

informed of their rights when they are involuntarily detained or when determined to be incapable of consenting to their own treatment. Most Canadian jurisdictions have mandatory reviews of commitment and CTOs after a prescribed period of time. Decisions reached by these review boards may be appealed to the courts.

Conclusion

The 13 mental health acts have shared core features, but also show some important variation in the major elements. There are similarities to the provisions in many other democratic jurisdictions. The ability to challenge any provision as not being in accord with the Canadian Charter of Rights and Freedoms, ultimately in the Supreme Court of Canada, is an important safeguard against unreasonable laws.

References

- Dawson, J. & Szmukler, G. (2006) Fusion of mental health and incapacity legislation. *British Journal of Psychiatry*, 188, 504–509.
- Gray, J. E. & O'Reilly, R. L. (2001) Clinically significant differences among Canadian mental health acts. *Canadian Journal of Psychiatry*, 46, 315–321.
- Gray, J. E., Shone, M. A. & Liddle, P. F. (2008) *Canadian Mental Health Law and Policy* (2nd edition). LexisNexis.
- Gray, J. E., McSherry, B. M., O'Reilly R. L., et al (2010) Australian and Canadian mental health laws compared. *Australian and New Zealand Journal of Psychiatry*, 44, 1126–1131.
- Gray, J. E., Shone, M. A. & O'Reilly, R. L. (2012) Alberta's community treatment orders: Canadian and international comparisons. *Health Law Review*, 20, 13–21.
- Kelly, M., Dunbar, S., Gray, J. E., et al (2002) Treatment delays for involuntary psychiatric patients associated with reviews of treatment capacity. *Canadian Journal of Psychiatry*, 47, 181–185.
- Solomon, R., O'Reilly, R., Nikolic, M., et al (2009) Treatment delayed – liberty denied. *Canadian Bar Review*, 87, 679–719.



A new Mental Health Act for Malta

Anthony Zahra,¹ Miriam Camilleri² and John Cachia³

¹Psychiatry Visiting Lecturer, Department of Psychiatry, University of Malta, email anthony.zahra@gmail.com

²Public Health Specialist, Office of the Commissioner of Mental Health, Mount Carmel Hospital, Attard, Malta

³Commissioner for Mental Health and Older Persons, Mount Carmel Hospital, Attard, Malta

Until recently, the care of persons with mental disorder in Malta was regulated by mental health legislation enacted in 1976. This was closely modelled on the 1959 British Mental Health Act. Now, the Mental Health Act 2012 is being implemented in two steps, in 2013 and 2014. The paper reviews its provisions.

The Maltese islands constitute a small independent country, a member state of the European Union since 2004, with a population of around 420 000 (National Statistics Office, 2011). Until recently, the care of persons with mental disorder was regulated by mental health legislation enacted in 1976. This was closely modelled on the 1959 British Mental Health Act (Saliba, 1994), focused on setting out formal procedures to be followed within mental healthcare provision.

The Mental Health Act 2012 was in development for over a decade; it is being implemented in two steps, in 2013 and 2014.

The Act has 11 parts, each comprising several articles. Its main aims are presented within the short title, 'an act to regulate the provision of mental health services, care and rehabilitation whilst promoting and upholding the rights of people suffering from mental disorders'. Such explicit expression of the principles guiding the legislation is a significant departure from the prescriptive nature of the previous law.

This paper outlines the more salient changes that have been introduced, following the structure of the Act itself.

Part I: Preliminary

Part I focuses on operational definitions of terms used within the Act. The new terminology used in this law reflects the division between clinical and managerial responsibility within mental healthcare facilities, recognises the contribution of all professions working in mental healthcare, removes stigmatising terminology and provides a more clinical definition of 'mental disorder'. Mental disorder has been defined as a significant mental or behavioural dysfunction exhibited by signs or symptoms including disturbance of thought, mood, volition, perception, cognition, orientation or memory, and deemed pathological in accordance with internationally accepted standards. Treatment has been defined as being medical, nursing, psychological and social, implicitly following the biopsychosocial model (Engel, 1980), and is a core component of care as defined by this law.

Part II: Rights of users and carers

The rights of persons with mental disorders and their carers are clearly stated. Treatment is to be delivered in the least restrictive manner and setting, with an emphasis on having treatment delivered primarily within the community. The law also sets out the principles of active participation of the patient in the planning of care, adequate information about the disorder, treatment options and services available, free informed consent, confidentiality, access to clinical information, free and unrestricted communication with the outside world and the right to receive visitors in private within all reasonable times.

A new concept of 'responsible carer' is introduced, wherein the person being provided with mental healthcare has the right to appoint a trusted person of choice to take an active representative role within the multidisciplinary care team and in other instances as required. This is a significant change from the earlier legislation, which had automatically designated the nearest relative as the person with a representative role. One of the projected advantages of having a carer chosen by the patient is to address the possible conflict of interests and to ensure greater autonomy for the patient. In cases of suspected abuse, the Commissioner (see below) may act to substitute the nominated carer.

Part III: Commissioner

A new role of Commissioner for the promotion of the rights of persons with mental disorders is introduced. This Commissioner is ascribed myriad functions, including the promotion and safeguarding of the rights of persons suffering from a mental disorder as well as of their carers, reviewing operational policies to facilitate social inclusion and well-being, and ensuring that patients are not held in institutional care any longer than necessary. The Commissioner ultimately approves orders for hospital involuntary treatment beyond the 10-day period of involuntary admission for observation or involuntary treatment in the community, through a process of external peer review.

The role of the Commissioner also extends to monitoring persons certified as lacking mental capacity and who are under curatorship or tutorship, authorising special treatments and clinical research, and ensuring guidelines and protocols to minimise restrictive care are in place. The Commissioner is the identified authority to receive and investigate complaints of breach of patient rights.

The Commissioner's functions are thus extensive and also subsume those of the previous Mental Health Review Tribunal, which therefore becomes redundant. Decisions or orders made by the Commissioner are all subject to appeal within the Court of Voluntary Jurisdiction.

Part IV: Admission to a licensed facility and community treatment

A person may be admitted to a facility specifically licensed to provide mental healthcare on either a voluntary or an involuntary basis.

Involuntary admission and treatment within a facility are based on three conditions, namely (1) the person has to have a severe mental disorder, due to which (2) there is a serious risk of physical harm to self or others, and (3) failure to admit the person would likely result in serious deterioration of the condition or prevent adequate treatment which cannot be safely provided in the community. Should one of these conditions cease to remain present, the person may no longer be kept under involuntary care.

Applications for involuntary admission for observation are still to be made by the responsible

carer (previously the nearest relative) or the mental welfare officer, with recommendations by two medical practitioners, one of whom must be a specialist in psychiatry. The period of involuntary admission for observation cannot exceed 10 days, whereas under the previous act this was 28 days. An exception remains in the case of an emergency, where a single medical recommendation by a medical practitioner together with the application from a responsible carer is sufficient for involuntary admission for observation. This retains holding power within a licensed mental health facility for 24 hours, as compared with the 72 hours under the previous act. The treatment order period has been reduced from the previous 12-month period to 10 weeks.

The possibility of having compulsory treatment in the community is another development introduced by this Act. Persons on a community treatment order may now be prescribed treatment in the community, within the context of a care plan focused on facilitating integration within a community setting.

Part V: Mental capacity

The Mental Health Act states that persons with mental disorders are presumed to retain mental capacity and competence to make decisions unless otherwise certified by a specialist in psychiatry. Capacity is broadly defined as the ability and competence to make and be responsible for different types of decisions, and may be determined by one psychiatric specialist.

The approaches to lack of capacity are contingent on the expected duration of this condition, with a period of less than 14 days requiring only documentation in the clinical case notes. If the lack of capacity is expected to last longer than 26 weeks, an application in the civil courts for incapacitation or interdiction can result in the appointment of a curator. Passage of parallel legislation will also enable the possibility of applying for a guardianship order as an alternative to incapacitation or interdiction in the near future.

Part VI: Minors

The law specifically mentions the need to preserve the relationship between persons under the age of 18 years who might be admitted into a facility providing mental healthcare and their parents or responsible carers, even if this is somewhat limited to providing flexible visiting hours. The prescribed periods of involuntary admission for observation and treatment are shortened in the case of minors to a maximum of 12 weeks. Continuing detention orders may be approved for a maximum 3 months, renewable.

Part VII: Special treatments, restrictive care and clinical trials or other medical or scientific research

Electroconvulsive therapy may be administered only after a second specialist opinion and with the informed consent of the patient. In the case of lack

of capacity to provide consent, a responsible carer shall provide such consent.

Part VIII: Patients involved in criminal proceedings

The courts may issue orders for observation in a mental health facility in order to assess the mental capacity of persons charged with a criminal offence for periods of 3 months, renewable. Power to order the discharge of a person detained in a mental healthcare facility upon the plea of insanity can be exercised by the court after a recommendation to the court by three specialists, one of whom is the responsible specialist. Leave of absence may still be granted by the minister responsible for justice in the context of a multidisciplinary treatment plan.

Part IX: Mental health licensed facility

All facilities which provide a mental health service will continue to be duly licensed as currently provided. However, facilities which provide services to persons detained on an involuntary basis, minors, and forensic patients (persons concerned in criminal proceedings and prisoners) need a specific licence to operate. Every licensed facility must have written patient care management protocols and operational guidelines for implementation of the requirements imposed by the new legislation.

Part X: Promotion of social inclusion

The law emphasises the need for social inclusion, and gives the Commissioner an advocacy role with legislative bodies to make recommendations on social policy. This part also gives the Commissioner an executive role in taking appropriate action against discrimination or exploitation of persons by reason of their mental health status.

Conclusion: challenges and opportunities

The new Act explicitly states a set of values and principles: the promotion of patient autonomy; care delivered to persons integrated in their community; the use of the least restrictive methods of care; and a managerial approach, with defined time frames, care plans and goals. It is expected to provide logistic challenges in its implementation, but if these are met, it can be expected that mental healthcare in Malta will reflect the progress made in clinical and academic psychiatry.

References

- Engel, G. L. (1980) The clinical application of the biopsychosocial model. *American Journal of Psychiatry*, 137, 535–544.
- National Statistics Office (2011) *Demographic Review 2010*. At http://www.nso.gov.mt/statdoc/document_file.aspx?id=3173 (accessed February 2013).
- Saliba, J. R. (1994) Psychiatry in Malta. *Psychiatric Bulletin*, 18, 368–370.



A survey of the mental healthcare systems in five Francophone countries in West Africa: Bénin, Burkina Faso, Côte d'Ivoire, Niger and Togo

Djibo Douma Maiga¹ and Julian Eaton²

¹Coordinateur, Programme National de Santé Mentale, Hôpital National de Niamey, Niger

²Senior Mental Health Advisor, CBM International West Africa Regional Office, Lomé, Togo, email julian.eaton@cbm-arow.org

A French translation of this paper is available on request from the corresponding author
Une traduction française de ce document est disponible sur demande auprès de l'auteur correspondant

Sub-Saharan Africa has a wide mental health treatment gap, with low levels of access to mental health services. This paper presents the findings of systematic situation analyses carried out in five Francophone countries in West Africa, which are among the poorest in the world. The findings showed low levels of budgetary allocation to mental health, poor health infrastructure (especially at primary level) and unequal distribution of human and financial resources. In this challenging context, there are signs of reform of services, based on international best-practice guidelines and practical considerations such as decentralisation of services, task-sharing and strengthening stakeholder skills to advocate for change.

Finding a way to respond to the huge burden of mental illness is a major public health challenge, particularly in low-income countries, where 76–85% of people with severe mental disorders receive no treatment (World Mental Health Survey Consortium, 2004).

In this paper, we assess aspects of mental healthcare in five Francophone countries of West Africa (Bénin, Burkina Faso, Côte d'Ivoire, Niger and Togo) and how they are reforming services to make them more accessible.

Method

The comparison uses situation analysis studies conducted in Côte d'Ivoire (2013), Togo (2012), Burkina Faso (2011) and Niger (2011) to guide