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Psychiatric Care and Mental Health Legislation in the English-Speaking Caribbean Countries

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Psychiatric Care and Mental Health Legislation
In the English-Speaking Caribbean Countries

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**Preface**

In PART I of this document the main mental health Acts of English-speaking Caribbean territories are listed and assigned to two major categories.

*Category One* contains the legislation of Grenada (1895), St. Lucia (1895), Guyana (1930), Belize (1953), Anguilla (1956), Montserrat (1956), St. Kitts-Nevis (1956), Antigua and Barbuda (1957), and Turks & Caicos (1959); and

*Category Two* contains that of the Bahamas (1969), Trinidad and Tobago (1975), The Cayman Islands (1979), British Virgin Islands (1985), Dominica (1987), St. Vincent & the Grenadines (1989), Barbados (1989), and Jamaica (1997). Attention is drawn to readily accessible texts, which point out the shortcomings of this legislation, and citations are included in footnotes for ease of reference.

PART II identifies the standards against which the legislation is measured. Some of the documents containing these standards have been reproduced in Annexes as a means of ensuring that policy-makers accessing this document would have readily important documents to further inform their deliberations during the preparatory process precedent to the enactment of revised mental health legislation.

PART III examines legislation identified in Part I, under *Category One*: Pre-1960 legislation containing Grenada, St. Lucia, Guyana, Belize, Anguilla, Montserrat, St. Kitts-Nevis, Antigua and Barbuda, Turks and Caicos; and *Category Two*: Post-1960 legislation containing Bahamas, Trinidad and Tobago, Cayman Islands, British Virgin Islands, Dominica, St. Vincent and the Grenadines, Barbados, and Jamaica. The information in this Part is arranged under the following sub-heads:

- Obsolete, irrelevant and imprecise terminology and definition of terms
- Curative care, rehabilitation and preventive care
- Admission, care, discharge and aftercare
- The special needs of children

PART IV proposes some guidelines for the revision of mental health laws taking into consideration the protection of the human rights of mentally ill persons. The cultural homogeneity of the region, the similarity of the social and political structure of the territories, and a legal system rooted in the common law, mean that the *Guidelines* are equally applicable to the revision of mental health legislation of the twelve territories comprising the English-speaking Caribbean region. This Part also contains a suggested draft model Mental Health Act. PART V contains a Report on Meetings in St. Lucia, St. Vincent and the Grenadines, Grenada, British Virgin Islands, Antigua and

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1 Note that this Ordinance is an adoption of English law. Section 2 (1) states: *Part VIII of the Mental Health Act 1959 of England is adopted as law in the Islands subject to the exceptions and modifications specified in the Schedule to this Ordinance.* [Side Note states: Adoption of English Law. 1959 c.72]
Barbuda, and St. Kitts-Nevis. These meetings were an integral part of the project.

PART VI is a bibliography of relevant documents.

ANNEX A, ANNEX B, ANNEX C and ANNEX D contain current recommended standards relating to mental health.
**Scope of Work**

To prepare a study on psychiatric care and mental health legislation under the following terms of reference:

1. To describe and analyze mental health laws as they apply to curative care, rehabilitation and preventive care, especially with respect to current recommended standards and international climate reform, and the social mores of English speaking Caribbean societies. Therefore, the work will:

2. Examine all aspects of the current laws with a view to highlighting obsolete, irrelevant and imprecise terminology and definitions of terms.

3. Examine and revise the current laws regarding admission, care, discharge and aftercare of mental patients. Determine if the legal framework make provision to the special needs of children and adolescents.

4. Examine and revise current laws as they refer to preventive care across all age groups and according to their special needs.

5. Examine and revise aspects of current laws concerned with the management of the properties and affairs of mental patients.

6. Examine and revise aspects of current laws relating to mentally ill patients with criminal proceedings.

7. Propose some guidelines for the revision of mental health laws in the English speaking Caribbean, taking into consideration the protection of the human rights of mental patients and the regional and cultural features of the region.

Countries included: Antigua and Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, St. Kitts and Nevis, St. Vincent and the Grenadines, St. Lucia, Jamaica, Trinidad and Tobago and the British Dependent Territories.
PART I: CURRENT MENTAL HEALTH LEGISLATION

The concern of Caribbean mental health legislation is solely with the admission of mentally ill persons to psychiatric hospitals, and with the management of their property and affairs. This conceptualization of mental health legislation was received into the English-speaking Caribbean during the colonial era, and has persisted as the dominant paradigm ever since that time. Revisions and amendments of the legislation in question, which has been undertaken by some of the territories, resulted in achieving, for those territories, more humane admission procedures; eradication of offensive terminology descriptive of persons who are mentally ill; a greater respect for the human rights of the mentally ill through the establishment of Mental Health Review Boards and Tribunals; and court-regulated safeguards of the property and affairs of mentally ill persons who lacked capacity to manage their own affairs.

This legislation falls into two categories roughly, the great divide being the year 1960. Category One contains the legislation of Grenada (1895), St. Lucia (1895), Guyana (1930), Belize (1953), Anguilla (1956), Montserrat (1956), St. Kitts-Nevis (1956), Antigua and Barbuda (1957), and Turks & Caicos (1959) and Category Two contains that of the Bahamas (1969), Trinidad and Tobago (1975), The Cayman Islands (1979), British Virgin Islands (1985), Dominica (1987), St. Vincent and the Grenadines (1989), Barbados (1989), and Jamaica (1997).

Although of the same genre generally speaking, Category Two legislation is undoubtedly a marked improvement on Category One legislation and includes those “essential requirements of mental health legislation” recommended by the World Health Organization in the 1970s. But there was no radical change in the conceptualization of such legislation. From the standpoint of the present, that observation cannot be regarded as a criticism of Caribbean legislators of the time, for if one accepts as Bhaskaran posits, that an essential requirement of mental health legislation is that “it must reflect currently accepted principles in psychiatric thinking and practice,” then Bhaskaran himself in composing his model could not have totally escaped the influence of the time in which he lived. Today there is greater concern for the human rights of patients.

Category One legislation, because it was never measured against Bhaskaran — it was never updated — to a great extent still manifest the antithesis to Bhaskaran’s model, a model which recommended that the following principles selected by this author should be applied to mental health legislation.

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2 Termed “British West Indies” during the colonial era until the territories achieved independence at various dates during the mid-decades of the 20th century.

3 Note that this Ordinance is an adoption of English law. Section 2 (1) states: Part VIII of the Mental Health Act 1959 of England is adopted as law in the Islands subject to the exceptions and modifications specified in the Schedule to this Ordinance. [Side Note states: Adoption of English Law. 1959 c.72].

1. It must be humane and reflect the dignity of the individual.
2. It must reflect currently accepted principles in psychiatric thinking and practice.
7. The use of stigmatizing terms like "lunacy", "insanity", "idiocy", "asylum", etc. should be totally avoided.
10. It must
   * avoid stigmatizing and degrading legal requirements for admission and discharge from hospitals; ...

His closing observation is particularly worthy of note. He stated:

If progressive and humane legislation with regard to the mentally ill and their care are to really achieve its purpose, efforts must be directed at the same time to:

a) converting custodial-type mental hospitals into well-staffed, well equipped, dynamic therapeutic communities;
b) establishing community-based therapeutic facilities to the treatment and rehabilitation of the mentally ill;
c) training adequate numbers of professional personnel in the field of mental health.

I have presented these excerpts from Bhaskaran in order to highlight some specific examples which have been adhered to in Category Two legislation, and which are largely lacking in Category One, and to show the coincidence of his closing comment which, with the exclusion of paragraph (a), are clearly advocated contemporary standards and principles recommended in the sphere of mental health.

Mental health legislation currently on the Statute Book of English-speaking Caribbean territories are:

[Anguilla] Lunacy and Mental Treatment Ordinance (Cap. 218)

[Antigua and Barbuda] Mental Treatment Act (Cap. 274)

[Barbados] Mental Health Act (Cap. 45)
   An Act to provide for the care and treatment of persons of unsound mind and for related matters.

[Bahamas] Mental Health Act (Cap. 215)
   An Act to make fresh provision for the care and treatment of mentally disordered persons and with respect to their property and affairs and for purposes connected therewith.

[Belize] Unsoundness of Mind Ordinance (Cap. 83)

[British Virgin Islands] Mental Health Ordinance (Cap. 191)

[Cayman Islands] Mental Health Law (Law 22 of 1979)
   A Law to make provision for the care, treatment and control of mentally disordered people.
[Dominica] *Mental Health Act (Cap. 40:62)*
An Act to provide for the care and treatment of persons who are mentally ill and for related matters.

[Grenada] *Mental Hospitals Act (Cap. 190)*
An Act to provide for the custody of lunatics.

[Guyana] *Mental Hospital Ordinance (Cap. 140)*
An Act to make provision for the care of persons of unsound mind and for the administration and management of the Mental Hospital, Berbice.

[Jamaica] *Mental Health Act, 1997 (Act 6 of 1997)*
An Act to repeal the Mental Hospitals Act and the Lunatics (Custody of and Management of their Estates) Act and to make new provisions with respect to the treatment and care of mentally disordered persons and with respect to their property and affairs; and for connected matters.

[Montserrat] *Lunacy and Mental Treatment Ordinance (Cap. 203)*

[St. Kitts-Nevis] *Lunacy and Mental Treatment Act (Cap. 218)*

[St. Lucia] *Mental Hospitals Act (Cap. 155)*
An Act to provide for the custody of persons of unsound mind.

[St. Vincent and the Grenadines] *Mental Health Act (Cap. 228)*
An Act to provide for the care and treatment of persons suffering from mental disorders and for related matters.

[Trinidad and Tobago] *Mental health Act (Cap. 28:02)*
An Act to provide for the admission, care and treatment of persons who are mentally ill and for matters connected therewith and incidental thereto.

[Turks and Caicos Islands] *Mental Health (Protection of Property) Ordinance (No. 14 of 1983)*
An Ordinance to make provision for the administration and protection of the property of persons who are incapable of managing their own affairs.

In 1995 we were told that “Trinidad and Tobago was the first country in this region to make a significant change in legislation. In December 1975, the Mental Health Act became law and minor amendments were made in 1979. The Barbados Mental Health Act was Gazetted in the early 1980s, but was not Proclaimed until 1989. Both of these, and subsequent national legislation, were based on the United Kingdom Mental Health Act of 1959.” However, much of Category One legislation

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1Mahy, George. *Trends and Issues in the Development of Mental Health Services in the Commonwealth Caribbean;* prepared by Dr. George Mahy for the Pan American Health Organization, World Health Organization, Office of
remains encumbered with what can be recognized (from this vantage point of the closing decade of the 20th Century) as serious disfunctionalities when one examines these Acts against current universal socio-legal human rights standards, and internationally recognized mental health standards which have been accepted in principle by the independent territories of the Commonwealth Caribbean, as well as by the British Dependent Territories, by virtue of their relationship to the Pan American Health Organization.

The shortcomings of current mental health laws in the Caribbean are extensively dealt with in readily accessible texts. See for example, the 1978 Curran and Harding survey *The Law and Mental Health*; the 1991 Herwood report *Mental Health Legislation in the Caribbean*; Dr. Izben Williams’ thesis report entitled *A Survey of Patients and Services and Strategies for Developing a Comprehensive Mental Health Program in St. Kitts-Nevis* in which the St. Kitts-Nevis legislation is discussed; and the analytical paper which focuses on the Grenada legislation written by the Consultant Psychiatrist of Mount Gay Mental Hospital in Grenada, entitled *Mental Health Legislation in Grenada: a Proposal for Reform.*

The need for legislative revision continued to be reiterated in various fora, an important one being the *Mental Health Consultation* held in May 1995 organized by the Pan American Health Organization as part of its effort to assist countries “in the development of comprehensive programs for the prevention and control of mental disorders, that is, in the achievement of mental health.” It was noted, at the consultation, that “no legislation addresses prevention and control of mental disorders ... ; that most legislation is outdated ... ; that legislation should ... safeguard patients’ rights; and that technical cooperation from PAHO could include: analysis of current legislation, needs assessment, and facilitation of the drafting of appropriate legislation.”


7 *Independent Territories*: Antigua & Barbuda, Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Jamaica, St. Lucia, St. Kitts-Nevis, St. Vincent and the Grenadines, Trinidad and Tobago.

8 *British Dependent Territories*: Anguilla, British Virgin Islands, Cayman Islands, Montserrat, Turks and Caicos Islands.


11 Williams, Izben C. *A Survey of Patients and Services and Strategies for Developing a Comprehensive Mental Health Program for St. Kitts-Nevis.* (Mona, Jamaica: Faculty of Medicine, Department of Psychiatry, 1994).


The Mahy and Barnett authoritative study entitled *Mental Health*, published in 1997 in *Health Conditions in the Caribbean*, reiterated that Herwood's findings of 1991 continues to be an accurate assessment of Caribbean mental health legislation. The Herwood report had stated that:

*The mental health legislation of the English-speaking Caribbean can generally be characterized by the following:*

1. It is chronologically old, some dating back to the 1800s or the 1930s or 40s.
2. It is anachronistic, having no resemblance to modern principles of legal psychiatry.
3. It is based on a service delivery system dominated by a central institution.
4. It concerns itself primarily with the adjudication, not the treatment of mental patients.
5. Its language is archaic and terminology reflects disrespect for those it supposedly protects.
6. It does not concern itself with the rights of patients.
7. It does not make provision for or even mention alternative or community-based modes of service.
8. It is not guaranteed with economic resources.
9. It does not make clear whether it reflects all existing mental health care or services in the country.
10. It presently is not compatible with the principles expressed by the Caracas conference — deinstitutionalization, integration with primary care, local health systems implementation, and community participation.

Obikoya considers that the Grenada legislation "is clearly unsatisfactory particularly considering the major changes which have taken place over the years with regard to the conceptualization and management of psychiatric disorders, such as the emphasis on community psychiatry, and the development of newer and more effective pharmacological agents, all of which have greatly improved the prognosis of psychiatric disorders to the extent that the majority of patients no longer require the custodial approach to treatment emphasized in the current laws." He also draws attention to terms such as "lunatic" and "idiot" as "reminiscent of 19th century concepts of mental illness and the mentally ill and as such they need to be expunged" and criticizes "the adversarial and bureaucratic legal process which are totally out of tune with current theory and practice in psychiatry." His findings are equally applicable to the legislation of some other Caribbean territories.

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15 Refers to The Declaration of Caracas, which was adopted by acclamation on 14 November 1990 by the Regional Conference on Restructuring Psychiatric care in Latin America, which was held in Caracas, 11-14 November 1990, under the auspices of the Pan American Health Organization/WHO Regional Office for the Americas. Reproduced in *Annex A*.

16 Herwood, ibid., at p. 11.
PART II: STANDARDS

The essential elements of this study as defined in the “Scope of Work” require that current mental health legislation of the English-speaking Caribbean be examined against the benchmark of current international standards. The specific mandate stated as “To prepare a study on psychiatric care and mental health legislation” can be interpreted as either positing a is a complementary approach between “psychiatry” and “mental health”, and thereby identifying two distinct concepts which can be accorded separate treatment in separate and distinct pieces of legislation, or one can interpret the phrase as indicative of a single indivisible concept best treated in a single Act. How are the terms best to be treated?

One of the Region’s leading psychiatrists states: “There is a difference between mental illness and mental health. In the case of mental illness, coping mechanisms have failed or [are] failing but in the case of mental health, one is aware of stress factors that could result in an illness and efforts are being made to prevent it.” He also finds, with respect to the Caribbean, that “So great are the demands on professionals in the psychiatric services to provide adequate care for the mentally ill that their role in helping others maintain good mental health is minor. Such maintenance is then left to other agencies or become the sole responsibility of the individual.”

“Psychiatry” is defined in the World Psychiatric Association approved Declaration of Madrid (25 August 1996) as “the branch of medicine that specializes in the care and protection of those who are ill and infirm because of a mental disorder or impairment”, and further states that “Psychiatry is a medical discipline concerned with the provision of the best treatment for mental disorders, with the rehabilitation of individuals suffering from mental illness and with the promotion of mental health.” In the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, adopted by the UN General Assembly through Resolution 46/119 (17 December 1991), the Definitions Section states “Mental health care” includes analysis and diagnosis of a person’s mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness. PAHO/WHO Resolution CD40.R19: Mental Health recognizes

17 Reproduced in the Preface.

18 Mahy, George. “Ethical Issues in Mental Health” (pp. 75–79) in Trauma in the Caribbean, and, Medical Ethics & Patients’ Rights: Proceedings of the Continuing Medical Education Symposia, Barbados, November 1990 & 1991. (Barbados: University of the West Indies, Faculty of Medical Sciences, 1992).

19Mahy, Trends and Issues, ibid., at p. 3


that mental health in its totality is concerned not only with the control of psychiatric disorders, but also the psycho social development of children; the integration of mental health programs as an integral component of national health plans; the reorientation of mental health services from an institutional to a community approach; support training for the managers of mental health programs in the schools of public health, and the protection of the human rights of persons with mental disabilities.

Other relevant standards are the *Declaration of Caracas* (14 November 1990)\(^\text{23}\), acclaimed at the Regional Conference on Restructuring Psychiatric care in Latin America; and the *Caribbean Charter on Health Promotion*\(^\text{24}\) which was developed in Port-of-Spain, Trinidad, at the First Caribbean Conference on Health Promotion on June 1-3, 1993, and presented to the Caribbean at the 1994 Conference of Ministers of Health, having been adopted by them at their caucus during an earlier Meeting of the Pan American Health Organization; and the *Ottawa Charter on Health Promotion* (1986) adopted in November 1986 at a conference co-sponsored by WHO, Health and Welfare Canada (the Canadian Ministry of Health and Welfare), and the Canadian Public Health Association, and the *Draft Charter for Patient Rights* presented at a Conference on Health Care Law and Ethics, held by the Faculty of Medical Sciences, University of the West Indies, Cave Hill Campus, Barbados, August 1993.\(^\text{25}\)

The *Declaration of Caracas* calls for the restructuring of psychiatric care on the basis of Primary Health Care and within the framework of local health systems; declares that the restructuring of psychiatric care in the Region implies a critical review of the dominant and centralizing role played by the mental hospital in mental health service delivery; requires the redrafting of legislation; and advocates that training in mental health and psychiatry should use a model that is based on the community health center and encourages psychiatric admissions in general hospitals. The *Caribbean Charter for Health Promotion* advocates the reorientation of health services; empowering communities to achieve well-being; creating supportive environments; and both developing and increasing personal health skills. Information on the topic is readily accessible in the Forrester, Thompson and Brandon paper entitled *Health Promotion*, which gives an overview of current developments in health promotion in the Caribbean.\(^\text{26}\) The *Ottawa Charter* states that “the

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\(^{23}\) Reproduced in *Annex A*.

\(^{24}\) *Caribbean Charter for Health Promotion*; developed at the First Caribbean Conference on Health Promotion, June 1-4, 1993. [Bibliographical form: 3-panel folder issued by Pan American Health Organization/World Health Organization, n.d.]

\(^{25}\) *Health Care Law and Ethics*; Proceedings of a Conference held by the University of the West Indies, Faculty of Medical Sciences, Cave Hill Campus, Barbados, August 1993. Edited by E.R. Walrond. (Barbados: 1993), Appendix on pages 74-76; *Draft Charter for Patient Rights*.

role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services,” and that “Health is created and lived by people within the settings of their everyday life: where they learn, work, play and love.” Stated in other words: “The most crucial defining factor of any health promotion strategy is that it starts out from health creation”.

The salient collective message of international and regional standards, is enunciated with clarity in the context of the English-speaking Caribbean, in the Mahy and Barnett study, in which they express the hope that “the focus will shift from mental illness to mental health, and from institutional to community-based care for the mentally ill.”28 And, in the final analysis, over-arching all of these standards, is Article 1 of the Constitution of the World Health Organization, which defines health as a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity. It cannot be too strongly stressed, therefore, that it is of the utmost importance to keep constantly in mind this WHO definition in which “physical, mental and social” components are equal and indivisible elements of the concept “health.” In other words, the placement of the adjective “mental” before “health” is in no way indicative of a metamorphosis of health into a category of illness.

PART III: DESCRIPTION AND ANALYSIS OF MENTAL HEALTH LAWS

Explanatory note:

The legislation which has been identified in Part I, under the following categories, are: Category One: Pre-1960 legislation containing Grenada, St. Lucia, Guyana, Belize, Anguilla, Montserrat, St. Kitts-Nevis, Antigua and Barbuda, Turks and Caicos; and Category Two: Post-1960 legislation containing Bahamas, Trinidad and Tobago, Cayman Islands, British Virgin Islands, Dominica, St. Vincent and the Grenadines, Barbados, and Jamaica --- will be examined against the standards recommended in Part II, which are:

- The Declaration of Caracas
- The Declaration of Madrid
- PAHO/WHO Resolution CD40.R19: Mental Health
- Draft Charter for Patient Rights
- Caribbean Charter for Health Promotion
- The Ottawa Charter on Health Promotion


Constitution of the World Health Organization, Article 1

and under the following heads:

- Obsolete, irrelevant and imprecise terminology and definition of term.
- Curative care, rehabilitation and preventive care
- Admission, care, discharge and aftercare
- Special needs of children

I. Obsolete, irrelevant and imprecise terminology and definition of terms

Category One: (Pre-1960)

[Guyana] Mental Hospital Act (Cap. 140)

“Person of unsound mind” means an idiot or a person who is suffering from mental derangement.

[St. Lucia] Mental Hospitals Act (Cap. 155)

“Person of unsound mind” “insane person” “patient” or “mental patient” includes —

(a) Any epileptic or other person who is suffering from temporary or permanent disease or derangement of the brain producing disordered action of the mind to such an extent as to put him in a condition varying from his normal self and out of relation with his environment so as to render him dangerous or inconvenient to himself or others;

(b) Any idiot, that is to say, a person so defective in mind from birth or from an early age as to be unable to guard himself against common physical dangers;

(c) Any imbecile, that is to say, a person in whose case there exists from birth or from an early age mental defectiveness not amounting to idiocy, yet so pronounced that he is incapable of managing himself or his affairs, or in the case of a child, of being taught to do so;

(d) Any feeble minded person, that is to say, a person in whose case there exists mental defectiveness not amounting to imbecility yet so pronounced that he requires care, supervision and control for his own protection or for the protection of others, or in the case of a child, that he by reason of such defectiveness appears to be permanently incapable of receiving proper benefit from instruction in an ordinary school;

(e) Any moral defective, that is to say, a person in whose case there exists mental defectiveness coupled with vicious or criminal propensities and who requires care, supervision and control for the protection of others.

“Pauper person of unsound mind” or “pauper patient” means any person of unsound mind: -

(a) Who is found wandering at large; or

(b) Who is not under proper care or not under proper control; or

(c) Who is likely to commit a crime.
[Grenada] Mental Hospitals Act (Cap. 190)
“lunatic” includes an idiot and any other person of unsound mind;
“pauper lunatic” means any lunatic —
(a) who is found wandering at large; or
(b) who is not under proper care or not under proper control; or
(c) who is likely to commit a crime.

[Belize] Unsoundness of Mind Act (Chapter 83) [Enacted 1953]
“defective” means —
(a) an idiot, that is to say, a person in whose case there exists mental defectiveness of such a degree that he is unable to guard himself against common physical dangers;
(b) an imbecile, that is to say, a person in whose case there exists mental defectiveness which, though not amounting to idiocy, is yet so pronounced that he is incapable of managing himself or his affairs or, in the case of a child, of being taught to do so;
(c) a feeble-minded person, that is to say, a person in whose case there exists mental defectiveness which, though not amounting to imbecility, is yet so pronounced that he requires care, supervision and control for his own protection or for the protection of others or, in the case of a child, that he appears to be permanently incapable by reason of such defectiveness of receiving proper benefit from the instructions in ordinary schools;
(d) a moral defective, that is to say, a person in whose case there exists mental defectiveness coupled with strongly vicious or criminal propensities and who requires care, supervision and control for the protection of others, and includes every person affected by section 19.

Section 19. — (1) A person who is a defective may be dealt with under this Part by being sent to an institution, approved for that purpose by the Minister, or placed under supervision or guardianship —
(a) at the instance of his parent or guardian, if he is an idiot or imbecile, or at the instance of his parent if, though not an idiot or imbecile, he is under the age of eighteen; or
(b) if in addition to being a defective he is a person —

(i) who is found neglected, abandoned or without visible means of support, or cruelly treated or with respect to whom a representation has been made to the Commissioner of Police by his parent or guardian that he is in need of care or training which cannot be provided in his home; or
(ii) who is found guilty of any criminal offence, or who is ordered or found liable to be ordered to be sent to an institution; or
(iii) who is undergoing imprisonment, except imprisonment under civil process, or is undergoing detention in a place of detention by order of a court, or in a certified institution or industrial school, or who is detained in an institution for persons of unsound mind; or
(iv) who is an habitual drunkard as defined by the Married Persons (Protection) Ordinance;
or

(v) in whose case such notice has been given by the Chief Education Officer as is mentioned in subsection (2);

or

(vi) who is in receipt of poor relief at the time of giving birth to an illegitimate child or when pregnant of such child.

(2) Notice shall, subject to regulations made by the Chief Education Officer to be approved by the Minister, be given by the Chief Education Officer to the Commissioner of Police under this Part in the case of all defective children over the age of seven —

(a) who have been ascertained to be incapable by reason of mental defectiveness of receiving benefit or further benefit in special schools and classes, or who cannot be instructed in a special school or class without detriment to the interests of the other children, or as respects whom the Chief Education Officer certifies that there are special circumstances which render it desirable that they should be dealt with under this Part by being sent to an institution or placed under supervision or guardianship;

(b) who on or before attaining the age of sixteen are about to be withdrawn or discharged from a special school or class, and in whose case the Chief Education Officer is of opinion that it would be to their benefit that they should be dealt with under this Part by being sent to an institution or placed under supervision or guardianship.

[Anguilla] Lunacy and Mental Treatment Act (Cap. 218) [Enacted 1956]

The Anguilla definitions are identical to those of St.Kitts-Nevis, and of Montserrat. A Bill for a new Mental Health Act has been drafted, but has not yet been enacted. The following definitions are included in the Bill.

“mental disorder” mean mental illness, arrested or incomplete development of mind, psychopathic disorder or any other disorder or disability of the mind;

“patient” means, except as provided for in Part III, a person suffering from or appearing to be suffering from mental disorder;

“psychopathic disorder” means a persistent disorder or disability of mind that results in abnormally aggressive or seriously irresponsible conduct on the part of a patient and requires, or is susceptible to, medical treatment.

[Montserrat] Lunacy and Mental Treatment Ordinance (Chapter 203) [Enacted 1956]

“insane person” or “person of unsound mind” or “patient” includes an idiot and any other person of unsound mind;

“pauper patient” means any insane person who is found wandering at large, or who is not under proper care or not under proper control, or who is likely to commit a crime.

[St. Kitts-Nevis] Lunacy and Mental Treatment Act (Cap. 218) [Enacted 1956]

“insane person” or “person of unsound mind” or “patient” includes an idiot and any other person of unsound mind;
“pauper patient” means any insane person who is found wandering at large, or who is not under proper care or under proper control, or who is likely to commit a crime.

[Antigua and Barbuda] Mental Treatment Act (Cap. 274)29[Enacted 1957]
“person of unsound mind” “mental patient” or “insane person” includes —
(a) any epileptic or other person who is suffering from temporary or permanent disease or derangement of the brain producing disordered action of the mind to such an extent as to put him in a condition varying from his normal self and out of relation with his environment so as to render him dangerous or inconvenient to himself or others;
(b) any idiot, that is to say, a person so defective in mind from birth or from an early age as to be unable to guard himself against common physical dangers;
(c) any imbecile, that is to say, a person in whose case there exists from birth or from an early age mental defectiveness not amounting to idiocy, yet so pronounced that he is incapable of managing himself or his affairs, or in the case of a child, of being taught to do so;
(d) any feeble minded person, that is to say, a person in whose case there exists mental defectiveness not amounting to imbecility yet so pronounced that he requires care, supervision and control for his own protection or for the protection of others, or in the case of a child, that he by reason of such defectiveness appears to be permanently incapable of receiving proper benefit from instruction in an ordinary school;
(e) any moral defective, that is to say, a person in whose case there exists mental defectiveness coupled with vicious or criminal propensities and who requires care, supervision and control for the protection of others.

[Turks and Caicos] Mental Health (Protection of Property) Ordinance (No. 14 of 1983)
There are no definitions.

Category Two: Post 1960

[Bahamas] Mental Health Act (Chapter 215) [Enacted 1969]
“mental disorder” means mental illness, arrested or incomplete development of the mind, psychopathic disorder and any other disorder or disability of mind, and “mentally disordered” shall be construed accordingly;

“psychopathic disorder” means a persistent disorder or disability of mind (whether or not including subnormality of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the patient, and requires or is susceptible to medical treatment;

29 Note that Section 3 (2) of this Act states: The word “lunatic” shall cease to be used in relation to any person of or alleged to be of unsound mind and there shall be substituted for that word wherever it occurs in any Act or in any order, regulation or other document issued under any Act the expression “person of unsound mind”, “person”, “patient”, “patient of unsound mind” or “unsound mind” or such other expression as the context may require.
“severe subnormality” (otherwise known as severe mental retardation) means a state of arrested or incomplete development of mind which includes subnormality of intelligence and is of such a nature or degree that the patient is incapable of living an independent life or of guarding himself against serious exploitation, or will be so incapable when of an age to do so;

“subnormality” (otherwise known as mental retardation) means a state of arrested or incomplete development of mind (not amounting to severe subnormality) which includes subnormality of intelligence and is of a nature or degree which requires or is susceptible to medical treatment or other special care or training of the patient.

[Trinidad and Tobago] *Mental Health Act (Chapter 28:02) [Enacted 1975]*

“mental disorder” means mental illness, arrested or incomplete development of mind and “mentally disordered” shall be construed accordingly;

“mental illness” means the condition of mind of a mentally ill person;

“mentally ill” or “mentally ill person” means a person who is suffering from such a disorder of mind that he requires care, supervision, treatment and control, or any of them, for his own protection or welfare or for the protection or welfare of others;

“mentally subnormal” or “mentally subnormal person” means a person in whom there is a condition of arrested or incomplete development of mind whether such condition arises from inherent causes or is induced by disease or injury before such person attains the age of eighteen years and includes a person who requires care, supervision, treatment and control, or any of them, for his own protection or welfare or for the protection or welfare of others;

“mental subnormality” means the condition of mind of a mentally subnormal person.

[Cayman Islands] *Mental Health Law, 1979 (Law 22 of 1979) [Enacted 1979]*

“mentally defective” is descriptive of a person who —

(a) before reaching the age of 18 years suffered from a condition of incomplete or arrested development of mind whether arising from inherent causes or induced by disease or injury; or

(b) by reason of mental defect is unable to guard himself from common physical dangers; or

(c) by reason of mental defect is incapable of managing his own affairs; or

(d) by reason of mental defect requires care, supervision and control for his own protection and that of others; or

(e) by reason of mental defect is of vicious or criminal propensities and requires to be kept under control for the physical protection of others;

“mentally disordered” includes “mentally ill and mentally defective”;

“mentally ill” means suffering from a disease of the mind responsive to medical treatment.
I. Mental Health Ordinance (Chapter 191) [Enacted 1985]

“mental disorder” means mental illness, arrested or incomplete development of mind, psychopathic disorder or any other disorder or disability of mind;

“psychopathic disorder” means a persistent disorder or disability of mind that results in abnormally aggressive or seriously irresponsible conduct on the part of a patient and requires, or is susceptible to, medical treatment.

II. Curative care, rehabilitation, and preventive care

Introduction

Noting

1. That conventional psychiatric services do not allow for attainment of the objectives entailed in community-based care that is decentralized, participatory, integrated, continuing, and preventative...
Considering

1. That Primary Health Care is the strategy that has been adopted by WHO and PAHO and endorsed by all the Member States ...

3. That mental health and psychiatric programs must incorporate the principles and guidelines on which these strategies and models of health care delivery are based ...
   [Excerpt from the Declaration of Caracas. See Annex A]

Comments

The majority of English-speaking Caribbean territories do not make specific provisions on curative care, rehabilitation, aftercare and preventive care in their mental health legislation. However, in spite of this lack of a legislative framework, there undoubtedly exists in all of the territories a number of community-based services, which are organized and administered by the chief psychiatrist and other mental health personnel from the psychiatric hospital, all aiming at the rehabilitation and aftercare of former patients. These are for the most part functionally effective services, although they exist in advance of formally enacted legislation. In other words, if one reads the mental health legislation of the territories, one will see that there are no provisions relating to organized community mental health services (with the exception of Jamaica of which fuller mention shall be made later) but observation confirms that in each of the territories a community psychiatric service is in existence.

These services are conducted at the regional clinics which are an integral part of the primary health care system, and which are located throughout the respective territories. Community mental health services are conducted by a team organized by the psychiatrist in charge of the mental hospital (or other senior medical practitioner attached to the hospital), and composed of himself/herself, psychiatric nurses, social workers and such other relevant personnel as may at any time be available. The team makes periodically scheduled visits to these primary health care centres.

Drug detoxification and rehabilitation units, half-way houses, crisis centres for abused women, schools for mentally handicapped children, and the manpower needed to service them — psychologists, occupational therapists, psychotherapists, psychiatric nurses, psychiatric social workers, counselors, and teachers with specialist training for working with children with mental disabilities, are all modalities of ‘curative care, rehabilitation, aftercare and preventive care’ whose rationale may more accurately be characterized as "promotion of mental health and prevention of mental illness."

Within the context of such services there are many community-based organizations supported by government subventions; financial and other assistance from the private sector; technical assistance from international organizations; and direct grants from international funding agencies. These establishments and services are generally not amenable to organization and implementation through mental health legislation, and consequently their in-depth study falls outside the “Scope of Work” of this Paper. Some examples of such services in the territories of St. Lucia, Grenada, and St. Vincent and the Grenadines are described briefly in Part V of this Paper.
The Jamaica and Dominica legislation noted below ought to be followed by the other territories whose legislation is lacking such provisions.

Example 1

The Mental Health Act, 1997 of Jamaica which has established a Community Mental Health Service, states in section 25:

_The Community Mental Health Service shall undertake the provision of—_

(a) services at outpatient clinics in health centres and general hospitals;
(b) rehabilitative services for persons after their discharge from a psychiatric facility;
(c) supervised home care and support for persons with mental disorders; and
(d) services for the promotion of mental health.

(2) The psychiatrists, medical practitioners, mental health officers and psychiatric aides shall, where necessary, consult and liaise with members of the other branches of the health service with a view to facilitating the provision of mental health care where such care is vital to the care being provided for other health problems.

Example 2

The Dominica legislation makes a provision which undoubtedly gives legislative recognition to the type of community based mental health service which is ongoing but without legislative recognition in a number of other Caribbean territories. Section 10 of the Dominica legislation states:

10. _A consultant psychiatrist or a medical practitioner may examine and treat any person who is, or appears to be suffering from a mental disorder in any hospital, health centre, health clinic or any other institution in the State, if in his opinion it is not necessary to admit such person to a psychiatric hospital for treatment._

III. Admission, care, discharge and aftercare

(Excerpts from _Principles for the Protection of Persons with Mental Disorders and the Improvement of Mental Health Care_ adopted by the United Nations General Assembly through Resolution 46/119 (17 December 1991)

_Principle 15 — Admission Principles_

1. Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission.

2. Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness.
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3. Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his retention as an involuntary patient, as set forth in principle 16 below, apply, and he or she shall be informed of that right.

**Principle 16 — Involuntary Admission**

1. A person may be admitted involuntarily to a mental health facility as a patient or, having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with principle 4, that person has a mental illness and considers:

   (a) That, because of the mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or

   (b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

   In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultations take place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs.

2. Involuntary admission or retention shall initially be for a short period as specified by domestic law for observation and preliminary treatment pending a review of the admission or retention by the review body. The grounds of the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall also be communicated promptly and in detail to the review body, to the patient’s personal representative, if any, and, unless the patient objects, to the patient’s family.

3. A mental health facility may receive involuntarily admitted patients only if the facility has been designated to do so by a competent authority prescribed by domestic law.

**Re: involuntary admissions by adjudication**

In the mental health legislation of territories in *Category One*, the admission of involuntary patients requires adjudication, and certification by a magistrate that a person is suffering from a mental illness, preliminary to admission into a mental hospital.
The St. Kitts-Nevis legislation, for example, states:

"Any Magistrate, upon the information upon oath of any informant to the effect that the informant has good cause to suspect and believe and does suspect and believe some person to be of unsound mind and a proper subject for confinement, may, in any place which he deems convenient, examine such person, and, in the same place or elsewhere, may hold an enquiry as to the state of mind of such person.

For the purpose of such inquiry the Magistrate shall have the same powers as if the person alleged to be of unsound mind were a person against whom a complaint for an offence punishable on summary conviction has been laid:

Provided that no person alleged to be of unsound mind shall be required to attend at any Magistrate's Court for examination by a Magistrate nor shall he be taken to any such court for such purpose. [s. 5(1)]

A Magistrate may, if he thinks fit, proceed with an inquiry under this section in the absence of the person alleged to be of unsound mind and without proof of the service of any summons upon such person. [S.5(2)]

"Where, upon such enquiry as is provided for by this Ordinance, it appears to the Magistrate that any person is of unsound mind and a proper subject of confinement, and such medical certificate as by this Ordinance is required of his unsoundness of mind has been given, the Magistrate may adjudge such person to be of unsound mind and a proper subject of confinement, and may proceed to make an order according to this Ordinance for the detention of such person in an institution ...

" [S. 9]

Through a close reading of the legislation, it is seen that the alleged mentally ill person is not considered a criminal. However, the adjudication process, which by its very nature gives that impression, is particularly stigmatizing to a mentally ill person. This procedure is clearly in conflict with Principle 15, para. 2, which states: "Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness." The mental health legislation of Grenada, St. Lucia, Guyana, Belize, Anguilla, Montserrat, Antigua and Barbuda (all contained in Category One) have similar provisions with respect to involuntary admission which are based on an adjudicatory process. Belize, additionally, entitles the person who is alleged to be of unsound mind to demand an inquiry before a jury, if he has the capacity to make such a demand. The situation with regard to Turks and Caicos is unclear.

**Re: Involuntary admissions**
**(medically recommended patients)**

The mental health legislation to the Bahamas, Trinidad and Tobago, Cayman Islands, British Virgin Islands, Dominica, St. Vincent and the Grenadines, Barbados, and Jamaica (contained in Category Two) have all undergone revision or have been repealed and replaced by new enactments which no longer use the adversarial legalistic approach of the earlier 'Category One' legislation for
involuntary (compulsory) admissions. The admission procedures in this newer legislation are now in the hands of doctors without the involvement of the court system, except in certain emergencies or in cases involving the involuntary admission of accused persons or prisoners. This type of involuntary admission will be examined in the following section.

The relevant sections of the Dominica legislation, which deal with medically recommended patients, have been reproduced in full below. This is followed by brief excerpts from the legislation of the other territories, when a particular provision appears to be a fuller interpretation of the Principles. Note, however, that in all of this legislation there is substantial conformity to Principle 16.

**Dominica [s. 7]**

[Side note: Medically recommended patients]

7. (1) The consultant psychiatrist of a psychiatric hospital may admit a patient to that hospital on receipt of —

   (a) an applicant signed by a parent or guardian of the patient; and
   (b) a medical certificate in a form approved by the Minister signed by another medical practitioner who is not employed at that hospital, and who bears no affinity to the patient;

   (2) A person admitted to a psychiatric hospital under subsection (1) is a medically recommended patient.

   (3) A medical certificate issued under subsection (1) must bear the date on which the patient was examined and contain —

      (a) the history of the patient;
      (c) a statement to the effect that the medical practitioner has personally examined the patient;
      (d) the facts on which the medical practitioner has based his opinion separately from the facts communicated to him by others;
      (e) a statement to the effect that after examination, the patient was found to be suffering from a mental disorder;
      (f) a statement to the effect that the patient is recommended for admission in the interest of his own health or safety or with a view to the protection of other persons.

   (4) A medical certificate must be completed within twenty-four hours of the examination.

   (5) A person recommended for admission to a psychiatric hospital under this section shall not be admitted thereto under this section if more than seven days have elapsed since he was last examined.

   (6) The case of a medically recommended patient must be reviewed within the first month of admission and thereafter at least once in every six months.

   (7) Notwithstanding subsections (5) and (6), a medical certificate issued under this section is valid for a period of twelve months and the discharge of a patient before the expiration of the period does not operate to prevent that patient from being re-admitted to the psychiatric hospital during the period without the issue of a fresh medical certificate.
(8) The consultant psychiatrist of a psychiatric hospital may, by certificate in writing, change the status of a medically recommended patient to that of a voluntary patient. [s. 7]

Bahamas legislation [s. 4; s. 5; s. 6; s.7]

See especially:
1. The requirement that the recommendation by a medical practitioner when setting out the grounds for admission shall also “specify whether other methods of dealing with the patient are available and, if so, why they are not appropriate.” [s. 5 (3)]
2. A medical recommendation shall not be given for the purposes of this Part of this Act [i.e. for compulsory admission] by any of the following persons —
   (a) the applicant;
   (b) a partner of the applicant or of a practitioner by whom a medical recommendation is given for the purposes of the same application;
   (c) an assistant of the applicant or of any such partner as aforesaid;
   (d) a person who receives or has an interest in the receipt of any payment made on account of the maintenance of the patient; or
   (e) the husband, wife, father, father-in-law, mother, mother-in-law, son, son-in-law, daughter, daughter-in-law, brother, brother-in-law, sister or sister-in-law of the patient, or of a practitioner by whom another medical recommendation is given for the purposes of the same application.” [s. 6 (3)].

Trinidad and Tobago legislation [s. 10; s. 11; s.12].

See the provision on conditional discharge:
“The Psychiatric Hospital Director or a duly authorized medical officer, may on the receipt of a written undertaking in the prescribed form by one or more of the relatives or friends of a medically recommended patient, authorize the conditional discharge of such a patient if he considers it conducive to the recovery of the patient that he should be under the care and in the custody of such relative or friend.” [s. 11 (1)].

British Virgin Islands. [s. 8].

See the provision on limitation on renewal of medical certificate:
“A medically recommended patient shall not be detained in a hospital for any period in excess of 21 days at a time without a fresh medical certificate.” [s. 8 (3)].

St. Vincent and the Grenadines. [s. 5].

Barbados. [s. 6]

Jamaica. [s. 6]

Note that compulsory admission to, and detention in, a psychiatric facility:
“may be made by —
(a) the patient’s nearest relative; or
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(b) subject to subsection (3) a mental health office, public health nurse or approved social worker (hereinafter referred to as a prescribed person), [s. 6 (2) (b)],

and such an application

"Shall not be made by a prescribed person —

(a) if, when admission is sought, the nearest relative of the patient has notified the prescribed person that he objects to the application being made; or

(b) unless the prescribed person has consulted with the person (if any) appearing to be the nearest relative of the patient so, however, that no such consultation is required if it appears that in the circumstances such consultation is not reasonably practicable or would involve unreasonable delay." [s. 6 (4)].

2. In relation to the provision of medical certificates:

"Where two separate certificates are submitted, one of the certificates shall be given by a medical practitioner approved for the purposes of this section by the Chief Medical Officer as having special experience in the diagnosis or treatment of mental disorder; and, unless that practitioner has previous acquaintance with the patient, the other certificate shall, if practicable, be given by a medical practitioner who has such previous acquaintance; [s. 7 (c)]

Where the application is for the admission of the patient to a hospital, one of the medical certificates may be given by a medical practitioner on the staff of that hospital; [s. 7 (d)];

A medical certificate shall not be given by —

(i) the applicant;
(ii) a partner of the applicant or of a medical practitioner by whom another medical certificate is given;
(iii) a person employed as an assistant by the applicant or by any such practitioner as aforesaid;
(iv) a person who receives or has an interest in the receipt of any payments made on account of the maintenance of the patient;
(v) except as provided by paragraph (d), a medical practitioner on the staff of the hospital to which the patient is to be admitted; or

(a) (iv) a medical practitioner who is related by blood or marriage to the patient, or who has given another medical certificate for the purposes of the same application." [s. 7 (e)].

Re: Involuntary admission
(Emotional situations)

The Trinidad and Tobago legislation in Sections 7 and 8 (whose side note indicates that the topic is "Admission of urgent admission patient") make the following provisions, which are essentially 'emergency situation' provisions, in that application can be made by "any person."
Trinidad [s. 7]
7. (1) The Psychiatric Hospital Director or a duly authorized medical officer may subject to subsection (3), admit to a hospital as an urgent admission patient any person in respect of whom an application is made.

(2) An application under subsection (1) —
   (a) may be made by any person who alleges that the person in respect of whom the application is made is mentally ill and, in the interest of his health and for the safety and protection of others, or either of them, ought to be detained in a hospital; and
   (b) shall be accompanied by a certificate of a medical practitioner other than the duly authorized medical officer responsible for the admission of the person.

(3) A person shall not be admitted to a hospital as an urgent admission patient if more than three days have elapsed since the date of issue of the medical certificates referred to in subsection (2) (b). [s. 7].

8. (1) The Psychiatric Hospital Director or a duly authorized medical officer shall, within forty-eight hours of admitting to a hospital an urgent admission patient, make or cause to be made on the patient such examination as he may consider necessary for determining whether or not the patient is mentally ill and in need of care and treatment in a hospital.

(2) If on examination the Psychiatric Hospital Director or the duly authorized medical officer is satisfied that the patient is in need of care and treatment in a hospital, he shall keep the patient in the hospital until he is satisfied that —
   (a) it is in the interest of the patient to discharge him; and
   (b) the patient is not in need of any further care and treatment in a hospital. [s.8].

Note also:

Trinidad [s. 15 (1), (2), (3), (4), (5), (6)]
15. (1) A person found wandering at large on a highway or in any public place and who by reason of his appearance, conduct or conversation, a mental health officer has reason to believe is mentally ill and in need of care and treatment in a psychiatric hospital or ward may be taken into custody and conveyed to such hospital or ward for admission for observation in accordance with this section.

(2) The Psychiatric Hospital Director or a duly authorized medical officer may, on the application of a mental health officer, admit to a psychiatric hospital or ward a person conveyed thereto pursuant to subsection (1).

(3) The Psychiatric Hospital Director or a duly authorized medical officer, shall as soon as practicable after the patient has been admitted, make or cause to be made on the patient such examination as he may consider necessary for determining whether or not the person is in need of care and treatment.
(4) A person who has been admitted to a psychiatric hospital or ward under subsection (2) shall not be kept therein for more than seventy-two hours unless on examination the Psychiatric Hospital Director or the duly authorized medical officer is satisfied that the person is in need of care and treatment.

(5) Where the Psychiatric Hospital Director is satisfied that a person to whom subsection (4) applies is in need of further care and treatment in a psychiatric hospital or ward, the person shall be deemed to be a medically recommended patient and all the provisions of this Act relating to a medically recommended patient shall apply to such a person.

(6) A police officer shall, if required by a mental health officer, render such assistance as may be necessary for the apprehension and safe conveyance to a psychiatric hospital or ward of a person referred to in subsection (1).

Also note that provisions similar to Trinidad Section 15 legislation are found in the legislation of several “Category Two” territories.

Barbados [s. 7 (3), (4), (5), (6)]

The Barbados legislation provides as follows:

7. (3) A person who, by reason of his general appearance or by his conduct in conversation, causes a member of the Police Force who has been so notified by a mental health officer, reasonably to believe that such person is suffering from mental disorder may be taken into custody without a warrant by a member of the Police Force not below the rank of sergeant or by a member of the Police Force of lower rank acting under the authority of a sergeant or officer of higher rank and conveyed directly to a mental hospital.

(4) Where a member of the police is informed by a mental health officer that a person suspected of being of unsound mind is in any building or on any premises, whether private or not, that member of the Police Force may, if necessary, obtain a warrant and enter such building or premises and take that person into custody.

(5) A member of the Police Force who takes a person into custody under subsection (3) or (4) may elect not to prefer a charge against him; but may instead convey him directly to a mental hospital and shall in any case, do so within 24 hours from the time of the taking of him into custody and as soon as possible thereafter

(a) inform the relatives and next-of-kin of the person taken into custody of the fact of his having been taken into custody and the reasons therefor; and
(b) make arrangements for the relatives and next-of-kin to communicate with him. [s. 6]

(6) A person conveyed to a mental hospital may be examined and admitted to that hospital for a period not exceeding 72 hours unless on examination he is found to be in need of further treatment in which case the senior consultant psychiatrist may authorize the change of his status to that of a medically recommended patient. [s. 7]
Dominica [s. 8 (3), (4), (5), (6)]

and;

St. Vincent [s.6 (1), (2), (3), (4), (5)]
are similar to the Barbados legislation, except that the Police in St. Vincent may act on their own
deliberate judgement and do not require notification by “a mental health officer” as is required in
Barbados and Dominica.

British Virgin Islands [s. 4 (1), (2), (3), (4), (5), (6), (7)]
In principle, there is not much difference in the British Virgin Islands legislation when compared
with that of Barbados, Dominica and St. Vincent, but given the higher status of mental health
officers in that territory which lacks a psychiatric hospital and which is frequently without a resident
psychiatrist, the mental health officer on receiving a notification (similar to that of Barbados carries
out

4. (2) “... such investigations as may be reasonable to determine whether the suspected person
might be in need of mental treatment.” [and only then]

(3) “When a mental health officer, after investigation, is of the view that a suspected person
notified to him might be in need of mental treatment, he may request the suspected person to
accompany him to a hospital for treatment.”

(4)“When a suspected person does nor co-operate with a mental health officer in accompanying
him to a hospital for treatment or the mental health officer is of the view that the suspected person
is likely to be of a violent nature and should not be permitted to remain at large, the mental health
officer may request assistance from any member of the Police Force below the rank of sergeant
acting on the instruction of a member of higher rank in conveying the suspected person to the
hospital.”

(5) “A request for assistance under subsection (4) must be made in the prescribed form and must
be addressed to the Commissioner of Police and the suspected person may be conveyed to the
hospital without reference to a court.”

(6) “A member of the Police Force described in subsection (4) shall comply with a request made
by a mental health officer.”

(7) “For the purposes of this section, a mental health worker or a member of the Police Force may
break open closed doors in order to comply with the requirements thereof.”

Cayman Islands [s. 5]
The ‘side note’ to Section 5 of the Cayman Islands legislation reads ‘Apprehension of person
suspected to be a danger.’
5. Where it appears to any constable that any person is, by reason of mental disorder, an immediate danger, or is likely to become a danger to himself or others, he may take such person into protective custody and with all reasonable dispatch bring him before a Government Medical Officer who shall examine such person and if such Medical Officer considers that such person should be further detained he shall direct that he be detained in a hospital or in a prescribed place of safety able to receive and care for him, there to await the decision of the Chief Medical Officer as to his further detention.

Bahamas [s. 8]
This Bahamas legislation is much like the Trinidad [s.7] legislation. The ‘side note’ to Section 8 of the Bahamas legislation reads ‘Admission for observation in case of emergency.’ No legislation equatable to Trinidad [s. 8] legislation has been noted.

Jamaica [s. 8, and s. 15]
This Jamaica [s. 8] legislation is much like the Trinidad [s. 7] and the Bahamas [s. 8] legislation. The Jamaica [s. 15] legislation is similar to the St. Vincent [s. 6] legislation.

Re: Involuntary admission
(accused persons or prisoners)

Principle 20 — Criminal Offenders

1. The present Principle applies to persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness.

2. All such persons should receive the best available mental health care as provided in Principle 1 above. The present principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances. No such modifications and exceptions shall prejudice the persons’ rights under the instruments noted in paragraph 5 of Principle 1 above.

3. Domestic law may authorize a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental facility.

4. Treatment of persons determined to have a mental illness shall in all circumstances be consistent with Principle 11 above. [see Annex B for Principle 1 — Fundamental Freedoms and Basic Human Rights, and for Principle 11 — Consent to Treatment]

The relevant sections of the legislation of Category One territories are as follows:.
Grenada [s. 28 - 33]; St. Lucia [s. 30 - 37]; Guyana [s. 33]; Belize [s. 22]; Anguilla [s. 7].
Montserrat [s. 7]; St. Kitts-Nevis [s. 7]; Antigua and Barbuda [s. 32 - s.37]; Turks and Caicos [position unclear].

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The relevant sections of the legislation of Category Two territories are as follows:
*Bahamas* [s. 25 - 29]; *Trinidad and Tobago* [s. 13; s. 14]; *Cayman Islands* [s. 11]; *British Virgin Islands* [s. 10 - 13]; *Dominica* [s. 8; s. 9]; *St. Vincent and the Grenadines* [s. 8; s. 9]; *Barbados* [s. 7 (1) & (2)]; *Jamaica* [s. 9 & 10]

**Category One** legislation, the court system plays a predominant role in procedures concerning the admission and discharge of mentally ill prisoners. At the time of admission for observation, it is to be expected the chief medical practitioner at the hospital is required to ascertain that the accused person or the prisoner is indeed mentally ill and to certify this information. However, on the basis of the certification by the medical practitioner (which is regarded as “evidence”), the actual admission to the mental hospital is “by warrant” under the Governor’s or Governor-General’s or Minister’s hand (depending on the territory in question).

Also, as stated in the **Grenada** legislation:

“*The Minister may order the discharge, absolutely or conditionally, of any person confined in a mental hospital for criminals, whether recovered or not.*” [s. 32 (1)]. Dominica includes a similar section in its 1987 mental health legislation, but with an addition specification in [s. 15 (2) (b)]. This corresponding section of the **Dominica** legislation states:

(1) Notwithstanding section 8 (1), where a person on trial before the High Court —
(a) is found unfit to plead; or
(b) is found guilty but is suffering from insanity, that Court shall order him to be detained in a psychiatric hospital until the President’s pleasure is known and thereupon the President may give an order for the safe custody of that person during the detention.

(2) The President —
(a) may by warrant absolutely or conditionally discharge any person detained under subsection (1);
(b) must before the discharge of that person order that his case be reviewed by the consultant psychiatrist and a report made to him.” [s. 15]

33. “A criminal lunatic escaping or having escaped from a mental hospital for criminals may at any time be retaken by any officer or employee of the hospital, or any police officer, or any constable or peace officer, and conveyed to the hospital and detained therein as if he had not escaped.” [s. 33].

**Category Two** legislation, includes the recent Jamaica legislation which states that:

“The managers of a public psychiatric hospital or a duly authorized medical officer shall, on the warrant of the Governor-General, admit and detain for treatment in that hospital persons who are —
(a) found unfit to plead on trial; or
(b) found by a Court to be guilty of an offence but are adjudged by the Court to be suffering from a mental disorder or diminished responsibility.” [S. 9]

and also, note the following section which states:
(1) The managers of a psychiatric facility or a duly authorized medical officer shall —
(a) within seventy-two hours of the compulsory admission of a patient to the facility pursuant to an application made under section 6 [s. 6 deals with Compulsory admission];
(b) within forty-eight hours of the admission of a voluntary patient to the facility pursuant to section 5 [s.5 deals with Voluntary admission] make or cause to be made of the patient such examination as may be considered necessary for determining whether or not the patient is mentally disordered.

(2) On the expiration of the period mentioned in subsection (1), the patient shall be released from the psychiatric facility unless the managers are or the duty authorized medical officer is satisfied that the mental condition of the patient is such that he should be detained for treatment in the facility for a further period. [s. 10]

Admission of a mentally ill offender to a mental hospital is handled under what is termed in the more recent legislation (i.e. legislation included in Category Two) a Hospital Order, and he is known as a Hospital Order Patient. His status is similar to that of any other person admitted involuntarily, although his status as a prisoner may require a necessary measure of additional security which that status obviously requires.

Re: The special needs of children
Principle 2 — Protection of Minors

Special care should be given within the purposes of the Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member.

The Belize legislation makes provision for children who: (a) appear “incapable of being taught to manage [themselves] ... or who appear to be permanently incapable by reason of such defectiveness of receiving proper benefit from the instructions in ordinary schools.” [s. 2 - “defective” (b) & (c)]. Such a child may be placed in an institution. “Institution” means an institution for persons of unsound mind or defectiveness approved under this Ordinance.” [s.2]

(a) at the instance of his parent or guardian, if he is an idiot or imbecile, or at the instance of his parent if, though not an idiot or imbecile, he is under the age of eighteen; or
(b) if in addition to being a defective he is a person —
(i) who is found neglected, abandoned or without visible means of support, or cruelly treated or with respect to whom a representation has been made to the Commissioner of Police by his parent or guardian that he is in need of care or training which cannot be provided in his home. [S. 19 (1) (a), & (b) (i)]

Notice shall, subject to regulations made by the Chief Education Officer to be approved by the Minister, be given by the Chief Education Officer to the Commissioner of Police under this Part in the case of all defective children over the age of seven —
(a) who have been ascertained to be incapable by reason of mental defectiveness of receiving benefit or further benefit in special schools or classes, or who cannot be instructed in a special school or class without detriment to the interests of the other children...;

(b) who on or before attaining the age of sixteen are about to be withdrawn or discharged from a special school or class, and in whose case the Chief Education Officer is of opinion that it would be to their benefit that they should be dealt with under this Part by being sent to an institution or placed under supervision or guardianship. [s. 19 (2) (a) & (b)]

A child shall not be placed in an institution or under supervision or guardianship “except upon certificates in the prescribed form signed by two duly qualified medical practitioners, unless certificates have been signed by two qualified medical practitioners, one of whom shall be a medical practitioner approved for the purpose by the Minister, and where the defective is not an idiot or imbecile, also signed, after such inquiry as he thinks fit, by a judicial authority for the purposes of this Part, stating that the signatories of the certificates are severally satisfied that the person to whom the certificates relate is a defective and the class of defectives to which he belongs, accompanied by a statement, signed by the parent or guardian, giving the prescribed particulars with respect to him. [s. 20]

The Antigua legislation [in s. 2] and the Cayman Islands legislation [in s. 2] both define a mentally ill child in similar terms to Belize, although there is a lack of the detailed additional information which is provided in the Belize legislation.

In the St. Lucia legislation only in the section dealing with inquiry into whether person is of unsound mind, is there a provision relating to children where it is stated in part: “Provided that in the case of a person suspected of being a feeble minded person or a child the informant shall be the parent, guardian or other person having the care of such person or child.” [s. 3 (1)].

The Guyana legislation merely states that a person who is legally responsible for the maintenance of a child shall be liable to pay a monthly sum towards that child’s maintenance during the period of the child’s stay “during the period while an inmate or the Mental Hospital.” [s. 17].

Anguilla, Grenada, Montserrat, and St. Kitts-Nevis legislation makes no mention of children.

The legislation of Category Two territories no longer define mentally ill children in the pejorative and demeaning terms of earlier legislation, they are not mentioned in the Interpretation section of any of these laws, and children are not mentioned in the Barbados legislation.

St. Vincent legislation states: “When a person is under the age of sixteen, an application for admission ... or discharge ... shall be made on his behalf by his parent or guardian.” [s. 4 (6)]

That part of the legislation headed: ‘Protection of Property of Patients Suffering from Mental Disorders’ states:
"The power of the Court —
(a) to provide for the settlement of the property of a patient is not exercisable at any time when the patient is an infant;
(b) to make or give an order, direction or authority for the execution of a will for a patient,
   (i) is not exercisable at any time when the patient is an infant; and
   (ii) shall not be exercised unless the Court has reason to believe that the patient is incapable of making a valid will for himself." [s. 22 (3)].

Similar provisions are contained in the legislation of Trinidad & Tobago [s.9 (2), s. 9 (4), s.39 (3)]; British Virgin Islands [s. 7 (2), s.21 (3)]; and Dominica [s. 6 (2), s. 6 (5), s. 19 (3)]. Note that in the British Virgin Islands there is the addition provision that: "... if the person admitted is a person under the age of sixteen years he must be examined in the presence of a person interested in his welfare who is not less than 18 years of age." [s. 7 (2)].

The legislation of Jamaica, in the context of voluntary admissions, provides that:

"Where the person to be admitted is a person under the age of eighteen years, then —
(a) if he has attained the age of sixteen years and is capable of expressing his own wishes, the application must be made by him; and

(b) in any other case the application shall be made by a parent, guardian or person in loco parentis. [s. 5 (3)]

Re the discharge of voluntary admissions, the following provision is made:

"A voluntary patient may request his discharge by giving notice in writing to the managers of the facility in which he is a patient or to a duly authorized medical officer; and where the patient is under the age of eighteen years, such notice shall be given by a patient, guardian or other person in loco parentis" [s. 17 (2)].

And relating to the Review Board:

"A patient who is admitted to a psychiatric facility pursuant to an application for admission for treatment may apply to the Mental Health Review Board within a period of six months beginning with the day on which he is so admitted or, in the case of a patient who is under the age of sixteen years, with the day on which he attains that age." [s. 27 (3)]

The Bahamas legislation contains the following provision, which matches Jamaica [s.5 (3)]:

"In the case of an infant who has attained the age of sixteen years and is capable of expressing his own wishes, any such arrangement may be made, carried out and determined notwithstanding any right of custody or control vested by law in his parent or guardian." [s. 3 (2)].
In the context of the reclassification of patients, the legislation provides:

"Where a report is furnished under the provisions of subsection (1) of this section in respect of a patient who has attained the age of sixteen years, the medical officer shall cause the patient and his nearest relative to be informed and the nearest relative to be supplied on request with a copy of the report." [s. 17 (2)].

The Bahamas legislation, similar to Jamaica’s [s.27 (3)], states:

"An application may be made to the Mental Health Review Tribunal by or in respect of a patient who is liable to be detained or received into guardianship under this Act in any of the following cases namely —

(a) where any patient has been admitted to a hospital in pursuance of an application for admission for treatment, within the period of six months from the date of such application or from the date on which he attains the age of sixteen years, whichever is the later; ... " [s. 31 (a)].

Relating to ‘the removal of person detained in industrial school, ch. 90', the Bahamas legislation states:

If the Minister is satisfied from the written report of two medical practitioners that ... a child or young person who is detained in an industrial school under the provisions of the Children and Young Persons (Administration of Justice) Act, is suffering from mental disorder and that the nature and degree of the mental disorder warrants his detention in a hospital for treatment, the Minister may, with the consent of the appropriate Minister, by transfer order, direct that such person be removed to and detained in a hospital." [s. 29 (1)].

PART IV: PROPOSED GUIDELINES FOR THE REVISION OF MENTAL HEALTH LEGISLATION

Introductory comments

This Part of the Paper is divided into two sections.

Following this introductory comment is the first section proper, which arranges excerpts from the St. Kitt-Nevis legislation under the following heads:

i. Obsolete, irrelevant and imprecise terminology and definition of terms.

ii. Admission, care, discharge and aftercare.

iii. Accused persons or prisoners.
These excerpts are followed by comments, which indicate areas of conflict between the legislation and current recommended standards contained in *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*. For ease of reference these Principles have been reproduced in *Annex B* and should be referred to when reading the comments.

References are made to similar sections in the mental health legislation of Antigua and Barbuda, Grenada and St. Lucia. Because of the close similarity of provisions in the legislation of these territories, only references have been made to the relevant Sections of the Acts in question. Comments immediately following the St. Kitts-Nevis legislation are equally pertinent to the legislation of Antigua and Barbuda, Grenada and St. Lucia. The reason for choosing to highlight the legislation of these territories is because they are representative of the oldest mental health legislation in the English-speaking Caribbean which are most urgently in need of revision.

The essence of those standards which are identified in Part II of this paper, is distilled and listed as *Ten Essential Guidelines* for the revision of mental health legislation. The standards referred to are:

- *The Declaration of Caracas.*
- *The Declaration of Madrid.*
- *Draft Charter for Patient Rights.*
- *Caribbean Charter for Health Promotion.*
- *The Ottawa Charter on Health Promotion.*
- *Constitution of the World Health Organization, Article 1.*

The Guidelines are followed by a *Draft Model of a Mental Health Act.*

**EXCERPTS FROM LEGISLATION**

**ST. KITTS-NEVIS**

**Lunacy and Mental Treatment Act (Cap. 218)**

*Obsolete, irrelevant and imprecise terminology and definition of terms*

**Section 2.**

(Margin note: Interpretation)

“insane person” or “person of unsound mind” or “patient” includes an idiot and any other person of unsound mind;

“pauper patient” means any insane person who is found wandering at large, or who is not under proper care or under proper control, or who is likely to commit a crime.
Admission, care, discharge and aftercare

Sections 5 (1); 5 (2)

(Margin note: Enquiry as to lunacy)

5. (1) Any Magistrate, upon the information upon oath of any informant to the effect that the informant has good cause to suspect and believe and does suspect and believe some person to be of unsound mind and a proper subject for confinement, may, in any place which he deems convenient, examine such person, and, in the same place or elsewhere, may hold an enquiry as to the state of mind of such person.

For the purpose of such inquiry the Magistrate shall have the same powers as if the person alleged to be of unsound mind were a person against whom a complaint for an offence punishable on summary conviction has been laid:

Provided that no person alleged to be of unsound mind shall be required to attend at any Magistrate's Court for examination by a Magistrate nor shall he be taken to any such court for such purpose.

5. (2) A Magistrate may, if he thinks fit, proceed with an inquiry under this section in the absence of the person alleged to be of unsound mind and without proof of the service of any summons upon such person.

(3) If, at any stage of an enquiry under this section, it shall be shown to the satisfaction of the Magistrate conducting such enquiry that the person alleged to be of unsound mind is a person whom it is expedient to put immediately under confinement pending the conclusion of the enquiry, it shall be lawful for such Magistrate either proprio motu or at the request of the informant —

(a) to make a written order for the detention of such person during a period which shall not exceed fourteen days in an institution;
(b) from time to time, on good cause shown to make further orders for such detention, in the like form, for periods none of which shall exceed eight days:

Provided that no such person shall be detained under observation for more than two months at a time;

(c) at any time, by order under his hand, to direct that the person detained be released.

Section 9.
(Margin note: Adjudication of person of unsound mind)

9. Where, upon such enquiry as is provided for by this Ordinance, it appears to the Magistrate that any person is of unsound mind and a proper subject of confinement, and such medical certificate as by this Ordinance is required of his unsoundness of mind has been given, the Magistrate may adjudge such person to be of unsound mind and a proper subject of confinement,
and may proceed to make an order according to this Ordinance for the detention of such person in an institution ... “

Section 39
(Margin note: Provision for voluntary treatment without certification of certain persons)

39. (1) Any person who is desirous of voluntarily submitting himself to treatment for mental illness in a mental hospital (hereinafter referred to as a “voluntary patient” and who makes a written application ... for the purpose, may without being adjudicated a person of unsound mind under this Act or an order issued thereunder, be sent, in accordance with the terms of an Arrangement, as a voluntary patient to a mental hospital.

Section 40
(Margin note: Provision for temporary treatment without certification of certain persons)

40. (1) Subject to the provisions of this section, a person who is suffering from mental illness and is likely to benefit by temporary treatment but is for the time being incapable of expressing himself as willing or unwilling to receive such treatment (hereinafter referred to as a “temporary patient”) may, on a written application duly made in accordance with the provisions of this section but without being adjudicated a person of unsound mind under this Ordinance or an order issued thereunder, be received as a temporary patient in a mental hospital for the purpose of treatment therein.

(2) An application under this section which shall be in duplicate shall be in the form numbered 17 in the Schedule, ... and shall if possible, be made by the husband or wife, or by a relative or guardian of the temporary patient or on the request of the husband or wife or, if a relative or guardian, by a registered medical practitioner, and if the application is not so made, it shall contain a statement of the reason why it is not so made, of the connection of the applicant with the temporary patient and of the circumstances in which he made the application.

Accused persons or prisoners

Section 7
(Margin note: Admission of accused persons for observation).

7. (1) Whenever a Judge or a Magistrate has reason to believe that a person committed for trial before him or charged before him with an offence is of unsound mind, he may, for the purpose of obtaining evidence as to whether such person is or is not of unsound mind, by written order direct that such person be received into an institution, to be named in the order, and be there detained under observation during such period, not exceeding fourteen days, as to the Judge or Magistrate may seem expedient:

Provided that on good cause shown such order may be enlarged for a further period or periods each not exceeding eight days at a time:
Provided further that no order under this subsection shall be made in respect of persons who are not being kept in custody pending trial.

(2) When an order has been made under this section a certificate under the hand of the medical officer in charge of the institution shall be sufficient evidence of the facts therein stated concerning the state of mind of the person kept under observation and it shall not be necessary to prove the handwriting of such officer, but the Judge or Magistrate may examine any member of the staff of such institution who shall have had the patient under observation.

(3) Every person ordered under this section to be received into an institution for observation shall be received into the institution named in the order and be there detained under observation for the period stated in the order or for such shorter period as the Judge or Magistrate who made the order may direct, and it shall be lawful for any person to whom the execution of the order is entrusted to convey the person named therein to such institution.

Comments

The following comments draw attention to principles in the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (see Annex B), which should be followed in revised legislation.

1. The use of stigmatizing terms in Section 2, is in conflict with Principle 1, paragraph 2.

2. This adjudication process provided for in Sections 5 and 9, conflicts with Principle 1, paragraph 2, and with Principle 15, paragraph 2. Even though a very careful reading of Section 5 shows that the alleged mentally ill person is not legally being considered a criminal, yet the very nature of the adjudication process with its strong connotations of criminality, as well as the possibility provided for in Section 5 (3) that the alleged mentally ill person may be institutionalized for up to two months before examination by the medical officer, an examination which is provided for in Section 5 (5), is particularly stigmatizing to a mentally ill person.

3. A comparison of Section 5 with Section 39 and Section 40, reveals unequal treatment of mentally ill persons, based, as may be surmised, on differing social and economic status. Adjudication by a Magistrate (as provided for in Section 5) is mandated only for those allegedly mentally ill persons who either lack the capacity to seek voluntary admission under Section 39, or who have no relative or friend sufficiently interested or knowledgeable to seek their admission under Section 40.

4. Discriminatory treatment is also revealed in the fact that a Section 40 admission into a mental hospital shall be for “a period not exceeding six months”, whereas under Section 5, it is possible to put the allegedly mentally ill person “under confinement pending the conclusion of the inquiry” as to whether he is mentally ill, and such confinement may be for as long as two months before the enquiry process has been completed. No maximum period of institutionalization following the enquiry (if the person is found to be mentally ill) is stated.
Several paragraphs of Principle 16 are breached by these discriminatory provisions.

5. In relation to an accused person, Section 7 (2) would appear to be endowing the Judge or Magistrate with powers to seek corroboration of the findings of the medical officer in charge of the institution, and Section 7 (3) further usurps the sphere of influence of the medical practitioner, in that the Judge or Magistrate makes the ultimate decision on the length of time during which the mentally ill offender remains institutionalized. Sub-sections 2 and 3 of Section 7 do not conform to Principle 4, paragraph 2.

6. There are no specific provisions covering curative care, rehabilitation, aftercare and preventive care, nor have any special provisions been made for children. There is urgent need for new legislation which would enact the standards set out in the following:

(1) Principle 2 - Protection of Minors; (2) Principle 8 - Standard of Care; (3) Principle 9 - Treatment; (4) Principle 11 - Consent to Treatment; (5) Principle 12 - Notice of Rights; (6) Principle 17 - Review Body; and (7) Principle 19 - Access to Treatment.

7. Additionally, the legislation is not compatible with the principles expressed in the Declaration of Caracas (1990) which require that mental health and psychiatry should be community based, and that psychiatric services and program admissions in general hospitals be encouraged. The Declaration has been included in Annex A.

ANTIGUA AND BARBUDA

Mental Treatment Act (Cap. 274)

Obsolete, irrelevant and imprecise terminology and definition of terms

Section 2

"person of unsound mind" "mental patient" or "insane person" includes —
(a) any epileptic or other person who is suffering from temporary or permanent disease or derangement of the brain producing disordered action of the mind to such an extent as to put him in a condition varying from his normal self and out of relation with his environment so as to render him dangerous or inconvenient to himself or others;
(b) any idiot, that is to say, a person so defective in mind from birth or from an early age as to be unable to guard himself against common physical dangers;
(c) any imbecile, that is to say, a person in whose case there exists from birth or from an early age mental defectiveness not amounting to idiocy, yet so pronounced that he is incapable of managing himself or his affairs, or in the case of a child, of being taught to do so;
(d) any feeble minded person, that is to say, a person in whose case there exists mental defectiveness not amounting to imbecility yet so pronounced that he requires care, supervision and control for his own protection or for the protection of others, or in the case of a child, that he by reason of such defectiveness appears to be permanently incapable of receiving proper benefit from instruction in an ordinary school;
(e) any moral defective, that is to say, a person in whose case there exists mental defectiveness coupled with vicious or criminal propensities and who requires care, supervision and control for the protection of others.

Admission, care, discharge and aftercare

Section 4
(Margin note: Enquiry as to whether person is of unsound mind)

Section 6
(Margin note: Admission of accused person for observation)

Section 9
(Margin note: Adjudication of person of unsound mind)

Section 50
(Margin note: Power to receive voluntary patient)

Section 52
(Margin note: Provision for temporary treatment without certificate of certain persons)

Accused persons or prisoners

Sections 31-37
(The heading at the beginning of these sections reads: Criminals of Unsound Mind)

GRENADA

Mental Health Act (Cap. 190)

Obsolete, irrelevant and imprecise terminology and definition of terms

Section 2
"lunatic" includes an idiot and any other person of unsound mind;

"pauper lunatic" means any lunatic —
(a) who is found wandering at large; or
(b) who is not under proper care or not under proper control; or
(c) who is likely to commit a crime.

Admission, care, discharge and aftercare

Section 3
(Margin note: Enquiry as to lunacy)

Section 6
(Margin note: Adjudication of lunacy)
Section 48
(Margin note: Power to receive voluntary patients)

Section 51
(Margin note: Provision for temporary treatment without certification of certain persons)

Accused persons as prisoners
Sections 28-33

(The heading at the beginning of these sections reads: Criminal Lunatics)

ST. LUCIA

Mental Hospitals Act (Cap. 155)

Obsolete, irrelevant and imprecise terminology and definition of terms

Section 2
“Person of unsound mind” “insane person” “patient” or “mental patient” includes —
(a) Any epileptic or other person who is suffering from temporary or permanent disease or
derangement of the brain producing disordered action of the mind to such an extent as to put him in
a condition varying from his normal self and out of relation with his environment so as to render him
dangerous or inconvenient to himself or others;
(b) Any idiot, that is to say, a person so defective in mind from birth or from an early age as to be
unable to guard himself against common physical dangers;
(c) Any imbecile, that is to say, a person in whose case there exists from birth or from an early age
mental defectiveness not amounting to idiocy, yet so pronounced that he is incapable of managing
himself or his affairs, or in the case of a child, of being taught to do so;
(d) Any feeble minded person, that is to say, a person in whose case there exists mental defectiveness
not amounting to imbecility yet so pronounced that he requires care, supervision and control for his
own protection or for the protection of others, or in the case of a child, that he by reason of such
defectiveness appears to be permanently incapable of receiving proper benefit from instruction in
an ordinary school;
(e) Any moral defective, that is to say, a person in whose case there exists mental defectiveness
coupled with vicious or criminal propensities and who requires care, supervision and control for the
protection of others.

Admission, care, discharge and aftercare

Section 3
(Margin note: Enquiry as to whether person is of unsound mind)

Section 6
(Margin note: Adjudication of unsoundness of mind)

Section 27
(Margin note: Voluntary patients)
Section 28
(Margin note: Provision of temporary treatment without certification of certain persons)

Accused persons or prisoners
Section 30-37
(The heading at the beginning of these sections reads: Prisoners of unsound mind)

(N.B. The comments made immediately following excerpts from the St. Kitts-Nevis legislation is equally applicable to the legislation of Antigua and Barbuda, Grenada and St. Lucia).

PART IV

GUIDELINES
Ten Essential Guidelines

1. The essential principle, which should be adhered to in every section comprising the legislative document, is the promotion of mental health.

2. Health as a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity, must be the original focus of policy-makers whose decisions through enactment become implementable legislation.

3. The ultimate aim of mental health legislation should be:

   (i) the promotion of mental health in the population;
   (ii) the provision of treatment, rehabilitation and aftercare for mentally ill persons;
   (iii) the establishment of a community mental health service;
   (iv) the protection of the public and the provision of effective and safe care for those with severe and enduring mental illness.

4. The rights of mentally ill persons which should be recognized and protected by legislation include:

   (a) the right to access to treatment
   (b) the right to informed consent about their treatment and care;
   (c) the right of access to medical records;
   (d) the right to confidentiality;
   (e) the right to independent legal and medical advice;
   (f) the right to an authorized representative (where possible patients should be empowered to nominate their own "representative");
   (g) the right to aftercare after discharge for a specific period

5. Legislation must provide for a court-appointed personal representative to manage the property and affairs of a mentally ill person who lacks capacity.
6. Legislation should establish Community Mental Health Services as an integral part of Primary Health Care, and the organization of such services should be the cooperative responsibility of the Head of the Primary Health Care Services and the Head Psychiatrist of the Psychiatric Facility (i.e. the Psychiatric Hospital, or Psychiatric Ward of General Hospital in territories without a separate psychiatric hospital).

7. The legislation should support effective treatment outside hospital, by making provision for the treatment of persons in their own homes or in residential settings and in community clinics for those types of mental disorders which can be treated by pharmacological means. Provisions for compliance with agreed care plans for patients who are not detained in a hospital must be ensured within the legislative framework.

8. Mental health legislation in its health promotion provisions, should contain sections specifically relating to specially vulnerable groups (e.g. teen-age mothers, abused children, the mentally handicapped, the elderly, victims of disaster, those living with HIV) at the community level.

9. The legislation must ensure that mentally disabled persons, drug abusers, and social non-conformists should not be institutionalized (either compulsorily or voluntarily) unless they are a physical danger to themselves and others, or are suffering from drug-induced psychoses which can best be treated in an institutional setting.

10. Mental health legislation should contain a “Code of Practice” which should provide the principles governing mental health care and should as far as possible be similar to those which govern physical health.
DRAFT MODEL LEGISLATION
MENTAL HEALTH ACT
DRAFT

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[DRAFT MODEL LEGISLATION]

MENTAL HEALTH ACT

An Act to make provision for the implementation of a preventive policy aimed at protecting and promoting mental health; the establishment of a Community Mental Health Service; the protection of the human rights of patients; the admission, treatment, and discharge of patients from a mental health facility; the establishment of a Mental Health Review Board and a Mental Health Appeal Tribunal; the safeguarding of the property of patients; the empowerment of the Minister of Health to make regulations for ensuring the implementation of all of the objectives and purposes of this Act, and for related issues.
PRELIMINARY

Citation

1. This Act may be cited as the Mental Health Act, 1999.

Interpretation

2. In this Act,

   “Caribbean Charter for Health Promotion” means the Charter developed at the First
   Caribbean Conference on Health Promotion, held in Port-of-Spain, Trinidad and
   Tobago, 1-4 June 1993;

   “Community Mental Health Service” means the service established under Part III of
   this Act;

   “Declaration of Caracas” means the Declaration adopted by the Regional Conference
   on Restructuring Psychiatric Care in Latin America, held in Caracas, Venezuela, 11-
   14 November 1990;

   “Declaration of Madrid” means the Declaration approved by the General Assembly
   of the World Psychiatric Association, meeting in Madrid (25 August 1996);

   “establishments for mentally retarded persons” means establishments providing
   rehabilitation, education, and care for mentally retarded persons, including sheltered
   workshops and psycho social counseling centers;

   “Health and Family Life Education Strategy” means the strategy developed as a
   multi-agency effort and accepted by the CARICOM Standing Committee of
   Ministers responsible for Education and Culture (SCME) in April 1996;

   “mental disorder” means a disorder of thought, mood, perception, orientation or
   memory that grossly impairs
   (i) judgment,
   (ii) behavior,
   (iii) capacity to recognize reality; or
   (iv) ability to meet the ordinary demands of life;

   “Mental Health Appeal Tribunal” means the tribunal established under section 25.

   “mental health care” includes analysis prevention and diagnosis of a person’s
   condition, and treatment, care and rehabilitation for a mental illness or suspected
   mental illness;
“mental health officer” means any person employed at a psychiatric facility as a nurse, or any other person who has successfully completed a course of study in mental health approved by the Minister responsible for Health;

“mental health practitioner” means a medical doctor, clinical psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care;

“Mental Health Review Board” means the review board established under Part V;

“Minister” means the Minister responsible for Health;

“nearest relative” means, with respect to a formal patient

(i) the adult person first listed in the following paragraphs, relatives of the whole blood being preferred to relatives of the same description of the half-blood and the elder or eldest of 2 of more relatives described in any paragraph being preferred to the other of those relatives regardless of gender:

(A) spouse,
(B) son or daughter,
(C) father or mother,
(D) brother of sister;
(E) grandfather or grandmother,
(F) grandson or granddaughter,
(G) uncle or aunt,
(H) nephew or niece;

or

(ii) any adult person the Board designates in writing to act as the nearest relative within any description in subclause (i) or if, in the opinion of the Board, the nearest relative determined under subclause (i) would not act or is not acting in the best interest of the formal patient;

“patient” means a person who is admitted to a facility as an in-patient, or as an out-patient for diagnosis or treatment services, or both;

“Patient's Bill of Rights” refers to the information set out in Part II of this Act;

“person with mental disorder” means a person who:

(a) manifests a mental dysfunction which, on the basis of medical knowledge, is classified as a mental disorder and requires specialized medical treatment whether in general health services or general services as determined by applicable ………;

(b) is mentally retarded;
(c) manifests psycho social disorders necessitating specialized psycho social treatment;

"personal representative" means a person charged by law with the duty of representing a patient's interests in any specified respect or of exercising specified rights on the patient's behalf, and includes the parent or legal guardian of a minor;

"Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care" means the Principles adopted by United Nations General Assembly resolution 46/119 of 17 December 1991;

"psychiatric facility" or "facility" means any
(a) psychiatric hospital;
(b) psychiatric department in a general hospital;
(c) primary health care clinic;
(d) nursing home;
(e) treatment and/or rehabilitation centre;

"psychiatrist" means a person who is registered under the ________ Act;

"psychosurgery" means any procedure that, by direct or indirect access to the brain, removes, destroys or interrupts the continuity of histologically normal brain tissue, or that inserts indwelling electrodes for pulsed electrical stimulation for the purpose of altering behavior of treating psychiatric illness, but does not include neurological procedures used to diagnose or treat intractable physical pain or epilepsy where those conditions are clearly demonstrable;

"spouse" with respect to a formal patient, includes a person who although not married to the patient cohabited with the patient as his spouse immediately preceding the patient's admission to a facility.

PART 1
MENTAL HEALTH SERVICE

Aims and Objectives
3. (1) A mental health service shall be provided through —

(a) a community Mental Health Service established under Part III of this Act; and

(b) a Psychiatric Facility Service dealt with in Part IV of this Act, providing for admission, treatment and discharge, when no other care of a less restrictive kind is appropriate and reasonably available to the patient.
(2) The principle objectives of the *Community Mental Health Service* are:

(a) the coordination of mental health services within the primary health care services and within the educational network;

(b) the dissemination of information to, and the sensitization and mental health education of, the general population;

(c) work aimed at the social reintegration of patients who, as the result of mental health problems, encounter difficulties in their family, educational, professional, or social life; and

(d) specific interventions directed towards target groups.

(3) The Psychiatric Facility Service provides for —

(a) the admission, diagnosis, treatment, rehabilitation, discharge and aftercare of a person with mental disorder, as an in-patient and/or an out-patient of a psychiatric facility; and

(b) the protection of the human rights of the patient in accordance with —

(i) the "Patient’s Bill of Rights" as set out in *Part II* of this Act;

(ii) the standards and principles of the "Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care";

(iii) the "Declaration of Madrid."

*Appointment of Mental Health Advisory Committee*

4. The Minister shall establish a Mental Health Advisory Committee specifically to advise him in making regulations for —

(a) the setting up and maintaining of rehabilitation centres, half-way houses, sheltered workshops, and schools for the mentally disabled;

(b) supporting the "Health and Family Life Education Strategy," the "Caribbean Charter for Health Promotion," and similar health promotional strategies and programmes of relevance to the field of mental health;

(c) strengthening the social work support systems, to the extent that they provide social support to persons who, by reason of a mental disease or retarded mental development, experience difficulties in leading a normal life;

(d) ensuring the appropriate environment for physical and emotional well-being through community-based programmes in healthy lifestyle living;
(e) monitoring and assisting with the teaching of mental health elements in training programmes for persons working in the sectors concerned with education, social assistance, health, administration, and the organization of recreational activities;

(f) encouraging research in the field of mental health improvement and the prevention of mental disorders, to the extent that such research is in accordance with internationally accepted ethical standards.

PART II
PATIENT'S BILL OF RIGHTS

Rights of patients
5. The patient has the right to the following:

(a) considerate and respectful care;

(b) to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information shall be made available to an appropriate person on his behalf. He has the right to know the name of the physician responsible for coordinating his care;

(c) to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent shall include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for procedures and/or treatment;

(d) to refuse treatment, and to be informed of the medical consequences of his action. Refusal of treatment shall be documented and reported to the patient's physician;

(e) to every consideration of his privacy concerning his own medical care programme. Case discussion, consultation examination and treatment are confidential and shall be conducted discretely. Those not directly involved in his care must have the permission of the patient to be present;

(f) to expect that all communications and records pertaining to his care shall be treated as confidential;

(g) to inspect his chart in the physician's presence and the treating nurse. Only the physician and/or consulting physician involved in the care of the patient may be allowed to review the chart;
(h) to obtain information as to any relationship of his hospital to other health care educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him;

(i) to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient ha the right to refuse to participate in such research projects without compromising his access to facility services;

(j) to expect reasonable continuity of care. He has the right to know in advance what appointment times and mental health personnel are available and where.

PART III
COMMUNITY MENTAL HEALTH SERVICE

Establishment of Community Mental Health Service
6. For the purposes of this Act, there is hereby established a Community Mental Health Service with the dual objective of providing —

(a) community psychiatric services; and

(b) mental health promotion services.

Community psychiatric service
7. The community psychiatric service shall undertake the provision of —

(a) services at out-patient psychiatric clinics, in health centres and general hospitals;
(b) rehabilitative services for persons after their discharge from a psychiatric facility, including psycho social counseling;

(c) home care and support for persons with mental disorders.

Mental health promotion.
8. (1) Mental health promotion includes services for the promotion of mental health, through

(a) the coordination of mental health services with the primary health care services and with the educational network;

(b) the dissemination of information to, and the sensitization and mental health education of the general population;

(c) rendering psycho social counselling assistance to crisis centres for abused women and children, drug rehabilitation units, half-way houses, schools, and such other institutions as may require similar interventions.
(2) The psychiatrists, medical practitioners, mental health officers and psychiatric social workers shall, where necessary, consult and liaise with members of the other branches of the health service with a view to facilitating the provision of mental health care where such care is vital to the care being provided for other health problems.

Matters relating to mentally retarded persons
9. A person who, owing to mental retardation:

   (a) is incapable of taking care of himself and catering for his vital needs;

   (b) does not receive assistance from other persons; and

   (c) has no need of psychiatric treatment,

shall be admitted, on the recommendation of a physician, to an establishment for mentally retarded persons.

PART IV
ADMISSION, TREATMENT AND DISCHARGE

Compulsory admission
10. (1) Any person who, by reason of mental disorders:

   (a) constitutes a danger to his own life or health or the life or health of others; or

   (b) is capable of benefiting from treatment in an institutional setting,

may be subjected to a psychiatric examination without his consent, pursuant to an application made by the nearest relative of the person or by a mental health officer.

   (2) The compulsory examination shall be carried out following the decision of the psychiatrist of the psychiatric facility, and the psychiatrist may order the immediate hospitalization of the person concerned.

Voluntary admission
11. (1) The person with mental disorders shall be admitted to a psychiatric facility after having given his written consent, if such admission has been requested by the Psychiatrist following a direct examination of the person concerned, and provided that the criteria and indications for hospital admission are meet.

   (2) The hospital admission of minors or incompetent persons shall require the written consent of a parent, a relative, a personal representative, or other authorized person.
Medical certificates
12. (1) An application for admission to a psychiatric facility shall be —

(a) addressed to the Head Psychi atrist;

(b) supported by medical certificates issued by two medical practitioners; and each certificate shall contain —

(i) a statement by the medical practitioner that in his opinion there is sufficient evidence that the patient is suffering from mental disorder which warrants his detention in a psychiatric facility; and that the patient ought to be detained in the interest of his own health or safety;

(ii) the reasons for his opinion; and

(iii) an indication whether other methods of dealing with the patient are available, and if so, why they are not appropriate.

(2) A medical certificate shall not be given by —

(a) the applicant;

(b) a partner of the applicant or of a medical practitioner by whom another medical certificate is given;

(c) a person employed as an assistant by the applicant or by any such practitioner as aforesaid;

(d) a person who receives or has an interest in the receipt of any payment made on account of the maintenance of the patient;

(e) a medical practitioner who is related by blood or marriage to the patient, or who has given another medical certificate for the purposes of the same application.

(3) It is sufficient if an emergency application is supported initially by only one of the medical certificates required. An emergency certificate shall cease to have effect on the expiration of a period of forty-eight hours from the time when the patient is admitted to the psychiatric facility, unless the second medical certificate is received by the facility within that period.

Admission on warrant of Governor-General
13. The Psychiatrist of a public psychiatric hospital or a duly authorized medical officer shall, on the warrant of the Governor-General, admit and detain for treatment in that hospital persons who are
(a) found unfit to plead on trial; or

(b) found by a Court to be guilty of an offence but are adjudged by the Court to be suffering from a mental disorder or diminished responsibility.

Powers of mental health officers
14. (1) Where a mental health officer has reason to believe that a person who appears to be living on the street or other public place is mentally disordered, he may, with or without the assistance of a constable, remove that person to a public psychiatric facility for treatment.

(2) A mental health officer may at any reasonable time enter and inspect any premises if he has reasonable cause to believe that a person who is mentally disordered and in need of proper care is on those premises; and may, with the assistance of a constable if necessary, cause that person to be admitted and detained in a public psychiatric facility for treatment.

(3) Admission and detention of a person under this section shall be treated as admission and detention under section 10, and the provisions of this Act shall apply accordingly.

Consent to hospitalization and to treatment
15. (1) A person with a mental disorder may not be placed in a psychiatric facility without his consent, unless by reason of his mental disorder he constitutes a danger to his own life or health or the life or health of others.

(2) The decision to admit a person shall be taken by the duly authorized medical officer only after he has personally examined the person concerned. The patient, the members of his family or his personal representative shall have the right to be informed of the grounds for such decision.

(3) A patient shall not be given treatment in a psychiatric facility without his consent unless a duly authorized medical officer certifies that the patient’s mental condition is such that he is not competent to give consent.

(4) Where a patient is unable to give consent to treatment, consent shall be given by the patient’s nearest relative or by his personal representative.

Treatment
16. (1) The person admitted to a psychiatric facility or his personal representative shall have the right to be fully informed of the curative treatment recommended by the psychiatrist.

(2) The information shall cover the method of treatment, the medication to be taken and their possible side effects, the anticipated results of the treatment, the duration of the treatment, other possible treatments, and any other pertinent information.

(3) If a patient who is mentally competent to make treatment decisions objects to any treatment he is receiving at a facility, treatment shall not be administered unless the Mental Health Review
Board makes an order under this section

(4) An attending physician who considers it in the best interest of a patient to administer treatment to which the patient objects may apply to the Review Board for an order directing that the treatment may be administered.

(5) Before making an order the Review Board must be satisfied after hearing the evidence of the attending physician and any other evidence if considers relevant that —

(a) the attending physician has examined the formal patient,

(b) the proposed treatment is in the best interest of the patient having regard to the following:

(i) whether or not the mental condition of the patient will be or is likely to be improved by the treatment;
(ii) whether the patient’s condition will deteriorate or is likely to deteriorate without the treatment;
(iii) whether or not the anticipated benefit from the treatment outweighs the risk of harm to the patient;
(iv) whether or not the treatment is the least restrictive and least intrusive treatment that meets the requirements of subsections (i), (ii) and (iii)

(6) In addition to the evidence referred to in subsection (5), the Review Board may authorize the examination of the patient by a psychiatrist who is not a member of the medical staff of the facility, for the purpose of obtaining his opinion as to whether the proposed treatment is in the best interest of the patient having regard to the considerations referred to in section (b) of that subsection

(7) Notwithstanding anything in this section, psychosurgery shall not be performed on a patient unless

(a) the patient consents of the psychosurgery, and
(b) the Review Board makes an order under this section directing that the psychosurgery may be performed.

Control
17. The authority to control a person under this Act is authority to control the person without his consent to the extent necessary to prevent serious bodily harm to the person or to another person by the minimal use of such force, mechanical means or medication as is reasonable, having regard to the physical and mental condition of the person

Discharge of voluntary patient
18. (1) A voluntary patient may request his discharge at any time, and the Head Psychiatrist may discharge him if satisfied that —
(a) the discharge is in the interest of the patient; and
(b) the patient is not in need of any further care and treatment in a facility.

(2) If it is found that the voluntary patient requesting his discharge is mentally disordered and in need of further care and treatment in a psychiatric facility, he may be kept in the facility as an involuntary patient. In such a case, the medical certificates required by section 14 must be obtained.

Discharge of involuntary patient
19. (1) The decision to discharge from a psychiatric facility a person who has been admitted without his consent as an involuntary patient, shall be taken by the Head Psychiatrist in cases where the patient concerned does not constitute a danger to himself or to others.

(2) The Head Psychiatrist shall inform the family or the personal representative of the person concerned, of this decision.

Conditional discharge
20. (1) The Psychiatrist or other authorized person may allow the conditional discharge of an involuntary patient if he considers it conducive to the recovery of the patient that he should be under the care and custody of such relative, friend or legal guardian who has requested his discharge.

(2) A patient conditionally discharged may be placed under the supervision of —

(i) a medical practitioner whose name shall be specified in the document of discharge,

or

(ii) a mental health officer.

(3) If within twelve months of the date of conditional discharge of an involuntary patient, an authorized person is satisfied that the patient has become so mentally disordered that his return to the facility is considered necessary, the authorized person may order that the patient be brought back to the facility.

(4) A patient who has been conditionally discharged shall, for a period of twelve months from the date of his discharge, be deemed to continue to be a patient of the psychiatric facility from which he was discharged, in the same manner and to the same extent and shall be subject to the same authority and control, as if he were not conditionally discharged.

(5) Unless an order has been made for his return to the facility, a patient who has been conditionally discharged shall be regarded as absolutely discharged on the expiration of twelve months from the date of his discharge.

Request for discharge
21. (1) A patient admitted to a psychiatric facility with or without his consent, his family or his personal representative should have the right to request his discharge at any time.
(2) If the request for discharge from the facility is refused, the person requesting the discharge shall have the right to apply to the Mental Health Review Board, and if the Board refused the application, appeal may be made to the Mental Health Appeal Tribunal whose decision shall be final.

Discharge of patient detained under warrant
22. The Minister responsible for justice shall cause to be made, at least once in every six months, an assessment of every person admitted and detained in a public psychiatric facility by a warrant issued under section 13 and may, if satisfied on medical evidence that the medical condition of the patient no longer warrants his detention in a psychiatric facility and that his discharge from the facility ought not to pose a threat to the health and safety of others, authorize his discharge from the facility, either absolutely or conditionally, into the custody of a relative, friend or legal guardian.

PART V
MENTAL HEALTH REVIEW BOARD

Establishment of Mental Health Review Board
23. (1) For the purposes of this Act, there is hereby established a Mental Health Review Board.

(2) The Minister shall appoint as members of the Board —

(a) a psychiatrist,

(b) a psychologist,

(c) a physician,

(d) an attorney-at-law of at least 5 years experience,

(e) a person having training and experience in matter relating to mental health,

(f) a member of the general public.

(3) Whenever the psychiatrist is clinically involved in a case under consideration by the Review Board the Minister may appoint a person of similar qualification to act in place of the psychiatrist.

(4) The provisions of the First Schedule shall have effect in relation to the operation of the Board and otherwise in relation thereto.

Functions of Review Board
24. (1) The functions of a Review Board are —
(a) to receive and investigate complaints from patients, relatives or personal representatives of patients on any matter connected with their care or treatment or their discharge from, or detention in, a psychiatric facility;

(b) to undertake a periodic review at least once every six months of all patients who have been undergoing treatment in a psychiatric facility, to determine whether the patient is a mentally ill person who should continue to be detained.

(2) For the purpose of performing its functions under this Act a Review Board shall have power to —

(a) summon the attendance of persons, including any member of staff of a psychiatric facility;

(b) take evidence under oath;

(c) require any person to produce such books, records or documents as it thinks appropriate;

(d) make such order as it thinks appropriate in any case, including an order for the discharge of the patient concerned.

(3) An appeal shall lie against the decision of the Review Board to the Mental Health Appeal Tribunal.

**Appeal**

25. (1) There is hereby established a Mental Health Appeal Tribunal for the purpose of hearing appeals from the decisions of the Review Board.

(2) The Appeal Tribunal may at the hearing of an appeal —

(a) dismiss the appeal and confirm the decision of the Review Board;

(b) allow the appeal and direct that the matter be reexamined by the Review Board;

(c) set aside the decision and substitute therefor such other decision as it thinks fit

**PART VI**

**PROTECTION OF PROPERTY OF PATIENTS**

**Jurisdiction of High Court**

26. (1) The High Court may, on the application of the nearest relative or the Attorney General, exercise jurisdiction over the management of the property and affairs of a patient if the Court is satisfied by evidence medical and otherwise on affidavit that the patient is incapable by reason of mental disorder of managing and administering his property and affairs.
(2) The Court, on an application being made to it under subsection (1), shall have the power to do all such things as appear to it to be necessary or expedient in the interest of and for the maintenance and benefit of the patient; and where it is deemed necessary also for a relative or dependant of the patient.

(3) The Court may, in giving effect to its power under subsection (2), give directions or make orders in respect of —

(a) the transfer, vesting, sale, lease, rental or exchange of the patient’s property;

(b) the acquisition of property in the name of or on behalf of the patient;

(c) the settlement of property by way of gift;

(d) the execution of a will on behalf of the patient;

(e) the carrying on of the patient’s business, trade or profession;

(f) the sale, lease or rental of the patient’s business or trade;

(g) the dissolution of a partnership of which the patient is a partner;

(h) the fulfilling of any of the patient’s contractual obligations;

(i) the payment of any debts incurred by the patient;

(j) the continuance or instituting of any legal proceeding on behalf of the patient;

(k) the exercise of any power of attorney vested in the patient;

(l) all financial affairs of the patient.

PART VII
GENERAL

Immunity from suit
27. A person is not liable to any suit or action in respect of any act done under lawful direction and authority pursuant to this Act or any regulations made thereunder unless it is shown to the satisfaction of the Court that the person acted without good faith or reasonable care.

Ill-treatment of patient
28. (1) A person commits an offence if, being in charge of or employed in a psychiatric facility, he ill-treats or wilfully neglects a patient, any person awaiting admission as a patient or a patient who is on the premises of the facility for the purpose of receiving care and treatment as an out-patient.
(2) A person commits an offence if he ill-treats or willfully neglects a person who is suffering from a mental disorder and is under his custody or under his care and protection.

(3) [Penalties to be inserted]

Sexual offences against patient
29. (1) A person commits an offence if —

(a) being in charge of or employed in a psychiatric facility he has sexual intercourse with a patient, a person awaiting admission as a patient or a person who is on the premises of the facility for the purpose of receiving care and treatment as an out-patient; or

(c) he has sexual intercourse with a person who is suffering from a mental disorder and who is in his custody or under his care and protection.

(2) It shall be a defence for a person who is charged under subsection (1) (a) of this section to prove that he did not know or had no reason to believe or to suspect that the person was suffering from a mental disorder.

(3) The burden of proving lack of knowledge in subsection (2) lies on the accused.

(4) No action shall be taken against a person in respect of any act of sexual intercourse between spouses.

(5) [Penalties for offence to be inserted].

Permitting escape of patient
30. (1) Any person who —

(a) unlawfully aids, abets or assists a patient who has not been discharged to leave a psychiatric facility; or

(b) harbours or assists a patient who has left such a facility without being discharged therefrom,

commits an offence.

(2) [Penalties for offence to be inserted]

Obstructing person in execution of duty
31. (1) A person who without lawful authority interferes with or obstructs any person in the execution of his duties under this Act or regulations made hereunder commits an offence.
(2) [Penalties for offence to be inserted]

Forgery, false statement
31. (1) A person who, with intent to deceive, forges —

(a) an application under Part IV;

(b) a medical certificate or report under that Part; or

(c) any other document required or authorized to be made for any of the purposes of this Act commits an offence.

(2) A person who —

(a) wilfully makes a false entry or statement in any application, certificate, report, record or other document required or authorized to be made for any of the purposes of this Act; or

(b) with intent to deceive, makes use of any such entry or statement knowing it to be false

Commits an offence.

(3) [Penalties for offences to be inserted]

Regulations
32. The Minister may make regulations for the better carrying out of the objects and purposes of this Act and in particular (but without prejudice to the generality of the foregoing) may make regulations prescribing provisions relating to —

(a) the operation of psychiatric facilities and rehabilitation centres;

(b) the creation of, and support to, establishments working in areas of prevention and counselling;

(c) intra-ministerial cooperation to ensure the appropriate environment for physical and emotional well-being through community-based programmes in healthy life-style living;

(d) the encouragement of multidisciplinary cooperation, and cooperation between the public and private sector including non-governmental organizations, in the interest of mental health promotion;

(e) the promotion of informed public opinion on matters relating to mental health by the publication of reports and information concerning mental health;

(f) the protection and management of the property or estate of mentally disordered persons;
(g) application to the Mental Health Review Board and appeals to the Mental Health Appeal Tribunal;

(h) anything required by this Act to be prescribed.

FIRST SCHEDULE

[To be inserted]

[In relation to the Mental Health Review Board, this Schedule contains such information as: Tenure of office; Acting appointments; Resignations; Revocation of appointments; Filling of vacancies; Publication of membership; Meetings; Remuneration of members; Protection of members; etc.]

SECOND SCHEDULE

[To be inserted]

[In relation to the Mental Health Appeal Tribunal, this Schedule contains information of its constitution, tenure of office of its members and conduct of meetings]

PART V: REPORT ON MEETINGS IN ST. LUCIA, ST. VINCENT AND THE GRENADES, GRENADA, BRITISH VIRGIN ISLANDS, ANTIGUA AND BARBUDA, AND ST. KITTS-NEVIS

PART I - SCHEDULE OF MEETINGS AND VISITS

ST. LUCIA
MONDAY, SEPTEMBER 14, 1998
10.30 a.m. - 11.00 a.m.
Meet with Dr. James St. Catherine, Chief Medical Officer and with Ms. Marcia Philbert-Jules, Permanent Secretary, Ministry of Health.

11.00 a.m. - 12.30 p.m.
Met with Mrs. Carolyn Archibald, Principal of Dunnottar School,

1.30 p.m. to 2.30 p.m.
Visited Turning Point, met with Mr. Bruce Phillips, Director, and toured the facility.
Meeting with the following persons at Golden Hope Hospital:
Mr. Patrick Lammie, Principle Nursing Officer
Dr. Andre Edward, House Officer
Mr. Imbert Bailey-Small, Charge Nurse
Mr. Luke Augustin, Staff Nurse (Rehabilitation)
Ms. Lucy Felix, Ward Sister
Ms. Jennifer Joseph, Social Worker
Ms. Marlene Whitfield, Hospital Administrator
Ms. Nicole Edgecombe, Psychologist/Psychotherapist
Ms. Patricia Joseph, Health Educator, Ministry of Health

ST. LUCIA
TUESDAY, SEPTEMBER 15, 1998
9.00 a.m. - 9.45 a.m.
Visited Dunnottar Home

10.00 a.m. - 10.45 a.m.
Met with Mr. Nicholas Monrose, Director of Human Services, Division of Human Services and Family Affairs, Ministry of Health

11.00 a.m. - 12.00 p.m.
Met with Ms. Prisca St. Paul, Director of the Optimum Garden Centre for Abused Girls.

2.30 p.m. - 4.00 p.m.
Visited the Psychiatric Ward of St. Jude’s Hospital, Vieux Fort, and met with Dr. Swamy.

ST. VINCENT
WEDNESDAY, SEPTEMBER 16, 1998
8.30 a.m. - 9.30 a.m.
Meeting with Mr. Carl F. Browne, Permanent Secretary, Ministry of Health and the Environment, and Dr. M. K. Debnath, Senior Registrar (Psychiatry), Mental Hospital.

10.00 a.m. - 10.30 a.m.
Met with Mrs. A. Browne

10.45 a.m. - 12.00 p.m.
Visited St. Vincent School of Nursing and met with Mrs. Young, Head of the School of Nursing.

2.00 p.m. to 2.30 p.m.
Met with Mrs. Wilson

2.45 p.m. - 4.00 p.m.
Met with Mrs. Ruby Browne, Chief Parliamentary Counsel (i.e. Legislative Draftsperson), and Ministry of Legal Affairs.
ST. VINCENT
THURSDAY, SEPTEMBER 17, 1998
10.00 a.m. - 10.45 a.m.
Visited Marion House.

11.00 a.m. - 1.00 p.m.
Meeting at Mental Health Centre (Psychiatric Hospital), with Dr. M.K. Debnath, Senior Registrar (Psychiatry); Dr. M. Badee; Mrs. G. Bascombe, Senior Nursing Officer; Sister A. Israel, Ward Sister; Sister A. Samuel, Ward Sister.

[Possible visit to Liberty House during the afternoon not followed up. Spend the afternoon in the Ministry of Health’s Conference Room reading documents, which included the latest Health Plan for St. Vincent and the Grenadines]

GRENADA
FRIDAY, SEPTEMBER 18, 1998
9.00 a.m.
Welcomed by Ms. Lana McPhail, Permanent Secretary, Ministry of Health. Planned to meet again during the afternoon at 3.35 p.m.

10.00 a.m. - 11.15 a.m.
Met with Dr. Obikoya, Psychiatrist, Rathdune Hospital.

11.15 a.m. - 11.45 a.m.
Met with Ms. Arlene David, Hospital Social Worker.

1.30 p.m. - 2.15 p.m.
Met with Ms. Desire St. Bernard, Legal Draftsman, Ministry of Legal Affairs.

2.30 p.m. - 3.00 p.m.
Meeting at Rathdune Hospital with the following persons:
Mr. Clement Gabriel, Hospital Administrator
Ms. Arlene David, Social Worker
Ms. Bernadette Gittens, Ward Sister, Carlton House
Ms. Joanna Humphrey, Ward Sister, Mount Gay Mental Hospital
Ms. Joycelyn Victor, Ward Sister, Mount Gay Mental Hospital
Mr. Benjamin C. Lewis, Social Worker
Ms. Marcia Hercules, Matron, Richmond Home
Ms. Beryl Williams, Matron, Mount Gay Mental Hospital
Ms. Avis McBurnie, Departmental Sister, Acute Psychiatric Unit, Rathdune Hospital.

3.40 p.m. - 4.15 p.m.
Met with Mr. David Alexander, Drug Avoidance Officer, Ministry of Education.
4:20 p.m. - 4:30 p.m.
Met with Ms. Myrna Lewis, Guidance Counselor, Ministry of Education.

[A 3.35 p.m. appointment with Ms. McPhail, Permanent Secretary, Ministry of Health, had to be
cancelled because of lack of time. This appointment had been scheduled as the final meeting of
[A 3.35 p.m. appointment with Ms. McPhail, Permanent Secretary, Ministry of Health, had to be
cancelled because of lack of time. This appointment had been scheduled as the final meeting of the
day, but serious time constraints occasioned by over-runs on all earlier meetings made it impossible
to meet the 3.35 p.m. time schedule. Ms. McPhail suggested that I telephone her at her home during
the evening, which I did around 9.00 p.m.]

GRENADA
SATURDAY, SEPTEMBER 19, 1998
9:00 a.m. - 11 a.m.
Met with parents of children with emotional problems and the children, at Rathdune. The meeting
was organized by Dr. Obikoya and Ms. A. David.

BRITISH VIRGIN ISLANDS
MONDAY, SEPTEMBER 28, 1998
9:00 a.m. - 9:15 a.m.
Met with Mr. Fahie, Permanent Secretary Ministry of Health and Dr. Potter, Chief Medical Officer.

9:30 a.m. - 10:15 a.m.
Mental Health Officers Mr. Williams, Mr. Farquharson and Ms. Lewis joined the meeting with Dr.
Potter.

10:35 a.m. - 11:00 a.m.
Meeting with Assistant Superintendent Smith of Her Majesty's Prison and Mr. Adrian Stanton,
Registered Mental Nurse at the prison.

11:30 a.m. - 1:00 p.m.
Meeting with Maris Hodge-Wright, Ph.D, Director of Sandy Lane.

2:00 p.m. - 2:45 p.m.
Meeting with Thomas Alexander, Ph.D, Educational Psychologists and Ms. Daniel, Guidance
Counsellor in the Ministry of Education.

3:00 p.m. - 4:00 p.m.
Visit to CADA (the BVI Community Agency on Drugs and Addiction), and met with Ms. Joanne
Penny, Executive Director of CADA.

4:15 p.m. - 4:45 p.m.
Visited the Mental Health Centre where Mental Health Officers Mr. Williams, Mr. Farquharson and
Ms. Lewis showed me around.
BRITISH VIRGIN ISLANDS
TUESDAY, SEPTEMBER 29, 1998
9.30 a.m. - 10.15 a.m.
Met with Ms. Nina O’Neale, Executive Officer, Women’s Desk in Chief Minister’s Office.

11.00 a.m. - 12.30 p.m.
Met with the Hon. Dancia Penn, Attorney General and with Mr. Jallow, the Chief Parliamentary Counsel.

[A tentative schedule for meetings with the Family Support Network and with the Police Department did not come off, due partly to an over-run of time at the 11.00 a.m. meeting].

1.00 p.m. - 1.30 p.m.
Scheduled meeting with key Mental Health Officers and Dr. Potter. [Due to unforeseen circumstances, Dr. Potter was unable to be there]

ANTIGUA
WEDNESDAY, SEPTEMBER 30, 1998
9.00 a.m. - 9.30 a.m.
Meeting with Mr. Mulraine, Chief Medical Officer.

9.30 a.m. - 10.00 a.m.
[The Minister of Health and his Permanent Secretary invited me to meet Senior Health Managers who were assembled at the Ministry for their customary monthly meeting]. Present at the meeting were:
The Hon. Sam R. Aymer, Minister of Health and
Mrs. Barbara Belle, Permanent Secretary
Mrs. Myrna Norde, Principal Assistant Secretary (H&CSA)
Mrs. Marilyn Simon, Hospital Administrator, Holberton
Mr. Edmeade Lake, Acting Chief Health Inspector
Mr. Eric Henry, Administrative Secretary Health Institutions
Mrs. Ivy-Jean Benjamin, Superintendent Public Health Nurses
Ms. Laurel Merchant, Principal Assistant Secretary, Medical Division
Ms. Olive Gardner, Principal Nursing Officer
Mrs. Ruby Gore, Acting Matron, Holberton
Ms. Vernessa Matthew, Acting Chief Training Officer
Ms. Pamela Otto, Senior Administrative Secretary (H&CSA)
Mr. David Matthias, Project Research Officer
[Unsuccessful attempts to get in touch with the Chief Parliamentary Counsel. The day was spent at the Ministry of Health]
ANTIGUA
THURSDAY, OCTOBER 1, 1998
9.00 a.m. - 9.45 a.m.
Discussions with Dr. Mulraine at the Ministry of Health. Attempts to set up meetings unsuccessful because of dislocation caused by aftermath of hurricane Georges.

10.00 a.m. - 10.30 a.m.
Visited the Child and Family Guidance Centre, Holberton Hospital, St. John’s, and had meeting with the Director

10.35 a.m. - 11.30 a.m.
Meeting with Dr. Mathurin Jorgensen and visit to the Mental Hospital.

3.30 p.m. - 4.00 p.m.
Debriefing session with Dr. Mulraine.

Acknowledgement

I want especially to thank Dr. Mulraine, Chief Medical Officer of Antigua, for the meticulous care he took to ensure that my visit was a fruitful one, in spite of the disruption of routines in several areas of the health services due to the recent passage of Hurricane George’s over the island. The widespread lack of telephone services made it difficult to re-schedule meetings, and the problem was compounded by the fact that I arrived a day earlier than he had anticipated. Perhaps for these reasons, Dr. Mulraine undertook to spend more time with me, in discussing the several aspects of the mental health situation of Antigua, than he perhaps would otherwise have done.

I also much appreciated the courtesy of the Honourable Minister of Health, Sam Aymer and of Mrs. Barbara Belle, Permanent Secretary, on Wednesday morning October 1, in inviting me into the monthly meeting of health care personnel held in the Ministry of Health, introducing me to the key persons in the Government’s health care services, and giving me the opportunity to briefly discuss the reason for my visit.

ST. KITTS-NEVIS
MONDAY, FEBRUARY 1, 1999
10.00 a.m. - 10.30 a.m.
Paid courtesy call on Minister of Health and Women’s Affairs, Dr. the Honourable Earl Asim Martin.

10.30 a.m. - 12.30 p.m.
Meeting with:
Permanent Secretary, Ministry of Health and Woman’s Affairs: Mr. Douglas Wattley,
Director of Health Services: Dr. Tissa Wickramasuriya,
Director of Primary Health Care: Dr. Thelma Phillip-Browne,
Health Planner: Ministry of Health, Mr. Elvis Newton.
2.00 p.m. - 4.00 p.m.
Meeting with:
   Permanent Secretary, Legal Affairs: Mrs. Caroline Richardson,
   Legal Draftsman: Mr. Francis Wilson.

ST. KITTS- NEVIS
FEBRUARY 2, 1999

9.00 a.m. - 11.00 a.m.
Meeting with:
   Executive Officer, Women’s Affairs: Miss Sheila Harris
   Mental Health Nurses (Community): Mrs. Cheryl Isaac, Ms. Mavis Frederick, Mrs Carmen Alleyne,
   Mental Health Nurses (Hospital): Miss Michelle Richards, Mr. Michael Henry, Mrs. Naomi Glasford.

11.15 a.m. - 1.30 p.m.
Meeting with:
   Director of Health Services: Dr. Tissa Wickramasuriya,
   Director of Primary Health Care: Dr. Thelma Phillip-Browne,
   Consultant Psychiatrist: Dr. Izben Williams,
   Health Planner: Mr. Elvis Newton.

All meetings were held in the Conference Room of the Ministry of Health.

REPORT ON THE MEETING IN ST. LUCIA, ST. VINCENT AND THE GRENADINES,
GRENADA, BRITISH VIRGIN ISLANDS, ANTIGUA AND BARBUDA, ST. KITTS AND NEVIS

FINDINGS

INTRODUCTION

Travel to St. Lucia, to St. Vincent and the Grenadines, and to Grenada, during the period September 14 - 19, 1998; to the British Virgin Islands, and Antigua, during the period September 27 - October 1, 1998; and to St. Kitts-Nevis on February 1 and 2, 1999, was undertaken under Contractual Services Agreement, No. ASC-98/00051 which mandated the description, analysis and assessment of mental health laws of the Caribbean, specifically in the areas of the promotion of mental health and the prevention of mental disorders.

Part I of this report lists meetings and visits which were arranged by the Ministry of Health of the respective territories and as advised by Dr. Beverley Barnett, Chronic Disease & Health Promotion Advisor, PAHO/WHO. These meetings were with policy makers in the Ministries of Health, as well as care givers at all levels inclusive of psychiatrists, clinical and educational
psychologists, nurses, hospital social workers, teachers of mentally disadvantaged children, persons engaged in drug avoidance programmes at the policy level, and educators and counselors working with drug abusers in detoxification and rehabilitation programmes. Curriculum development in the schools, as well as the courses offered at the primary health care level and in the School of Nursing were also examined from the aspects of mental health promotion. Meetings were also held with representatives of the Ministry of Legal Affairs inclusive of the Legislative Draftsmen. All of the meetings were of central importance, since policy decisions of Governments which are to be successfully implemented through legislation, require input and acceptance by all care givers.

Psychiatric Hospitals: General Comments.

In St. Lucia, St. Vincent and the Grenadines, Grenada, and Antigua, there was uniform acknowledgement that there is need for a greater de-institutionalization process at the respective psychiatric hospitals, a process which would remove from the mental hospitals certain categories of persons who have been institutionalized for a variety of reasons, but who are now able to function outside of the confines of the mental hospital. Such persons include drug abusers; elderly persons exhibiting signs of senile dementia; and persons whose mental illness may at one time have required a period of hospitalization, but who are now capable once more of functioning in the community, provided that they can be monitored on a continuing basis by community psychiatric workers. These psychiatric workers would not only provide the extra-mural counseling so essential for reintegration of the recovering patient into the wider extra-mural social setting, but they would also ensure that prescribed medication is being taken.

The de-institutionalization process is to a large extent retarded by the fact that some patients who are ostracized by their families have no place to go after they have reached a stage at which they can function at home with the aid of medication. With regard to old persons suffering from senile dementia, there are some genuine cases where immediate relatives lack the financial resources and physical facilities to care for them. It was suggested by several persons at the various meetings, that legislation should be introduced to make it mandatory for the close relative of a person who is ready to return home to be responsible for the welfare of that formerly mentally ill person. This responsibility would include ensuring that the medication is taken as specified, and that periodic visits are made to the community mental health clinic for continuing assessment and counselling.

There is no psychiatric hospital in the British Virgin Islands, nor in St. Kitts-Nevis. Mental health officials and senior officers of Her Majesty’s Prison in the B.V.I. feel strongly that a small psychiatric hospital is needed where persons with serious psychoses can be treated. When the behavior of such persons becomes seriously threatening to their own safety and the safety of others, they are sent to Peebles the general hospital which has two “strong-rooms”, but this accommodation is limited and inadequate. Persons with serious and chronic mental illnesses and who require institutional care which is not available in the British Virgin Islands, are sent to the mental hospital in Antigua. Like the British Virgin Islands, St. Kitts-Nevis also lacks a psychiatric hospital, however there has been a psychiatric unit at the general hospital since 1987. Prior to that date there may have been, in St. Kitts-Nevis, a situation similar to that which still pertains in the British Virgin Islands.
Psychiatric hospitals: Specific Meetings.
St. Lucia. Golden Hope. (Sept. 14, 2.30 p.m.)

It was not possible for the Head of the hospital to be present at the meeting. Mr. Lambie, Principle Nursing Officer, deputized effectively in her absence. The meeting was a long one and the persons present were very articulate in identifying what they perceived as the requirements for improvement in the mental health situation in St. Lucia, and which they felt could be addressed by legislation. Main areas of concern addressed at the meeting were that “there is no active de-institutionalization process”, there is need for an occupational therapist, a psychologist, and other specialist staff to pursue rehabilitative work with the patients, and that there is also a need for further training of psychiatric nurses especially in the area of psycho-social counselling skills.

The meeting acknowledged that the Friends of Golden Hope are working towards educating families of the mentally ill specifically, and the public generally, with a view to lessening the tendency to ostracize persons whom has spent time at a psychiatric hospital.

In the context of the training of psychiatric nurses, a Short-Term Cuban Training Program was criticized as being of limited value because of the language difficulty. It was explained, by those who were critical of it, that unlike a formal conference or workshop at which simultaneous translation is the norm, the actuality of working in-the-field was hampered somewhat by communication difficulty, since Cuban bi-lingual competence as is generally acknowledged, was not everywhere apparent. Additionally, the short training period was considered insufficient and decidedly inferior to the one year, or the eighteen-month training formerly provided in Jamaica and in Barbados.

One of the discussants at the meeting spoke of “a malaise in St. Lucia’s administration” which she explained as the tendency of Government to send a person for training who is bonded to return, but who on return is assigned to another department. The result of such re-assignment is that the original need remains unanswered. From the discussion, it was apparent that the reason for the seemingly inequitable situation is that the enhanced qualification resulting from additional training, and the lack of a commensurate post in the department to accommodate the person who returns with a higher qualification, results in that person being reassigned to a post which carries a higher salary and for which she now holds the required qualification. As explained at the meeting “we cannot now, after returning more highly qualified, be expected to continue to work for the same salary as before." The rationale is understandable even if not necessarily plausible.

It is only fair at this point, to state my understanding, from a senior policy maker, that in the Health Sector Reform White Paper which is due for release before the end of the year, recognition will be given to manpower training needs for psychiatric social workers, psychologists, occupational therapists and counselors. It was also pointed out, with frankness, that “the placing of training on the priority list is a competition for scarce resources, it is a whole question of resources which are hard to come by.”
St. Lucia. St. Jude’s General Hospital. (September 15, 2.30 p.m.)

Psychiatrist, Dr. Swamy, explained that the hospital psychiatric services as organized at St. Jude’s, provides hospital care for acute psychotic patients in medical wards much as is provided for any other patient, and this arrangement has decreased the stigma attached to psychiatric illness.

There are also outpatient clinics and emergency room services for patients with complaints requiring psychiatric assessment and management. Such complaints include child abuse (physical; sexual; verbal); drug abuse including alcohol abuse and dependency; suicidal ideas or attempts; acute stress reaction; marital discord or strained relationships; and other cases requiring psychological support and intervention.

The following undertakings aim to prevent serious mental illnesses from developing: (1) ward referrals mainly from Medicine and also from Paediatric, Surgical and Gynaecological Wards; (2) group therapy for substance abusers; (3) out-patients clinics which function as a substitute for confinement in a mental hospital; (4) child guidance clinics; and (5) training programmes developed with the Ministry of Health, Human Services and Family Affairs along with a UNICEF consultant.

With the assistance of the Ministry of Health and a Cuban Delegation who visited earlier in the year, the St. Jude’s Hospital Psychiatric Unit is further developing community based psychiatric and rehabilitation services. Community based services aim to reduce the stigma attached to psychiatric illness and confinement in a mental hospital.

The psychiatric services at St. Jude’s Hospital offers a model on which similar services could be patterned in other territories.

St. Vincent. Mental Health Centre (September 17, 11.00 a.m.)

The visit to the Mental Health Centre (which is the name given to the psychiatric hospital) took the form of a short meeting at which Dr. M.K. Debnath, Senior Registrar (Psychiatry) introduced the hospital’s medical doctor, the Senior Nursing Officer, and two Ward Sisters. A discussion of the physical, administrative and staffing deficiencies was followed by an extensive tour of the hospital.

The tour revealed over-crowded wards in which chronic psychotic patients were housed with drug addicts who were hospitalized because of drug-induced psychoses, and with elderly persons suffering from senile dementia. This state of affairs stems from a lack of physical facilities, which would allow a separation of patients according to the severity and character of their illnesses. There was also a lack of facilities and a shortage of staff to undertake rehabilitative therapies. It was anticipated, however, that a new ward which was then in the process of construction would alleviate the space problem, and would additionally allow a setting more conducive to the rehabilitation of those patients who may benefit from therapy and counselling.
The lack of a half-way house to accommodate persons whose mental illness resulted from the abuse of marijuana and other illegal drugs, meant that on completion of detoxification and return to the community they frequently reverted to their addictive habits of drug abuse. Such persons would be re-admitted to the hospital, and accounted for the largest number of mentally ill persons institutionalized at the centre. A halfway house is necessary to re-introduce the recovering drug addict into society under the guidance of counselors, and the instruction of teachers in life-skills development.

The meeting identified the inadequacies of the physical plant (notwithstanding its idyllic geographical location), and agreed on the need for a psychologist, an occupational therapist, counselors, and an increase in the number of psychiatric nurses. I would like to record, however, that it was very apparent that there is strong empathy, concern and compassion which Dr. Debnath and his staff share with their patients at the Mental Health Centre.

Dr. Debnath’s responsibilities extend to the community mental health centres which operate in several areas of the island as part of the primary health programme. More will be said about these community mental health centres in the appropriate section of this paper.

Grenada. Rathdune Hospital (September 17, 10.00 a.m. and 2.30 p.m.)

At 10.00 a.m. on September 17, a meeting with Psychiatrist, Dr. Obikoya, took place at Rathdune General Hospital which has a Psychiatric Ward where mentally ill persons are treated in surroundings which do not attract the stigma commonly attributed to psychiatric hospitals. Dr. Obikoya spoke enthusiastically of the work which is being done in Grenada at a number of well-organized community mental health centres which have been set up throughout Grenada as part of the primary health care system.

The organization of these community mental health centres is under the direct control of the Psychiatrist who makes periodic visits, and who conducts Group Therapy sessions. The health care workers at these community mental health centres provide counselling services and check to ensure that persons, who have returned to the community after a stay at the hospital, are taking their prescribed medication, and attending counselling sessions.

Dr. Obikoya had done considerable work on preparing a draft of new mental health legislation for Grenada. Brief comments on his draft legislation would not do justice to it, it needs to be read in full.

At 2.30 p.m. on September 17, another meeting was held at Rathdune, at which a number of persons representative of the health care profession were present. These included Rathdune’s Hospital Administrator; the Departmental Sister of the Acute Psychiatric Unit of Rathdune; the Matron and two Ward Sisters of Mount Gay Mental Hospital; Ward Sister of Carlton House (a rehabilitation centre for recovering alcohol and drug abusers); the Matron of the Richmond Home; and Hospital Social Workers.
Lack of sufficient manpower at health-care institutions generally, the need for additional training of nurses in psycho-social counselling skills especially those who work in primary health care and are consequently the first to make contact with persons exhibiting signs of mental illness, and the lack of facilities for the adequate care and treatment of emotionally disturbed children, were identified at the meeting as urgent needs. The solution to these problems require the application of greater financial resources, and cannot be solved by legislative enactments per se.

**British Virgin Islands.** (September 28, 9.30 a.m.)

In attendance at the meeting were Dr. Potter the Chief Medical Officer, and the “Mental Health Team” which is the name given to the three chief mental health officers, Mr. Williams, Mr. Farquharson and Ms. Lewis who are for the most part, nurses with psychiatric training.

There is no psychiatric hospital in the territory, and no resident psychiatrist. Psychiatric services are provided during periodic visits by Dr. Mahy a psychiatrist from Barbados, and by a psychiatrist from the neighboring U.S. Virgin Islands who, during her annual extended vacations to the B.V.I., offers her services in a private capacity.

Persons exhibiting serious psychotic illnesses and who require long-term institutionalization are sent to the psychiatric hospital in Antigua, in accordance with long-standing arrangements between these territories. Dr. Potter revealed that in the foreseeable future there would be a full-time psychiatrist in the territory. He is currently pursuing training overseas under government sponsorship.

At the Peebles General Hospital two “strong rooms” which are used by mentally ill persons who require restraint, were described at the meeting, as inadequate to meet the demand. The increasing incident of drug addiction, which frequently leads to drug-induced psychoses requiring a period of institutionalization during detoxification, has created a problem of some magnitude for the territory since it lacks a psychiatric hospital.

The lack of a psychiatric hospital creates a dilemma in those cases where persons perceived as acting in ways which present a threat to the safety of themselves and of others, and appear in need of institutionalization, may end up at Her Majesty’s Prison because, if Peebles “strong rooms” are in use, there is no where else to take them. These are persons who are, for the most part, drug addicts exhibiting psychoses, and who cannot be adequately treated in the prison.

The opinion of the Mental Health Team is that there is need for a small psychiatric hospital, or of a residential drug rehabilitation centre to provide the treatment facilities needed by these persons.

**Antigua. Holberton Hospital** (Thursday, October 2, 10.00 a.m.)

Dr. Mathurin Jurgensen, Superintendent of the Mental Hospital, shares with her counterparts in Grenada, St. Kitts-Nevis, St. Lucia, and St. Vincent, and with the Mental Health Team in the British Virgin Islands, strong advocacy of the community mental health model which has now been
introduced into all of the territories. The service, in varying degrees in the different territories, reveals the need for further development usually in the context of an increase of social workers with training in psycho-social counselling.

Community mental health is an integral part of the primary health care services, and it is therefore essential that those healthcare workers who are among the first persons to interact with the public, must be trained to recognize the signs of mental disorders, as well as to promote mental well-being through effective counselling to families, school children, women's organizations, and community groups of all kinds. Community mental health centres should also be organized and staffed to provide occupational therapy and psychotherapy group sessions to recovering drug addicts, physically and mentally abused persons, and such other category of persons who may be in need of such services.

It is important to be aware that community mental services, which depend on a sufficient number of trained psychologists, psychiatric social workers, counselors, and nurses with training in psycho-social counselling to ensure its success, is aimed not only at rehabilitation, but also at the promotion of mental health and the prevention of mental illnesses.

During the visit to the Holberton Mental Hospital, I toured a new building in the final stages of construction, into which those chronically mentally ill persons who require a permanently secure environment will be relocated. Input into the architectural design was made by Dr. Mathurin Jergenson to ensure that a sense of connection with the outdoors is maintained through the presence of an internal courtyard to which the residents of the building would have access.

Notwithstanding the emphasis on community mental health and the move away from institutionalization, it is not unreasonable to recognize that there will continue to be the need for residential care for severely mentally ill patients. The architectural design of this new ward at the Holberton Hospital is an attractive model, which could be adopted by other territories when in due course the further development of the community mental health model makes it desirable to replace the traditional large and sombre structures with smaller units.

**St. Kitts-Nevis.** (Monday & Tuesday, February 1 & 2, 1999)

Hurricane Georges of September 1998 had destroyed the psychiatric ward of the general hospital, causing patients to be temporarily housed in shared accommodation within another ward of the hospital. I did not visit the hospital. Understandably, as explained at the initial meeting, the temporary situation is far from ideal, fortunately funding has been obtained for the re-building of a small psychiatric facility attached to the hospital.

It is my impression that my visit to St. Kitts was regarded as a natural progression from a visit made to that territory in early 1998 by Dr. Levav of PAHO Washington when he made a study of the mental health situation in the island, and recommended that new mental health legislation was needed, among other things. Following from this emphasis, then, it was entirely appropriate that the following three documents should form the basis of meetings held with representatives of the mental health field in the territory: (1) *Mental Health Models for the Caribbean, Caribbean Community
Secretariat. Twelfth Meeting of the Conference of Ministers Responsible for Health, Bridgetown, Barbados, 16-20 July, 1990. (CMH 90/12/12); (2) Mental Health Policy Proposals for St. Christopher and Nevis, formulated by Izben C. Williams M.D., D.M. Psych. (ICW/October 1994); (3) Draft Mental Health Bill, St. Christopher and Nevis, [undated].

The emphasis during the St. Kitts-Nevis visit was on examining the territory’s draft Bill for a new Mental Health Act to replace the current Lunacy and Mental Treatment Act. The views of the participants at the 10.00 a.m. meeting on February 1, and at the 11.00 a.m. meeting of February 2, concurred with those expressed in Dr. Obikoya’s paper (reproduced in Appendix B), and consequently shall not be restated here. A 1994 project report entitled A Survey of Patients and Services and Strategies for Developing a Comprehensive Mental Health Program in St. Kitts-Nevis, prepared by Dr. Izben Williams, Consultant Psychiatrist, and made available to me at the end of the meetings, offers similar critical comment on the St. Kitts-Nevis mental health legislation which Dr. Williams rightly views as bearing “little relevance to present day circumstances or to current understanding of psychiatric disorders.” Dr. Williams also offers a brief critique of the draft bill, and acknowledges that it “does reflect some enlightened views” of which he gives examples. He recommends, however, that some fundamental alterations should be considered before it is enacted.

Mental Health Promotion: General Comments.

Health care policy makers in all of the territories visited were intensely aware of their responsibilities to ensure that “health” as enunciated in the WHO Charter was concerned as much with the prevention of mental illness as it is with the curing of disorders. Indeed, the Antigua Health Policy 1997 could well be speaking for all of the territories in its claim that “Health services delivery ... has to do with well-being and not merely with illness, so that the health services should always be concerned with wellness and the prevention of disease even as it is concerned with illness and the curing of disorders as they occur” and in its policy goal that “Emphases will be placed on community participation in the promotion of healthy lifestyles” among other things. [See document: Health Policy. Government of Antigua and Barbuda. (Ministry of Health and Civil Service Affairs, St. John’s, Antigua, February 1997)]

Psycho social problems of domestic violence, child abuse, and substance abuse, as well as provisions made for mentally disadvantaged children and for persons with physical disabilities, are all of relevance in the context of mental health promotion. With this in mind, visits were made to organizations, which can be characterized as being concerned with the promotion of mental health, even though such organizations may not have articulated their objective in those exact words.

The organizations visited provided services to women who are victims of domestic violence; to children experiencing physical or emotional abuse; to persons recovering from substance abuse; with the ultimate objective of the psycho-social development of the individual and his/her reintegration into the community as an emotionally and mentally healthy individual. These organizations provide counselling and rehabilitation services based on occupation therapy and psychotherapy, and such other modalities as would assist the achievement of mental well-being. Education in basic life skills is also an important part of the work of several of them.

Some of these organizations are in receipt of government subventions, although a number of them are non-governmental organizations funded by international funding agencies, with assistance from regional and local sources. Visits paid to the organizations noted in this report were with the objective of assessing the legislation under which they currently operated, or alternatively, to see in what ways a legislative framework would assist their further development.

**Mental Health Promotion**

**The Child and Family Guidance Centre, Antigua.** (October 2, 1998)

The Centre is managed by the Collaborative Committee for the Promotion of Emotional Health in Children (CCOPE), a local non-profit organization “comprising of a group of concerned professionals” as stated in the descriptive brochure provided by the Centre. It provides services to children who have suffered physical or emotional abuse, or who are exposed to situations that may cause such problems. Services include evaluation, diagnosis and treatment of children with emotional problems; public information and education, and community sensitization; training and counselling of parents and other care givers; psychological assessment; referrals to other agencies; and educational assessment.

Referrals to the Centre may be made by doctors, nurses and other health personnel, teachers, parents and guardians, the Clergy, and youth and community leaders. An initial fee of between $5.00 and $25.00 is charged for in initial consultation and evaluation and additional fees may be charged for special treatment programmes. However, no one is denied services because of inability to pay.

The Centre receives assistance from Government through the Ministries of Health and Education. It also receives funds from international, regional and local donor agencies and from individual benefactors.

**The Optimum Garden Centre for Abused Girls, St. Lucia** (September 15, 1998)

Ms. Prisca St. Paul, Director of the Centre, spoke with enthusiasm and concern about the Centre. She spoke with enthusiasm about the fine work the Centre is doing in providing counselling for abused children, for women who had suffered from domestic violence, and for pregnant teenagers who are frequently in need of emotional counselling. She expressed concern about the lack of a permanent place dedicated to certain programmes, which needed physical amenities for their operation.
Assistance has been rendered from time to time, to the Centre, by Peace Corps Volunteers, and a Government subvention assists in classes in social skills training. The Director of the Centre pointed out the need of field workers to do follow-up work and to assist in counselling.

**Turning Point, the Alcohol and Drug Detoxification and Rehabilitation Centre, St. Lucia (September 14, 1998)**

This is an impressive facility. The Director, Mr. Bruce Phillips spoke enthusiastically and in detail about its organization, administration, management, programmes and services; produced for my perusal, several documents and files relating to the various services offered; and gave me a detailed tour of the facility which he described as providing an environment of short-term care to chronic persons who are unable to abstain outside of a controlled environment.

File documents described the detoxification programme as providing 24-hour care and services under medical direction for the treatment of present or anticipated alcohol withdrawal syndrome and withdrawal from other chemicals such as cocaine. It also performs evaluation and treatment of concurrent physical injuries and illness, and linkage of clients to ongoing chemical dependence and alcoholism treatment and rehabilitation services.

The goals and objectives of the rehabilitation programme can be summarized as the acceleration of recovery from alcoholism or chemical dependency through intensive professional services designed to improve physical and emotional health, promote spiritual growth, and make social adjustments towards a chemical free lifestyle.

In order to increase service utilization, high risk groups are reached through continuous dialogue and networking with other service systems such as schools, health, correction, law enforcement, and other social service agencies. High risk groups include: (1) Youth abusing alcohol alone or in combination with other substances; (2) Occupational alcoholics in Civil Service employment and in industry; (3) Individuals charges with “Driving while intoxicated” (DWI); (4) Women alcohol and substance abusers; (5) General hospital and psychiatric hospital populations. [Stated in document headed “Target Population”].

Its information brochure states that “The Centre was established in May 1988, the result of a major collaborative effort between the friends of Golden Hospital, the Government of St. Lucia, and from financial contributions from nationals (individuals, groups, and businesses) and aid from international donor agencies. ... Fees are based on the standard fee schedule for all Government institutions. No person will be denied treatment for either social or financial reason and management is always willing to make arrangements for payment during the aftercare period. The current fee is E.C. $50.00 per day. This includes accommodation and meals.”

**Sandy Lane, British Virgin Islands (September 28, 1998)**

This facility which is managed by Dr. Maris Hodge-Wright, a qualified Counselling Psychologist, operates under the aegis of the Ministry of Health and Welfare. It is essentially an educational-cum-counselling facility, which aims at the rehabilitation of recovering abusers of
alcohol and marijuana mainly, and their re-integration into society. Equal emphasis is also placed on counselling young persons and women who have been emotionally traumatized by sexual and emotional abuse. It’s clientele comprises mainly young persons between the ages of fourteen and twenty-five who attend daily sessions 8.45 a.m. - 4.15 p.m., and who on registration must seriously promise to attend daily, to remain drug-free during their attendance at Sandy Lane, and to refrain from certain modes of behaviour which would jeopardize their recovery and re-integration into society.

The Sandy Lane programme of 5 to 6 weeks duration, is structured into holistic modules covering such topics as nutrition, group therapy, recreational therapy, occupational therapy, counselling, family relationships, and basic life skills training (with included such subjects as, for example, personal hygiene, budgeting and food preparation, and stress management). Subjects such as “Addiction and Mental Health” and “Emotions and Facing the Community” are examined in some detail in formal class-room settings.

It was pointed out at the meeting with Dr. Hodge-Wright that since Sandy Lane is not structured to cater to drug abusers who are currently suffering from drug-induced psychoses, there is a great need for a residential detoxification/rehabilitation unit in the territory, as well as a half-way house, to complement the work of Sandy Lane. Rationale for a half-way house is set out in *Proposal of Half-Way House for Dual Diagnosed Clients*, prepared by Dr. Maris Hodge-Wright (and others).

Dr. Hodge-Wright is also concerned that there “is no legislation to remove children from their mothers for safe-keeping”. Situations have come to her attention of children who have been seriously abused by their mothers. She advocates that legislation be enacted which would provide that, where a mother is found to be mentally incompetent to care for her child, that mother should be compelled to give the child up to a care giver who can ensure that child’s healthy development.

Other concerns voiced by Dr. Hodge-Wright are: (1) that the law be revised to enable cases concerning the sexual abuse of a child, to be held in private in order to safeguard the child victim from the additional trauma of an open court hearing; (2) that there is an urgent need for additional counselors, for additional training of counselors “already on the ground”, and for an occupational therapist at Sandy Lane; and (3) that part-time instructors in such things as shoe repair, fabric design, local handicrafts, and other skills be acquired to provide Sandy Lane graduates with some means of livelihood on completion of the programme (since many of them have no work history).

**CADA: Community Agency on Drugs & Addiction, British Virgin Islands (September 28, 1998)**

A meeting was held with Ms. Joanne Penney, Executive Director of CADA, a non-governmental organization established in 1981 to help with drug prevention work, and which now plays an important part in the integration of Demand Reduction Strategies by working in partnership with other public/private sector agencies.
Ms. Penney spoke about CADA’s work in educating people about drugs; in providing assessment, counselling and treatment referral services through the Phone Line and Employee Assistance Programmes (EAP); in encouraging the use of and support for the BVI Government’s drug treatment and rehabilitative facility, the Sandy Lane Centre; and in sitting on the National Drugs Advisory Council in revising and implementing the Drug Policy Master Plan.

CADA describes itself as a voluntary, non-profit, non-governmental, national organization, largely funded by community donations. Membership is comprised of individuals, corporations, service clubs, government and non-governmental organizations [For fuller description, including information on its benefactors, patrons, special supporters, and friends, see CADA Fifteenth Anniversary 1981-1996. Road Town, Tortola, 1996]

Expiating on the readily acceptable theme that (in her words) “Drug Prevention is Health Promotion” Mrs. Penney mentioned that recidivism could largely be reduced if there were a half-way house in the B.V.I. She would also like to see greater emphasis placed on education and treatment of drug abusers, on equal par with law enforcement. CADA had been fortunate in obtaining UNDCP funding to assist in writing a curriculum on drug education for the schools, and the organization has also contributed to discussions on mental health coverage in Group Insurance policies. CADA is advocating recognition that addiction is a disease and should be covered and treated as such in health insurance policies.

Marion House, St. Vincent (September 17, 1998)

Marion House is a non-governmental organization founded in 1989 as a joint response to community needs by the Roman Catholic Church in St. Vincent and the National Children’s Home, a U.K. agency with headquarters in Barbados. Today, it is, additionally, also in receipt of funding from local benefactors and from the Government.

Some of Marion House’s programmes are clearly characterized in their titles, as for example the Young Parents Empowerment Programme, and the Youth Assistance Programme. The former seeks to empower parents to take more control of their lives and greater responsibility for the development of their children. Some of its basic components are stated as “Discipline and child abuse prevention”, “Budgeting and nutrition”, “Family relationships” and “Backyard gardening”. The Youth Assistance Programme has the goal of offering “a comprehensive programme to young unemployed persons aimed at increasing their employability and independence”. Apprenticeship and skills training, adult educations, and, career guidance, figure prominently among its components.

Another important programme is The Right Step, which is described as “a rehabilitative programme for those struggling with alcohol and drug abuse”. Its components include group therapy, individual counselling, family therapy, and addiction and recovery education. Additional funding for its counselling services, and also for the realization of its community outreach goal to decentralize Marion House’s activities within rural communities, would be well used. Marion House is a non-residential facility which is open from 8.00 a.m. to 4.00 p.m. and during these hours there is always a contact person available to answer call from persons in need of the services they offer.
Drug Avoidance Secretariat, Ministry of Education, Grenada (September 18, 1998)

The Drug Avoidance Secretariat was established in the Ministry of Education in 1989 to carry out the administrative duties of the National Drug Avoidance Committee which was first appointed in 1986, and re-appointed in 1988 with a mandate by Government to “shape policies and oversee the implementation of action programmes aimed at reducing the demand for drugs in our society.” At the meeting with Mr. David Alexander, Drug Avoidance Officer in the Ministry of Education, the discussion centered on efforts by the Grenada Government to deal with the increasing incidents of drug abuse in the territory. It is widely recognized that the use of illicit drugs frequently results in mental disorders, and this being the case, the eradication of drug abuse must be recognized as an essential aspect of health promotion and the prevention of mental illness.


The Master Plan identifies the four treatment/rehabilitation institutions, namely: (1) Carlton House, which offers six weeks of treatment and rehabilitation for alcohol, cocaine and marijuana addicts, followed by a limited out-patient and home visiting service; (2) the Rathdune Psychiatric Unit at the General Hospital which provides short-term care for patients with psychiatric disorders including acute drug-use problems, and which also serves as a detoxification unit; (3) Mt. Gay Mental Hospital which provides long-term stay for patients with prolonged psychiatric disorders including drug-related psychoses; and (4) Grand Bacolet Rehabilitation Centre, established in 1992 jointly by the Government of Grenada and the Richmond Fellowship of England to provide services for young persons mainly under 20 years of age who encounter problems with the law such as petty crimes and illicit drug use.

The importance of education is aptly stated in the following excerpts have been taken from the Master Plan: (1) Reducing local drug consumption through prevention and education is increasingly accepted as the only sustainable and economical justified method to control and restrain illicit drug trafficking; (2) Critical to the success of the primary prevention aspects of the programme will be the ability of the programme to influence the drug related behavior and attitude of the school aged population; (3) School personnel will be informed of the nature and scope of the drug problem (holistic view; impact on the social and economical development of the country), so as to get them motivated to participate actively in the school prevention programme; (4) An enhanced on-going extra curricular programme within the school of selected communities involving sporting, cultural and community activities; promoting healthy life-styles through participation in co-curricular and extra-curricular activities, and creation of inter-peer students counselling groups.
The Master Plan also gives information on the various international Conventions and Regional Agreements to which Grenada is signatory, and which aim at the control of illicit drugs. Among them are the Maritime Counter-Drug Agreement, also known as the Ship-Rider Agreement, which was entered into by the United States of America and Grenada on May 16, 1995 (and amended on November 26, 1996); and the Hemispheric Anti-Drug Strategy agreed to by Grenada and the Organization of American States (OAS) on March 25, 1997 and the following two United Nations Conventions: the 1971 Convention on Psychotropic Substances, and the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.
PART VI: REFERENCES


ANNEX A

DECLARATION OF CARACAS

The following Declaration was adopted by acclamation on 14 November 1990 by the Regional Conference on Restructuring Psychiatric care in Latin America, which was held in Caracas, 11-14 November 1990, under the auspices of the Pan American Health Organization/WHO Regional Office for the Americas:

"The legislators, associations, health authorities, mental health professionals, and jurists assembled at the Regional Conference on the Restructuring of Psychiatric Care in Latin America within the Local Health Systems Model.

Noting

1. That conventional psychiatric services do not allow for attainment of the objectives entailed in community-based care that is decentralized, participatory, integrated, continuing, and preventive;

2. that the mental hospital, when it is the only form of psychiatric care provided, hampers fulfilment of the foregoing objectives in that it:

(a) isolates patients from their natural environment, thus generating greater social disability;

(b) creates unfavourable conditions that imperil the human and civil rights of patients;

(c) absorbs the bulk of financial and human resources allotted by the countries for mental health care;

(d) fails to provide professional training that is adequately geared to the mental health needs of the population, the general health services, and other sectors.

Considering

1. That Primary Health Care is the strategy that has been adopted by WHO and PAHO and endorsed by all the Member States as the means for attaining the goal of Health for all by the Year 2000;

2. that the Local Health Systems model has been implemented by the countries of this Region as the means for reaching that target through the provision of better conditions for the development of programs that are based on the health needs of the population and that emphasize decentralization, social participation, and the preventive approach;

3. that mental health and psychiatric programs must incorporate the principles and guidelines on which these strategies and models of health care delivery are based,
DECLARE

1. That the restructuring of psychiatric care on the basis of Primary Health Care and within the framework of the Local Health Systems model will permit the promotion of alternative service models that are community based and integrated into social and health networks.

2. That the restructuring of psychiatric care in the Region implies a critical review of the dominant and centralizing role played by the mental hospital in mental health service delivery.

3. That the resources, care, and treatment that are made available must:
   (a) safeguard personal dignity and human and civil rights;
   (b) be based on criteria that are rational and technically appropriate; and
   (c) strive to ensure that patients remain in their communities.

4. That national legislation must be redrafted if necessary so that:
   (a) the human and civil rights of mental patients are safeguarded; and
   (b) that the organization of the services guarantees the enforcement of these rights.

5. That retaining in mental health and psychiatry should use a service model that is based on the community health center and encourages psychiatric admissions in general hospitals, in accordance with the principles that underlie the restructuring movement.

6. That the organizations, associations, and other participants in this Conference hereby undertake to advocate and develop programs at the country level that will promote the restructuring desired, and at the same time that they commit themselves to monitoring and defending the human rights of mental patients in accordance with national legislation and international agreements.

   To this end, they call upon the Ministries of Health and Justice, the Parliaments, social Security and other care-providing institutions, professional organizations, consumer associations, universities and other training facilities, and the media to support the restructuring of psychiatric care, thus assuring its successful development for the benefit of the population in the Region.”
ANNEX B


Application

These principles shall be applied without discrimination of any kind such as on grounds of disability, race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, legal or social status, age, property or birth.

Definitions

In the present Principles:

“Counsel” means a legal or other qualified representative;

“Independent authority” means a competent and independent authority prescribed by domestic law;

“Mental health care” includes analysis and diagnosis of a person’s mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness;

“Mental health facility” means any establishment, or any unit of an establishment, which as its primary function provides mental health care;

“Mental health practitioner” means a medical doctor, clinical psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care;

“Patient” means a person receiving mental health care and includes all persons who are admitted to a mental health facility;

“Personal representative” means a person charged by law with the duty of representing a patient’s interests in any specified respect or of exercising specified rights on the patient’s behalf, and includes the parent or legal guardian of a minor unless otherwise provided by domestic law;

“The review body” means the body established in accordance with principle 17 to review the involuntary admission or retention of a patient in a mental health facility.
Principle 1

Fundamental freedoms and basic rights

1. All persons have the right to the best available mental health care, which shall be part of the health and social care system.

2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.

3. All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.

4. There shall be no discrimination on the grounds of mental illness. "Discrimination" means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion or preference undertaken in accordance with the provisions of the present Principles and necessary to protect the human rights of a person with a mental illness or other individual.

5. Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.

6. Any Decision that, by reason of his or her mental illness, a person lacks capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is at issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.

7. When a court or other competent tribunal finds that a person with a mental illness is unable to manage his or her own affairs, measures shall be taken, as far as is necessary and appropriate to that person's condition, to ensure the protection of his or her interests.
Principle 2
Protection of Minors

Special care shall be given within the purposes of the Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including, if necessary, the appointment of a personal representative other than a family member.

Principle 3
Life in the community

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

Principle 4
Determination of a mental illness

1. Determination that a person has a mental illness shall be made in accordance with internally accepted medical standards.

2. A determination of mental illness shall never be made on the basis of political, economic or social status, or membership in a cultural, racial or religious group, or for any other reason not directly relevant to mental health status.

3. Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person’s community, shall never be a determining factor in the diagnosis of mental illness.

4. A background of past treatment or hospitalization as a patient shall not in itself justify any present or future determination of mental illness.

5. No person or authority shall classify a person as having, or otherwise indicate that a person has, a mental illness except for purposes directly relating to mental illness or the consequence of mental illness.

Principle 5
Medical examination

No person shall be compelled to undergo medical examination with a view to determining whether or not he or she has a mental illness except in accordance with a procedure authorized by domestic law.
Principle 6
Confidentiality

The right to confidentiality of information concerning all persons to whom the present principles apply shall be respected.

Principle 7
Role of community and culture

1. 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.

2. Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible.

3. Every patient shall have the right to treatment suited to his or her cultural background.

Principle 8
Standards of care

1. Every patient shall have the right to receive such health and social care as is appropriate to his or her needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.

2. Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or other acts causing mental distress or physical discomfort.

Principle 9
Treatment

1. Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient’s needs and the need to protect the physical safety of others.

2. The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.

3. Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics relevant to the role of health personnel, particularly physicians. Mental health knowledge and skills shall never be abused.
4. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

**Principle 10**

**Medication**

1. Medication shall meet the best health needs of the patient, shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others. Subject to the provisions of paragraph 15 of principle 11 below, mental health practitioners shall only administer medication of known or demonstrated efficacy.

2. All medication shall be prescribed by a mental health practitioner authorized by law and shall be recorded in the patient’s records.

**Principle 11**

**Consent to treatment**

1. No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principles.

2. Informed consent is obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:
   
   (a) The diagnostic assessment;
   
   (b) The purpose, method, likely duration and expected benefit of the proposed treatment;
   
   (c) Alternative modes of treatment, including those less intrusive;
   
   (d) Possible pain or discomfort, risks and side-effects of the proposed treatment.

3. A patient may request the presence of a person or persons of the patient’s choosing during the procedure for granting consent.

4. A patient has the right to refuse or stop treatment, except as provided for in paragraphs 6, 7, 8, 13 and 15 of the present principle.

5. A patient shall never be invited or induced to waive the right to informed consent. If the patient should seek to do so, it shall be explained to the patient that the treatment cannot be given without informed consent.

6. Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 of the present principle, a proposed plan of treatment may be given to a patient without a patient’s informed consent if the following conditions are satisfied:
(a) The patient is, at the relevant time, held as an involuntary patient;

(b) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 of the present principle, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic law so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent;

(c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.

7. Paragraph 6 does not apply to a person with a personal representative empowered by law to consent to treatment for the patient; but, except as provided in paragraphs 12, 13, 14 and 15 of the present principle, treatment may be given to such a patient without his or her informed consent if the personal representative, having been given the information described in paragraph 2 of the present principle, consents on the patient's behalf.

8. Except as provided in paragraphs 12, 13, 14 and 15 of the present principle, treatment may also be given to any patient without the patient's informed consent if a qualified medical health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.

9. Where any treatment is authorized without the patient's informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.

10. All treatment shall be immediately recorded in the patient's medical records, with an indication of whether involuntary or voluntary.

11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period, which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A person who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

12. Sterilization shall never be carried out as a treatment for mental illness.
13. A major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the needs of the patient and where the patient gives informed consent, except that, where the patient is unable to give informed consent, the procedure shall be authorized only after independent review.

14. Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given informed consent and an independent and external body has satisfied itself that there is a genuine informed consent and that the treatment best serves the health needs of the patient.

15. Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose.

16. In the cases specified in paragraphs 6, 7, 8, 13, 14 and 15 of the present principle, the patient or his or her personal representative, or any interested person, shall have the right to appeal to a judicial or other independent authority concerning any treatment given to him or her.

**Principle 12**

*Notice of rights*

1. A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with the present Principles and under domestic law, and the information shall include an explanation of those rights and how to exercise them.

2. If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient’s interests and willing to do so.

3. A patient who has the necessary capacity has the right to nominate a person who should be informed on his or her behalf, as well as a person to represent his or her interests to the authorities of the facility.

**Principle 13**

*Rights and conditions in mental health facilities*

1. Every person in a mental health facility shall, in particular, have the right to full respect for his or her:
   (a) Recognition everywhere as a person before the law;
   (b) Privacy;
(c) Freedom of communication, which includes freedom to communicate with other persons in the facility; freedom to send and receive uncensored private communications; freedom to receive, in private, visits from a counsel or personal representative and, at all reasonable times, from other visitors; and freedom of access to postal and telephone services and to newspapers, radio and television;

(d) Freedom of religion or belief.

2. The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age and in particular shall include:

(a) Facilities for recreation and leisure activities;

(b) Facilities for education;

(c) Facilities to purchase or receive items for daily living, recreation and communication;

(d) Facilities, and encouragement to use such facilities, for a patient’s engagement in active occupation suited to his or her social and cultural background, and for appropriate vocational rehabilitation measures to promote reintegration in the community. These measures shall include vocational guidance, vocational training and placement services to enable patients to secure or retain employment in the community.

3. In no circumstances shall a patient be subject to forced labour. Within the limits compatible with the needs of the patient and with the requirements of institutional administration, a patient shall be able to choose the type of work he or she wishes to perform.

4. The labour of a patient in a mental facility shall not be exploited. Every such patient shall have the right to receive the same remuneration for any work which he or she does as would, according to domestic law and custom, be paid for such work to a non-patient. Every patient shall, in any event, have the right to receive a fair share of any remuneration which is paid to the mental health facility for his or her work.

**Principle 14**

**Resources for mental health facilities**

1. A mental health facility shall have access to the same level of resources as any other health establishment, and in particular:

(a) Qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy;
(b) Diagnostic and therapeutic equipment for the patient;
(c) Appropriate professional care;
(d) Adequate, regular and comprehensive treatment, including supplies of medication.

2. Every mental health facility shall be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment and care of patients comply with the present Principles.

Principle 15
Admission Principles

1. Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission.

2. Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness.

3. Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or her retention as an involuntary patient, as set forth in principle 16 below, apply, and he or she shall be informed of that right.

Principle 16
Involuntary admission

1. A person may be admitted involuntarily to a mental health facility as a patient or, having already been admitted voluntarily as a patient, may be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines, in accordance with principle 4 above, that person has a mental illness and considers:

(a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or

(b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.
In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs.

3. Involuntary admission or retention shall initially be for a short period as specified by domestic law for observation and preliminary treatment pending review of the admission or retention by the review body. The grounds of the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall also be communicated promptly and in detail to the review body, to the patient’s personal representative, if any, and, unless the patient objects, to the patient’s family.

4. A mental health facility may receive involuntarily admitted patients if the facility has been designated to do so by a competent authority prescribed by domestic law.

Principle 17

Review Body

1. The review body shall be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law. It shall, in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account.

2. The initial review of the review body, as required by paragraph 2 of principle 16 above, of a decision to admit or retain a person as an involuntary patient shall take place as soon as possible after that decision and shall be conducted in accordance with simple and expeditious procedures as specified by domestic law.

3. The review body shall periodically review the cases of involuntary patients at reasonable intervals as specified by domestic law.

4. An involuntary patient may apply to the review body for release or voluntary status, at reasonable intervals as specified by domestic law.

5. At each review, the review body shall consider whether the criteria for involuntary admission set out in paragraph 1 of principle 16 above are still satisfied, and, if not, the patient shall be discharged as an involuntary patient.

6. If at any time the mental health practitioner responsible for the case is satisfied that the conditions for the retention of a person as an involuntary patient are no longer satisfied, he or she shall order the discharge of that person as such a patient.

7. A patient or his personal representative or any interested person shall have the right to appeal to a higher court against a decision that the patient be admitted to, or be retained in, a mental health facility.
Principle 18

*Procedural Safeguards*

1. The patient shall be entitled to choose and appoint a counsel to represent the patient as such, including representation in any complaint procedure or appeal. If the patient does not secure such services, a counsel shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.

Principle 19

*Access to Information*

1. A patient (which term in the present Principle includes a former patient) shall be entitled to have access to the information concerning the patient in his or her health and personal records maintained by a mental health facility. This right may be subject to restrictions in order to prevent serious harm to the patient’s health and avoid putting at risk the safety of others. As domestic law may provide, any such information not given to the patient should, when this can be done in confidence, be given to the patient’s personal representative and counsel. When any of the information is withheld from a patient, the patient or the patient’s counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.

2. Any written comments by the patient or the patient’s personal representative or counsel shall, on request, be inserted in the patient’s file.

Principle 20

*Criminal Offenders*

1. The present Principle applies to persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness.

2. All such persons shall receive the best available mental health care as provided in principle 1 above. The present Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances. No such modifications and exceptions shall prejudice the person’s rights under the instruments noted in paragraph 5 of principle 1 above.

3. Domestic law may authorize a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such person be admitted to a mental health facility.

4. Treatment of persons determined to have a mental illness shall in all circumstances be consistent with principle 11 above.
Principle 21

Complaints

Every patient and former patient shall have the right to make a complaint through procedures as specified by domestic law.

Principle 22

Monitoring and Remedies

States shall ensure that appropriate mechanisms are in force to promote compliance with the present Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient.

Principle 23

Implementation

1. States shall implement the present Principles through appropriate legislative, judicial, administrative, educational and other measures, which they shall review periodically.

2. States shall make the present Principles widely known by appropriate and active means.

Principle 24

Scope of Principles relating to mental health facilities

The present Principles apply to all persons who are admitted to a mental health facility.

Principle 25

Saving of existing rights

There shall be no restriction upon or derogation from any existing rights of patients, including rights recognized in applicable international or domestic law, on the pretext that the present Principles do not recognize such rights or that they recognize them to a lesser extent.

X III WORLD PSYCHIATRIC ASSOCIATION APPROVES DECLARATION OF MADRID
(25 AUGUST 1996)

The General Assembly of the World Psychiatric Association, meeting in Madrid, approved the following Declaration on 25 August 1966:
In 1977 the World Psychiatric Association approved the Declaration of Hawaii, setting out ethical guidelines for the practice of psychiatry. The Declaration was updated in Vienna in 1983. To reflect the impact of changing social attitudes and new medical developments on the psychiatric profession, the World Psychiatric Association has once again examined and revised these ethical standards.

Medicine is both a healing art and a science. The dynamics of this combination are best reflected in psychiatry, the branch of medicine that specializes in the care and protection of those who are ill and infirm because of a mental disorder or impairment. Although there may be cultural, social, and national differences within and between countries, the need for ethical conduct and continual review of ethical standards is universal.

As practitioners of medicine, psychiatrists must be aware of the ethical implications of being a physician and of the specific ethical demands of the specialty of psychiatry. As members of society, psychiatrists must advocate fair and equal treatment of the mentally ill, social justice and equity for all.

Ethical behavior is based on the psychiatrists’ individual sense of responsibility towards the patient and their judgment in determining what is correct and appropriate conduct. External standards and influences such as professional codes of conduct, the study of ethics, or the rule of law by themselves will not guarantee the ethical practice of medicine.

Psychiatrists should at all times, keep in mind the boundaries of the psychiatrist-patient relationship and be guided primarily by respect for patients and concern for their welfare and integrity.

It is in this spirit that the World Psychiatric Association approved the following guidelines concerning ethical standards that should govern the conduct of psychiatrists worldwide:

1. Psychiatry is a medical discipline concerned with the provision of the best treatment for mental disorders, with the rehabilitation of individuals suffering from mental illness and with the promotion of mental health. Psychiatrists serve patients by providing the best therapy available and consistent with accepted scientific knowledge and ethical principles. Psychiatrists should devise therapeutic interventions that are the least restrictive to the freedom of the patient and seek advice in areas of their work about which they do not have primary expertise. While doing so, psychiatrists should be aware of and concerned with the equitable allocation of health resources.

2. It is the duty of psychiatrists to keep abreast of scientific developments of the speciality and to convey updated knowledge to others. Psychiatrists trained in research should seek to advance the scientific frontiers of psychiatry.
3. The patient should be accepted as a partner by right in the therapeutic process. The therapist-patient relationship must be based on mutual trust and respect to allow the patient to make free and informed decisions. It is the duty of psychiatrists to provide the patient with relevant information so as to empower the patient to come to a rational decision according to his or her personal values and preferences.

4. When the patient is incapacitated and unable to exercise proper judgement because of a mental disorder, the psychiatrists should consult with the family and, if appropriate, seek legal counsel to safeguard the human dignity and the legal rights of the patient. No treatment should be provided against the patient’s will, unless withholding treatment would endanger the life of the patient and/or those who surround him or her. Treatment must always be in the best interest of the patient.

5. When psychiatrists are requested to assess a person, it is their duty to inform the person being assessed about the purpose of the intervention, about the use of the findings, and about the possible repercussions of the assessment. This is particularly important when the psychiatrists are involved in third party situations.

6. Information obtained in the therapeutic relationship should be kept in confidence and used only for the purpose of improving the mental health of the patient. Psychiatrists are prohibited from making use of such information for personal reasons, or for financial or academic benefits. Breach of confidentiality may only be appropriate when serious physical or mental harm to the patient or to a third person could ensue if confidentiality were maintained; in these circumstances, psychiatrists should whenever possible, first advise the patient about the action to be taken.

7. Research that is not conducted in accordance with the canons of science is unethical. Research activities should be approved by an appropriately constituted ethical committee. Psychiatrists should follow national and international rules for the conduct of research. Only individuals properly trained for research should undertake or direct it. Because psychiatric patients are particularly vulnerable research subjects, extra caution should be taken to safeguard their autonomy as well as their mental and physical integrity. Ethical standards should also be applied in the selection of population groups, in all types of research including epidemiological and sociological studies and in collaborative research involving other disciplines or several investigating centers”.

(INTERNATIONAL DIGEST OF HEALTH LEGISLATION, 1991. 48(2). PP. 240-241.)
ANNEX C: DRAFT CHARTER FOR PATIENT RIGHTS

Access

Each person has the right to equal and timely access to health staff and facilities regardless of their age, race, religion, gender, perceived class, political or other affiliations.

Respect

Any person seeking health care has the right to the respect and dignity accorded to any other person, anywhere else in the community.

Confidentiality

Each person has a legal right to privacy. Privacy includes information obtained from a patient whether it pertains to history, physical signs or investigations. It also includes the patient’s diagnosis, methods of payment, treatment and its outcome.

Information should not be divulged outside professional settings, such as patient care “conferences” and training situations. In such professional situations information should remain impersonal when it is not strictly necessary to do otherwise.

Patients have the right to physical privacy within the limits possible in each health care setting — this includes visual and auditory isolation during examination.

Patients have the right to bring before relevant authorities, instances where they consider their confidentiality has been compromised, and to be protected from limitation of access to health care as a consequence of such complaint.

Patients have the right to be refused to be seen, questioned or examined in any way (including perusal of notes) by anyone professional or otherwise without their explicit consent.

Culture and Religion

Each person has a right to their cultural and religious expression and should be allowed to wear, use or have access to modes of dress, personal grooming, including symbols, provided they are not illegal, offensive to the rights of others, or breach the codes of hygiene and safety in the health care setting.

Identity of Staff

Patients have the right to know the identity and roles of any health care staff including administrators, porters etc. involved directly or indirectly in their care.
Access to Information

Patients have the right (with few exceptions) to have access to all information regarding their medical condition, and to have it provided in a form they can be expected to understand. Patients are also entitled to have information on them provided in writing, for their use, as they desire whether it be for medical or legal use. The information expected could include the opinion of the physician in charge in relation to the diagnosis, prognosis and advised course of treatment.

Next of kin or guardians of the patient have the right to access to information in the same manner as the patient, if the patient is not legally or medically competent to access the information himself or herself.

Information can only be given to relatives including spouses and close relatives with the consent of the patient, and in clear good faith if such consent has not been given explicitly.

Patients have the right to obtain information in the form of certificates etc, for the purpose of insurance and any other legal purpose.

Access to Opinions

Patients have the right of access to other opinions, medical or otherwise. The physician in charge should provide such access through information available, providing it does not breach the ethical guidelines of the profession, e.g. Referral to unqualified persons.

Protection from Abandonment

No patient shall have their care abandoned unless clear arrangements have been put in place for their care to be taken over by a physician of their choice.

Security

Patients have the right to be protected from physical and mental harm in the health care setting, such harm could come from the health professionals, the facilities, relatives or other visitors.

For example, undue noise including loud voices can be considered harmful to patients.

Patients expect that information on themselves should be kept secure and confidential in the health care setting, so that unauthorized persons should not have access to them.

Consent

Patients have the right to be informed about, and to participate in, decisions about their care, whether these relate to history, examination, investigations and treatment of any sort.
Explicit and informed consent should be obtained for all invasive procedures, investigations, or treatment, which may do harm whether it is physical or mental.

**Refusal of Treatment**

Any legally competent patient can refuse to be treated, unless law has mandated such treatment.

**Basic Necessities**

Patients are entitled to be provided with the basic necessities during their stay in a health care setting — these include adequate “housing” (i.e. bed linen etc.) food and information pertaining to the rules of organization, fees etc.

[Located as an Appendix in: Health Care Law and Ethics; Proceedings of a Conference held by the Faculty of Medical Sciences, University of the West Indies, Cave Hill Campus, Barbados, August 1993. Edited by E.R. Walrond. (Barbados: UWI Faculty of Medical Sciences, 1993) pages 74-75].
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