defines mental disorder and the threshold for compulsory treatment. We describe its use in clinical practice and the wider legal and constitutional context which psychiatrists need to be aware of in their relationships with patients.

New Zealand has an established history of mental health legislation that sits within a framework of human rights, disability and constitutional protections.

The historical perspective

The modern state of New Zealand was established in 1840 with the signing of the Treaty of Waitangi between Maori tribal leaders and the British crown. By 1844, 'pauper lunatic asylums' had been set up in Wellington and Auckland, next to the local jails, to manage people with mental illnesses who were perceived to be dangerous. The colonial authorities introduced the first mental health legislation, the Lunatics Ordinance of 1846 (Brunton, 2005), which set out a framework for 'certification', whereby a person with a mental illness could be sent to a jail or a hospital.

In 1852, the New Zealand Constitution Act set up the New Zealand Parliament and the first elections were held the subsequent year. This also placed the responsibility for healthcare with provincial authorities, which went on to establish asylums in each province; these were modelled on the British asylum movement of the time. In the 1860s and 1870s, asylums were built in most provinces but a

Joint Parliamentary Committee was established in 1871 to look into reported poor standards in some of the facilities. This resulted in the recommendations that large asylums should be run by medical superintendents and that a national inspectorate be established. All asylums were then centralised under the Lunatics Asylum Department in July 1876. The Mental Defectives Act came into force in 1911, which allowed voluntary admissions to hospital for the first time; it aimed to align the mental health system with the wider health system. The Social Security Act of 1938 provided for the costs of hospitalisation to be met through taxation and not patient fees. In 1969, Parliament passed the Mental Health Act, which has formed the basis of our current legislation, as amended in 1992.

The Mental Health (Compulsory Assessment and Treatment) Act 1992

Compulsory treatment of people with mental illness in New Zealand is governed by the Mental Health Act. The principles underpinning the Act are stated in the associated guidelines (Ministry of Health, 2012a):

The Act is not a comprehensive framework for mental health treatment. It should instead be thought of as an entry point to services for people experiencing a mental illness which causes or may cause serious harm to themselves or others. Compulsory treatment under the Act provides an opportunity for a person experiencing a serious mental illness to begin to live well in the community and take self-ownership of their healthcare. This is promoted through a focus on regular collaborative consultation between compulsory patients and clinicians, and the statutory presumption in favour of minimally restrictive treatment in the community.

The Act defines mental disorder as 'an abnormal state of mind (whether of a continuous or an intermittent nature) characterised by delusions, or by disorders of mood or perception or volition or cognition'. However, no one can be subject to an assessment or treatment order based on mental disorder alone, but must also present risks to