出國報告（出國類別：考察）

103 年度斐濟精神衛生之醫療照護體系功能提升計畫事實調查暨友好國家醫事人員訓練計畫歷年學員返國後成效評估任務返國報告

出差人員：　國際合作發展基金會人道援助處曾組長筠清
國際合作發展基金會人道援助處鄧計畫經理雅文
馬偕紀念醫院精神科方主任俊凱
馬偕紀念醫院精神科陳教授喬琪
馬偕紀念醫院精神科劉護理組長智如
馬偕紀念醫院精神科林職能治療師苑真
馬偕紀念醫院國際醫療中心林副主任怡吟

派赴國家：　斐濟

出國期間：　103 年 06 月 01 日至 06 月 12 日

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摘要

本會於本(103)年 2 月接獲斐國衛生部提出精神衛生醫療服務之計畫概念書，為能確認斐國精神衛生疾病現況、衛生部合作意願、計畫主體架構及未來合作之可能性評估，本會於本年 6 月 1 日至 12 日赴斐濟執行本次事實調查任務。另鑒於自 95 年迄今，斐濟已派遣 9 名醫事人員來台參加友好國家醫事人員訓練計畫，本次一併辦理該計畫之學員返國後成效追蹤，計完成 7 名學員問卷訪談。

本次任務期間參訪 St. Giles 醫院、中央區醫院(CWM)及相關非政府組織，並與斐國衛生部、St. Giles 醫院、斐濟國立大學及相關非政府組織等產、官、學、研單位進行多次利害關係人會議，建立以預防、治療及復健三主軸作為精神衛生體系提升方向之發展共識，爰本次任務建議：

一、強化各機構功能：在衛生部體系下建立自殺防治中心，另協助 St. Giles 醫院重啟日間照護以及健全庇護工場之功能，以整合及強化精神衛生機構功能；

二、提升治療、復健方面之相關人員能力建構：協助斐國精神科醫師加強各次專科臨床訓練；協助斐國資深護理人員加強訓練精神衛生相關知識及臨床經驗；協助斐國之社工、心理、護理相關人員在職能治療方面之專業訓練；協助斐國之社工和護理相關人員建立個案管理能力；前述人員應成為斐國精神衛生相關人員之種子教師，透過駐地訓練培訓足夠人力以提供全國之精神衛生服務；

三、建立平台並透過定期舉行利害關係人會議，凝聚各部門及相關機構之對精神衛生議題之執行共識。

另，友好國家醫事人員訓練計畫斐濟學員返國後成效追蹤之結果看來，學員或渠等職場同事均對渠等來台受訓表示正面評價，已可見本訓練計畫之成效。惟多數學員建議：一、倘來台受訓之課程能成為認證課程，將有助於學員未來發展；二、來台受訓學員人選的選擇應配合夥伴國醫療需求及政策方能確實有效。未來本會除配合中、長期專案計畫挑選來台學員外，另在成效追蹤問卷設計上可再簡化以符合實際狀況。

Executive Summary

The Ministry of Health, Fiji (MOH) submitted a concept paper regarding the strengthening of mental health research in Fiji to the TaiwanICDF in February 2014. The TaiwanICDF carried out a fact-finding mission from June 1 to 12, 2014 to confirm the status of mental health in Fiji, the extent of cooperation with the MOH and the scope of the project, and to assess the feasibility of implementing a project in cooperation with the MOH. In addition, since nine healthcare trainees have visited Taiwan for the TaiwanICDF's Healthcare Personnel Training Program since 2006, this mission also conducted post-training follow-up among trainees, with seven of them being evaluated.

The mission visited and evaluated St. Giles Hospital, the Colonial War Memorial Hospital (CWM) and a number of NGOs. The TaiwanICDF, the MOH, St. Giles Hospital, Fiji National University (College of Medicine, Nursing and Health Sciences) and the NGOs reached a consensus that project resources would enhance mental health care by focusing on prevention, intervention and rehabilitation. The recommendations of this mission are summarized as follows:

1. Strengthening of mental health care functions: In order to integrate and enhance mental health care functions, establish a suicide prevention center under the MOH and assist St. Giles Hospital in reopening a daycare center and establishing a sheltered workshop.
2. Development of competent mental health-related medical professionals and care providers: Assist psychiatric attending physicians to strengthen clinical capabilities in psychotherapy and child and adolescent psychiatric care; assist senior nurses to strengthen mental health-related knowledge and clinical capabilities; assist in training social workers, counseling psychologists, and nursing personnel for occupational therapy; assist

social workers and nursing personnel in building case management abilities; these personnel should be trained as seed teachers for providing mental health education to local persons.

3. Establish a platform and hold regular stakeholders' meetings to reach a consensus on mental health-related issues.

In terms of post-training follow-up of trainees who had attended the TaiwanICDF's Healthcare Personnel Training Program, trainees or their colleges affirmed the value of this program and the program therefore as being effective. However, most trainees also made the following recommendations: First, it would be more helpful for trainees' career development if the Taiwanese program was recognized as a certificated program; second, trainees attending this program should be chosen in accordance with the medical policies and needs of partner countries. Therefore, trainees will be chosen in accordance with TaiwanICDF's mid-term and long-term projects. The follow-up questionnaire should also be simplified to better suit the actual situation encountered by missions.

壹、 任務說明

一、計畫緣起

精神衛生之疾病負擔係近年來嚴峻及耗費資源之全球性衛生問題，根據世界衛生組織(WHO)的估計，全世界約有 1.25 億人酗酒並受酒精導致之精神障礙所苦，在精神、神經及物質使用障礙所造成的負擔佔全球疾病總負擔的 14%，其中又有四分之三的負擔由低收入和中等收入國家承擔。

斐濟近年來在精神衛生方面面臨嚴重問題，根據2010 年資料顯示，精神疾病病患於斐濟 St. Giles 醫院住院長度平均為 110 天，佔床率為 108.25(總計 136 床)。顯示該國既有之精神衛生相關醫療照護資源不足以支應該國所需。此外，相關資料顯示斐國門診病患經診斷，45%為精神分裂、30%為情緒失調疾病；住院病患 50.7%為精神分裂、38%為情緒失調疾病、2%為人格障礙，爰精神分裂係該國精神衛生重要挑戰，而相關患者倘可適時接受協助，則可降低演變為精神重病患者之機率。

斐濟政府雖已將精神衛生納入該國 2011 至 2015 年內之重要健康政策，惟在相關精神衛生醫療團隊人員之能力、衛生資訊系統涵蓋面、相關流行病學資料等方面仍相當缺乏，爰斐濟向我國提出本計畫，希冀透過我國之經驗，強化該國精神衛生體系構能力提升為主軸，為回應斐國需求，爰赴斐濟進行本計畫之事實調查任務。

另鑒於自 2006 年迄今，斐濟已派遣 9 名醫事人員來台參加友好國家醫事人員訓練計畫，本次藉由赴斐濟進行任務期間，一併辦理前揭計畫之學員返國後成效追蹤。

(一) 執行期間

本計畫評估任務自本年 6 月 1 日至 6 月 12 日止(含飛航行程共 12 日)。

(二) 任務目標

1. 確認斐國精神衛生疾病現況、衛生部合作意願及相關資料收集

2. 確認計畫主體架構(影響、成果及產出)及工作計畫書初稿(含DMF 表)
3. 瞭解當地非政府組織現行計畫及未來合作之可能性評估
4. 瞭解合作單位擬投入資源及意願
5. 確認計畫之假設與風險
6. 進行友好國家醫事人員訓練計畫學員返國後成效追蹤

(三) **執行人員**

本案由本會人道援助處曾組長筠清、鄧計畫經理雅文偕同馬偕紀念醫院精神科方主任俊凱、陳教授喬琪、劉護理組長智如、林職能治療師苑真、國際醫療中心林副主任怡吟等，計 7 人共同執行本次任務。

(四) **執行工作範圍及評估重點**

1. 確認斐國精神衛生疾病現況、衛生部合作意願及相關資料收集
   (1) 確認斐濟精神衛生體系目前遭遇之困難與問題、相關醫療人員能力及醫療機構功能；
   (2) 瞭解目前斐國執行與精神衛生相關之公衛醫療計畫；
   (3) 確認斐國未來對精神衛生領域之發展重點、本會可協助項目及計畫並討論未來計畫合作模式；
   (4) 瞭解斐國衛生資訊系統(HIS)現況與功能。
2. 確認計畫主體架構(影響、成果及產出)及工作計畫書初稿(含DMF 表)
   (1) 確認核心問題與斐國利害關係人分析
   (2) 確認本計畫主體架構，並與斐國相關人員討論工作計畫書草稿。
3. 瞭解當地非政府組織現行計畫及未來合作之可能性評估。
   (1) 瞭解國際組織現行公衛醫療相關計畫內容；
   (2) 瞭解未來發展方向與本會可合作項目。
4. 瞭解合作單位擬投入資源及意願

5. 確認計畫之假設與風險

6. 進行友好國家醫事人員訓練計畫學員返國後成效追蹤

(五) 執行人員工作分配

國家	單位	姓名	職稱	考察任務
斐濟	國際合作發展基金會	曾筠清/ TSENG YUN-CHING	組長	確認本計畫各項細節、執行方式及合作模式等
	國際合作發展基金會	鄧雅文 TENG YA-WEN	計畫經理	聯繫、安排考察流程，彙整本次考察建議及相關資料。
	馬偕紀念醫院精神科	方俊凱/ FANG CHUN-KAI	主任	瞭解斐國精神衛生醫療現況，從醫療專業角度提供計畫發展建議。
	馬偕紀念醫院精神科	陳喬琪 CHEN CHIAO-CHICY	教授	瞭解斐國精神衛生醫療現況，從醫療專業角度提供計畫發展建議。
	馬偕紀念醫院精神科	劉智如 LIU CHIH-JU	護理組長	瞭解斐國精神衛生醫療現況，從護理專業角度提供計畫發展建議。
	馬偕紀念醫院精神科	林苑真 LIN YUAN-CHEN	職能治療師	瞭解斐國精神衛生醫療現況，從職能治療專業角度提供計畫發展建議。
	馬偕紀念醫院國際醫療中心	林怡吟 LIN YI-YIN	副主任	協調馬偕紀念醫院團隊，瞭解斐國精神衛生醫療現況，從國際醫療專業角度提供計畫發展建議。

(六) 考察行程：

詳細行程請參照附件一。

貳、任務發現與建議方案

一、斐濟現況說明

(一) 國家概況

在 1970 年斐濟獨立以前，為英國殖民該國地近一世紀，於 1970 年獨立。，斐國係一三權分立國家：國家領導人為總統，國會為兩院制、行政機關為內閣制，行政機關最高領導人為總理。斐濟分為 2 個直轄市、4 個行政大區和羅圖馬島。直轄市分別是蘇瓦(Suva)和 Labasa；行政大區分別是中央大區、西部大區、北部大區和東部大區，其下分為 14 個省。

15 歲以上識字比率為 93.7%。該國人口種族斐濟原住民（Indigeneous Fijan or i-tauke)約佔 56 %，印度裔斐濟人佔 36 %，其他 8%則是華人、白人、歐亞混血及太平洋島國人種組成，官方語言為英語、斐濟語和印度斯坦語（Hindustani）。

宗教方面，信奉基督教的人佔 52.9%，而信奉印度教和信奉伊斯蘭教的人各佔 38.1%和 7.8%。全國人口約 896,758 人(2013 年，另據斐國衛生部表示2014年人口數已達約100萬人)，在全球排名第 162 名，其中 0-14 歲人口佔 28.4%、15-24 歲人口佔 17.4%、25-54 人口佔 41.1%、55-64 人口佔 7.6%、65 歲以上人口則佔 5.6%；城市人口約佔 52%(2011 年)。

(二) 地理與氣候概況

斐濟坐落於大洋洲的南太平洋島群，萬那杜以東、東加以西、吐瓦魯以南，全國面積 18,274 平方公里，在全球排名第 157 名。該國的群島共包括了 330 個島嶼，主要為珊瑚礁環繞的火山島，僅1/3有人居住，其中維提島(Viti Levu)和瓦努阿島(Vanua Levu)兩個主要島嶼的人口佔全國的 87%，為熱帶海洋氣候並伴隨著輕微季節性的溫度變化。

(三) 斐國產業

該國具有 200 英里的經濟海域，經濟以觀光、農業、漁業、林業、礦產業為主，具有木材、魚、黃金、銅、海上石油潛力、

水電等自然資源經濟概況漁業對斐濟經濟具有重大意義，因為它不但是本地居民蛋白質的主要來源，也是就業和外匯收入重要項目，斐濟是太平洋最主要的鮪魚捕撈船隊作業基地；主要農業經濟作物為：甘蔗、椰子、卡瓦(Kava)、樹薯(cassava)、芋頭(taro)、木瓜；林業則以檀香(sandalwoods)桃花心木(mahogany)、斐濟松木(Fiji Pine)為主要出口項目；礦業，則以舉世聞名的斐濟水(Fiji Water)及金礦為主要出口。

(四) 斐國經濟

斐濟 GDP 國內生產總值(PPP 購買力平價）近 37 億美元，全世界第 169 名，人均 GDP 為$4,200 美元，全世界第 155 名。斐濟蘊含了豐富的森林，礦產和漁業資源，在太平洋島嶼經濟發展程度僅次於 PNG。 食糖出口、旅外國人匯款、和不斷增長的旅遊產業（以每年 40 萬至 50 萬遊客）是外匯的主要來源。惟斐濟的旅遊業因 2006 年 12 月的政變，截至目前為止尚未恢復，2007 年入境旅遊人數下降了近 6%，伴隨著服務業的大量失業及國內的生產總值下跌；這次政變造就了斐國艱難的經濟困境，歐盟已暫停所有援助，直至臨時政府對新選舉採取措施。長期的問題包括低投資、不確定的土地所有權、政府無力管理其預算。且斐濟人在科威特和伊拉克的海外工作匯款已顯著下降。 斐濟的國庫赤字 2006 年達到高峰，佔 GDP 的 23%，但在 2012 年時下降至 GDP 的 12.5%。

二、計畫原因：斐國精神衛生現況、公共衛生部門表現、問題與機會 (Rationale: Current status, Sector Performance, Problems, and Opportunities)

(一) 精神衛生現況說明

1. 主要醫療體系為三級制

斐濟健康照護體系依地理劃分為三個區域(中央大區/東部大區、西部大區、北部大區)，三個區域皆設有區域醫院以照護各區域民眾(Colonial War Memorial Hospital(CWM)、Lautoka Hospital、

Labasa Hospital)，另向下設有二級醫院(21 間)、衛生中心(77 間)及村落診所(Clinic)(900 間)、護士站(103 所)提供衛生照護。此外，斐濟設有一間私人醫院-Suva Private Hospital、兩間教會醫院(Ra Maternity Hospital、Ba Mission Hospital)[1]。

2. 精神衛生議題為區域共通問題

本次考察期間，參訪及與衛生部、各級醫療院所、斐濟國立大學護理及健康學院、精神衛生相關之非政府組織及 WHO 駐斐辦事處等單位會談，本次考察發現斐國醫護及教育人員對此議題相當重視，更表示精神衛生醫療體系不僅是斐國本身的重要課題，亦是目前太平洋島國各國政府迫切需面對之共同區域議題，故此精神衛生醫療體系若能有效建構，將能作為該區各國在精神衛生之發展指標，建立之模式亦可供區域各國未來發展參考。

(1) 青少年自殺問題嚴重

依據斐國衛生部提供 2014 年資料：斐國全國自殺率為 12.23/每十萬人(台灣自殺率為 16.2/每十萬人)，但青少年自殺率為 10.76/每十萬人(13-19 歲)(台灣約為 7/每十萬人[1])；2012 年一份研究針對斐濟接受諮詢之病患所進行之研究顯示，5,581 位接受諮商之病患，有 2.7%是因試圖自殺而需接受諮商。而這些試圖自殺之病患多數非當地斐濟種族(non-Indigenous Fijian race)、男性、青少年族群、未婚、具高學歷。而最主要導致病患產生自差意圖的原因主要為人際關係缺失(69%)，其次為家庭關係不穩定(36%)、缺乏自我認同(29%)。這些人當中超過一半卻乏自制能力，另外，10%的人之前已嘗試過自殺。

(2) 缺乏預防及個案管理機制

研究顯示，接受過諮商後，評估病患之各項警訊皆有顯著改善錯誤! 找不到參照來源。[1]。惟本次考察期間發現，斐國目前於精神衛生預防方面，主要委由非政府組織：Youth Champs for Mental

[1] 衛生福利部 2012 年統計資料，青少年為 15-24 歲
http://www.mohw.gov.tw/cht/DOS/Statistic.aspx?f_list_no=312&fod_list_no=2747

Health 辦理青少年暨社區心理衛生教育宣導，較缺乏國家層級建全之預防機制。

(3) 缺乏流行病學及危險因子分析研究報告

公共衛生資訊處 Dr. Devina Nand 表示目前精神衛生之資料來源為 St. Giles 醫院，精神疾病盛行率於 2013 年約達 0.018%，2012 年臨床診斷為精神疾病比例為，男性族群為 0.02%及女性族群為 0.017%(女性罹患精神疾病情況增加中)；而人種方面，印度裔病患明顯較多(56.3%)、斐濟裔為 34.7%、其他為 9.0%(2013 年)；精神病患(躁鬱症和思覺失調症)之好發年齡有兩個高峰，分別為 20 至 24 歲及 45 至 49 歲。2013 年度 St. Giles 醫院門診病患人數達 4,694 名、住院人數為 438 名且急性病房平均住院天數為 22 天及院外門診人數達 2,223 名。除此之外，斐國 50%的地區醫院無精神衛生醫療服務；倘病患於地區醫院就醫，則會因無病床無精神科醫師而被送至警察局。

目前斐濟缺乏精神衛生相關流行病學資料，斐濟國立大學護理及健康學院刻正進行研究調查(擬於本年年底提供予斐國衛生部)，因此無法準確評估該國因精神衛生導致之疾病負擔。另因目前斐國並未針對求助行為進行系統性之研究，爰無法提出有效防治之政策。

(二) 疾病基礎防治體系表現指標與分析(Performance Indicators and Analyses)

1. 整體衛生部門表現

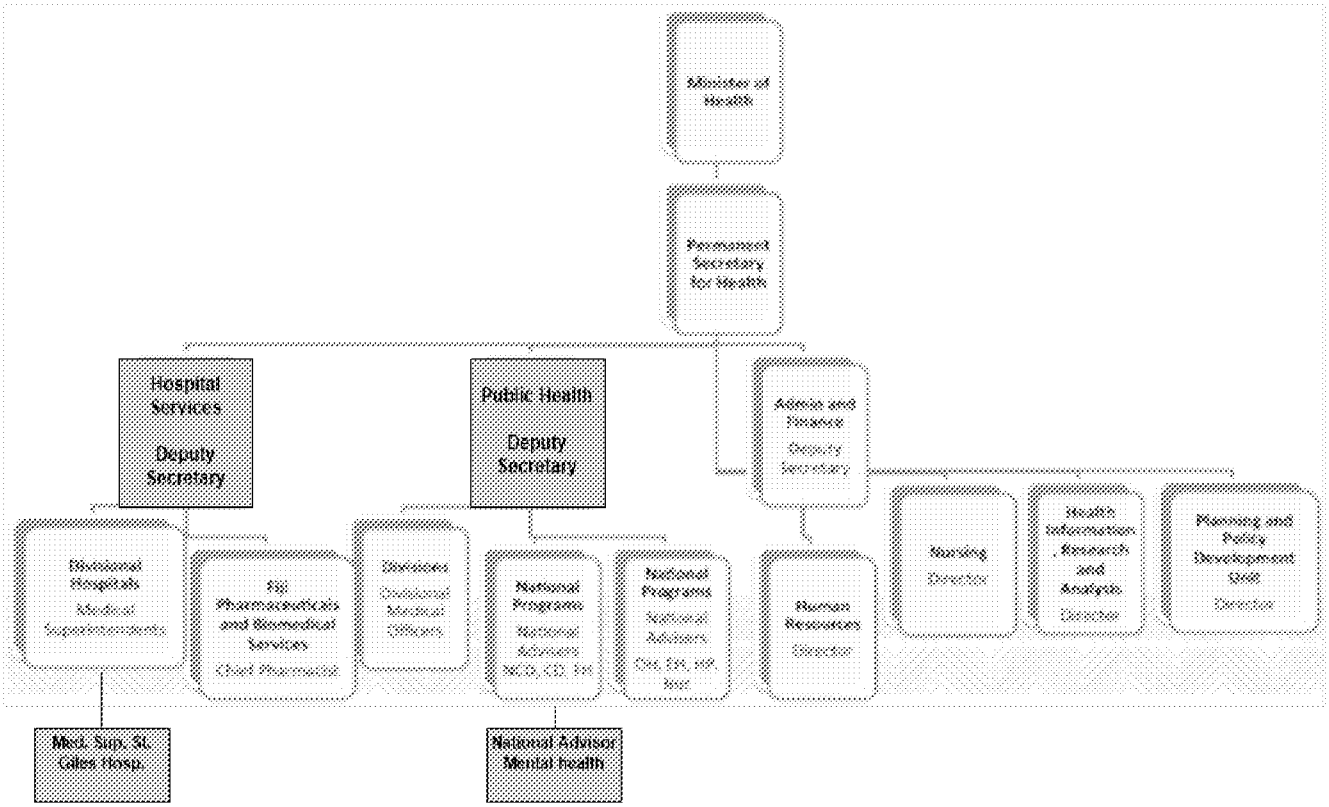
(1) 公部門精神衛生組織架構及法規：

A. 組織架構(詳如圖一)：

a. 衛生部公共衛生部門下設立全國精神衛生委員會，進行精神衛生相關政策提案及醫療體系與衛生部之協調。

b. 公立醫院設有 1 間精神專科醫院(St. Giles 醫院)。

B. 斐國精神衛生法規自 2010 年立法迄今逐步落實中，且台灣的差距不大且尚完備(詳如附件四)。



圖一、斐濟衛生部組織架構圖。

(2) 公部門精神衛生疾病預防能力：主要委由非政府組織：Youth Champs for Mental Health 辦理青少年暨社區心理衛生教育宣導，較缺乏國家層級之建全預防機制。

(3) 公部門精神衛生疾病治療能力：

C. 目前斐濟僅有一間精神專科醫院 St. Giles Hospital，提供 82 個病床(9.8 床/每十萬人)，包含急性及慢性病房(男女分開)，急性病房平均住院天數 22 天(2013 年)；三間地區醫院則設置精神科單位壓力病房(Stress Management Wards)：中央區 CWM 醫院提供 8 床(1.8 床/每十萬人)、北區 Labasa 醫院提供 5 床(3.7 床/每十萬人)、西區 Lautoka 醫院提供 10 床(3.8/每十萬人)。除此之外，二級醫院未設有精神科單位，但分別由一名護士兼職負責精

神衛生相關工作。

D. 斐國精神科相關人力方面：

a. St. Giles 醫院：4 名全職醫師，其中 1 名留職進修 2 年中；32 名護士，仍有 43 名職缺仍待填補；36 名看護人(M/Orderlies)，仍有 17 名職缺仍待填補。

b. 北區 Labasa 醫院壓力病房：1 名全職醫師，6 名護士，2 名看護人。

c. 西區 Lautoka 醫院壓力病房：1 名全職醫師，8 名護士，2 名看護人。

d. 中央區 CWM 醫院壓力病房：1 名全職醫師，7 名護士，3 名看護人。

e. 無職能治療師、無臨床心理師、無精神科社工師。另，僅 1 名諮商師服務於斐濟衛生部(斐國多數諮商服務由非政府組織提供)。

f. 面臨之挑戰：斐國精神科專業醫療人員不足，醫病比為 0.8 名醫師/每十萬人、6.3 名護士/每十萬人，未來挑戰為如何吸引更多醫師及護士投入精神專科領域、接受精神專科訓練、並使專業人力能留任斐國。

E. 確認斐國精神科醫師人力不足且缺乏次專科訓練：

a. 斐國國立大學醫學護理及健康學院(FNU-CMNH)提供 6 年期之醫科大學學位(含基礎精神衛生知識及 9 週精神科實習)及自 2012 年起提供予在職醫事人員(含醫師、護士及其他相關人員)進修之 1 年精神專科學程(PGDMH)，惟臨床實習課程及師資不足、且亦無精神次專科訓練。目前斐國 100 名家醫科醫師(GP)執業，1 名 GP 受過精神科訓練，歷年參與學程之學生人數統計如表一。

b. 面臨之挑戰：FNU-CMNH 表示 1 年精神專科學程學生除了正職工作外，課業的份量也等同一般生，爰招收之學生數少；需要知道衛生部的需求及未來規劃後，才能考量如何規劃精神科碩士學程。

表一、歷年參與精神專科學程人數統計

醫師	2012 年	2013 年	2014 年
專科醫師	3	3	1
一般科醫師	-	-	1
其他國籍醫師	-	3 (帛琉、吉里巴斯、萬那杜)	1 (東加)
其他-當地護士	3	-	-

F. 斐國精神科護理訓練方面(FNU-CMNH)：多數島嶼國家精神衛生相關工作主要由護士執行。

a. 護士 3 年進階專業文憑(大學學程)，包含 6 週精神科相關學科及 3 週臨床實習(St. Giles 醫院及社區精神衛生服務)；2014 年 170 名學生。

b. 護士 3 年學士學位含 9 週精神衛生相關學科(包括 3 週於 St. Giles 醫院及社區精神衛生服務之臨床實習)；2013 年 214 名學生。

c. 基礎精神衛生專科認證(Post Basic Certificate in Mental Health)：每學期 28 週分兩階段，每階段各含 2 週理論及 5 週臨床實習；計 50 名畢業生(斐濟 48 名、萬那杜 1 名、吉里巴斯 1 名)。

d. 精神衛生專科護士專業文憑(PGDMH Nursing，1 年期)：預計 2015 年起提供。另，目前 1 名護士完成在職醫事人員進修之 1 年精神專科學程。

(4) 公部門精神衛生疾病復建能力：

A. 人力

a. 斐國公部門僅 St. Giles 醫院目前設置 1 處職能治療室，現有人力為 3 名：1 名護士(年資 17 年，去年度轉任為專職職能治療工作)、2 名看護人；急性病房內 2 名看護人。

b. St. Giles 醫院所在之社區，設有 1 處社區精神衛生站，計 5 名社區護士追蹤出院病患。

B. 服務內容

a. St. Giles 醫院職能治療室：由 St. Giles 醫院醫師開立轉介單將病患轉至職能治療室

i、 現有輔導病患為 18 名。

ii、 病患轉入後先進行評估(評估表為 GAF, Life Skills Profile)，於職能治療室兩周後，再評估一次。倘後測分數較低，負責職能治療(Occupational Therapy 會與醫師及病患家屬進行討論是否安排病患再次住院或出院(倘病患認知功能仍健全)。

iii、 出院病人三個月內再住院率約 67%。

b. St. Giles 醫院急性病房之園藝計畫(Farming project)，由本會農業技術團指導病房社工師(助理員)2 名基本園藝技術，協助渠等帶領急性病房病患種植蔬菜及水果，作物所得收入存入復健基金，待渠等出院後可領取。

c. 社區護士(5 名)追蹤出院病患：第 28 天及第 3 個月與病患約定時間在衛生站或診所追蹤狀況。不用電話連繫追蹤的困難為，病患不一定會接電話，病患家屬也不會協助。

C. 精神衛生服務目前遭遇問題及需求：

a. 在職人員缺乏訓練(如團體治療、職能治療進階技術等)、缺乏專業人力(如職能治療師、社工師、臨床心理師等)

及缺乏。

b. 缺乏幫助經規律治療與復健下，症狀日趨穩定且能正常工作之精障人員進行工作能力復健之單位(庇護工場)。

(5) 衛生資訊系統功能(Fiji Health Information System, FHIS)

A. 該系統建置經費來源為AUSAID並於2001年導入，目前存有近800,000筆病患病歷資料；另，全國有39間醫院使用該系統，目前醫師可登入系統獲取病歷資訊，但不輸入病歷資料，另以人工方式登錄紙本病歷資料，爰系統資料無法呈現即時資訊。

B. 由公共衛生資訊處 Simon Salveen Kumar 先生維護該系統。全國有11名IT人員，中央區5名(含2名系統分析程式員，3名系統問題排除員)、北區及西區各2名和4名之系統問題排除員。另，系統細項調整可由該處進行，惟主要功能變更須提報PATIS委員會通過並同意後通知AUSAID，由當地資訊公司 Dadec Fiji 執行。

C. 衛生部冀期應用該系統資料配合政策重新規劃，爰需要本次團隊給予建議並考量配合未來計畫方向推動。

2. 非政府組織精神疾病防治能力：

(1) 公衛推廣服務方面:與精神衛生相關的非政府組織主要有Youth for Mental Health，該組織目前有三位正職人員，其他成員均依專案需求組成；該組織主要經費來源為斐濟政府，於各級中小學宣導精神衛生。另，該組織表示未來想建立共用之宣傳文宣(Toolkit) 1套，以利統一宣導方式，惟目前仍尋求資源中。

(2) 復建方面

A. Fiji Alliance for Mental Health：斐國總統夫人為該協會之贊助人之一。該組織關心除醫事人員以外之精神衛生方面的領域，包含精神疾病去汙名化、及康復病友之團體活動(目前有8名來自中央區之病友固定於每周

二、四上午九時至下午三時至該協會由澳洲志工進行藝術治療團體)。

B. Psychiatnic Survivors association Fiji：該組織提供類似社區精神衛生服務之功能，辦公室位於 FNCDP(勞動力重建處)，斐國身心障礙者職業訓練中心亦在該址，惟該中心提供之課程包括電腦、園藝、印刷、裁縫及手工加工等項目，難度或複雜度較高，較不適合精障者參與。另，每年進行 1 次全國病友訪視活動；該組織每年接受 AUSAID 捐贈斐濟幣 64,000 元。

3. 其他：本次考察亦拜訪 WHO 斐濟辦事處，該處負責範圍涵蓋太平洋群島 21 國家，並表示在 2013 年太平洋區域會議中，區域各國亦達成精神衛生是很重要共通議題之共識；另，WHO 表示目前無其他國際組織於斐濟進行精神衛生相關計畫，爰本計畫執行應無與其他國際組織資源重複之情形發生。

(三) 本會策略 ICDF's Strategy for Operations

本會願景 2022 策略書公共衛生具體目標為協助合作國家強化健康照護及衛生體系，行動方案之一為協助合作國家提升醫療衛生體系功能。而本計畫在提斐國精神衛生之醫療健康體系功能，透過，衛生資訊確實調查、人員能力建構、醫療資訊系統強化、疾病分析建議等方式，完備精神衛生之預防、治療及復健三大面向之功能，符合本會提升衛生體系功能之核心策略。

(四)計畫原因

1. 精神衛生之疾病負擔係近年來嚴峻及耗費資源之全球性衛生問題，根據世界衛生組織(WHO)的估計，全世界約有 1.25 億人酗酒並受酒精導致之精神障礙所苦，在精神、神經及物質使用障礙所造成的負擔佔全球疾病總負擔的 14%，其中又有四分之三的負擔由低收入和中等收入國家承擔。

2. 斐濟近年來在精神衛生方面面臨嚴重問題，根據本次考察發

現，精神疾病病患於斐濟 St. Giles Hospital 住院長度平均為 22 天，佔床率為 54.95%(總計 82 床)。顯示該國既有之精神衛生相關醫療照護資源不足以支應該國所需。

3. 本次考察發現相關資料顯示斐國 St. Giles 醫院門診病患精神疾病盛行率於 2013 年約達 0.018%，2012 年臨床診斷為精神疾病比例為，男性族群為 0.02%及女性族群為 0.017%(女性罹患精神疾病情況增加中)；而人種方面，印度裔病患明顯較多(56.3%)、斐濟裔為 34.7%、其他為 9.0%(2013 年)；精神病患(躁鬱症和思覺失調症)之好發年齡有兩個高峰，分別為 20 至 24 歲及 45 至 49 歲。足以顯示躁鬱症和思覺失調症係該國精神衛生重要挑戰，而相關患者倘可適時接受協助，則可降低演變為精神重病患者之機率。

4. 依據 WHO 資料顯示，精神衛生議題為太平洋區域重要議題。2013 年太平洋區域衛生領袖會議中，亦將之列為優先及重要議題之一。另，斐濟政府將精神衛生納入該國之重要健康政策，惟在相關精神衛生醫療團隊人員之能力、衛生資訊系統涵蓋面、相關流行病學資料等方面仍相當缺乏，透過本計畫將可協助斐國健全該國預防、治療、復健之精神衛生醫療體系，並有助於提升精神衛生服務之可近性。

三、計畫書初稿

請參考附件二：工作計畫書初稿、計畫 DMF 表及指標規劃表，另相關指標將由斐方於本年 8 月底前提供以茲確認。

四、斐濟歷年友好醫事人員訓練計畫學員返國成效評估

(一)、執行方式與內容

1. 執行方式：

斐國歷年友好醫事人員訓練計畫 9 名學員名單(附件五)於任務行前洽請駐處惠轉斐國衛生部協助安排訪談事宜，由本會人道援助處曾組長筠清及鄧計畫經理雅文執行學員訪談評估。

斐國衛生部為避免本會訪談人員舟車勞頓，安排已聯繫上之 4 名受訪學員們至衛生部辦公室或以 Skype 通話方式進行。另，藉由與受訪學員訪談中得知其餘學員聯絡方式後，分別約談及以電子郵件寄送訪談紀錄表的方式進行。

2. 執行內容：

本次成效評估紀錄表問題綱要設計沿用本年 2 月之評估報告，係針對受評人詢問其個人在台所學知識技能、返國後有無運用在個人工作上並分享予職場同事、受評人個人未來規劃以及受評人未來發展潛力等 5 個面向評核。

有關訪談受評人職場上之同事(包含長官及下屬)面向，因本次訪談安排並非至受評人工作地進行而闕如，且僅 2 位受評人完成此面向評核，爰本次僅針對受評人共計 5 面向進行學員返國後之成效評估。

(二)、評核發現(學員訪談紀錄彙整表整理如附件六)：

1. 斐國醫事人員調動頻率高或服務地點分散於各地：

(1)本次擬評核之 9 名學員，透過面對面訪談者 3 名(位於 Suva 附近)、Skype 通話訪談者 3 名(位於北島)以及電子郵件回收訪談紀錄表 1 名，共計完成 7 名學員返國後評估。其中僅 2 名職務及服務地點與受訓前相同，其餘皆調動過(1 名辭職改任教於斐濟國立大學護理學院)。

(2)另外，未受訪學員計 2 名：T 女士(2009 年來台受訓)業已辭職無法聯繫上、Q 女士(2013 年來台受訓)職務及服務地點未變更但無回應(透過電子郵件傳送訪談紀錄表)。

2. 受評人方面：

(1)7 名學員對在台所學大部分均能清楚描述。於返國後，在職場上除能將在台所學運用於工作上，亦能用報告分享與臨床實際操作之方式與同事分享，或能將斐國現有衛生體制與在台所學相比較，進而推動改善。

(2)本次訪談評核由本會人員自行擔任，無額外聘請醫療相關

領域專家協助，爰渠等在專業知識上之水平面向較難給予評核。

(3)另，本次訪談安排主要集中於斐國衛生部辦公室，未能直接至受評人工作現場實地訪視並記錄具體改善情形，惟3名位於本次任務所在地Suva附近之學員，於會後另安排至渠等工作現場訪視。

A.R醫師：於Suva糖尿病中心增設無障坡道，以俾不良於行之病患行動；另將所學融合斐國所需，刻正擬定足部照護指南(guildline)，訪談時可看見該中心醫護實習生針對糖尿病及營養相關議題的小組均討論踴躍。

B.K女士：設置發燒病患急診隔離區(登革熱)、改善候診環境及流程，並分享及教導其他護士配合醫師，詳細撰寫醫囑，以利醫生掌握病患病情。

C.S女士：提醒院區護理人員更新執業執照。

3. 受評人同事評核受評人方面：本次訪談學員R醫師、K女士以及S女士均提供1至2位同事協助填寫問卷及接受訪談；渠等之同事表示渠等返國後，均能在工作環境中與同事分享在台經驗且對渠等之專業技能表示肯定，惟S女士於2周前才自北島Labasa醫院調至CWM醫院，伊之2名同事僅表達希望未來CWM人員也能參與類似在職訓練計畫。

(三)、分析與建議

1. 從學員訪談質性結果看來，無論是學員本身或是職場同事均對渠等來台受訓表示正面之評價，並能於返國後與同事們分享其在台所學，已可見本訓練計畫之成效，若能持續追蹤與評估以維持在台所學之知識與技術，本計畫「有效提升夥伴國醫事人員之能力建構」之目標應能達成。

2. 承上，亦由本會評核人依訪談結果給予學員評分(學員評核資料量性分析：計量表各項評量分數由1至5，總分以50分計；評值分數代表意義為1-5無明顯進步、6-10尚待改

進、11-15 尚可、16-20 佳、21-25 優)，7 名學員評核計量表彙整如附件七：

(1)本次共有 7 名在台受訓之學員由本會人員評核，得分為 19-25 分，平均分數為 21.29 分(優)。

(2)其中 K 女士及 T 醫師敘述渠在台所學之課程內容及其所學面向時，較無組織及具體說明，爰得分較低。

3. 針對友好國家醫事人員訓練計畫之未來建議

(1)專科的認證課程：斐國缺乏專科訓練課程，學員表示倘能在來台受訓後獲得認證，也將有助渠等於職場上的發展。

(2)來台受訓學員人選的選擇應配合夥伴國醫療需求及政策：本次 9 名學員返國後大多未有升遷機會，更有 2 名返國後離開原臨床醫療體系，建議夥伴國於推薦人選時慎重考量學員返國後之發展，以達本訓練計畫效益。

(3)鑒於本計畫過去挑選來台受訓學員時，較無明確策略，運用現有評估表進行返國後成效評估時，有許多限制，未來除建議配合中、長期專案計畫挑選來台學員外，在問卷設計上或許可再簡化以符合實際狀況。

4. 在評核方法上的限制與建議說明如下:

(1)評核人非相關醫療專科背景，爰「受評人在專業知識上之水平」面向評核闕如：歷年友好國家醫事人員訓練計畫學員受訓專科廣泛，本次斐濟 9 名學員受訓科別包括內科、醫務管理、護理、營養及公共衛生，且本次評核人由本會人員擔任非醫療背景，亦難邀請熟悉所有專科別之單一專家擔任，此為進行本計畫成效評估之最大限制。

(2)訪談非至受評人工作地點進行：

A. 量性評核分數由本會人員僅藉受評人敘述主觀評核，缺少實地參訪確認受評人敘述內容。

B. 訪談職場同事(包含長官及下屬)之受評人工作效能改變、分享、貢獻及實地訪查等面向闕如。

C. 未來倘配合專案計畫，可視條件允許，運用志工或駐地計畫經理協助進行訪談，方可排除此一限制。

(3) 學員返國後多調動：訪談職場同事(包含長官及下屬)因渠與受評人共事時間不長，訪談效果有限，且鑒於人員調動為發展中國家之常態，未來建議應改為彈性方式辦理，倘情況許可則可選擇訪談職場同事，而非必要，以避免誤差。

5. 不易聯絡上返國學員進行訪談：

(1) 渠等來台受訓時所提供之工作電子郵件信箱，易因渠等歷經職務調動失去聯繫；另，部分學員表示無經常查閱電子郵件之習慣。

(2) 本次共計完成 7 名訪談報告，其中 4 名事前未聯繫上但由受訪人提供，且 1 名因聯繫太匆促，雖有意願接受面對面訪談而無時間。

(3) 未來將盡量收集學員手機或電話，以改善不易連絡之問題。

參、結論與建議

一、結論

與斐國達成計畫共識，計畫資源將著以疾病預防、治療及復健三方面提升精神衛生體系功能。本次考察與斐國衛生部部長 Dr. Neil Sharma 先生、醫療服務局副祕書長 Dr. Meclusela Tuicavau 先生、St. Giles 醫院院長 Dr. Peni Biukoto 先生及斐濟國立大學醫學護理及健康學院(FNU CMNH)院長 Ian Rouse 教授討論各項計畫項目，並建立本計畫將強調疾病預防、治療及復健之能力建構之發展共識，為此分別訂定主要計畫影響、成果、產出如下：

計畫影響：降低精神病患之再住院率

計畫成果：提升精神衛生服務之可近性

計畫產出：1. 精神衛生所需之醫療及照護團隊之能力建構；2. 強化精神衛生照護機構功能；3. 協助政府對精神健康議題之掌握。

另計畫詳細內容由斐國指派協調窗口，後續協助規劃詳細

時間、預算等後續事項於本年八月底前提供，並達成下列共識：

(一) 預防方面

1. 馬偕紀念醫院設立時間與 St. Giles 醫院相差約 4 年，惟精神衛生醫療服務發展差異甚大，主要原因為斐國缺乏自殺防治中心，爰將在衛生部架構下設置具通報系統及精神障礙者個案追蹤管理系統。
2. 建立一套精神健康教學所需之標準教材，爰請馬偕紀念醫院提供大綱並協助斐國發展符合當地文化風俗之內容。
3. 依計畫設計，自殺防治中心之資料應能協助界定斐國危險因子分析報告 1 份(求助行為調查報告)，提供斐國未來政策擬定之參考。
4. 本計畫旨在提升斐國精神衛生之醫療健康體系功能，倘能建立典範經驗(best practice)將有助與太平洋區域島國分享，爰建議計畫內納入辦理 1 場次之區域研討會。

(二) 治療：斐國醫護人力缺乏，各項訓練需分年完成，並以種子教師方式進行返國後培訓當地相關醫護人員訓練。

1. 目前斐國精神專科醫師養成僅 1 年的訓練並欠缺次專科訓練如心理治療(psychotherapy)及兒童青少年心智科(child and adolescent psychiatric)，爰來台外訓延長至 9 個月並冀參與本次考察團之馬偕紀念醫院能以國際學位學程方式，於受訓完畢時與斐濟大學共同頒發證書予斐國精神科醫師。
2. 原規劃建立一套遠距諮商機制以供斐國精神科醫師受訓返國後仍可與本次考察團之馬偕紀念醫院顧問進行個案討論，斐國國立大學護理及健康學院(FNU CMNH)院長 Ian Rouse 教授表示將由該院提供設備。

(三) 復健

1. 於 St. Giles 醫院建置 1 處日間照護中心及 1 處庇護工廠，協助訓練出院病患逐步回歸社會。

2. 依計畫設計，斐國缺乏之職能治療師及個案管理師將以培訓護理相關人員轉任之，為達此目標，職能治療師及個案管理師種子教師訓練課程須通過斐國國立大學護理學院審核通過，爰請參與本次考察團之馬偕紀念醫院顧問協助提出前述課程規劃，斐國衛生部將協助該課程通過審核。

二、 建議

(一)精神衛生議題近年來成為 WHO 重要關注議題，且在 2013 年太平洋區域會議中，區域各國亦達成精神衛生是很重要共通議題之共識，鑒於斐國在政治、學術及社會影響力均扮演南太平洋國家領導者之角色，本會介入此一計畫有助於透過協助斐國建立可行之精神衛生健康體系，未來將計畫效果外溢至區域國家，擴大影響力。

(二)承上，公共衛生計畫建議可以區域角度思考：

1. 斐濟為太平洋區域各島國中，屬精神衛生方面之先驅：
   (1)該區域僅斐濟及巴布亞紐幾內亞具有精神科醫院，且其他各島國皆有醫師赴斐受精神專科之一年訓練課程。
   (2)WHO 斐濟辦事處精神衛生技術員 Dr. Yutaro Setoya 表示，曾偕同斐國國立大學 Dr. Odille Chang 至 Tonga 辦理精神衛生相關訓練課程。
2. 鑒於公衛醫療在預防、治療等面向，均可借用區域經驗來實踐，未來選擇夥伴國可優先以該區域具代表性(領導地位)之國家為考量，有助於擴大計畫效益。

(三)未來可思考透過計畫提升我國醫療教育國際能見度：依本計畫設計，斐國精神科醫師來台於參與本次考察團之馬偕紀念醫院進行為期9個月之次專科訓練，倘能將訓練課程規劃為正式認證學程，更有助於我國醫療教育於國際上能見度之提升。

三、 潛在風險

依本計畫設計，影響、成果及產出皆有不同之風險，包括下列數點：

(一) 影響的部分倘斐國政治情況及政策改變，計畫設計之各項要素無法均能落實執行，此節後續應視大選結果再與斐方確認計畫規劃

符合斐國所需。

(二) 醫療機構及警消單位通報不確實、個管人員無確實追蹤、偏遠地區個案無法追蹤及各機構間合作聯繫不良，此節將由衛生部居中協調並每季召開利害關係人會議建立共識。

(三) 來台受訓之種子師資返回斐國後未能續留原職發揮所長，因人才流動造成訓練後之計畫成果無法累積，此節建議由斐國衛生部與我國專家顧問共同遴選合適對象，並由衛生部與受訓人員訂定返國後服務契約。

肆、後續追蹤

一、 2014年8月底前由斐國衛生部提交本計畫計畫書時程規劃及斐方投入之預算。

二、 預計2014年10月底前完成計畫評估任務及提報董事會。

三、 2015 年 9 月前完成相關文件及兩國協定草稿，並請駐處協助洽斐國於2015年12月前確認協定內容相關事宜。

上述為暫訂時程規劃，將視斐國大選後再行調整。

伍、駐處意見

駐斐濟代表處程大使其蘅對本次計畫事實調查任務之成果表示肯定，從各場利害關係人會議討論踴躍度來看，斐國政府很重視有關精神衛生議題。另建議本次考察團應將斐國當地文化民情納入考量，以俾計畫順利執行。

陸、誌謝

本次赴斐國進行「斐濟精神衛生之醫療照護體系功能提升計畫」事實調查任務期間，在駐斐濟代表處程大使其蘅及全體館員安排與協助下，考察行程方能順利完成，在此一併誌謝。

附件一、行程表

Program for Medical Professional visitors from ICDF and Makay Hospital

Monday, June 2, 2014

08:35 Arrival at Nadi on KE137
12:10 Arrival at Suva on FJ011
15:00 Pick up from Southern Cross Hotel
15:35 Courtesy call to Honorable Minister of Health Dr. Neil Sharma
16:30 Courtesy call to the Fiji National Medical School
17:50 Pick up from Southern Cross
18:00 Welcome dinner at Café 30

Tuesday, June 3, 2014

9:00 Pick up from Sounthern Cross Hotel to MOH
9:30 Presentations
Dr. Devina Nand
Mr. Simon Salveen Kumar
Dr. Jane Andrews
Dr. Eric Rafai
15:00 Taiwan group meeting
16:00 Visiting Trade Mission of the Republic of China (Taiwan) to the Republic of Fiji, meeting with Reprecentative Ms. R. Jane Cheng

Wednesday, June 4, 2014

9:00 Pick up from Sounthern Cross Hotel to
9:30 Presentations
Ms. Lesieli Tuiwawa
Mr. Ratish Singh
Dr. Mecuisela Tuicakau
Dr. Peni Biukoto
FNU Dr. Myrielle Allen
Dr. Rammohan Malesu
NGOs
Mr. Ratish Singh
13:50 LUNCH
14:00 Visiting WHO Fiji Office, meeting with Dr. Yutaro Setoya

Thursday, June 5, 2014

9:00 Pick up from Sounthern Cross Hotel

9:10	Visiting NOGs: Mental Health Alliance, Youth Champs for Mental Health, Psychiatnic Sunvivors association Fij
10:15	Visiting St. Giles Hospital
15:00	Courtesy call to Fiji President

Friday, June 6, 2014

10:00	Pick up from Sounthern Cross Hotel
10:30	Debrief with the Minister, PSH and Senior Management
12 Noon	LUNCH (Courtesy of the MOH)
13:00	Wrap up meeting
17:00	Debrief with Reprecentative Ms. R. Jane Cheng

Saturday, June 7, 2014

07:30	Makay Hospital 4 person check out and depart to Nausori Airport (FJ10 10:00)

Sunday, June 8, 2014

07:30	Makay Hospital 4 person check out and depart to Nausori Airport (FJ10 10:00)

Monday, June 9, 2014

09:30	Pick up from Sounthern Cross Hotel to MOH
10:00	Interviewing with Dr. R-
11:00	Interviewing with Ms. V- by Skype
11:40	Interviewing with Dr. T- by Skype
13:00	Interviewing with Ms. K- by Skype
14:10	Interviewing with Dr. M- (supervises Ms. S- and Ms. K-) by Skype

Tuesday, June 10, 2014

09:30	Pick up from Sounthern Cross Hotel to MOH
10:00	Interviewing with Ms. S-
11:30	Visiting CWM (Ms. S-)
12:00	Visiting Valelevu Medical Health Center for Interviewing with Ms. K- and her coworkers, Dr. F- and Dr. S-
14:00	Visitng CWM Diebetes Center (Dr. R-) and interviewing with Dr. F- (supervises Dr. R-)

Wednesday, June 11, 2014

04:30 TaiwanICDF 2 person check out and depart to Nausori Airport (FJ006 06:30)
09:55 Depart to Incheon Airport (KE138 9:55)
17:35 Arrived at Incheon, Korea

Thursday, June 12, 2014
08:00 TaiwanICDF 2 person check out and depart to Incheon Airport (KE691 10:35)
13:00 Arrived at Taiwan

附件二、工作計畫書初稿、計畫 DMF 表及指標規劃表

斐濟精神衛生之醫療照護體系功能提升計畫工作計畫書初稿

一、計畫摘要

（一）計畫名稱：斐濟精神衛生之醫療照護體系功能提升計畫

（二）計畫領域：公共衛生

（三）執行地點：亞太地區 (Asia Pacific)/斐濟 (Fiji)

（四）計畫期程：民國 105 年 01 月 01 日至民國 107 年 12 月 31 日

（五）執行單位：斐濟 (Fiji)衛生部

（六）計畫金額：美金 0 元

1. 斐濟 (Fiji)：美金 0 元
2. 國合會 (TaiwanICDF)：美金 0 元

（七）摘要說明：精神衛生之疾病負擔係近年來嚴峻及耗費資源之全球性議題，根據世界衛生組織(WHO)的估計，全世界約有 1.25 億人酗酒並受酒精導致之精神障礙所苦，在精神、神經及物質使用障礙所造成的負擔佔全球疾病總負擔的 14%，其中又有四分之三的負擔由低收入和中等收入國家承擔。斐濟近年來在精神衛生方面面臨嚴重問題，既有之精神衛生相關醫療照護資源不足以支應該國所需，斐濟政府亦已將此議題納入 2011 至 2015 年之國家策略文件中，並認為應藉由訓練增加精神衛生相關工作者，並在各社區增加相關服務，以解決該國精神衛生相關問題。目前斐濟精神衛生領域遭遇之挑戰包括：缺乏有訓練的精神衛生專業人員以及精神衛生照護工作者、全國唯一之精神科醫院(St. Gilesl)缺乏完整照護功能、缺乏精神衛生相關流行病學資料等。鑒於我國在精神衛生方面，具備完善醫療資源且具備完善之個案管理系統，爰本計畫將透過以下方式協助斐國提升精神衛生體系：1. 精神衛生所需之醫療及照護團隊之能力建構；2. 強化專科醫院之精神衛生照護機構功能； 3. 協助完成精神衛生現況相關流行病學分析報告。

二、計畫緣由

（一）計畫來源：

精神衛生之疾病負擔係近年來嚴峻及耗費資源之全球性衛生問題，根據世界衛生組織(WHO)的估計，全世界約有 1.25 億人酗酒並受酒精導致之精神障礙所苦，在精神、神經及物質使用障礙所造成的負擔佔全球疾病總負擔的 14%，其中又有四分之三的負擔由低收入和中等收入國家承擔。 斐濟近年來在精神衛生方面面臨嚴重問題，根據 2010 年資料顯示，精神疾病病患於斐濟 St. Giles Hospital 住院長度平均為 110 天，佔床率為 108.25(總計 136 床)。顯示該國既有之精神衛生相關醫療照護資源不足以支應該國所需。此外，相關資料顯示斐國門診病患經診斷，45%為精神分裂、30%為情緒失調疾病；住院病患 50.7%為精神分裂、38%為情緒失調疾病、2%為人格障礙，足以顯示精神分裂係該國精神衛生重要挑戰，而相關患者倘可適時接受協助，則可降低演變為精神重病患者之機率。斐濟政府雖已將精神衛生納入該國 2011 至 2015 年內之重要健康政策，惟在相關精神衛生醫療團隊人員之能力、衛生資訊系統涵蓋面、相關流行病學資料等方面仍相當缺乏，爰斐濟向我國提出本計畫，希冀透過我國之經驗，強化該國精神衛生體系。

（二）現況說明：

目前斐濟精神衛生領域遭遇之挑戰包括：缺乏有訓練的精神衛生專業人員以及精神衛生照護工作者、全國唯一之精神科醫院(St. Gilesl)缺乏完整照護功能、缺乏精神衛生相關流行病學資料等。在精神衛生照護方面嚴重不足，鑒於我國在精神衛生管理功能上功能健全，無論在醫療照護能力或精神病患者之相關處置模式皆有豐富經驗，相關精神衛生作業方面均已有完整之標準作業程序(SOP)，可協助斐國強化精神衛生之醫療及照護體系，降低精神疾病之負擔。爰斐濟向我國提出技術協助請求，盼藉由我國成熟經驗協助斐國提升精神病患者之醫療及照護體系，進而改善該國公衛醫療品質。

三、 預期結果：

（一）計畫影響：

降低精神病患之再住院率

（二）計畫成果：

提升精神衛生服務可近性(被個管之企圖自殺病人死於自殺需少於 5%)

（三）計畫產出：

1. 精神衛生所需之醫療及照護團隊之能力建構
   (1) 提供斐國 13 名精神衛生所需醫療照護團隊人員。
   (2) 由已受訓之種子教師返回斐國後，進行當地相關人員之培訓，預計共將培訓 57 名。
   (3) 建立精神健康教學所需之標準資源 1 套。
2. 強化精神衛生照護機構功能
   (1) 協助設置 1 處日間照護中心及 1 處庇護工廠(St. Giles 醫院)。
   (2) 建置自殺防治中心(MoH 架構下)
3. 協助政府對精神健康議題之掌握
   (1) 協助提出斐國危險因子分析報告 1 份(求助行為調查報告)。
   (2) 透過利害關係人會議每季至少 1 次建立共識。
   (3) 至少舉辦 1 次精神健康議題相關研討會。

計畫「計畫設計及監控架構」(DMF)表 (概要版)

	設計概要	標的/指標	監控機制	假設/風險
影響	降低精神病患之再住院率	● 計畫結束後 3 年，精神病患之再住院率降低至 30%	● 斐國衛生部提供之數據	假設：計劃設計之各項要素均能落實執行。 風險：斐國政治情況及政策改變。
成果	提升精神衛生服務可近性	● 計畫結束時，被個管之企圖自殺病人死於自殺需少於 5%(每名個管師管理至少 20 個病人/每月)	● 個案管理系統產生之數據	假設：通報體系及個案管理系統均發揮應有功能 風險：醫療機構及警消單位通報不確實、個管人員無確實追蹤、偏遠地區個案無法追蹤
產出	1. 精神衛生所需之醫療及照護團隊之能力建構 (1) 提供斐國 13 名精神衛生所需醫療照護團隊人員 (2) 由已受訓之種子教師返回斐國後，進行當地相關人員之培訓，預計共將培訓 57 名 (3) 建立精神健康教學所需之標準資源 1 套 2. 強化精神衛生照護機構功能 (1) 建置 1 處日間照護中心及 1 處庇護工廠	● 在計畫結束前，提供斐國 13 名精神衛生所需醫療照護團隊人員。 ● 在計畫結束時，由已受訓之種子教師返回斐國後，進行當地相關人員之培訓，預計共將培訓 57 名。 ● 在計畫結束時，建立精神健康教學所需之標準資源 1 套。 ● 計畫結束時，協助建置 1 處日間照護中心(St. Giles 醫院)及 1 處庇護工場(St. Giles 醫院，產品將在市場販賣) ● 計畫結束時，在斐國衛生部架構下建置自殺防治	● 計畫經理按月監控進度	假設：經過訓練的醫護人員皆合格並且願意留在該區工作 假設：各機構間合作無礙 風險：各機構間合作聯繫不良

	(St. Giles 醫院) (2) 建置自殺防治中心 3. 協助政府對精神健康議題之掌握 (1) 協助提出斐國危險因子分析報告 1 份(求助行為調查報告)。 (2) 透過利害關係人會議每季至少 1 次建立共識。 (3) 至少舉辦 1 次精神健康議題相關研討會。	中心：通報系統及精神障礙者個案追蹤管理系統。 ● 計畫結束時，協助提出斐國危險因子分析報告 1 份(求助行為調查報告)。 ● 計畫結束前，透過利害關係人會議每季至少 1 次建立共識。 ● 計畫結束時，至少舉辦 1 次精神健康議題相關研討會。		
	<u>活動及里程碑</u>： 1. 精神衛生所需之醫療及照護團隊之能力建構 1.1. 提供斐國 13 名精神衛生所需醫療照護團隊人員 1.1.1. 計畫開始後第 8 個月完成 1 名精神科主治醫師，第 20 個月完成 2 名精神科主治醫師來台 9 個月專科訓練(心理治療、老人精神科及兒童青少年心智科) 1.1.2. 計畫開始後第 12 個月完成 2 名資深護理人員，第 22 個月完成 5 名資深護理人員來台 2 個月臨床實習 1.1.3. 計畫開始後第 5、12 個月完成 2 名職能治療師，第 17、22 個月完成 4 名職能治療師來台 4 個月臨床實習(每次來台 2 個月) 1.1.4. 計畫開始後第 5 個月完成 2 名個案管理師來台 2 個月訓練 1.2. 由已受訓之種子教師返回斐國後，進行當地相關人員之培訓，預計共將培訓 57 名 1.2.1. 計畫開始後第 36 個月，種子精神科住院醫師 3 名返回斐國後完成須完成至少 3 名精神科住院醫師培訓 1.2.2. 計畫開始後第 24、36 個月，種子資深護理人員 5 名返回斐國後完成須分別完成至少 20 名、50 名護理人員培訓 1.2.3. 計畫開始後第 24、36 個月，種子職能治療師 4 名返回斐國後完成須分別完成至少 2 名、4 名職能治療師培訓 1.2.4. 計畫開始後第 24 個月，種子個案管理師 2 名返回斐國後完成須分別完成至少 4 名個案管理師培訓			**<u>投入</u>**： **<u>國合會</u>**： **<u>馬偕紀念醫院</u>**： **<u>斐濟</u>**：待斐國提供確切投入金額

1.3. 建立精神健康教學所需之標準資源 1 套 1.3.1. 計畫開始後第 18 個月完成建立精神健康教學所需之標準教材 1 套 1.3.2. 計畫開始後第 24 個月完成訓練 30 名精神健康衛教員 1.3.3. 計畫開始後第 36 個月，已受訓之精神健康衛教員完成辦理 60 場宣導課程，參加者至少 1,000 名。 2. 強化精神衛生照護機構功能 2.1. 計畫開始後第 24 個月完成建置 1 處日間照護中心(St. Giles 醫院)及 1 處庇護工廠(CWM) 2.2. 計畫開始後第 12 個月完成建置自殺防治中心 3. 協助政府對精神健康議題之掌握 3.1. 計畫開始後第 36 個月完成協助提供斐國危險因子分析報告 1 份(求助行為調查報告)，供後續相關政策訂定之參考 3.2. 計畫開始後第 4、8、12、16、20、24、28、32、36 個月辦理利害關係人會議至少各 1 次以建立共識 3.3. 計畫開始後第 36 個月，至少舉辦 1 次精神健康議題相關研討會	

指標規劃表

	指標 Index	指標的內容與定義 Content and definition of index	基線與標的 Baseline and goal	資料來源及蒐集方式	監控及蒐集資料的頻率	負責人
影響	降低精神病患之再住院率	■ 精神病患:急性、慢性、日間照護中心之住院病患 ■ 再住院:精神病患在出院後3個月內再次住院至急性病房 ■ 再住院率: 精神病患再住院人數÷自急性 an acute 、慢性、日間照護中心出院之人數	**標的 Goal**： ● 計畫結束後 3 年降低至 30% **基線 Baseline**： 斐國衛生部 2014 年 67%(St. Giles 醫院病患再住院率，待斐國確認)	1. 斐國衛生部提供之數據 2. 每半年追蹤一次、每年提報一次	1. 計畫結束後 3 年	1. 斐國協調人聯絡衛生部定期提供該國統計資料
成果	提升精神衛生服務可近性	■ 精神衛生服務: 由精神醫師、護理人員、職能治療師、個案管理師、政府衛生部門相關人員所能提供之預防、治療、復健等 ■ 可近性:被個管之企圖自殺患者獲得精神衛生服務之頻率	**標的**： ● 在計畫結束時，被個管之企圖自殺病人死於自殺需達到少於 5% **基線**： 個案管理系統第一年底產生之數據。	個案管理系統產生之數據	1. 計畫執行第 24 個月 2. 計畫結束時	1. 由本會駐外計畫經理負責規劃及監控進度 2. 由斐國協調人負責
產出	1.1. 斐國精神衛生所需醫療照護團隊人員數	■ 精神衛生所需醫療照護團隊人員: 由精神醫師、護理人員、職能治療師、個案管理師、政府衛生部門相關人員等組成	**標的**： ● 計畫開始後第 8 個月(months)完成 1 名主治醫師來台專科(心理治療、老人精神科及兒童青少年心智科)訓練 ● 計畫開始後第 20 個月完成 2 名精神科主治醫師來台專科訓練(心理治療、老人精神科及兒童青少年心智科) ● 計畫開始後第 12 個月完成 2 名資深護理人員來台臨床實習	實際監控	1. 計畫執行第 12 個月 2. 計畫執行第 24 個月 3. 計畫結束時	1. 由本會駐外計畫經理負責規劃及監控進度 2. 由斐國協調人負責課程聯繫與安排 3. 由會內計畫經理聯繫代訓單位及學員在台

	指標 Index	指標的內容與定義 Content and definition of index	基線與標的 Baseline and goal	資料來源及蒐集方式	監控及蒐集資料的頻率	負責人
			● 計畫開始後第第 22 個月完成 3 名資深護理人員來台臨床實習 ● 計畫開始後第 5、12 個月完成 2 名職能治療師(occupational therapist) ● 計畫開始後第第 17、22 個月完成 4 名職能治療師來台臨床實習 ● 計畫開始後第 5 個月完成 2 名個案管理師(case manager)來台訓練			相關事宜
	1-2. 由已受訓之種子教師返回斐國後，進行當地相關人員之培訓人數	■ 種子教師：由斐國一人員專業、個性及背景等考量，推薦之適合來台訓練人選，渠等返國後將在駐地訓練其餘醫護人員。 ■ 當地相關人員：精神科住院醫師、護理人員、職能治療師及個案管理師。	標的： ● 計畫開始後第 24 個月，種子資深護理人員 5 名、種子職能治療師 4 名、2 名種子個案管理師返回斐國後完成須分別完成至少 20 名護理人員、2 名職能治療師、4 名個案管理師培訓 ● 計畫開始後第 36 個月，種子精神科住院醫師 3 名、種子資深護理人員 5 名、種子職能治療師 4 名返回斐國後完成須分別完成至少 3 名精神科住院醫師、50 名護理人員、4 名職能治療師培訓	實地監控	1. 計畫執行第 24 個月 2. 計畫結束時	1. 由本會駐外計畫經理負責規劃及監控進度 2. 由斐國協調人負責課程聯繫與安排 3. 由種子師資進行授課
	1.3. 建立精神健康教學所需之標準資源數	■ 精神健康教學所需之標準資源：精神健康之預防、治療及復健等知識之推廣教材。	標的： ● 計畫開始後第 18 個月完成建立精神健康教學所需之標準教材 1 套 ● 計畫開始後第 24 個月完成訓練 30 名精神健康衛教員 ● 計畫開始後第 36 個月，已受訓之精神健康衛教員完成辦理 60 場宣導課程，參加者至少 1,000 名。	實際監控	1. 計畫執行第 18 個月 2. 計畫執行第 24 個月 3. 計畫結束時	1. 由本會駐外計畫經理負責規劃及監控進度 2. 由斐國協調人負責課程聯繫與安排
	2-1. 建置日	■ 日間照護中心：讓精神症狀穩	標的：	實際監控	1. 計畫執行第 24 個月	1. 由本會駐外計

	指標 Index	指標的內容與定義 Content and definition of index	基線與標的 Baseline and goal	資料來源及蒐集方式	監控及蒐集資料的頻率	負責人
	間照護中心(St. Giles 醫院)及庇護工廠(CWM)數	定的病人，白天接受治療之單位：提供藥物治療、健康護理指導、生活技巧訓練、工作訓練、團體活動、社交技巧訓練和戶外運動等活動，以維持其部份社會及工作能力，來協助病人及早回到社區；晚上則回家過家居的生活。 ■ 庇護工廠：幫助經規律治療與復健下，症狀日趨穩定且能正常工作之精障人員進行工作能力復健之單位。	● 計畫開始後第 24 個月完成建置 1 處日間照護中心(St. Giles 醫院)及 1 處庇護工廠(CWM)			畫經理負責規劃及監控進度 2. 由斐國協調人負責聯繫與安排
	2-2 於衛生部架構下建置自殺防治中心數	■ 自殺防治中心：協助各區推動自殺防治關懷網絡，促進標準化自殺防治通報及介入流程，活絡社區支持網絡，落實於以病人為中心、家庭為單位、社區為基礎之全人醫療，並有效對自殺企圖者進行妥善照顧之國家級機構。	標的： ● 計畫開始後第 12 個月完成建置自殺防治中心，含 1 套通報系統(report system，專線、email 及傳真通報)及 1 套精神障礙者個案追蹤管理系統(包括因自殺住院之病患出院後之追蹤) ● 計畫開始後第 13 個月起，每個案追蹤至少 3 個月，直至不危險時倘能結案：高危精神障礙者每周進行 1 次電話追蹤、電話無法聯繫者每月家訪 1 次；中危精神障礙者每 2 周 1 次電話追蹤、電話無法聯繫者每 3 月家訪 1 次；低危精神障礙者每月 1 次電話追蹤、電話無法聯繫者每 3 月家訪 1 次。	實際監控	1. 計畫執行第 12 個月 2. 計畫結束時	1. 由本會駐外計畫經理負責規劃及監控進度 2. 由斐國協調人負責聯繫與安排 3. 由 FHIS 人員進行系統撰寫與上線
	3-1. 提供斐國危險因子分	■ 危險因子分析報告：根據自殺防治中心、各級醫院及斐國衛	標的： ● 計畫開始後第 36 個月完成協助提供斐國	實際分析撰寫	1. 計畫執行第 X 個月 2. 計畫執行第 X 個月	1. 由本會駐外計畫經理負責撰

	指標 Index	指標的內容與定義 Content and definition of index	基線與標的 Baseline and goal	資料來源及蒐集方式	監控及蒐集資料的頻率	負責人
	析報告份數(求助行為調查報告)	生部之資料，依各種族、性別、年齡、等族群之精神疾病型態進行統計，計算疾病發生率及盛行率，分析疾病原因並提出可改善方案及政策建議。 ■ 求助行為：指一個人或體系有需求或有問題時，向他人求助的過程。	危險因子分析報告 1 份(求助行為調查報告)		3. 計畫結束時	寫 2. 由斐國協調人負責聯繫與安排 3. 蒐集活動由斐國協調人負責
	3-2. 利害關係人會議次數	■ 利害關係人：斐國衛生部、教育部、警消單位、斐國國立大學及 NGO 等	標的： ● 計畫開始後第 4、8、12、16、20、24、28、32、36 個月辦理利害關係人會議至少各 1 次以建立共識	實地監控	1. 計畫執行第 4 個月 2. 計畫執行第 8 個月 3. 計畫執行第 12 個月 4. 計畫執行第 16 個月 5. 計畫執行第 20 個月 6. 計畫執行第 24 個月 7. 計畫執行第 28 個月 8. 計畫執行第 32 個月 9. 計畫結束時	1. 由本會駐外計畫經理負責規劃及監控進度 2. 由斐國協調人負責聯繫與安排
	3-3.舉辦精神健康議題相關研討會次數	■ 研討會：邀請區域專家參與，共同討論計畫執行成果與影響	標的： ● 計畫開始後第 36 個月，至少舉辦 1 次精神健康議題相關研討會	實地監控	計畫結束時	1. 由本會駐外計畫經理負責規劃及監控進度 2. 由斐國協調人負責聯繫與安排

附件三、考察期間會議暨工作紀錄

相關附件資料因涉及個人資料之保護，保留不予公開

附件四、斐國精神衛生法規

EXTRAORDINARY 1285

REPUBLIC OF FIJI ISLANDS GOVERNMENT GAZETTE

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[1778]

GOVERNMENT OF FIJI

MENTAL HEALTH DECREE 2010
(DECREE NO. 54 OF 2010)

SECTIONS

MENTAL HEALTH DECREE 2010
(DECREE NO. 54 OF 2010)

IN exercise of the powers vested in me as President of the Republic of Fiji and the Commander in Chief of the Republic of Fiji Military Forces by virtue of the Executive Authority of Fiji Decree 2009, I hereby make the following Decree—

A DECREE TO PROVIDE FOR THE ADMINISTRATION OF MENTAL HEALTH IN FIJI

PART 1—PRELIMINARY

Short title, commencement and application

1.—(1) This Decree may be cited as the Mental Health Decree 2010.

(2) This Decree shall commence on a date or dates appointed by the Minister by notice in the *Gazette*.

(3) This Decree shall bind the State.

Interpretation

2.—(1) In this Decree, unless the context otherwise requires—

"accused person" means a person who is charged with a criminal offence or in respect of whom police or other official investigations with respect to a suspected offence are being conducted;

"administer" in relation to treatment includes cause or knowingly permit the treatment to be administered;

"adult" means a person aged 18 years or over;

"Advisory Council" means the National Advisory Council on Mental Health established by section 10;

"ambulance officer" or "transport officer", in relation to the transport of a patient includes—

(a) a person employed by or on behalf of the State to carry out ambulance services; or

(b) persons defined as an ambulance officer under the National Ambulance Decree 2010;

(c) if there is no person described in *(a)* or *(b)* available than a responsible member of the public;

"approved", in relation to a form or other matter, means approved in writing by the Permanent Secretary;
"authorised health care professional" means a health care professional who is designated under section 14;
"authorised medical practitioner" means a medical practitioner authorised in writing by the Permanent Secretary to exercise the functions of an authorised medical practitioner under this Decree;
"Board of Mental Health Visitors" means a Board of Mental Health Visitors established for a mental health facility under section 101;
"child" means a person under the age of 14 years;
"child guardian" means a person who has been appointed guardian of a child under any written law and includes—

(a) a person other than a parent of the child who has lawful custody of the child; and
(b) a person to whose care the child has been committed for the time being by a court;

"community treatment order" means an order of a kind referred to in section 57;
"Council" means the body established pursuant to section 10;
"court" means a court of competent jurisdiction as defined in the Interpretation Act (Cap. 7);
"detained person" means a person who is detained in a mental health facility pursuant to Part 4 or who is receiving involuntary inpatient treatment in a mental health facility pursuant to section 61;
"ECT" means electro-convulsive therapy;
"ECT inquiry" means an ECT administration inquiry or an ECT consent inquiry conducted pursuant to section 75;
"estate" includes property as defined in the Interpretation Act (Cap. 7)
"guardian" means—

(a) a person lawfully having charge of a child other than the parents; or
(b) a person to whose care a child has been committed even temporarily, by a person having authority over the child;

and "guardianship" has a corresponding meaning;

"health care professional" for the purposes of this Decree includes persons defined as a "health professional" in the Medical and Dental Practitioner Decree 2010; a medical assistant and any other person declared by the Minister by order to be a health care professional for the purposes of this Decree;
"health facility" means—

(a) a hospital, health centre, nursing station or prison clinic; and
(b) any other place prescribed for the purposes of this definition by the Minister by order;

"informed consent" means written consent give by a person freely and voluntarily on the basis of an informed explanation about the course of action or treatment given to the person in accordance with this Decree;
"inpatient" of a mental health facility means a person who is admitted to the facility for assessment or for care, support, treatment or protection and who has not left or been released from the facility;
"inpatient treatment order" means an order of a kind referred to in section 61;
"involuntary patient" means a patient who is not a voluntary patient and—

(a) includes a detained person in a mental health facility; but
(b) does not include a prisoner who does not have a mental disorder;

"management order" means an order made by the Court under section 108;
"manager" means the person or persons appointed under a management order to manage the whole or a part of the affairs of a person with mental incapacity;
"medical director" of a mental health facility—

(a) means the person designated or appointed as medical director of the facility under section 15; and
(b) includes an authorised health care professional to whom the relevant function has been delegated by the medical director of that facility under section 118 (2);

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"medical practitioner" means a person defined as such and is registered in the Medical and Dental Practitioner Decree 2010, "registered medical practitioner" has a corresponding meaning;

"mental disorder" means a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment or memory, motivation or emotion, whether or not the disturbance or defect is or is caused by—

(a) mental illness;
(b) personality disorder;
(c) dementia;
(d) intellectual disability; or
(e) substance abuse;

"mental health facility" means a prison hospital or clinic; or an area declared under section 8 of this Decree;

"mental health hospital" means the premises described in section 8(1) and Part A of Schedule 1;

"Mental Health Review Board" means the Mental Health Review Board established by section 95;

"mental health unit" means premises listed in Part B of Schedule 1, section 87 in regards to Part 8 and any other premises so designated by the Permanent Secretary who may amend such designations from time to time;

"mental health visitor" means a member of a Board of Mental Health Visitors or a person designated as a mental health visitor under section 101;

"mental illness" means a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person and is characterised by the presence in the person of any of the following symptoms—

(a) delusions;
(b) hallucinations;
(c) serious disorder of thought form;
(d) a severe disturbance of mood;
(e) severe motivational deficit;
(f) sustained or repeated irrational behaviour indicating the presence of the symptoms referred to above;

"mental incapacity", in relation to a person, means a mental disorder such that, because of the disorder, the person is unable to make or communicate reasonable judgments in respect of all or any of the matters relating to the person or the person's circumstances or estate;

"mentally disturbed" means a psychological or behavioural pattern that occurs in an individual and is thought to cause distress or disability that is not expected as part of normal development or culture which may result in the person being temporarily detained under this Decree;

"National Mental Health Advisor" means the person appointed to that post under section 13;

"near relative" of a person includes a parent, brother, sister, child, grandparent, aunt, uncle or spouse of the person or other familiar person such as the step parents or half siblings;

"outpatient" means a person who attends a mental health facility for examination, assessment or treatment but who is not an inpatient;

"parent" means the parent who has care and control of a child or young person (or either parent if they have joint care and control), and includes a guardian;

"patient" means a person who is—

(a) the subject of a medical examination, assessment or order under this Decree;
(b) receiving treatment at a mental health facility either as an outpatient or an inpatient;

"Permanent Secretary" means the Permanent Secretary of Health;

"prescribed" means prescribed by regulations or an order made under section 119;

"primary carer" in relation to any patient means the friend of the patient or the member of the patients family group who is most evidently and directly concerned with the oversight, administration or care and attention of the patient ;

"prisoner" means a person in custody following conviction for a criminal offence;

"private facility" means a facility licensed as a private mental health facility under section 9;
"public hospital" means a public hospital as defined in the Public Hospitals and Dispensaries Act (Cap. 110);
"recommendation certificate" means a certificate given under section 24;
"Review Board" means the Mental Health Review Board;
"special medical treatment" means—

(a) any treatment, procedure, operation or examination that is intended, or is reasonably likely, to have the effect of rendering infertile the person on whom it is carried out; or
(b) any other kind of treatment declared by the Minister by order, on the advice of the Advisory Council, to be special medical treatment for the purposes of this Decree;

"surgical operation" means a surgical procedure, a series of related surgical operations or surgical procedures, but shall not apply to the administration of an anaesthetic for the purpose of medical investigation;
"treatment team" means a treatment team as provided for by section 64;
"voluntary patient" means—

(a) a person who has been admitted to a mental health facility under Part 3; or
(b) a person who has been re-classified as a voluntary patient under this Decree;

"young person" means a person aged 14 or over but under 18.

(2) For the purposes of this Decree, written consent includes consent evidenced by a thumbprint if the person giving it cannot write.

Persons not to be regarded as having mental disorder

3.—(1) For the purposes of this Decree, a person is not to be regarded as having a mental disorder by reason only that—

(a) the person expresses or refuses or fails to express, or has expressed or has refused or failed to express, a particular political opinion or belief;
(b) the person expresses or refuses or fails to express, or has expressed or has refused or failed to express, a particular religious opinion or belief;
(c) the person expresses or refuses or fails to express, or has expressed or has refused or failed to express, a particular philosophy or cultural belief;
(d) the person expresses or exhibits or refuses or fails to express, or has expressed or has refused or failed to express, a particular sexual preference or sexual orientation;
(e) the person engages in or refuses or fails to engage in, or has engaged in or has refused or failed to engage in, a particular political activity;
(f) the person engages in or refuses or fails to engage in, or has engaged in or has refused or failed to engage in, a particular religious activity;
(g) the person engages in or has engaged in sexual promiscuity;
(h) that the person engages in or has engaged in immoral conduct;
(i) the person engages in or has engaged in criminal or other illegal conduct;
(j) the person engages in or has engaged in antisocial or delinquent behaviour;
(k) the person takes or has taken alcohol or any other drug, volatile substance or other substances capable of inducing intoxication or an altered state of mind; or
(l) any other behaviour involving a personally made decision or modus vivendi not amounting to a mental disorder.

(2) Subsection (1) *(k)* does not prevent the serious temporary or permanent physiological, biochemical or psychological effect of volatile substance taking from being regarded as an indication that a person has a mental disorder.

Principles of the Decree

4.—(1) In interpreting and implementing the provisions of this Decree, due regard must be given as far as practical and subject to available resources—

(a) to the principles approved by the World Health Organization ('WHO') in relation to mental health;

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(b) to other international agreements and standards concerning the care and treatment of the mentally disordered, including the International Covenant on Human Rights, the United Nations Convention on the Rights of the Child and the Convention on the Rights of People with Disability.

(2) As far as practicable, and subject to available resources, those responsible for implementing this Decree must aim to—

(a) promote and treat mental health and prevent mental disorders in Fiji;
(b) provide access to basic mental health care for all who need it;
(c) provide for the making of mental health assessments and diagnoses in accordance with internationally accepted principles;
(d) provide the least restrictive type of mental health care that is practicable in the circumstances of a given case;
(e) promote and provide access to mental health care in the community;
(f) promote the right of self-determination by those with a mental disorder;
(g) ensure the availability of complaint procedures and a periodic review mechanism;
(h) promote the appointment of qualified decision-makers on mental health issues;
(i) ensure the well being, safety and adequate working conditions, welfare, support, capabilities and efficiency of all persons providing any mental health services; and
(j) ensure respect for the rule of law and for human rights in regard to mental health issues.

(3) This Decree should be applied in such a manner that restrictions on the liberty of persons with a mental disorder and interference with their rights, dignity and self-respect are kept to a minimum, so far as is consistent with—

(a) their proper care, support, treatment and protection;
(b) the safety, health and welfare of other persons; and
(c) in relation to persons in custody and prisoners, the good order and security of the mental health facility, prison, or other place where they are detained.

Objectives of the Decree

5. The objectives of this Decree are—

(a) to provide for the care, treatment, management, rehabilitation and protection of people with mental illness and other mental disorders;
(b) to regulate mental health care, treatment and rehabilitation services in a manner that makes mental health care, treatment and rehabilitation services available to the population equitably, efficiently and in the best interest of mental health care users within the limits of the available resources;
(c) to co-ordinate access to mental health care, treatment and rehabilitation services by various categories of mental health care users;
(d) to integrate the provision of mental health care services into the general and wider human services environment in the cultural context of Fiji;
(e) to promote the rehabilitation of persons with mental disorders and their integration into the community at the earliest appropriate time;
(f) to facilitate the development of community mental health services including the establishment of respite and halfway homes, residential facilities and group homes;
(g) to clarify the rights and obligations of mental health care users and the obligations of mental health care providers; and
(h) to regulate the manner in which the property of persons with mental disorders may be dealt with.

Responsibilities in dealing with mental health issues

6.—(1) Persons and bodies exercising functions under this Decree, should as far as practicable and subject to available resources, aim to—

(a) ensure that persons with a mental disorder or mental illness receive the best available care, support and, if required, treatment and protection;
(b) support families and communities that are providing care and support for a person with a mental disorder;

(c) provide proper recognition of the importance and significance to persons with a mental disorder of the person's ties with his or her family, extended family and family group, with proper respect for the persons cultural and ethnic identity, language, religious and ethical beliefs and with proper recognition of the contributions those links and the values make to the person's health and well being;

(d) work towards lessening the adverse effects of mental disorder on persons with a mental disorder, their families and their communities;

(e) strengthen, develop and co-ordinate services for persons with a mental disorder their families, extended families and their communities;

(f) assist and encourage non-government agencies and organisations to provide care, support and other services for persons with a mental disorder, their families and their communities;

(g) assist and encourage the development of services designed to reduce the incidence and adverse impact of mental disorder in the community;

(h) promote informed public opinion, discussion and understanding of mental disorder and the rights of persons who have such a disorder;

(i) seek to eliminate discrimination against, and abuse, mistreatment and neglect of, persons with a mental disorder;

(j) promote a high standard of training for those responsible for the care, support, treatment and protection of persons with a mental disorder; and

(k) promote psychosocial rehabilitation; and

(l) promote research into the problems of mental disorder.

(2) Every Ministry, state entity or department responsible for health, housing, employment and community services shall subject to available resources determine and co-ordinate the implementation of its policies and measures so as to—

(a) ensure the provision of the best available mental health care, treatment and rehabilitation services in establishments managed by it;

(b) promote the provision of community-based care, treatment and rehabilitation services for mental health care users;

(c) promote the rights and interests of mental health care users;

(d) where practicable, provide access to employment and employment support for persons who suffer or have suffered from mental disorder; and

(e) generally, promote and improve the mental health status of the population.

(3) A person exercising a function under this Decree, or under an order of a Review Board, in relation to a patient, must not, except in an emergency situation and to protect the safety or health of the patient or of other persons—

(a) impose any restrictions on the patient's personal freedom, other than those authorised by this Decree or by an order made under it; or

(b) infringe the patient's dignity and self-respect more than is inherent in the restrictions so authorised.

(4) Every Ministry, state entity or department responsible for health, employment and the public service should seek to ensure—

(a) that the rights and safety of mental health workers and staff working in mental health facilities are respected and maintained as a matter of Government policy and in accordance with the laws governing occupational health and safety and employment relations;

(b) that adequate human resources and infrastructure are provided for each mental health care facility to enable best practice to be followed for risk situations (including, but not limited to at least a one-to-one staff ratio which allows for no more than 8 hours out of any period of 24 hours shift for suicidal or high risk patients);

(c) that a physical environment is provided for patients and staff at each mental health facilities to enable the least restrictive care to be provided, consistent with safety to staff and the public;

(d) that appropriate compensation and extra allowances are paid to mental health workers in positions that pose a high risk of physical assault or emotional distress in providing care and treatment to patients;

(e) that proper and adequately secured areas are provided which ensures that the appropriate staff may conduct without interruption interviews, examination, treatment, counselling and visits having due regard to the safety and privacy of staff, any particular patient and all other patients around a secure area designated under section 57.

Anti-discrimination

7.—(1) For the purposes of this section, the prohibited grounds for discrimination are the grounds that a person has or has had a mental disorder or mental illness or has been an inpatient at a mental health facility.

(2) If an applicant for employment or a worker is qualified under the standard or prescribed requirements for work of any description, an employer or a person acting or purporting to act on behalf of an employer must not—

(a) refuse to employ the applicant on work of that description which is available on the ground that the applicant has a mental disorder or mental illness;

(b) offer or afford the applicant or the worker less favourable terms of employment conditions of work, or other fringe benefits, and opportunities for training, promotion, and transfer that are made available to applicants or workers of the same or substantially similar capabilities employed in the same or substantially similar circumstances on work of that description;

(c) terminate the employment of the worker, or subject the worker to any detriment, in circumstances in which the employment of other workers employed on work of that description would not be terminated, or in which other workers employed on work of that description would not be subjected to such detriment; or

(d) retire the worker, or to require or cause the worker to retire or resign, subject to any written law or employment contract imposing a retirement age, by reason of any of the prohibited grounds of discrimination set out in subsection (1).

(3) A contravention of this section is deemed to be a contravention of the Employment Relations Promulgation 2007.

(4) If a word or expression used in this section is defined in the Employment Relations Promulgation 2007, the word or expression has the same meaning in this section.

(5) Nothing in this section limits the provisions of Part 9 of the Employment Relations Promulgation 2007 or any other written law relating to anti-discrimination.

PART 2—ADMINISTRATION

Declaration of mental health facilities

8.—(1) The premises described in Part A of Schedule 1 are declared to be a mental health hospital for the purposes of this Decree.

(2) The parts of public hospitals and public health centres described in Part B of Schedule 1 are declared to be mental health units or facilities for the purposes of this Decree.

(3) The Minister after consulting the National Advisor or the Permanent Secretary, may by order amend Schedule 1 to add or delete or vary premises as—

(a) a mental health hospital for the purposes of this Decree; or

(b) a mental health unit for the purposes of this Decree.

(4) Premises may by order be declared by the Minister to be a mental health unit or facility including—

(a) a public hospital;

(b) a public health centre;

(c) a nursing station;

(d) a prison hospital or clinic; or

(e) any other premises the Minister considers desirable and suitable to be so designated.

(5) The Minister, on the advice of the National Advisor or the Permanent Secretary, may by order—

(a) assign a name to a mental health hospital;

(b) limit the provisions of this Decree or the purposes under this Decree for which premises are used as a mental health facility;

(c) designate a mental health facility as a facility of a specified class as mentioned in subsection (4);
(d) designate the purposes for which a mental health facility of a specified class may be used;
(e) impose restrictions on the use of a mental health facility for specified purposes;
(f) designate a psychiatric ward;
(g) impose any other conditions in relation to the operation of a mental health facility.

Private mental health facilities

9.—(1) The Minister, on the advice of the Advisory Council, may license private premises as private mental health facilities for the purposes of this Decree.

(2) Private premises may not be licensed as private mental health facilities unless—

(a) the premises are operated by health services providers within the meaning of the Medical and Dental Practitioner Decree 2010;
(b) the premises and equipment have been inspected by the National Mental Health Advisor and the Review Board and certified by both of them as suitable for use as private mental health facilities;
(c) the owner or person in control of the premises has agreed, in writing to the Permanent Secretary, to their being premises to which this section applies.

National Mental Health Advisory Council

10.—(1) The Minister must appoint a National Mental Health Advisory Council.

(2) The Council is to consist of—

(a) the Permanent Secretary as Chairperson;
(b) the National Mental Health Advisor;
(c) a senior member of the clinical staff at St Giles Hospital;
(d) one person nominated by a non-governmental organisation or consumer group selected by the Minister who has expertise, expefience or interest in mental health issues;
(e) one person nominated by the Ministry of Fijian Affairs (or its equivalent);
(f) one person nominated by the Commissioner of Police ;
(g) not more than 2 other persons with expertise, experience or interest in mental health chosen by the Minister.

(3) In the absence of the Advisory Council or pending its appointment, the Minister may act alone.

Functions of the Advisory Council

11.—(1) The functions of the Advisory Council are to—

(a) advise the Minister on the administration and operation of this Decree;
(b) develop a national mental health policy;
(c) implement and review the national mental health suicide prevention policy;
(d) issue guidelines for the conduct of persons dealing with a mental disorders;
(e) raise awareness of mental health in the community and promote a better understanding of mental disorders;
(f) encourage informed public opinion, discussion and understanding of mental disorder and the rights of persons with mental disorders;
(g) destigmatise mental illness and seek to eliminate discrimination against, abuse, mistreatment, neglect and other human rights violations of, persons with a mental disorder;
(h) promote a high standard of facilities and training for those responsible for the care, support, treatment and protection of persons with a mental disorder;
(i) ensure the development and appropriate remuneration of an adequate mental health workforce, including allied mental health workers such as psychologists; psychiatric social workers, occupational therapists and counsellors;
(j) promote research into the problems of mental disorder;
(k) monitor the operation of this Decree and the treatment of patients under it;
(l) exercise other functions determined by the Minister or prescribed by regulation; and
(m) provide advice and make recommendations to the Minister on mental health issues as required by this Decree and generally;

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(2) The Advisory Council should consider and make recommendations to the Minister regarding the decentralisation of mental health services through—

(a) the integration of such services into the primary health care and general health care systems;
(b) strengthening of community mental health services; and
(c) the establishment of community mental health facilities for despite, residency and rehabilitation for persons with mental disorder.

Terms and conditions of membership

12.—(1) A member of the Advisory Council—

(a) is appointed for a term, not exceeding 3 years, specified in the instrument of appointment; and
(b) at the expiration of a term of appointment, is eligible for reappointment.

(2) A member of the Advisory Council other than the Permanent Secretary or, National Mental Health Advisor, who respectively hold office ex officio may not hold office for consecutive terms that exceed 9 years in total.

(3) The Minister may remove a member of the Advisory Council from office if the member—

(a) conducts himself or herself in a manner that brings the work of mental health workers or of the Council into disrepute;
(b) is absent for 3 consecutive meetings of the committee without reasonable excuse recorded by the Chairman;
(c) fails to carry out or becomes incapable of performing satisfactorily the duties of a committee member.

(4) The office of a member of the Advisory Council becomes vacant if the member—

(a) completes a term of office and is not reappointed;
(b) resigns by written notice to the Minister;
(c) ceases to satisfy the qualification by virtue of which the member was eligible for appointment to the committee; or
(d) is removed from office under subsection (3).

(5) The quorum for a meeting of the Committee is 2/3 of its members.

(6) The procedure to be adopted by the Advisory Council at its meetings is as determined by the Council, consistently with its functions and this Decree and subject to any directions of the Minister.

National Mental Health Advisor

13.—(1) The Public Service Commission, after consulting the Minister, must appoint a suitably qualified person to be the National Mental Health Advisor, on appropriate terms to fixed by the Commission after such consultation.

(2) The functions of the National Mental Health Advisor are—

(a) to be a national focal contact for the development of mental health services nationally;
(b) to assist the Advisory Council in the development and review of a mental health policy;
(c) to coordinate and promote decentralisation of mental health services through their integration into the primary health care and general health care systems;
(d) to devise ways of strengthening existing community mental health services through the provision of training and adequate infrastructure and resources in the community;
(e) to promote decentralization of psychotropic pharmaceuticals to the divisional level;
(f) to advise on the development of the mental health workforce (including allied mental health workers) through training, capacity building, and recruitment of appropriate staff;
(g) to develop treatment and procedural guidelines for persons engaged in the provision of mental health services;
(h) to develop forensic mental health services, psychosocial and substance abuse rehabilitation and other specialist mental health services;
(i) to perform any other functions assigned by the Minister from time to time in writing or prescribed by regulations.

(3) In the absence, or pending the appointment of a National Health Advisor, the Medical Superintendent of St Giles Hospital shall act in that role.

Authorised health care professionals

14.—(1) The Permanent Secretary may in writing, after consulting the National Mental Health Advisor, designate specified health care professionals or any specified class of health care professionals as authorised health care professionals for the purposes of this Decree.

(2) A designation may be general, or may be limited to the exercise of particular functions specified in the instrument of designation and may permit the exercise named functions in emergency situations where no person with a full authorisation is available.

(3) A person with a limited designation may exercise functions as an authorised health care professional in connection only within the specified functions.

(4) A limited designation may be made by reference to functions other than specified functions.

(5) A designated person ceases to be an authorised health care professional if—

(a) the Permanent Secretary revokes the designation;
(b) the person otherwise ceases to be a health care professional; or
(c) if relevant, the person ceases to be within a class of health care professionals referred to in subsection (1).

Medical directors

15.—(1) The Permanent Secretary, after consulting the National Mental Health Advisor, must designate for every mental health facility other than a private facility a public officer to be the medical director of the facility.

(2) The owner of every private facility—

(a) must appoint a person as medical director of the facility;
(b) may change the appointment at any time;
(c) must notify the Permanent Secretary in writing as soon as practicable of such an appointment or any such change.

(3) The medical director of a mental health facility is responsible for the overall administration of the facility.

(4) The medical director of a mental health hospital is, in addition to responsibilities regarding the hospital, responsible for providing advice and direction to one or more mental health units, as determined by the Permanent Secretary.

PART 3—VOLUNTARY ADMISSION AND ASSESSMENT

Principles for voluntary care, treatment and support

16.—(1) In providing care, support and, where required, treatment and protection for persons with a mental disorder, the Minister, the Ministry, the courts, health care professionals and all other persons providing care, support, treatment or protection must, where possible and subject to available resources, and subject in all cases to the approval of an authorised medical officer responsible for a person's case management give preference to the provision of care, support, treatment or protection—

(a) on a voluntary basis; and
(b) within the family and community in which the person lives.

(2) For the purposes of this section, a person may be provided with care, support, treatment and protection on a voluntary basis only if—

(a) the case practitioner says so;
(b) the person is given information and explanations in writing about the care, support treatment and protection in a style and manner that the person is most likely to understand;
(c) options and choices of care, support, treatment and protection are available;
(d) information about the options and choices and the right to choose which options and choice are given prior to such choice to the person in writing;
(e) the person appears to the medical director to be have the capacity to freely and voluntarily agree to or refuse care, support, treatment and protection; and

(f) the person's agreement or refusal is respected and given effect to without unreasonable pressure or influence.

(3) The information to be given under subsection (2) must be in a language that the person understands, except if the language is not English, Fijian or Hindustani, the information may be translated to the person orally.

(4) All persons providing care, support, treatment or protection of a person with a mental disorder must endeavour as far as practicable to do so within the family or community in which the person lives, unless—

(a) the person cannot be cared for, supported, treated or protected within that family or community; or
(b) the safety, health and welfare of other persons requires otherwise.

Voluntary admissions

17.—(1) Subject to this section, a person may be admitted to a mental health facility as a voluntary patient on written application to the medical director of the facility in the prescribed form.

(2) A medical director may refuse to admit a person to a mental health facility as a voluntary patient if the officer is not satisfied that the person is likely to benefit from care or treatment as a voluntary patient.

(3) A young person must not be admitted to a mental health facility as a voluntary patient except—

(a) on the written application of the young person; and
(b) with the informed written consent of the young person and of his or her primary carer.

(4) A child aged 12 or 13 may be admitted to a mental health facility as a voluntary patient if the primary carer so requests in writing and the medical director of the facility is satisfied that the child understands the nature of the request.

(5) A child under the age of 12 must not be admitted to a mental health facility as a voluntary patient even if the primary carer consents to the admission.

(6) A person under guardianship must not be admitted as a voluntary patient if the person's guardian objects to the admission to the medical director.

(7) The Minister, on the advice of the Advisory Council, may by order reduce the age of 12 in subsection (4) and (5) if the Minister is satisfied that the availability of child psychiatry services in Fiji justifies such a reduction.

Voluntary assessment

18.—(1) A person may, subject to available resources, be assessed in accordance with this section with the informed consent of the person.

(2) The person may be assessed at the person's place of residence, at a health care facility or at some other suitable place.

(3) An assessment under this section may be carried out only by an authorised medical practitioner and in accordance with any prescribed requirements.

(4) Following an assessment under subsection (3)—

(a) if the medical practitioner who carries out the assessment certifies in writing that the person assessed meets the criteria set out in section 58, an authorised health care professional may make a community treatment order in respect of the person;
(b) if the medical practitioner who carries out the assessment certifies in writing that the person assessed meets the criteria set out in section 62, an authorised health care professional may make a voluntary or compulsory inpatient treatment order in respect of the person, depending on whether subsection (2) or subsection (3) respectively of that section applies.

(5) Nothing in this section prevents the assessment of a person otherwise than in accordance with this section with the person's informed consent, but such an assessment does not have any effect for the purposes of this Decree.

Discharge of voluntary patients

19.—(1) A medical officer may discharge a voluntary patient at any time if he or she is of the opinion that the patient is not likely to benefit from further care or treatment as a voluntary patient.

(2) Subject to section 20, a voluntary patient who is an adult may discharge himself or herself from or leave a mental health facility at any time.

(3) Subject to section 20, a medical director must discharge—

(a) a voluntary patient who is a child if the primary carer of the patient requests that the patient be discharged;

(b) a voluntary patient who is a young person if the primary carer of the patient requests that the patient be discharged, unless the patient elects to continue as a voluntary patient; or

(c) a voluntary patient who is a person under guardianship if the person's guardian requests that the person be discharged.

(4) In the case of a discharge of a voluntary patient who is a child or young person, the medical director should where practical notify the primary carer of the child or young person not less than 24 hours, and preferably 48 hours, before the discharge.

(5) When a voluntary patient is discharged under this section, appropriate information relating to follow-up care to be provided to the person being discharged should be given to the patient or, in the case of a child or young person, to his or her primary carer.

Detention of voluntary patients

20.—(1) If in respect of a voluntary patient at a mental health facility the medical director considers that—

(a) there is a serious likelihood of immediate or imminent harm to that person or to other persons if the person is discharged without further assessment; or

(b) in the case of a person whose mental illness is severe and whose judgement is impaired failure to 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,

the director may take all appropriate steps to detain the person in that or another mental health facility under Part 4.

(2) A patient detained in a facility by virtue of subsection (1) is deemed to have been detained in the facility under section 24 when the medical director takes action to detain the patient.

Review of voluntary patients

21.—(1) The Review Board must, within 3 months of admission and thereafter at least every 3 months, review the case file of every person who is receiving care or treatment, or both, as a voluntary patient at a mental health facility, in accordance with section 100.

(2) In addition to any other matters it considers on a review, the Review Board must consider whether the patient has given informed consent 14 days prior to the review to continue as a voluntary patient.

(3) The Review Board may on a review order the discharge of the patient from the mental health facility.

(4) The Review Board may defer the operation of an order for the discharge of a patient for a period of up to 14 days, if the Board considers that the conditions mentioned in section 20 (1)(a) or (b) are met in relation to that patient.

(5) The medical director of a mental health facility must notify the Review Board of the name of any voluntary patient whose case the Review Board is required to review.

Review of decision to refuse or discharge voluntary patient

22.—(1) If a medical director—

(a) refuses a person admission to a mental health facility as a voluntary patient; or

(b) refuses to discharge a person as a voluntary patient,

the person affected by the decision may apply to the Review Board for a review of the decision in accordance with section 99.

(2) The Review Board must review a decision under subsection (1) within 7 days or as soon thereafter as practicable after receiving an application for its review and may confirm the decision, admit or discharge the person

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as a voluntary patient or take any other action under this Decree that the Review Board thinks fit, consistent with its powers under Part 9.

PART 4 – DETENTION AND INVOLUNTARY ASSESSMENT

Detention

When detention is permissible

23. A person may be detained for assessment in a mental health facility only—

(a) on a recommendation certificate given by a medical practitioner, as provided by section 24;
(b) on the order of a magistrate or judge, as referred to in section 27;
(c) on transfer from another health facility, as provided by section 28;
(d) on action taken by a medical director in relation to a voluntary patient under section 20; or
(e) action by the police officer under section 25.

Detention on recommendation of a medical practitioner

24.—(1) A person may be taken to and detained in a mental health facility on the basis of a certificate issued by a medical practitioner recommending detention in that facility and endorsed by the person in charge of that facility.

(2) A medical practitioner can recommend detention in a mental health facility only if the practitioner –

(a) has personally examined the person or observed the person's condition immediately before or shortly before completing the certificate;
(b) is of the opinion that the person has a mental disorder;
(c) is satisfied—
(i) that there is a serious likelihood of immediate or imminent harm to that person or to other persons if the person is not detained in a mental health facility; or
(ii) that in the case of a person whose mental disorder is severe and whose judgement is impaired, failure to retain the 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;
(d) is not the primary carer or a near relative of the person; and
(e) has no other interest in relation to the person or the facility that might affect the practitioner's judgement.

(3) A recommendation certificate may contain an endorsement, in a form approved by the Permanent Secretary, that police assistance is required if the person giving the certificate is of the opinion that there are serious concerns relating to the safety of the person or other persons if the person is taken to a mental health facility without the assistance of a police officer.

Detention after intervention of a police officer

25.—(1) A police officer who—

(a) in any place, finds a person who appears to the officer to be mentally disturbed and whom the officer suspects may have a mental disorder; and
(b) reasonably believes it would be beneficial to the welfare or safety of the person or the public to be dealt with in accordance with this Decree,

may request the person to accompany the officer to the premises of a medical practitioner for examination.

(2) If it is not reasonably practicable to arrange for examination by a medical practitioner except at a mental health facility, the officer may request the person to accompany the officer to the nearest mental health facility for that purpose.

(3) If the officer reasonably believes that—

(a) the person has recently attempted to kill himself or herself; or
(b) it is probable that the person will attempt to kill himself or herself or any other person or attempt to cause serious physical harm to himself or herself or any other person; or
(c) it is probable that the person will suffer physical or sexual harm if not taken to a mental health facility,

the officer should take action as in subsection (2).

(4) If, when requested under subsection (2) or (3), a person refuses to accompany a police officer to the premises of a medical practitioner, or to a mental health facility, as the case may be, the police officer may—

(a) arrest the person without a warrant; and

(b) take the person for examination to the premises of a medical practitioner or to a mental health facility, in accordance with section 51.

(5) If the person has committed an arrestable offence, the police officer may arrest the person without a warrant and convey him or her to a police station and there arrange for examination and assessment in accordance with this Decree within 24 hours if possible or as soon as practicable thereafter.

(6) A police officer acting pursuant to subsection (4) or (5) may request the assistance of an ambulance officer or other person the police officer reasonably believes to be a responsible member of the public if the police officer us of the opinion that there are concerns relating to the safety of the person or other persons if the person is taken to premises of a medical practitioner or to a mental health facility or to a police station, as the case may be, without the assistance of an ambulance officer or such member of the public.

Detention after intervention of an ambulance officer

26.—(1) An ambulance officer who provides ambulance services in relation to a person may take a person who appears to the officer to have a mental disorder to the premises of a medical practitioner for examination if—

(a) the ambulance officer reasonably believes that—

(i) the person has recently attempted to kill himself or herself; or

(ii) it is probable that the person will attempt to kill himself or herself or any other person or attempt to cause serious physical harm to himself or herself or any other person; and

(b) the ambulance officer reasonably believes that it would be beneficial to the person's welfare to be dealt with in accordance with this Decree.

(2) If it is not reasonably practicable to arrange for examination by a medical practitioner except at a mental health facility, the ambulance officer may take the person to a mental health care facility for that purpose.

(3) An ambulance officer may request the assistance of a police officer if of the opinion that there are serious concerns relating to the safety of the person or other persons if the person is taken to the premises of a medical practitioner or to a mental health facility, as the case may be, without the assistance of a police officer.

Detention on order of a court

27. A person may be taken to and detained in a mental health facility in accordance with an order made by a court on the recommendation of a medical practitioner under the Criminal Procedure Decree 2009 and the Crimes Decree 2009.

Detention after transfer from another health facility

28.—(1) If the medical director of a health facility considers a patient at the facility to have a mental disorder which requires the patient's detention in a mental health facility, the medical director may order the transfer of the patient to a mental health facility and the detention of the person in that facility.

(2) A person who is transferred to a mental health facility pursuant to subsection (1) is deemed to be detained in that facility under section 24 from the time the person arrives at the facility.

(3) A transfer under this section should only be considered once the physical condition of the patient in the first health facility has stabilized.

Assistance by police officers

29.—(1) A police officer who receives notice of an endorsement on a recommendation certificate under section 24(3), or of a request for assistance by an ambulance officer under section 26(3) must, if practicable—

(a) take or assist in taking the person the subject of the certificate or request to a mental health facility, and if necessary arrest the person for that purpose; or

(b) require or make arrangements for some other police officer to do so.

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(2) A police officer acting in relation to a person pursuant to subsection (1) may—

(a) enter premises to arrest the person;
(b) arrest the person without a warrant; and
(c) exercise the powers conferred by section 49 as being authorised under that section to take a person to a mental health facility or another health facility.

(3) An arrest under subsection (2) must be carried out humanely and—

(a) as speedily as practicable;
(b) with the minimum of force required in the circumstances; and
(c) in the least restrictive environment practicable in the circumstances.

Assistance by ambulance officers

30.—(1) An ambulance officer who receives notice of a request for assistance by a police officer under section 25 (3) may provide all reasonable assistance to a police officer in arresting of necessary, taking the person the person the subject of the request to a mental health facility.

(2) An ambulance officer may enter premises in the company of a police officer to assist the police officer in arresting the person concerned.

Involuntary assessment

Detainee to be assessed

31.—(1) When a person is detained pursuant to this Part, an assessment of the person under this Part must commence within 24 hours, unless the person is sooner released.

(2) If the detained person gives informed consent to the assessment, it is a voluntary assessment and section 18 applies. If not, it is an involuntary assessment and section 32 applies.

(3) An assessment under this section may be carried out only by an authorised medical practitioner, who must not be the practitioner that issued a certificate under section 24

(4) A person must not be detained for longer than 72 hours (including the initial 24 hours for assessment) without a decision being made whether to release the person or make an order for involuntary inpatient treatment, community treatment or that person agreeing to voluntary treatment.

Involuntary assessment

32.—(1) For the purposes of this Part, the criteria for the involuntary assessment of a person are that—

(a) the person appears to have a mental disorder;
(b) the person appears unwilling or unable to be assessed on a voluntary basis; and
(c) the person appears to require care, support and treatment—
(i) for the protection of the safety, health and welfare of the person; or
(ii) to protect another person or persons.

(2) A person who meets the criteria set out in subsection (1) may be assessed in accordance with this section without the person's consent.

(3) An authorised health care professional who has reasonable grounds to believe that a person meets the criteria set out in subsection (1) may arrange for that person to be assessed without that person's consent at that person's place of residence, at a health care facility or at some other suitable place.

(4) An authorised health care professional may, for the purposes of an assessment under this section, restrain the person and transport him or her to the proposed place of assessment.

(5) An authorised health care professional may request one or more police officers or ambulance officers to provide reasonable assistance with the restraint and transportation of a person for the purposes of assessment under this section.

(6) Any restraint under subsection (4) must only be imposed under the direction of an authorised health care professional.

(7) If necessary in order to provide assistance requested under subsection (5), a police officer may arrest a person who requires assessment under this section.

(8) Section 29(3) applies to an arrest under this section.

(9) Section 50 applies to the transport of a person under to this section.

(10) An assessment under this section may include—

(a) detention of the person being assessed for up to a maximum period of 72 hours commencing from the time the person first presents for assessment to the person who is to carrying out the assessment; and

(b) any health care treatment (not limited to treatment for a physical or mental condition or disorder) that the person carrying out the assessment believes the person urgently requires to preserve the person's life, health or safety or to protect another person or persons.

Action following involuntary assessment

33.—(1) Following an assessment under section 32 if the medical practitioner who carries out the assessment certifies in writing that the person assessed—

(a) does not appear to have a mental disorder; or

(b) does not appear to require care, support, treatment or protection in the interests of the person or to protect another person or persons,

an authorised health care professional must release the person and arrange for the person to be transported to his or her place of residence or another place reasonably requested by the person (subject to subsection (4).

(2) Following an assessment under section 32 if the medical practitioner who carries out the assessment certifies in writing that the person assessed meets the criteria set out in section 58 an authorised health care professional may make a community treatment order in respect of the person.

(3) Following an assessment under section 32 if the medical practitioner who carries out the assessment certifies in writing that the person assessed meets the criteria set out in section 61 an authorised health care professional may make a voluntary or compulsory inpatient treatment order in respect of the person, depending on whether subsection (2) or subsection (3) respectively of that section applies.

(4) If the person who has been assessed does not appear to have a mental disorder but was detained on an order of a court, the authorised health care professional must notify the court which ordered the detention and the court must within 24 hours make a further order that the person be removed from the mental health facility to another secure facility in accordance with the Criminal Procedure Decree 2009 and the Crimes Decree 2009.

PART 5—PRINCIPLES FOR CARE AND TREATMENT

Principles

Principles for care and treatment

34. The following principles must subject to this Decree and as far as practicable, be given effect to with respect to the care and treatment of people with a mental disorder—

(a) people with a mental disorder must receive the best possible care and treatment in the least restrictive environment available in Fiji which enables proper care and treatment to be effectively given under the supervision of a health care professional;

(b) people with a mental disorder must be provided with timely and high quality treatment and care in accordance with professionally accepted standards;

(c) the provision of care and treatment must be designed to assist people with a mental disorder, wherever and so far as possible, to live, work and participate in the community;

(d) the provision of care should include opportunity for educational, vocational, and recreational activities and should meet the religious and cultural needs of people with a mental disorder;

(e) the prescription of medicine to a person with a mental disorder must meet the health needs of the person and medicine must be given only for therapeutic or diagnostic

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(f) needs and not as a punishment or for the convenience of others;

(g) people with a mental disorder must be provided with appropriate information about-

(i) assessment procedures; and

(ii) treatment, treatment alternatives and the effects of treatment;

(h) the age-related, gender-related, religious, cultural, language and other special needs of people with a mental disorder must be recognised;

(i) all reasonably practicable steps must be taken to involve persons with a mental disorder in the development of treatment plans and plans for ongoing care;

(j) people with a mental disorder must be informed of their legal rights including the right to legal representation and other applicable entitlements under this Decree and all reasonable efforts must be made to ensure that the information is given in the language, mode of communication or terms that they are most likely to understand;

(k) the role of carers for people with a mental disorder must be respected and their rights to be kept regularly informed be observed.

Right to be given order, statement and explanation of rights

35. (1) If a person is made subject to a community treatment order or inpatient treatment order, the authorised health care professional who made the order must within 24 to 74 hours of making the order give or cause to be given to the person—

(a) a copy of the order;

(b) a copy of any application for review;

(c) an explanation in a language, style and manner that the person is readily able to understand of –

(i) the order;

(ii) the reasons why the order has been made;

(iii) what the order requires of the person;

(iv) the person's rights under this Decree; and

(v) the person's right to consult a lawyer,

(2) If the authorised health care professional considers it to be in the best interest of the person, or if the person so requests, the documents referred to in subsection (1) must also be given to the person's primary carer and the person's lawyer.

Offence to ill-treat patients

36.—(1) Subject to subsection (3), an authorised health care professional, and any person employed at or visiting a mental health facility, must not—

(a) strike, wound or otherwise use force against a patient or person detained at the facility;

(b) neglect or ill-treat a patient or person detained at the facility;

(c) in any way abuse or insult a patient or person detained at the facility;

(d) in any way sexually assault or abuse a patient or person detained at the facility.

(2) A person who commits an offence under this section is liable on conviction to a fine not exceeding $500 or up to 2 years imprisonment or both.

(3) It is a defence to a prosecution under subsection (1) *(a)* to show that the defendant used force against a patient or person detained only—

(a) in self-defence;

(b) because the use of force was reasonably required when handling an aggressive patient or person detained; or

(c) limited to what was reasonably necessary for the purpose of self defence.

(4) This section is in addition to and does not derogate from the requirements of the Crimes Decree 2009 relating to assaults and sexual offences.

Seclusion and restraint

37.—(1) Seclusion and restraint of a patient at a mental health facility, or either—

(a) may only be used by or with the authority of the medical director of the facility;

(b) should only be used in exceptional cases to prevent the person causing immediate or imminent harm to the patient or others;

(c) must never be used as a means of punishment or for the convenience of staff at the facility.

(2) A period of seclusion and restraint, or either—

(a) should not exceed 4 hours without the approval of an authorised health care professional;

(b) should not follow immediately after another period of seclusion or restraint.

(3) Patients in seclusion and under restraint, or either, should be—

(a) observed and monitored regularly; and

(b) assessed every 4 hours by an authorised health care professional.

(4) The reasons for and duration of each incident of seclusion and restraint, or either, must be—

(a) recorded in the mental health register; and

(b) made available to the mental health visitors for the facility and to the Mental Health Review Board on request.

(5) The primary carer of a patient placed in seclusion and under restraint, or either, must be informed of the fact and of the reasons for it as soon as practicable.

Assistance of interpreters

38.—(1) Subject to subsection (1), if—

(a) an authorised health care professional or medical practitioner conducts a medical examination or assessment of a person under this Decree; and

(b) the person is unable to communicate adequately in the language spoken by the health care professional or medical practitioner but can communicate adequately in another language,

the health care professional or medical practitioner, as the case may be, must take all reasonable steps to have an appropriate interpreter present at the medical examination or assessment to provide interpretation services.

(2) If it is not reasonably practicable to arrange for an interpreter to be present within 24 hours—

(a) the medical examination or assessment may proceed; but

(b) the consequences and results of the examination or assessment must be interpreted to the person or his or her primary carer as soon as reasonably practicable.

Confidentiality

39.—(1) Subject only to sub section (3), information about a person obtained in the course of providing care, treatment and support to the person under this Decree must be kept confidential and only used for the purpose of assessing, monitoring or improving the mental health of the person.

(2) Health care professionals and others who have access to information about a patient pursuant to this Decree must not make use of such information for personal reasons, or financial or academic benefits.

(3) Disclosure amounting to a breach of confidentiality may be made with the authority of a medical director in order to avoid serious physical or mental harm to the person or other persons.

(4) If a health care professional proposes to breach a person's confidentiality for a reason mentioned in subsection (3), the professional must so advise the person or his or her primary carer prior to the disclosure.

Access to records

40.—(1) Subject to subsection (2), every patient at a mental health facility is entitled to have access to his or her personal records concerning that patient held by the facility.

(2) The medical director of a mental health facility may refuse a patient access to his or her records if such refusal is in the director's opinion necessary in order to avoid serious physical or mental harm to the person or other persons.

(3) Any such information not given to the patient should, when this can be done in confidence, be given to the patient's primary carer.

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(4) When any relevant information is withheld from a patient—

(a) the patient or the primary carer must receive notice of the withholding and the reasons for it; and

(b) the withholding is subject to appeal to the Review Board by way of judicial review.

Notification

Primary carers

41.—(1) The primary carer of a patient is—

(a) if the patient is under guardianship – the guardian;

(b) if the patient is a child – the parent (subject to any nomination by the patient referred to in paragraph *(c)*;

(c) if the patient is over the age of 14 years and is not a person under guardianship - the person nominated by the patient as the primary carer;

(d) if the patient is not a patient referred to in paragraph *(a)* or *(b)* and if there is no nomination in force as referred to in paragraph *(c)* —

(i) the spouse of the patient, if any, if the relationship between the patient and the spouse is close and continuing;

(ii) any person who is primarily responsible for providing support or care to the patient (other than wholly or substantially on a paid basis); or

(iii) a close friend or relative of the patient.

(2) In this section, "close friend or relative" of a patient means a friend or relative of the patient who—

(a) maintains both a close personal relationship with the patient through frequent personal contact and a personal interest in the patient's welfare; and

(b) who does not provide support to the patient wholly or substantially on a commercial basis.

Nomination of primary carer

42.—(1) A person aged 14 or over who is the subject of a medical examination, assessment or order under this Decree or who is detained in a mental health facility (the 'patient') may nominate a person to be the patient's primary carer for the purposes of this Decree.

(2) A patient may in a nomination specify either by name or by class of person those persons who are not to be given notice or information about the patient under this Decree.

(3) A patient under the age of 18 years without the consent of the medical director or authorised health care professional may not exclude the patient's parent by a nomination under subsection (2).

(4) A patient who makes a nomination may vary or revoke it at any time.

(5) A nomination remains in force for 12 months or until it is earlier revoked, but may be renewed by the patient.

(6) A nomination, or any variation, revocation or renewal of a nomination, must be made in writing and may be given to the medical director at the facility concerned, or to any authorised health care professional.

(7) A medical director or authorised health care professional must, in carrying out his or her functions under this Decree, give effect to any nomination, or variation or revocation of a nomination, of which he or she is given notice.

(8) A medical director or authorised health care professional need not give effect to a nomination, or a variation or revocation of a nomination, if he or she reasonably believes -

(a) that to do so may put the patient or nominated person or any other person at risk of serious harm; or

(b) that the patient who made the nomination, variation or revocation was incapable of making the nomination, variation or revocation.

Information about medication

43.—(1) On a request made under this section, the medical director of a mental health facility must provide particulars of the types of medication and dosages of each type of medication currently being administered or recently administered to a patient or person detained in the facility pursuant to under this Decree.

(2) A request under this section may be made by—

(a) the patient or person detained in the mental health facility; or

(b) the primary carer of any such patient or person.

Information to be given to detained persons

44.—(1) The medical director of a mental health facility must give the following persons an oral explanation and a written statement of notice of their legal rights and other entitlements under this Decree—

(a) a person who is taken to the facility and detained under Part 4;

(b) a person who is a voluntary patient in the facility, if it is decided to take steps to detain the person under section 20;

(c) a person in respect of whom an involuntary inpatient treatment order is made under Part 6.

(2) The explanation and statement must be given as soon as practicable after the person is taken to the mental health facility or it is decided to take steps to detain the person, whichever is sooner.

(3) The written statement must be in writing and in the approved form and include information about—

(a) rights of voluntary patients to discharge themselves;

(b) the right to have decisions relating to involuntary admission and treatment reviewed by the Review Board;

(c) rights in relation to confidentiality;

(d) the right to make an advance directive;

(e) the right to be represented by a lawyer;

(f) any other matters required by the regulations.

(4) The medical director must, if the person is unable to communicate adequately in the language spoken by the director or health care professional but is able to communicate adequately in another language, arrange for the oral explanation to be given in that other language.

Notification to detained persons of certain events

45. A person detained in a mental institution under an involuntary inpatient treatment order must, so far as practicable, be informed in writing within a reasonable time before—

(a) it is proposed to transfer the person to another mental health facility or some other health facility;

(b) if it is proposed that the person be re-classified as a voluntary patient;

(c) it is proposed to apply to the Review Board for an ECT inquiry under section 75;

(d) it is proposed to apply to the Review Board for consent to a surgical operation under section 80 or to special medical treatment under section 81; and

(e) where a patient has engaged a lawyer, the information may be given to the lawyer.

Notification to primary carers of events affecting detained persons

46.—(1) When a person is detained in a mental health facility pursuant to section 19 or Part 4, the medical director of the facility must, not later than 24 hours after the person was detained, take all reasonably practicable steps to notify the primary carer of the person that the person has been detained in the facility.

(2) Unless the person so requests, notice need not be given under subsection (1) if the person is discharged from the facility or classified as a voluntary patient within the period of 24 hours.

(3) When a person is detained in a mental health facility pursuant to an inpatient treatment order under Part 6, the medical director of the facility must notify the primary carer and, if the patient has engaged a lawyer, than that lawyer of the a person whenever the director becomes aware that—

(a) the person is absent from the facility without permission or has failed to return at the end of a period of leave;

(b) it is proposed to transfer the person to another mental health facility or some other health facility;

(c) it is proposed to discharge the person from the mental health facility;

(d) the person has been re-classified as a voluntary patient;

(e) it is proposed to apply to the Review Board for an ECT inquiry under section 75;

(f) a surgical operation is to be performed on a person, with the person's consent under section 77, or in an emergency under section 78;

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(g) it is proposed to apply to the Review Board for consent to a surgical operation or operation or special medical treatment under section 81; or

(h) an application has been made to the Review Board for review of any other decision concerning the person under this Decree.

(4) In the case of a proposed transfer, the notice must be given in writing before the relevant order or arrangement is made, except in an emergency.

(5) Subject to subsection (6), the medical director of a mental health facility must identify the primary care and notify the primary carer of a person who—

(a) is examined or assessed at the facility under this Decree;

(b) is receiving treatment as a voluntary outpatient;

(c) is admitted as a voluntary inpatient;

(d) is detained as an involuntary inpatient;

(e) is discharged from the facility or transferred to another mental health facility or health facility;

(f) is transferred to the facility from another mental health facility or from a health facility.

(6) Notification under subsection (5) in respect of a voluntary patient who is an adult must only be done if the patient so requests or agrees in either case in writing.

(7) The medical director of a mental health facility must also notify the primary carer of a person—

(a) on whom surgery or special medical treatment is performed under this Decree;

(b) who is subject to seclusion and restraint, or either; or

(c) who dies while a patient at the facility.

(8) The medical director must take all reasonably practicable steps to give the notice required by subsection (3), (5) or (7) where practicable before or otherwise as soon as practicable after becoming aware that the event has occurred.

Movement of patients

Discharge and other planning

47.—(1) The medical director of a mental health facility must take all reasonably practicable steps to ensure that a person detained in the facility, and the primary carer of the person, are consulted in relation to planning the person's discharge and any subsequent treatment or other action considered in relation to the person.

(2) In planning the discharge of any such person, and any subsequent treatment or other action considered in relation to the person, the medical director must take or cause to be taken all reasonably practicable steps to consult—

(a) any agency or organisation that provides or can be expected to provide social welfare including housing, counselling or similar services to the person;

(b) any primary carer of the person; and

(c) any adult dependant of the person.

(3) The medical director of a mental health facility must take all reasonably practicable steps to provide any person who is discharged from the facility, and the person's primary carer, with appropriate information as to follow-up care.

Transfer of patients to or from mental health facilities

48.—(1) An involuntary patient or a person detained in a mental health facility may be transferred from the mental health facility to another mental health facility or to some other health facility.

(2) A person who is a patient in a health facility other than a mental health facility may be transferred from the health facility to a mental health facility for the purpose of detention or assessment under Part 4 (Detention and Involuntary Assessment).

(3) A transfer of a patient or person to a health facility other than a mental health facility may be made on the grounds that the patient or person requires medical treatment for a condition or illness other than a mental disorder.

(4) A transfer under this section must be done in accordance with an arrangement between the medical directors of each facility.

(5) An arrangement under this section is sufficient authority for the transfer of a patient or person, and the reception into, the mental health facility or other health facility to which the patient or person is transferred.

(6) As far as possible a person should be kept in a facility which is close to the person's community and family, to ensure that the person still receives visits from his or her family and friends

Persons authorised to transport patients

49.—(1) The following persons may transport or assist in the transport of patients to or from a mental health facility or other health facility—

(a) a member of the nursing or medical staff of a mental health facility;
(b) a member of the nursing or medical staff of a health facility;
(c) an ambulance officer;
(d) a police officer.

(2) The Minister may by order—

(a) prescribe other classes of persons who may transport or assist in the transport of patients to or from a mental health facility or other health facility;
(b) specify the circumstances in which such transport or assistance may be provided by those other persons;
(c) provide for the payment of costs associated with providing or assisting in the transport of patients.

Powers of person transporting or assisting in transport of patients

50.—(1) A person authorised by this Decree to take or assist in the transport of a patient to or from a mental health facility or other health facility may, after attempting all other appropriate management options and having regard to the safety of the patient and other persons—

(a) use reasonable force in exercising functions under this section (or any other provision of this Decree applying this section); and
(b) restrain the patient in any way that is reasonably necessary in the circumstances.

(2) A patient may be sedated, by a person authorised by law to administer the sedative, for the purpose of being taken to or from a mental health facility or other health facility under this Decree, if it is necessary to do so to enable the patient to be taken safely to or from the facility.

(3) A person authorised by this Decree to take a patient to or from a mental health facility or other health facility may carry out a search of the patient, if the person reasonably suspects that the patient is carrying any article—

(a) that would present a danger to the patient or any other person; or
(b) that could be used to assist the patient to escape from the person's custody.

(4) The authorised person may seize and detain an article found in a search if it is a thing of a kind referred to in subsection (3) *(a)* or *(b)*.

Control of treatment and drug use

Treatment may be given to patients

51.—(1) Subject to the following sections and Part 6 of this Decree, the medical director of a mental health facility may give, or authorise the giving of, any treatment (including any medication) the director thinks fit to a voluntary patient or to an involuntary patient detained in the facility in accordance with this Decree.

(2) Subsection (1) does not displace—

(a) the requirement for periodic review of inpatient treatment or the right of any person to ask for review of a decision pursuant to Part 9;
(b) the ethical standards that apply in Fiji to the giving of medical treatment and the performance of surgical operations.

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Prohibited treatments

52.—(1) A person must not administer to or perform on another person—

(a) deep sleep therapy;
(b) insulin coma therapy;
(c) psychosurgery; or
(d) any other treatment or operation prohibited by the Minister by order.

(2) The Minister may by order prescribe other operations or treatment that is prohibited for the purposes of this section.

(3) In this section, "psychosurgery" means—

(a) the creation of one or more lesions, whether made on the same or separate occasions, in the brain of a person by any surgical technique or procedure, when it is done primarily for the purpose of altering the thoughts, emotions or behaviour of the person;
(b) the use for such a purpose of intracerebral electrodes to produce such a lesion or lesions, whether on the same or separate occasions; or
(c) the use on one or more occasions of intracerebral electrodes primarily for the purpose of influencing or altering the thoughts, emotions or behaviour of a person by stimulation through the electrodes without the production of a lesion in the brain of the person; but
(d) does not include a technique or procedure carried out for the treatment of a condition
(e) or illness prescribed for the purposes of this definition.

(4) A person who contravenes subsection (1) or an order under subsection (2) commits an offence and is liable for a fine not exceeding $1,000 or imprisonment for a term not exceeding 5 years or both.

Administration of excessive or inappropriate drugs

53.—(1) A medical practitioner must not, in relation to any mental disorder or suspected mental disorder, administer, or cause to be administered to a person a drug or drugs—

(a) in a dosage that, having regard to professional standards, is excessive or inappropriate;
(b) merely for the convenience of health care staff at a mental health facility.

(2) A person who contravenes subsection (1) commits an offence and is liable for a fine not exceeding $1,000 and/or imprisonment of not more than 5 years.

(3) This section is in addition to, and not in substitution for, the provisions of the Medical and Dental Practitioner Decree 2010 regarding disciplinary action in respect of prescriptions.

Review of drug use in mental health facilities

54.—(1) The Permanent Secretary, after consulting the National Mental Health Advisor, must establish for every mental health facility an internal review system to monitor and review—

(a) the prescription and use of drugs in the facility;
(b) the prescription and use of drugs under community treatment orders implemented by the facility.

(2) The review system established under subsection (1) must, in respect of each mental health facility—

(a) monitor the frequency of administration and dosages of drugs in the facility;
(b) monitor the intended and unintended effects of any drugs administered and the appropriateness of their use;
(c) provide for a registered pharmacist to regularly audit the treatment records of the facility; and
(d) provide for regular peer review of the prescription practices at the facility.

Advance directives

Right to make advance directive

55.—(1) Every person, whether receiving treatment under this Decree or not, has a right to make a written statement (referred to in this Decree as an "advance directive") specifying either or both of the following—

(a) the ways the person wishes to be cared for and treated for a mental disorder;
(b) the ways the person wishes not to be so cared for and treated,

in the event of his or her becoming affected by a mental disorder and his or her ability to make decisions about the matters referred to in paragraphs *(a)* and *(b)* being, because of that, significantly impaired.

(2) An advance directive may be made by a person whether or not he or she has suffered from a mental disorder in the past and whether or not he or she has received treatment for a mental disorder in the past.

(3) When deciding how to treat a person who has made an applicable advance directive, a health care professional must take the directive into consideration but is not bound by it.

(4) If a health care professional disregards an applicable advance directive when treating a patient, the health care professional must provide a written report to the Permanent Secretary and to the Review Board explaining why the directive has been wholly or partly disregarded.

Advance directives: Supplementary

56.—(1) An advance directive must be—

(a) made in writing to the person's current treating medical practitioner;
(b) kept in the person's patient record with a copy for the patient;
(c) reviewed and amended after each admission to a mental health facility.

(2) An advance directive may at any time be amended by the person who made it and may be cancelled, in which case a note to that effect should be made in the person's patient record.

(3) The Minister may make regulations as to—

(a) the form and content of advance directives; and
(b) the circumstances in which and extent to which health care professionals may disregard such directives.

PART 6—TYPES OF TREATMENT

Community treatment

Community treatment orders

57.—(1) The criteria for a community treatment order for a person are that—

(a) the person has a mental disorder;
(b) as a result of the mental disorder the person requires care, support or treatment –
(i) in the interests of the person; or
(ii) to protect the safety, health and welfare of another person or persons;
(c) the care, support or treatment—
(i) is not of a kind that requires inpatient treatment; but
(ii) cannot be provided in a less restrictive manner than under a community treatment order;
(d) the person is unwilling or unable to receive care, support or treatment for the mental disorder on a voluntary basis.

(2) If a medical practitioner certifies that the criteria set out in subsection (1) are met in respect of a person after an assessment under section 19, 32 or 33, an authorised health care professional may make a community treatment order in respect of the person.

(3) A community treatment order must require the person subject to the order—

(a) to receive the care, support or treatment that an authorised health care professional determines from time to time;
(b) to attend at—
(i) a specified medical, health care or rehabilitation service; or
(ii) a specified therapist or place of therapy;
(c) to refrain from specified drugs or substances that are contra-indicated in relation to the mental health treatment the person is receiving.
(d) to comply with other terms and conditions imposed in writing by an authorised health care professional from time to time.

(4) The terms and conditions imposed under subsection (3) must only be such as are in the opinion of the health care professional in the best interests of the mental health of the person who is subject to the order.

Issue, etc. of community treatment orders

58.—(1) A community treatment order may be issued for a specified period not exceeding 12 months, but is subject to review before the end of that period in accordance with Part 9.

(2) A community treatment order must be in writing and in the approved form and must comply with any prescribed requirements.

(3) An authorised health care professional may, following a further assessment of a person subject to a community treatment order, from time to time—

(a) vary the terms of the community treatment order, but so that the order still complies with section 57 (4) and (5);

(b) renew the order within one month before its expiry, for a further specified period not exceeding 12 months; or

(c) reduce the duration of the order.

(4) An authorised health care professional may, following a further assessment of a person subject to a community treatment order, revoke a community treatment order if he or she, after consulting the person who made the order or, if the order was made by the same person, after consulting another authorised health care professional, is satisfied that the person no longer meets the criteria set out in section 61.

(5) An authorised health care professional must revoke a community treatment order if 2 medical practitioners—

(a) have examined the person subject to the order; and

(b) certify that the person no longer meets the criteria set out in section 57.

Compliance with community treatment orders

59.—(1) A person subject to a community treatment order—

(a) should be encouraged to make every possible attempt to comply with the order; but

(b) may be given care, support or treatment called for by the order even if the person does not comply with all the conditions of the order.

(2) If a person subject to a community treatment order is unable or unwilling to comply with the order, an authorised health care professional may require the person to attend that or another authorised health care professional specified in the order at a specified mental health facility for further assessment.

(3) In making a decision about a person under subsection (2), an authorised health professional should disregard any non-compliance with the order resulting from unavailability of medication or staff or other circumstances beyond the control of the person.

(4) An authorised health care professional who makes an order under subsection (2) may request the assistance of a police officer to take the person to the specified mental health facility.

(5) The provisions of section 31 and 50 apply to assistance and transport provided pursuant to a request under this section.

Review of community treatment orders

60.—(1) The Review Board must, within 6 months of the making of a community treatment order under section 57 (3), and thereafter at least every 6 months, review the case of every person in respect of whom such an order is made, in accordance with section 27.

(2) The medical director of every mental health facility must notify the Review Board whenever a person is released from the facility but made subject to a community treatment order.

(3) The Permanent Secretary must notify the Review Board of the name of any person whose case the Review Board is required to review under this section.

(4) On a review under this section the Review Board has the powers set out in section 100.

Inpatient treatment

Making of inpatient treatment orders

61.—(1) The criteria for an inpatient treatment order for a person are that—

(a) the person has a mental disorder;

(b) as a result of the mental disorder the person requires care, support, treatment or protection-

(i) in the interests of the person; or

(ii) to protect the safety, health and welfare of another person or persons;

(c) the care, support, treatment or protection cannot be provided in a less restrictive manner than by inpatient treatment; and

(d) such treatment is available in Fiji.

(2) If a person—

(a) requests in writing an authorised health care professional to make an inpatient treatment order in respect of that person; and

(b) gives informed consent in writing to the making of such an order, the authorised health care professional, if satisfied that the criteria set out in subsection (1) are met, may make a voluntary inpatient treatment order in respect of the person.

(3) If—

(a) a medical practitioner certifies in respect of a person, after an assessment under sections 18, 31 or 32, that the criteria set out in subsection (1) are met in respect of the person; and

(b) the person is unwilling or unable to receive care, support, treatment or protection for the mental disorder on a voluntary basis, an authorised health care professional may make a compulsory inpatient treatment order in respect of the person.

Terms of an inpatient treatment order

62.—(1) An inpatient treatment order must require the person subject to the order—

(a) to be detained and remain an inpatient at a mental health facility specified in the order or another mental health facility specified by an authorised health care professional;

(b) to receive the care, support, treatment or protection that an authorised health care professional determines from time to time;

(c) subject to subsection (5), after release from the mental health facility, to attend at—

(i) a specified medical, health care or rehabilitation service;

(ii) a specified therapist or place of therapy; or

(iii) some other specified activity, service, person or body; and

(d) to comply with all other terms and conditions imposed in writing by an authorised health care professional from time to time.

(2) The terms and conditions imposed under subsection (1) must only be such as are in the opinion of the health care professional in the best interests of the mental health of the person who is subject to the order.

(3) An inpatient treatment order may be issued for a specified period not exceeding 3 months, but may be renewed following an assessment and further certificate by an authorised health care officer for further periods of 3 months.

(4) An inpatient treatment order must be in writing and in the approved form and must comply with any other prescribed requirements.

(5) On the expiry or revocation of an inpatient treatment order in respect of a person, an authorised health care professional may in writing, following an assessment instead of imposing conditions under subsection (1)(c) if he or she considers it necessary to substitute a community treatment order in accordance with section 58.

(6) A community treatment order issued under subsection (2) cannot be for longer than 3 months in the first instance and must be reviewed by the Review Board at the end of that period.

Reception notices

63.—(1) When a person is admitted to a mental health facility under a compulsory inpatient treatment order, the primary carer of the person must at the time or as soon as practicable, sign a reception notice.

(2) A reception notice is an acknowledgement by the primary carer of a person—

(a) that the person has been admitted to the mental health facility as an involuntary inpatient;

(b) that the primary carer is the person legally entitled to receive notifications under section 46; and

(c) that the primary carer accepts the responsibility or arranges care for looking after the person upon the person's release from the facility.

(3) To the extent practicable, and subject to available resources, the primary carer of a person released from compulsory inpatient treatment should be provided with assistance and education in rehabilitating the person to enable the carer to fulfil the obligation under subsection (2)*(c)*.

Treatment team

64.—(1) The medical director of a mental health facility may designate 2 or 3 persons as the treatment team for a person or persons subject to an inpatient treatment order.

(2) The medical treatment team should whenever possible consist of—

(a) a medical officer;

(b) a member of the nursing staff of the facility; and

(c) a social worker or occupational therapist,

but if all 3 are not available, may consist of a person within paragraph *(a)* or *(b)* and a person within paragraph *(c)*.

(3) The medical director may vary the composition of a treatment team from time to time by revoking the designation of a person or designating another person as a member of the team.

(4) The function of a treatment team at a mental health facility is to advise authorised health care professionals on their functions under this decree, including, but not limited to—

(a) performing assessments;

(b) making, varying, reducing, renewing or revoking community treatment orders and inpatient treatment orders.

Variation and renewal of inpatient treatment orders

65. An authorised health care professional may, following a further assessment of a person subject to an inpatient treatment order, and after obtaining the advice of the treatment team—

(a) vary the terms of the inpatient treatment order, but so that the order still complies with section 61 (4) and (5);

(b) renew the order within one month before its expiry, for a further specified period not exceeding 6 months, if the criteria for the making of the order set out in section or 61(1) continue to be met; or

(c) reduce the duration of the order.

Revocation of inpatient treatment orders

66.—(1) If—

(a) the treatment team for a person subject to an inpatient treatment order unanimously advise an authorised health care professional that the person does not need to continue to be subject to the order; and

(b) the authorised health care professional agrees with that advice,

the authorised health care professional may revoke the order.

(2) An inpatient treatment order can only be revoked under subsection (1) if all members of the treatment team, and the authorised health care professional—

(a) have examined, or observed an examination, of the person subject to the order; and

(b) believe that the person no longer meets the criteria set out in section 61.

(3) The medical director of the mental health facility concerned may revoke an inpatient treatment order if the medical director—

(a) has examined, or observed an examination, of the person subject to the order;

(b) believes that the person no longer meets the criteria set out in section 61; and

(c) considers it appropriate to do so having regard to all the circumstances.

Compliance with inpatient treatment orders

67.—(1) A person subject to an inpatient treatment order—

(a) should be encouraged to make every possible attempt to comply with the order; but

(b) may be given care, support, treatment or protection called for by the order even if the person does not comply with all the conditions of the order.

(2) An authorised health care professional who issues an inpatient treatment order must provide copies to—

(a) the medical director of the mental health facility to which it relates; and

(b) the Permanent Secretary; and

(c) the Tribunal

within 2 working days after the order is issued.

Leave of absence for inpatients

68.—(1) An authorised health care professional may in writing authorise a person subject to an inpatient treatment order to be absent on leave from a mental health facility for a continuous period not exceeding 14 days (336 hours).

(2) Leave of absence may be granted subject to conditions stated in the document.

(3) Conditions imposed under subsection (2) must only be such as are calculated to ensure compliance with the order and the patient's return, and must be consistent with this Part and the Decree generally.

(4) The authorised health care professional who granted leave of absence or any other authorised health care professional may cancel any leave of absence granted under this section—

(a) if there has been a breach of a term or condition applying to the leave absence;

(b) if cancellation is warranted in the interests of the person or to protect another person or persons; or

(c) in other prescribed circumstances.

Return of inpatients to mental health facility

69.—(1) Despite any other law, if a person subject to an inpatient treatment order—

(a) is absent from a mental health facility without the permission of an authorised health care professional; or

(b) fails to return to a mental health facility—

(i) within the period of any leave of absence granted under section 65; or

(ii) immediately upon the cancellation of leave of absence under that section,

an authorised health care professional may request the assistance of a police officer to take the person to a specified mental health facility.

(2) The provisions of sections 31 and 50 apply to assistance and transport provided pursuant to a request under this section.

Offences concerning removal of inpatients

70.—(1) A person who, without lawful excuse—

(a) removes or attempt to remove a person subject to an inpatient treatment order from a mental health facility;

(b) assists or attempts to assist a person subject to an inpatient treatment order to leave a mental health facility;

(c) harbours or attempts to harbour a person subject to an inpatient treatment order, when the person is absent from a mental health facility without the permission of an authorised health professional; or

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(d) hinders or attempts to hinder a health care professional or police officer in exercising any function under section 69, commits an offence.

(2) A person who commits an offence under this section is liable on conviction for a fine not exceeding $1, 000 and/or imprisonment of not more than 5 years or both.

Review of inpatient treatment orders

71.—(1) The Tribunal must, within 3 months of admission and thereafter at least every 3 months, review the case of every person who is detained in a mental health facility under a compulsory inpatient order, in accordance with section 98.

(2) The medical director of a mental health facility must notify the Tribunal of the name of any patient whose case the Tribunal is required to review under this section.

(3) On a review under this section the Tribunal has the powers set out in section 100.

Administration of ECT

72.—(1) ECT may only be administered to a person—

(a) in its modified form that is to say with the use of anaesthesia and muscle relaxants,

(b) by a medical practitioner;

(c) in a mental health hospital;

(d) to a person who is an adult; and

(e) in accordance with this Part.

(2) ECT must not be administered to a person unless there are present during the administration of the ECT not less than 2 medical practitioners (of whom the medical practitioner administering the ECT may be one)—

(a) one of whom is experienced in the administration of ECT; and

(b) another of whom is trained and experienced in the administration of anaesthetics.

(3) ECT may be administered to a voluntary patient only if—

(a) the person has given informed consent as described in section 73 and

(b) a medical certificate has been given as described in section 74.

(4) In the case of—

(a) an involuntary patient who does not consent or is incapable of giving consent;

(b) a voluntary patient who is incapable of giving informed consent; or

(c) a voluntary patient in respect of whom it is unclear whether the person is capable of giving consent,

ECT may be administered only in accordance with a decision of the Tribunal at an ECT inquiry under section 73.

(5) Subject to subsection (7), a person is presumed to be incapable of giving informed consent to the administration of ECT if, when consent is sought, the person is affected by medication that impairs the person's ability to give that consent.

(6) In a situation as described in subsection (5), the decision to administer ECT should be deferred until such a time as the person is able to give or refuse his or her informed consent.

(7) A person who administers ECT in contravention of this section is guilty of an offence and is liable for a fine not exceeding $1, 000 or imprisonment for a term not exceeding 5 years or both.

Informed consent requirements for ECT

73.—(1) A person is deemed to have given informed consent to the administration of ECT only if he or she gives a free, voluntary and written consent on the approved form after the following subsections are complied with.

(2) Before informed consent to ECT is obtained from a person, the person must be given in writing—

(a) a full explanation of the techniques or procedures to be followed, including identifying and explaining any technique or procedure about which there is not sufficient data to recommend it as recognised treatment or to reliably predict the outcome of its performance;

(b) a full description, without exaggeration or concealment, of any possible discomforts and risks of the treatment (including possible loss of memory);

(c) a full description of any expected benefits from the treatment;

(d) full disclosure, without exaggeration or concealment, of any appropriate alternative treatments that would be advantageous to the person;

(e) notice that he or she is free to refuse or to withdraw consent and to discontinue the procedures or any part of them at any time;

(f) information about any financial relationship between the person proposing the administration of the treatment, or the administering medical practitioner, or both of them, and the facility in which it is proposed to administer the treatment; and

(g) notice of his or her right to obtain legal and medical advice and to be represented before giving consent.

(3) A person from whom informed consent to ECT is sought must be given—

(a) an approved form setting out the matters referred to in subsection (2) and inviting the person to consent to ECT in writing; and

(b) an oral explanation of the implication of signing the form in a language he or she understands.

(4) After the person has been given an opportunity to ask questions concerning the procedures or any part of them, and given appropriate answers, and if the person appears to have understood the answers, the person must be invited to sign the consent form.

(5) Signing of a consent form, or making a thumbprint on a consent form if the person cannot write, will be taken to be informed consent to the administration of ECT.

Medical certificate requirements for ECT

74.—(1) A medical certificate for purposes of this section is one given by at least 2 medical practitioners, at least one of whom is a specialist in psychiatric medicine.

(2) A medical certificate in respect of a person must certify that, after considering the clinical condition and history of treatment of, and any appropriate alternative treatments for, the person, the medical practitioners are of the opinion that ECT is—

(a) a reasonable and proper treatment to be administered to the person; and

(b) necessary or desirable for the safety or welfare of the person.

ECT inquiries

75.—(1) In the situation described in section 72 (5) *(c)* (unclear whether a voluntary patient is capable of giving informed consent to ECT), an authorised health care professional may apply to the Review Board for an ECT consent inquiry.

(2) In either of the situations described in section 72 (5)*(a)* or *(b)* (involuntary patient, or voluntary patient incapable of giving informed consent) an authorised health care professional may apply to the Review Board for an ECT administration inquiry on production of a medical certificate relating to the patient as described in section 74.

(3) On an application by an authorised health care professional under subsection (1) or (2), the Review Board must as soon as practicable conduct the appropriate ECT enquiry.

(4) Notice of an application for an ECT enquiry about a person must be given to the person and to the person's primary carer in accordance with section 46.

(5) The function of the Review Board on an ECT consent inquiry is to determine whether or not a voluntary patient is capable of giving informed consent to the administration of ECT and has given that consent.

(6) On an ECT consent enquiry, if the Review Board—

(a) finds that a voluntary patient is—

(i) incapable of giving informed consent to the administration of ECT; or

(ii) is capable of giving informed consent but has refused; or

(iii) has neither consented nor refused; and

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(b) after considering the medical opinions and other information placed before it, is satisfied that ECT is a reasonable and proper treatment and is necessary and desirable for the safety or welfare of the patient,

the Review Board may endorse a course of treatment and must specify the number of treatments that are approved (not exceeding 12 during each course of treatment).

(7) The function of the Review Board on an ECT administration inquiry is to determine whether or not ECT should be administered to an involuntary patient.

(8) On an ECT administration enquiry, if after considering the medical opinions and other information placed before it, the Review Board is satisfied the ECT is a reasonable and proper treatment and is necessary and desirable for the safety or welfare of the patient, the Review Board may approve a course of treatment and must specify the number of treatments that are approved (not exceeding 12 during each course of treatment).

(9) For the purposes of an ECT inquiry, the Review Board must—

(a) find out from the person about whom the inquiry is being held whether or not notice of the inquiry was given in accordance with this Part;

(b) inform the person about whom the inquiry is being held of the nature and possible results of the inquiry, if the person has not or appears not to have been informed of them;

(c) inquire about the administration of any medication to the person about whom the inquiry is being held and take account of its effect on the person's ability to communicate;

(d) consider the views of the person about whom the inquiry is being held about the treatment;

(e) consider any other relevant information placed before it.

(10) A decision on an ECT enquiry has effect for 6 months from the date the determination is made unless a shorter period is specified in the decision.

ECT register

76.—(1) The medical director of a mental health hospital at which ECT is administered must keep a register in an approved form containing information relating to the administration of ECT at the facility.

(2) Particulars of a proposed administration of ECT must be entered in the register before the therapy is administered, and any differences in the particulars of treatment actually administered must be subsequently noted and explained in the register.

(3) The register may be inspected at any time by the Board of Mental Health Visitors, any other mental health visitor, the Permanent Secretary and the National Mental Health Advisor.

Surgery and other treatment

Requirement for informed consent to surgery or other treatment

77.—(1) No surgical operation or special medical treatment may be performed upon a patient except with the informed consent of the patient, or in the circumstances described in the following sections.

(2) Informed consent given for the purposes of this and the following sections must be free, voluntary, in writing in the approved form, and signed (or thumb printed) by the person giving the consent.

(3) Before consent to an operation or treatment is obtained from a person, the person must be given in writing—

(a) an explanation of the techniques or procedures to be followed;

(b) a description of any possible discomforts and risks involved;

(c) a description of any expected benefits and disclosure of alternative treatments that might be advantageous to the person.

Emergency surgery for involuntary patients

78.—(1) Subject to subsection (2), an authorised health care professional or authorised medical practitioner may in writing authorise the performance of a surgical operation on an involuntary patient if of the opinion that—

(a) the patient is incapable of giving informed consent to the operation or is capable of giving consent but refuses to give that consent or neither gives nor refuses to give that consent; and

(b) it is necessary, as a matter of urgency, to perform a surgical operation on the patient in order—
(i) to save the patient's life;
(ii) to prevent serious damage to the patient's health; or
(iii) to prevent the patient from suffering or continuing to suffer significant pain or distress.

(2) Before giving an authority for an operation under subsection (1), the authorised health care professional or authorised medical practitioner must take all reasonable steps to obtain the informed consent of the primary carer of the patient to the operation, but if the primary carer —
(a) is not readily available; or
(b) does not give informed consent to the operation,

the professional or practitioner may proceed as if the patient had not consented.

(3) The authorised health care professional at the mental health facility in which the involuntary patient is detained must, as soon as practicable after the performance of a surgical operation authorised under this section, notify the Review Board of the operation.

(4) Informed consent given to an emergency surgical operation by a primary carer of a patient who does not have the capacity to consent has the same effect as if it were given by the patient and the patient had the capacity to consent.

Non-emergency surgery for involuntary patients

79.—(1) If an authorised health care professional is of the opinion that a surgical operation is necessary for a patient but that the urgency is not such that section 78 applies, the authorised health care professional must allow a reasonable period to elapse in which the patient can recover his or her ability to give or refuse informed consent;

(2) Thereafter, if the authorised health care professional is still of the opinion that an operation is necessary and if the patient—
(a) is still incapable of giving or refusing informed consent; or
(b) is capable and refuses such consent,

the authorised health care professional may apply to the Review Board to authorise the performance of the surgical operation pursuant to section 80

(3) An application under this section must be made not earlier than 14 days after notice of the proposed application is given under section 46, but may be made sooner if—
(a) the authorised health care professional is of the opinion that the urgency of the circumstances requires an earlier determination of the matter; or
(b) the person notified consents in writing to the application being made before the expiry of 14 days.

Review Board may authorise surgery

80.—(1) If informed consent to a surgical operation being performed on an involuntary patient detained in a medical facility is not given by the patient, an authorised health care professional at the facility may apply to the Review Board to authorise the performance of the operation.

(2) On an application, the Review Board may authorise the performance of a surgical operation on a patient only if the Review Board is satisfied that—
(a) the operation is the only or most appropriate way of treating the patient;
(b) the operation is manifestly in the best interests of the patient; and
(c) any guidelines issued by the Advisory Council and relevant to the performance of the operation have been or will be complied with as regards the patient.

Special medical treatment

81.—(1) A person who is not a medical practitioner must not carry out special medical treatment on a patient.

(2) A medical practitioner must not carry out special medical treatment on a patient unless—
(a) informed consent to the treatment being carried out is given by the patient;
(b) authority for the treatment is given by the Review Board in accordance with section 83 or

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(c) 2 other medical practitioners are of the opinion, and certify to the effect, that it is necessary, as a matter of urgency, to carry out the treatment on the patient without informed consent or authority, in order to save the patient's life or to prevent serious damage to the patient's health.

(3) A person who contravenes subsection (1) or (2) commits an offence and is liable on conviction to a fine not exceeding $10,000 or imprisonment for a period not exceeding 5 years or both.

Review Board may authorise special medical treatment

82.—(1) If informed consent to special medical treatment being carried out on an involuntary patient detained in a medical facility is not given by the patient, an authorised health care professional at the facility may apply to the Review Board to authorise the carrying out of such treatment on the patient.

(2) On an application, the Review Board may authorise the carrying out of special medical treatment on a patient only if the Review Board is satisfied that—

(a) the treatment is the only or most appropriate way of treating the patient;

(b) the treatment is manifestly in the best interests of the patient; and

(c) any guidelines issued by the Advisory Council and relevant to the carrying out of the treatment have been or will be complied with as regards the patient.

(3) The Review Board must not authorise the carrying out of special medical treatment on a patient under the age of 18 years.

(4) An application for authority under this section must be made not earlier than 14 days after notice of the proposed application is given under section 46 but may be made sooner if—

(a) the authorised health care professional is of the opinion that the urgency of the circumstances requires an earlier determination of the matter; or

(b) the person notified consents in writing to the application being made before the expiry of 14 days.

PART 7—CHILDREN AND YOUNG PERSONS

Treatment, accommodation and rights of children and young persons

83.—(1) The psychiatric, medical and other treatment given to a child or young person under this Decree must take account of the age, developmental stage and condition of the child or young person.

(2) An authorised health care professional dealing with a child admitted to a mental health institution or receiving treatment or advice pursuant to this Decree should consult the child on the various treatments and other options available, in a manner consistent with the child's apparent intellectual and emotional development

(3) A child or young person who is an inpatient at a mental health facility must, wherever practicable, be accommodated—

(a) in accommodation that is suited to the age, developmental stage and condition of the child or young person; and

(b) away from adult inpatients, except while the child or young person is under close

(c) and continuous supervision by responsible staff of the mental health facility concerned.

(4) Provision must be made to the extent practicable for the continued education of a child or young person who is an inpatient at a mental health facility.

(5) A child or young person who is not an inpatient at a mental health facility has the right to make visits, at reasonable times and with reasonable frequency, to his or her close relatives who are inpatients at a mental health facility.

(6) Close relatives of a child or young person who is an inpatient at a mental health facility and detained under this Decree have the right to make visits, at reasonable times and with reasonable frequency, to the child or young person.

(7) If the mother of a child under the age of 2 years is an inpatient at a mental health facility, the mother has the right where there are available facilities—

(a) to have the child accommodated at the facility; and

(b) to have access to the child at all times, unless the safety and welfare of the child would be at serious risk if access were provided.

(8) The regulations may make provision for or with respect to—

(a) the treatment referred to in subsection (1);

(b) the accommodation and supervision referred to in subsection (2); and

(c) the implementation of the rights referred to in subsections (3) to (5).

Informed consent by primary carer of a child

84. Informed consent given by a primary carer of a child has the same effect as if it were given by the child for all purposes of this Decree.

PART 8—PERSONS IN CUSTODY AND PRISONERS

Application of Decree to persons in custody and prisoners

85.—(1) Subject to subsection (2), the provisions of this Decree apply to persons in custody or remand and to prisoners who are serving a sentence of imprisonment, to the extent appropriate and in a manner consistent with their status as persons in custody or prisoners.

(2) The following provisions of this Decree do not apply to persons in custody or prisoners—

(a) Part 3 (Voluntary admission and assessment);

(b) Sections 23 to 28 (Detention) except that section 27 (Detention on order of a court) applies;

(c) Section 39 (Confidentiality) to the extent of any inconsistency with lawful prison rules on confidentiality;

(d) Sections 47 to 49 (Movement of patients) except that section 51 (Powers of person transporting, etc.) applies;

(e) Sections 57 to 59 (Community treatment);

(f) Sections 61, 63, 64 and 68 to 70 relating to inpatient treatment.

(3) The Minister may following consultation with the National Mental Health Advisor by order—

(a) declare the extent to which provisions of this Decree not mentioned in subsection (2) apply to persons in custody and prisoners; and

(b) make appropriate any modifications to those provisions apply.

(4) This Decree affects the provisions of the Criminal Procedure Decree with regard to persons—

(a) found unfit to stand trial by reason of mental disorder; or

(b) found to have done the act charged but to be not guilty by reason of mental disorder; or

(c) ordered to be detained for assessment under this Decree during the course of a trial or on conviction

as it appears in Schedule 2.

Rights of persons in custody and prisoners

86.—(1) The following principles are, as far as practicable, to be given effect to with respect to the care and treatment of persons in custody and prisoners with a mental disorder—

(a) they must receive the best care and treatment practicable and in circumstances that will enable the care and treatment to be effectively given;

(b) they must be provided with timely and high quality treatment and care in accordance with professionally accepted standards;

(c) the prescription of medicine to them must meet their health needs and must be given only for therapeutic or diagnostic needs and not as a punishment or for the convenience of others;

(d) they must be provided with appropriate written information about –

(i) assessment procedures; and

(ii) treatment, treatment alternatives and the effects of treatment;

(e) their age-related, gender-related, religious, cultural, language and other special needs must be recognised;

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(f) all reasonable efforts must be made to involve them in the development of treatment plans and plans for ongoing care;

(g) they must be informed in writing of their legal rights and other entitlements under this Decree and all reasonable efforts must be made to give the information in the language, mode of communication and terms that they are most likely to understand.

(2) Without limiting any other applicable provision of this Decree, persons in custody and prisoners with a mental disorder have the right to be treated with dignity and respect.

(3) A reference in the following sections of this Part to a prisoner other than section 92 includes a person in custody as defined in section 2(1).

Secure units for treatment of prisoners

87.—(1) The Minister may, on the advice of the Advisory Council, by order designate an area of a mental health facility as a secure unit for purposes of this Part.

(2) All or part of a prison hospital or prison clinic may be designated under subsection (1) as a secure unit for purposes of this Part.

(3) The Minister may by order—

(a) limit the provisions of this Decree or the purposes under this Decree for which a secure unit may be used;

(b) designate a secure unit as a unit of a specified class;

(c) designate the purposes for which a secure unit of a specified class may be used;

(d) impose any other conditions in relation to the operation of a secure unit.

Inquiry into mental health status of prisoner

88.—(1) If it appears to the person in charge of a prison, through personal observation or from information provided, that a prisoner may have a mental disorder, the person in charge of the prison must cause the mental health status of the prisoner to be inquired into by a medical practitioner or an authorised health care professional.

(2) The person conducting the inquiry under subsection (1) must submit a written report to the person in charge of the prison, and must specify in the report—

(a) the mental health status of the prisoner; and

(b) a plan for the care, treatment and rehabilitation of the prisoner.

(3) If the person conducting an inquiry under subsection (1) finds that the mental disorder of the prisoner is such that the prisoner could appropriately be cared for, treated and rehabilitated in the prison, the person in charge of the prison must take the necessary steps to ensure that the required levels of care, treatment and rehabilitation services are provided to the prisoner in the prison, or under prison rules.

(4) If the person conducting the inquiry finds that the mental disorder of the prisoner is such that the prisoner should be kept in the secure unit of a prison, the person in charge of the prison must—

(a) cause the prisoner to be removed to the designated secure unit of the prison; or

(b) if there is no such unit, or it is not appropriate for the purpose, request the Officer in Charge of Prisons to initiate action under section 89 for a transfer of the prisoner.

(5) If the person conducting the inquiry finds that the mental disorder of the prisoner is such that the prisoner ought to be cared for and treated in a mental health facility, the person in charge of the prison must request the Officer in Charge of Prisons to initiate action under section 89 for a transfer of the prisoner.

(6) If a prisoner or person in custody is found, on an inquiry under subsection (1), to have a mental disorder, the person in charge of the prison must arrange for a medical practitioner to examine the person in accordance with section 24 and if the medical practitioner certifies as stated in that section, the person is deemed to be the subject of an involuntary inpatient treatment order and section 62, 65 to 67 and 71 apply accordingly, with appropriate modifications.

Transfer of prisoners on order of Review Board

89.—(1) The Review Board may, upon the application of the Officer in Charge of the Prison where the prisoner is jailed and whether or not a court order has been given order the transfer of a prisoner with a mental disorder—

(a) from prison to a mental health hospital of facility;

(b) from a mental health hospital or facility to prison; or

(c) from one prison to another,

if it is necessary for the care, treatment and rehabilitation of the prisoner in terms of this Decree.

(2) Upon an application under subsection (1), the Review Board must inquire into the mental health status of the prisoner as well the space allocations available at the mental health hospital or facility and make a decision as to whether the transfer applied for, or some other transfer, would be appropriate, and make an order accordingly.

(3) If the Review Board considers that a person with a mental disorder who is in prison should be cared for, treated and rehabilitated at a mental health hospital or facility, the Review Board must order the transfer of the person to a mental health hospital or facility specified in the notice.

(4) If the Review Board considers that a prisoner or person in custody with a mental disorder who is in a mental health hospital or facility can be cared for, treated and rehabilitated in prison, the Review Board may order the transfer of the person to a prison to be designated for the purpose by the Officer in Charge of Prisons.

(5) If the Review Board makes an order under subsection (4) for transfer of a person to a designated prison, the Review Board must include a requirement that the Officer in Charge of the Prison with which the prisoner is being transferred to and other responsible senior prison officer are to take all practicable steps to ensure that the required levels of care and treatment are provided to the prisoner in the prison, or under prison rules.

Procedure on transfer of prisoners

90.—(1) On making an order under subsection (3) of section 89 for transfer of a person from prison to a mental health facility the Review Board must issue a notice of transfer to the medical director of the facility and to the Officer in Charge of Prison of the Prison where the prisoner is jailed; and those persons must make arrangements for the transfer.

(2) On making an order under subsection (4) of section 89 for transfer of a person from a mental health facility to a prison—

(a) the Review Board must issue a notice to the medical director of the facility and to the Officer in Charge of Prisons;

(b) the Officer in Charge of Prisons must designate the prison to which the person is to be transferred; and

(c) the Officer in Charge of Prisons, the medical director and the person in charge of the prison must make arrangement for the transfer.

(3) A transfer pursuant to an order under section 89 must be effected as soon as practicable after the making of the order and in any event within 7 days of receipt of the notice under this section by all the persons to whom it is directed.

(4) Section 50 applies to the transport of prisoners under this Part as it applies to other persons under other provisions of this Decree, with necessary modifications.

(5) Whenever a transfer of a prisoner to a mental health facility is effected under this Part, the medical director of the mental health facility receiving the prisoner is—

(a) deemed to have lawful custody of the prisoner on admission; and

(b) responsible for the safe custody of the prisoner,

and for that purpose may require the person to be kept in the designated secure unit at the facility.

Internal review of mental health status of prisoners

91.—(1) The medical director of a mental health facility in which a prisoner with a mental disorder is detained must cause the mental health status of the prisoner to be reviewed every 3 months from the date on which the prisoner was received in the facility.

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(2) The review must—

(a) specify the mental health status of the prisoner; and

(b) include recommendations regarding—

(i) a plan for further care, treatment and rehabilitation services for the prisoner; and

(ii) the merits of returning the prisoner to the prison from which the prisoner was initially transferred.

(3) The medical director of the mental health facility must as soon as practicable submit a summary report of the review to the Officer in Charge of Prison of the Prison where the prisoner was transferred from, the Review Board and the Permanent Secretary, and the Review Board may inquire further into the matter and order transfer of the person under section 89 in the light of that review if it thinks appropriate.

(4) The person in charge of a prison must cause the mental health status of every prisoner with a mental disorder to be reviewed every 3 months from the date on which the prisoner was received in the prison.

(5) The provisions of subsections (2) and (3) apply to a review under subsection (4) with necessary modifications.

Recovery of prisoners with a mental disorder

92.—(1) If the medical director of a mental health facility is satisfied, from personal observation or from information obtained, that—

(a) a prisoner with a mental disorder has recovered from the mental disorder to such an extent that the prisoner no longer requires care, treatment and rehabilitation; or

(b) the required care, treatment and rehabilitation can be appropriately given at a prison,

the medical director must—

(i) compile an appropriate discharge report and send it to the Review Board and the Permanent Secretary;

(ii) inform the Officer in Charge of the Prison that the prisoner was transferred from that the prisoner is ready for discharge and collection by prison officers; and

(iii) comply with any other prescribed requirements.

(2) If the person in charge of a prison is satisfied, from personal observation or from information obtained, that a prisoner with a mental disorder has recovered from the mental disorder to such an extent that the prisoner no longer requires to be kept in a secure unit, the person must—

(a) inform the Officer in Charge of the Prison where the prisoner was transferred from; and

(b) remove the person from the secure unit.

Prisoners who abscond from mental health facilities

93.—(1) If a prisoner has absconded or is deemed to have absconded from a mental health facility, the medical director of the facility must—

(a) immediately notify the Commissioner of Police;

(b) request police officers in the area where the facility is situated to locate, arrest and return the prisoner to the centre;

(c) notify the Officer in Charge of the Prison where the prisoner was transferred from within 48 hours of having notified the police; and

(d) comply with any other prescribed requirements.

(2) Police officers in the area where the mental health facility is situated must comply with a request made pursuant to subsection (1) *(b)*.

(3) The medical director of the mental health facility centre must notify the police if the prisoner is considered dangerous.

(4) A prisoner arrested under this section must be held in custody for as long as is needed to effect a return of the prisoner to the mental health facility from which the prisoner escaped.

(5) An arrest under subsection (4) must be carried out humanely and –

(a) as speedily as practicable;

(b) with the minimum of force required in the circumstances.

Expiry of term of imprisonment of prisoner with a mental disorder

94.—(1) A prisoner with a mental disorder must, subject to subsections (2) and (3), be released from the prison or a mental health facility at which the prisoner is detained on expiry of the term of imprisonment to which he or she was sentenced.

(2) If the person is in prison, the Officer in Charge of the Prison that the prisoner was transferred from may, not earlier than 90 days before he or she is due to be released, apply to the Review Board for—

(a) a recommendation that a community treatment order be made in respect of the person under section 57(4);

(b) a recommendation that an inpatient treatment order be made in respect of person under section 61; or

(c) an aftercare recommendation to the Permanent Secretary in terms of subsection (5).

(3) If the prisoner is in a mental health facility, the medical director of the facility may before he or she is due to be released, apply to the Review Board for an order or recommendation as described in subsection (2).

(4) If a recommendation is made under subsection (2) *(a)* or *(b)*, the Permanent Secretary must initiate the making of a community treatment order or inpatient treatment order, as the case may be, in respect of the person, pursuant to section 57 or 61 respectively.

(5) An after care recommendation—

(a) is a recommendation to the Permanent Secretary that the person be provided with continued care, treatment and rehabilitation after release from prison or a mental health facility; and

(b) must be acted on by the Permanent Secretary within the resources available and consistently with this Decree.

PART 9—REVIEW MECHANISMS

Mental Health Review Board

Establishment of the Mental Health Review Board

95.—(1) This section establishes a Mental Health Review Board, subject to subsection (6).

(2) The Review Board consists of 5 members appointed by the Minister, of whom—

(a) the President must be qualified to be a judge of the High Court;

(b) one member must be a registered medical practitioner;

(c) 2 members must have relevant experience or qualifications in psychiatric practice or nursing; and

(d) one member must be a person who can represent the interests of mental health service users and their families.

(3) The member appointed under paragraph (2)*(b)* may be a person who is not registered as a medical practitioner in Fiji but who has equivalent qualifications and has had appropriate experience in mental health matters in another country.

(4) The appointed members of the Review Board must include one woman and one man.

(5) The Minister must designate a public officer to be the Secretary of the Review Board.

(6) The Minister, on the advice of the Advisory Council, may by order—

(a) establish a Mental Health Review Board for any area of Fiji to review the cases of persons living in that area or detained in a mental health facility in that area;

(b) specify the area of jurisdiction and the type of case that can be reviewed by such a Board (which will exclude the jurisdiction of any other Review Board in that area for that type of case);

(c) apply the provisions of this Part to any such Board with appropriate modifications.

(7) If the Minister appoints additional Boards under subsection (6), references in this Decree to 'the Review Board' in relation to a person or a mental health facility are references to the Review Board for the area where the person or facility is located at the relevant time.

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Terms and conditions of membership of the Review Board

96.—(1) Members of the Review Board are appointed on conditions determined by the Minister for a term not exceeding 3 years and may be on the conditions so determined be re-appointed.

(2) The Minister may remove a member of the Review Board from office—

(a) for breach of, or non-compliance with, a condition of appointment;

(b) for misconduct; or

(c) for failure or incapacity to carry out official duties satisfactorily.

(3) The office of a member of the Review Board becomes vacant if the member—

(a) resigns by written notice to the Minister;

(b) ceases to satisfy the qualification by virtue of which the member was eligible for appointment to the Review Board; or

(c) is removed from office under subsection (2).

(4) A member of the Review Board is entitled to remuneration, allowances and expenses determined by the Minister.

(5) If there is a vacancy on the Review Board, the vacancy must be filled as soon as practicable but meanwhile the Board can proceed if there is a quorum as specified in section 100 (2) subject to the temporary appointment of a President qualified.

(6) An act or proceeding of the Review Board is not invalid by reason only of a defect in the appointment of a member.

Functions of the Review Board

97.—(1) The functions of the Review Board are to—

(a) hear applications for review of orders brought under section 98;

(b) periodically review the case of every person who is receiving care or treatment as a voluntary patient at a mental health facility as required by section 20;

(c) review a decision to refuse or to discharge a voluntary patient as in section 19 on an application under section 21;

(d) periodically review the case of every person who is subject to a community treatment order, as required by section 59;

(e) periodically review the case of every person who is detained in a mental health facility under a compulsory inpatient order, as required by section 71;

(f) conduct an ECT consent enquiry on an application under section 75(1);

(g) conduct an ECT administration enquiry on an application under section 75(2);

(h) decide whether to authorise a surgical operation on an application under section 80(1);

(i) decide whether to authorise special medical treatment on an application under section 81(1);

(j) conduct enquiries and make orders about the transfer of prisoners on an application under section 89;

(k) make recommendations and interim orders about released prisoners on an application by the Officer in Charge of the Prison where the prisoner was transferred from or where the prisoner is kept under section 94;

(l) review orders brought to its attention by mental health visitors pursuant to section 103 (4)

(m) perform any other functions conferred on the Review Board by this Decree; and

(n) perform any other prescribed functions.

(2) If no provision is made in this Decree for an application to the Review Board, the function of the Board is to be performed at the instigation of the Secretary of the Board, who is deemed to be the applicant.

Applications for review of orders

98.—(1) A person subject to a community treatment order or inpatient treatment order, or the person's primary carer, or any other person with a bona fide interest in the matter, may, during the currency of the order, apply to the Review Board for a review of the order, irrespective of the Board's obligation to conduct a periodic review of the order.

(2) An application for review under subsection (1) must be—

(a) in a form approved by the President of the Review Board;

(b) processed by an authorised health care professional; and

(c) filed in accordance with this Part and the procedures of the Review Board.

(3) In deciding whether to grant the application for review, the Review Board must have regard to all the circumstances of the case, including but not limited to—

(a) the number of applications made by or in respect of the person subject to the order during the currency of the order;

(b) the number of hearings already held for the person subject to the order.

(4) An authorised health care professional who is aware of a request for a review by a person subject to a community treatment order or inpatient treatment and who, without lawful or reasonable excuse, fails to process an application for review as required by subsection (2)*(b)*, commits an offence and is liable for a fine not exceeding $10,000 or imprisonment for a term not more than 5 years or both.

(5) Notwithstanding anything in this section, any person applying for a review under this section may have only one complete hearing of the matter unless the Review Board decides that there are exceptional circumstances justifying a further hearing.

(6) In this section, "process"—

(a) involves giving all necessary assistance required by or in respect of a person subject to a community treatment order or inpatient treatment order to complete an application for a review as required by this section; and

(b) includes giving assistance with the filing of the application, with transportation to and from the place where the hearing is conducted, and with facilities during the time of the hearing by the Review Board.

Powers of the Review Board

99.—(1) On a review of an order, the Review Board may confirm, reverse or vary the decision that is the subject of the review, and may substitute its own decision for that subject to review, in a manner consistent with this Decree.

(2) The Board may make orders as to the costs of a review, but the costs must not be borne by the patient or the parent or primary carer of the patient.

(3) When reviewing the case of a person who is subject to a community treatment order, the Review Board must consider whether the patient should continue to be subject to the order, or should be subject to different conditions, having regard to—

(a) the criteria set out in section 57;

(b) the requirements of the person and of other persons in all the circumstances.

(4) If the Review Board considers that the person should not continue to be subject to the community treatment order, the Board may either—

(a) revoke the order; or

(b) vary the order in a manner consistent with this Decree.

(5) When reviewing the case of a person who is detained in a mental health facility under an inpatient treatment order, the Review Board must consider whether the patient should continue to be detained as an inpatient, or be subject to different conditions, having regard to—

(a) the criteria set out in section 61;

(b) the requirements of the person and of other persons in all the circumstances.

(6) If the Review Board considers that the person should not continue to be detained in a mental health facility, the Board may either—

(a) order the discharge of the patient from the mental health facility; or

(b) substitute for the inpatient treatment order a community treatment order with appropriate conditions.

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(7) The Review Board may defer the operation of an order for the discharge of a patient for a period of up to 14 days, if the Board thinks it is in the best interests of the patient to do so.

(8) A community treatment order or inpatient treatment order made by the Review Board in exercise of its powers under this Part has the same effect as an original order made under the corresponding section of this Decree, and any amendment or revocation of such an order by the Board has effect as if done by the person who made the original order.

Procedure of the Review Board

100.—(1) A member of the Review Board must not take part in any review of an assessment or order or any enquiry into a case in which the member was involved as a medical practitioner or nurse.

(2) Except when the President of the Review Board is authorised by this decree to act alone, the quorum for the Board under is 4 members.

(3) Any decision of the Board is by a majority of members, except that if there are only 4 members present and able to vote on a matter, the President has an additional and casting vote.

(4) An application under section 98 for a review of an order in respect of a person must be made by notice to the Secretary of the Board who must send a copy to—

(a) the medical practitioner or authorised health care practitioner who made the order;
(b) if the person is detained in a mental health facility the medical director of the mental health facility;
(c) if the application is not by a person's primary carer, the person's primary carer;
(d) any other person who appears to the Secretary of the Board to have an interest in the subject-matter of the review but subject to the requirement of confidentiality described in section 39.

(5) Any other application relating to a patient or prisoner must be—

(a) commenced by written notice to the Secretary of the Board; and
(b) copied to the patient or prisoner and his or her primary carer and he relevant medical director or person in charge of the prison where the person is detained, as the case may be.

(6) When conducting a review or enquiry under this Decree, the Board—

(a) must act according to equity and good conscience and without regard to technicalities or legal forms;
(b) is bound by the rules of natural justice;
(c) must conduct proceedings in the least formal manner possible in the circumstances;
(d) must allow the applicant for a review and to be represented by a legal practitioner or other person acceptable to the Board;
(e) may sit in any suitable place or venue;
(f) is not bound by the rules or practice as to evidence that govern a court;
(g) may inform itself in relation to any matter in the way it thinks fit; and
(h) for that purpose may—
(i) summon and examine witnesses; and
(ii) require any medical director, person in charge of a prison, the Officer in Charge of Prison, the Permanent Secretary, the National Mental Health Advisor and any authorised health care professional to report orally or in writing on the subject-matter of the review.

(7) A person who fails to obey a summons issued under subsection (4)(h) or to produce a report required under that paragraph is in contempt of the Board unless the Board finds that there is good reason for the refusal or failure, and may be dealt with by the High Court for a contempt of court.

(8) Evidence before the Review Board in a review or enquiry conducted under this Part cannot be used in any civil or criminal proceedings, other than proceedings for an offence against this Decree or for contempt of court or perjury.

(9) Subject to this section the procedure of the Review Board is as determined by the President of the Board.

Board of Mental Health Visitors

101.—(1) The Minister, on the advice of the Advisory Council, should appoint a Board of Mental Health Visitors for any one or more mental health facilities and any one or more mental health unit in a prison.

(2) In the case of a public hospital which has a Board of Visitors appointed under the Public Hospitals and Dispensaries Act (Cap. 110), the Minister may designate that Board as the Board of Mental Health Visitors for the hospital.

(3) In the case of a mental health unit in a prison which has a visiting committee appointed in the Prisons Act the Minister may—

(a) designate that committee as the Board of Mental Health Visitors for the unit; and

(b) if necessary appoint an additional member to make up the 5 members required by subsection (4).

(4) A Board appointed under this section must consist of not fewer than 5 persons who have interest, experience or expertise in mental health or social service issues, including—

(a) a mental health professional;

(b) a consumer group representative;

(c) a representative of current or past mental health service users or their families;

(d) a representatives of service clubs and philanthropic organisations.

(5) A Board may not include a member of the staff of the mental health facility for which it is appointed but such a member may not play a determining role in the activities of the Board.

(6) The Minister must ensure that as far as practicable there is a fair ethnic and gender balance on each Board.

(7) The Minister must designate one member of the Board, who may not be members of the staff at St. Giles Hospital as presiding member.

(8) The procedure of a Board is as determined by the Board, subject to this Decree, any regulations, and any directions of the Minister.

(9) The Permanent Secretary and National Mental Health Advisor are by virtue of their office mental health visitors for all mental health facilities.

Functions of Board of Mental Health Visitors

102.—(1) The duty of a Board of Mental Health Visitors for a mental health facility is to ensure as far as possible the welfare of people with mental disorders who are admitted to the facility.

(2) The functions of a Board of Mental Health Visitors in relation to a mental health facility are to—

(a) conduct regular inspections of the facility and advise the medical director on improvements to its physical conditions;

(b) receive and review unusual incident reports and death records relating to the facility and make recommendations as appropriate;

(c) respond to complaints of patients regarding their treatment or conditions in the facility by reporting the matter to the medical director of the facility;

(d) respond to complaints from patients, members of their families, health and concerned persons about the exercise of powers under this Decree in the facility by reporting the matter to the Permanent Secretary;

(e) ensure so far as possible that the rights of patients under this Decree and their families are appropriately respected and enforced in the facility.

(3) Each Board of Mental Health Visitors must maintain data and statistics on matters which come to or are brought to the attention of the Board.

(4) If a Board of Mental Health Visitors, or an individual mental health visitor visiting alone, considers that a patient in a mental health facility has been wrongly detained or that an inappropriate inpatient treatment order has been made in respect of the patient, the Board or visitor must inform the Mental Health Review Board and that Board must initiate a review of the order in accordance with section 98.

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Visits by Board of Mental Health Visitors

103.—(1) The Board of Mental Health Visitors for a mental health facility must arrange for at least 2 of its members, together and at least once in every 3 months—

(a) to inspect every part of the facility;

(b) to see and examine—

(i) every inpatient of the facility;

(ii) the documents authorising the presence in the facility of each inpatient admitted since their last visit; and

(iii) the books and other records of the facility;

(c) keep a written record of their findings with regard to the condition and management of the facility and its patients.

(2) A mental health visitor other than a member of a Board may visit any mental health facility on any day and at such time and for such length of time as the visitor thinks fit.

(3) The medical director of a mental health facility must, on demand by a Board or by a mental health visitor making a visit under this section, show to the Board or visitor every person detained in the facility, including in any house, outhouse, place or building connected with the facility.

Complaints to Board of Mental Health Visitors

104.—(1) Subject to subsection (2), every patient in a mental health facility, and the primary carer of a patient, has the right to complain to a mental health visitor about any aspect of care and treatment provided by mental health facility.

(2) Patients and carers who wish to complain about any aspect of their treatment in a mental health facility should be encouraged to make the complaint in the first instance to the medical director of the facility.

(3) A complaint to a mental health visitor may be made—

(a) in person or through a representative;

(b) orally or in writing;

at the time of the periodic Board visit mentioned in section 103 (1) or at any other time.

(4) If the patient or carer wishes to make an oral complaint at a time other than the periodic visit, it may be made to a single member of the Board or another mental health visitor.

(5) All complaints must be treated in confidence, except insofar as identifying the complainant is necessary for the purposes of the report to be made under section 106.

(6) A patient must not be discriminated against because of having made a complaint to a mental health visitor.

(7) The medical director of every mental health facility must ensure that all patients in the facility, and their primary carers, are informed of the right to make a complaint to a mental health visitor, and of the procedure for doing so.

Reports by Board of Mental Health Visitors

105.—(1) On 31st January of each year, and more often if the Permanent Secretary so requests in writing, each Board of Mental Health Visitors for a mental health facility must provide a written report to the Permanent Secretary stating in respect of the facility its opinion on—

(a) the state, condition and management of the facility;

(b) the conduct of the persons in charge and staff of the facility; and *(c)* the care of the inpatients of the facility.

(2) In a report made under subsection (1) a Board may—

(a) make recommendations on how to improve mental health services at the facility in question;

(b) make such other observations in relation to any matters connected with the facility as it thinks fit.

(3) In addition to an annual report under subsection (1), the Board of Mental Health Visitors of a mental health facility and any mental health visitor so directed must make a special report to the Minister on any matter connected with the facility if the Minister in writing so directs.

Inpatients' letters to Board of Mental Health Visitors

106. Every letter written by an inpatient of a mental health facility to the Board of Mental Health Visitors for the facility, or any mental health visitor, must be forwarded unopened to the Board or visitor.

Internal inquiries

Internal mental health inquiries

107.—(1) If an inpatient or person receiving treatment at a mental health facility dies or is the subject of an injury or a notifiable incident, an inquiry into the circumstances of the death, injury or incident (an "internal mental health inquiry") must be conducted as soon as practicable.

(2) An internal mental health inquiry in respect of a mental health facility is to be conducted in accordance with—

(a) the Ministry's guidelines for clinical governance and risk management in relation to such facilities;

(b) any prescribed requirements for such inquiries; and

(c) any additional requirements determined by the medical director in relation to the particular facility.

(3) The medical director of a mental health facility must ensure that an internal mental health inquiry at the facility is commenced, conducted and concluded properly and in a manner which leads to improvements in the management of the facility.

(4) The person or persons conducting the internal mental health inquiry must prepare a report about the death, injury or incident, which must include—

(a) recommendations to avoid further deaths, injuries or incidents of the same or a similar kind; and

(b) any other particulars or matters required by the Permanent Secretary in writing in the particular case.

(5) Copies of a report under subsection (4) must be made available to staff at the facility, but material may be omitted from those copies if the medical director reasonably believes that—

(a) the material is confidential and disclosure of it would be in breach of the requirements of this Decree as to confidentiality;

(b) the material is such that disclosure of it or would cause harm to the mental health of a person in the facility; or

(c) disclosure of the material might prejudice the interests of justice or the efficient management of the facility.

(6) A copy of a report under subsection (4) must be sent to the Permanent Secretary within 2 weeks after the conclusion of the inquiry.

(7) This section does not affect the conduct of an inquest, investigation or inquiry under any other written law which relates to the subject-matter of the mental health inquiry.

(8) A mental health inquiry must be postponed or not conducted if the person conducting or responsible for an inquest, investigation or inquiry referred to in subsection (7) makes a request to that effect to the Permanent Secretary and the Permanent Secretary so directs.

(9) In this section, "notifiable incident" means an incident—

(a) that involves physical, verbal, mental or sexual abuse of a patient; or

(b) otherwise causes undue disturbance to other patients in the facility.

PART 10—MANAGEMENT OF ESTATE AND AFFAIRS OF PERSONS WITH MENTAL DISORDERS

Management orders

108.—(1) The criteria for a management order in respect of a person are that—

(a) the person has a mental incapacity;

(b) as a result of the mental incapacity the person is unable to make reasonable judgments in respect to all or any part of the person's estate or affairs by reason of the incapacity; and

(c) the person is in need of a manager to administer the whole or part of the person's estate or affairs.

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(2) If on the application to the Court by an authorised health care professional, or any other person who appears to the Court to have a proper interest in the matter, the Court considers that the person who is the subject of the application meets the criteria in subsection (1), the Court may make a management order in respect of the person in accordance with this Part.

(3) Before making a management order, the Court must inquire, or direct enquiries to be made, into—

(a) the mental capacity of the person who is the subject of the application;

(b) the nature of the estate of the person; and

(c) any other relevant matter the Court thinks fit.

(4) Reasonable notice of the time and place appointed for an inquiry must be given to the person who is the subject of the application and to any other person the Court considers should be notified.

(5) A management order—

(a) is an order made by the court appointing a person or persons to manage either the whole or a part of the estate or affairs of a person with a mental incapacity;

(b) may be made for a period not exceeding 12 months unless the Court is of the opinion that a longer period should be specified in the order;

(c) may be made subject to terms and conditions as the Court thinks fit;

(d) must include reporting and accountability requirements for the appointed manager as the Court imposes in the order;

(e) may be the subject of an appeal to the Court of Appeal in accordance with rules of court.

Powers and duties of manager

109.—(1) Subject to the terms of the management order, a manager must—

(a) act in the best interests of the person who is the subject of the order;

(b) take into account as far as is possible the wishes of the person who is the subject of the order, if such wishes were made known by the person before he or she suffered the mental incapacity;

(c) take possession and care of, recover, collect, preserve and administer the property and other estate of the person and generally manage the affairs of the person (including but not limited to financial and legal affairs) and exercise all rights (statutory or otherwise) that the person might exercise if the person had legal capacity; and

(d) in the name and on behalf of the person, generally do all acts and exercise all powers with respect to the estate and affairs of the person as effectually and in the same manner as the person could have done if the person were not under a legal disability.

(2) A manager has such additional powers and duties over the person's estate and affairs as the court may give the manager from time to time.

(3) This Decree does not confer on a manager—

(a) the power to execute a will in the name of the person who is the subject of a management order;

(b) the power to legally bind a person to an agreement relating to the marriage or divorce of a person who is the subject of a management order without a specific order of the Court to do so;

(c) the power to consent to the adoption of a person who is the subject of a management order by another person without a specific order of the court to do so; or

(d) the power to consent to the adoption of any children of a person who is subject to a management order by another person without a specific order of the court to do so.

(4) A manager must not receive any fee, remuneration or other reward from the estate of a person who is subject to a management order, or from any other person, for acting as manager, unless the court otherwise specifies in the management order.

Restrictions on powers of person subject to a management order

110.—(1) If the court has made a management order, the person who is the subject of the order cannot, while subject to the order and to the extent that the person's estate is under the control of the manager—

(a) deal with, transfer, alienate or charge money or property or any part of it;

(b) become liable under any contract,

without an order of the Court or the written consent of the manager.

(2) Every dealing, transfer, alienation or charge by any person in respect of any part of an estate that is under the control of a manager is void, and the money or property the subject of the dealing, transfer, alienation or charge is recoverable by the manager in a court of competent jurisdiction.

(3) For the purposes of this section, the acceptance of payment of the whole or any part of a debt or an agreement to forego the recovery of a debt is a dealing with property.

Review of management orders

111.—(1) The Court—

(a) must conduct a review of a management order before the expiry of the order; and

(b) may conduct a review at any time on the Court's own initiative or on the application of the person who is subject to the order or of any other person who appears to the Court to have a proper interest in the matter.

(2) On completing a review under this section, the Court—

(a) must revoke the management order unless the Court is satisfied that—

(i) the person subject to the order continues to meet the criteria set out in section 108(1); and

(ii) the order continues to be required in all of the circumstances to meet the criteria set out in section 108(5);

(b) may amend, vary, continue or replace the order subject to any conditions or requirements the Court thinks fit, consistent with this Part.

(3) Any further management order made by the Court under this section must—

(a) be made for a specified further period not exceeding 2 years; and

(b) is subject to review in accordance with this section.

Manager may apply to Court for directions and further powers

112.—(1) A manager may apply to the Court from time to time for—

(a) directions as to any matter concerning the estate or affairs of the person subject to the management order or concerning any other matter touching on the management order; or

(b) any additional or other powers the manager may require.

(2) On hearing an application under subsection (1), the Court may give such directions or make such orders as the Court thinks fit.

(3) A manager who is subject to any direction or order made by the Court under this section must comply with the direction or order.

Exercise of Court's powers under this Part

113.—(1) In exercising its functions under this Part, the Court—

(a) has all of the powers the Court has concerning the conduct of any civil proceedings;

(b) must act according to equity and good conscience without regard to technicalities or legal forms;

(c) is bound by the rules of natural justice;

(d) must conduct proceedings in the least formal manner possible in the circumstances;

(e) is not bound by rules or practice as to evidence and may inform itself in relation to any matter in such manner as the Court thinks fit; and

(f) may sit in any suitable place or venue.

(2) Evidence before the Court in proceedings conducted for the purposes of this Part cannot be used in any civil or criminal proceedings other than proceedings for an offence against this Decree or for contempt of court or perjury.

(3) The Chief Justice may make rules of court regulating the procedure of the Court for the purposes of this Part.

PART 11—MISCELLANEOUS PROVISIONS

International transfers

114.—(1) The Minister, with the approval of the Cabinet, may make arrangements with the government of any country or territory outside Fiji—

(a) for the transfer to that country or territory of a person who is the subject of an involuntary community treatment or inpatient treatment order made under this Decree; or

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(b) for the transfer from another country or territory to Fiji of a person who is the subject of an order in that country or territory equivalent to an involuntary community treatment or inpatient treatment order made under this Decree.

(2) An arrangement under this section may only be made if—

(a) the person has a connection with that country or territory, or with Fiji, as the case may be;

(b) the Minister has reason to believe, on the basis of advice from at least on authorised health care professional, that the person would be more readily rehabilitated in that country or territory, or in Fiji, as the case may be;

(c) the person, if in Fiji, gives informed consent or, if the person is unable to give such consent, the person's primary carer gives informed consent (or, in the other country or territory, equivalent consent has been given);

(3) When a person from another country or territory is transferred to Fiji pursuant to this section—

(a) the person is deemed to be detained on transfer from another facility under section 28;

(b) the person must be assessed under section 31 within 24 hours of arrival; and

(c) the provisions of this Decree will then apply to the person.

(4) When a person is sent from Fiji to another country or territory pursuant to this section, copies of all relevant records must be sent to the reciprocating authority in that country or territory so that at equivalent assessment can be made on the person's arrival.

Visits by persons other than Board of Mental Health Visitors

115.—(1) The Permanent Secretary may by notice in the *Gazette* specify the days and hours during which persons may be permitted to visit patients in a mental health facility (the "official visiting hours".)

(2) Subject to subsection (4), no visitor may enter any ward or visit any patient in a mental health facility at any time other than the official visiting hours.

(3) No child under the age of 16 years may visit a patient in a mental health facility, except with the express permission of the medical director of the facility.

(4) The medical director of a mental health facility may—

(a) in the interest of the patient or of other patients, refuse permission for a visit to a particular patient in the facility even during official visiting hours;

(b) in special circumstances permit a visitor to see a patient at the facility at a time other than the official visiting hours for a period and subject to conditions the medical director decides.

(5) A minister of religion may at any time, with the permission of the medical director of a mental health facility, visit patients of the same religious denomination in the facility.

(6) No visitor may, without the permission of the medical director, give to a patient in a mental health facility any money, food, drink or any other article whatsoever.

(7) No person may take into a mental health facility—

(a) any volatile or illicit substance;

(b) any matches, cigarette or other lighter; or

(c) any knife, razor, razor blade or other sharp or dangerous implement,

unless it is reasonably required by a member of the staff of the facility in connection with his or her duties.

Segregation of male and female patients

116.—(1) Subject to subsection (2), male and female patients in a mental facility must be kept separate.

(2) The medical director of a mental health facility may authorise the mixing of patients of different genders whose mental condition is sufficiently stable, if such mixing is appropriate for the purpose of rehabilitation and group work for the purpose of benefit to the patient.

(3) No male staff member may attend on a female patient unless a female staff member is also present.

Mental health registers

117.—(1) The medical director of every mental health facility must keep a register in the approved form of every person who is—

(a) examined or assessed at the facility under this Decree;
(b) admitted for treatment as a voluntary outpatient;
(c) admitted as a voluntary inpatient;
(d) detained as an involuntary inpatient;
(e) discharged from the facility or transferred to another mental health facility or health facility;
(f) transferred to the facility from another mental health facility or from a health facility;
(g) reclassified as a voluntary patient;
(h) the subject of a review by the Review Board;
(i) discharged from the facility;
(j) on whom surgery or special medical treatment is performed under this Decree.

(2) The register must also contain information about every person—

(a) who is absent from the facility without permission or who fails to return at the end of a period of leave;
(b) on whom surgery or special medical treatment is performed under this Decree;
(c) who is held in restraint and seclusion, or either, at the facility; or
(d) who dies while a patient at the facility.

(3) An entry in the register must be made within 24 hours of the event to which it relates.

(4) The register must be made available for inspection on demand by—

(a) every mental health visitor for that facility;
(b) members of the Review Board acting in that capacity;
(c) the Permanent Secretary and National Mental Health Advisor.

(5) The Permanent Secretary must keep appropriate registers of voluntary patients and of community treatment orders relating to persons who are not admitted to a mental health facility which shall be kept as confidential information.

Delegation

118.—(1) The Permanent Secretary may delegate any function conferred on the Permanent Secretary by this Decree, other than this power of delegation, to an officer of the Ministry who is a health care professional, and may vary or revoke any such delegation.

(2) A medical director may, with the approval of the Permanent Secretary, delegate any function conferred on a medical director by this Decree, other than this power of delegation, to an officer of the Ministry who is a health care professional, and may revoke or vary any such delegation.

(3) If authorised to do so by the relevant instrument of delegation, a delegate of a medical director may sub-delegate a delegated function, other than this power of sub-delegation, to an officer of the Ministry who is a health care professional, and may revoke or vary any such sub-delegation.

(4) Sections 31A to 31C of the Interpretation Act (Cap. 7) apply to sub-delegations under this section in the same way as they apply to delegations.

Regulations and Orders

119.—(1) The Minister may make Regulations or Orders to give effect to the provisions of this Decree and, subject to the express requirements of the Decree, consistent with its principles and objectives.

(2) Without limiting subsection (1), Regulations or Orders made under it may make provision, or additional provision, for or with respect to—

(a) fees and charges for the purposes of this Decree;
(b) the carrying out of assessments for purposes of this Decree;
(c) the treatment, accommodation and rights of children and young persons;
(d) the way in which provisions of this Decree apply to persons in custody and prisoners who have or may have a mental disorder;

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(e) the management and control of mental health facilities generally;
(f) the manner in which complaints may be made to a Board of Mental Health Visitors;
(g) any matter that is required or empowered by this Decree to be prescribed.

(3) Regulations or Orders made under subsection (1) may—
(a) apply generally or be limited in their application by reference to specified exceptions or factors;
(b) apply differently according to different factors of a specified kind; or
(c) authorise any matter or thing to be from time to time determined, applied or regulated by a specified person or body;
(d) do any combination of those things.

Forms

120.—(1) The Permanent Secretary may in writing approve forms for use in connection with this Decree.

(2) Wherever an approved form is required to be used under this decree—
(a) a form approximating the approved form may be used; and
(b) action taken under this Decree is not unlawful by reason only of any defect in the form used in connection with the action.

Repeal and savings

121.—(1) The Mental Treatment Act (Cap 113) is repealed.

(2) Saving for orders and designations under Cap. 113

Consequential amendments

122. The written laws mentioned in Schedule 2 are amended as provided in that Schedule.

Transitional provisions

123.—(1) Any person admitted to the psychiatric hospital on a Presidential Order under the Mental Treatment Act (Cap. 113) shall seek a review to the court.

(2) Schedule 3 has effect.

GIVEN under my hand this 5th day of October 2010.

EPELI NAILATIKAU
President of the Republic of Fiji

SCHEDULE 1
(sections 8 and 9)

MENTAL HEALTH FACILITIES

PART A – MENTAL HOSPITALS

1. All that land together with buildings thereon known as St. Giles Hospital, Suva and specified in the Annex is declared to be a mental health hospital for the purposes of this Decree.

ANNEX

All that land in the city of Suva containing an area of 11 acres 2 roods and which is more particularly described as follows:—

Starting at an iron peg on the western side of Reservoir Road being also the south-eastern corner of the Military Cemetery; thence in a south-easterly direction following the western side of Reservoir Road by the following lines:—

On a bearing of 162 degrees 16 minutes 00 seconds for a distance of 182.13 links to a concrete peg. On a bearing of 124 degrees 47 minutes 50 seconds for a distance of 237.01 links to a concrete peg. On a bearing of 147 degrees 42 minutes 10 seconds for a distance of 594.17 links to a concrete peg. On a bearing of 186 degrees 25 minutes 00 seconds for a distance of 38.25 links to a concrete peg;

Thence in a westerly direction by the following lines:—

On a bearing of 244 degrees 32 minutes 30 seconds for a distance of 89.33 links to a concrete peg. On a bearing of 294 degrees 42 minutes 30 seconds for a distance of 312.98 links to a concrete peg. On a bearing of 257 degrees 18 minutes 50 seconds for a distance of 359.08 links to a point on the northern boundary of Lands Department plan No. S. 765; thence following the northern boundary of said S. 765, on a bearing of 226 degrees 07 minutes 00 seconds for a distance of 459.3 links. On a bearing of 270 degrees 00 minutes 00 seconds for a distance of 209.9 links to an iron peg;

Thence in a northerly and easterly direction by the following lines:—

On a bearing of 345 degrees 45 minutes 30 seconds for a distance of 150.84 links to a concrete peg. On a bearing of 1 degree 46 minutes 10 seconds for a distance of 358.49 links to a concrete peg. On a bearing of 3 degrees 40 minutes 30 seconds for a distance of 491.38 links to a concrete peg. On a bearing of 340 degrees 53 minutes 00 seconds for a distance of 331.86 links to a concrete peg. On a bearing of 5 degrees 05 minutes 10 seconds for a distance of 221.36 links to a concrete peg. On a bearing of 54 degrees 21 minutes 30 seconds for a distance of 158.04 links to a concrete peg. On a bearing of 94 degrees 50 minutes 40 seconds for a distance of 409.29 links to a concrete peg on the western boundary of the Military Cemetery, plan No. S. 742;

Thence in a southerly and easterly direction following the western and southern boundaries of the Military Cemetery by the following lines:—

On a bearing of 180 degrees 08 minutes 00 second for a distance of 432.15 links to a concrete peg. On a bearing of 90 degrees 08 minutes 00 seconds for a distance of 241.30 links to an iron peg on the western side of Reservoir Road and being the starting point.

Such land being more particularly delineated on plan S. 1191 lodged in the office of the Director of Lands, Suva.

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PART B—MENTAL HEALTH UNITS

The areas of the public hospitals or public health centres shown below are declared to be mental health units for the purposes of this Decree.

Public hospital or health centre	Area
Colonial War Memorial Hospital, Suva	
Lautoka Hospital	
Labasa Hospital	

SCHEDULE 2
(section 122)

CONSEQUENTIAL AMENDMENTS

PUBLIC HOSPITALS AND DISPENSARIES ACT (CAP. 110)

(1) Section 8 of the Public Hospitals Dispensaries Act (Cap. 110) is herby amended by inserting after sub section (2)—

"(3) At least one of the members of a Board of Visitors is to be a person who has an interest, experience or expertise in mental health issues."

CRIMINAL PROCEDURE DECREE 2009 (Decree No. 43 of 2009)

(1) Section 104 of the Criminal Procedure Decree, 2009 is amendment by—

(a) deleting at the beginning of the sub section (4) "Upon consideration of the court record the President" and inserting" The Court".

(b) deleting in sub section (5) the word "President" whenever it appears and substituting "court".

(2) Section 105 of the Criminal Procedure Decree, 2009 is amended by deleting sub sections (2) and (3) and substituting—

"(2) When a special finding is made under sub section (1) the court shall order that the accused is –

(a) to be confined in a mental hospital, prison, a declared mental health facility or other suitable place for safe custody; and

(b) to be dealt with in accordance with any law dealing with mental health".

(3) Section 108 of the Criminal Procedure Decree, 2009 is amended by—

(a) deleting in sub section (2) (b) after the word 'detained', "during the President's pleasure" and substituting "for such period and upon such conditions as the court thinks fit;

(b) deleting in sub section (3) after the word 'detained', "during the President's pleasure" and substituting "under sections 104 or 105";

(c) deleting the word "President" whenever it appears and substituting "court";

(d) deleting in sub section (4) the words "his or her" and substituting "its"; and

(e) deleting sub section (5)

SCHEDULE 3
(section 123)

TRANSITIONAL PROVISIONS

Existing voluntary patients

Within 6 months of the commencement of the Decree all provisions for voluntary patients within this Decree must be followed.

Existing detention orders on patients, etc.

Within 6 months of the commencement of the Decree all existing detention orders are to be amended in accordance with this Decree.

Existing CTOs and IITOs

Within 6 months of the commencement of the Decree all existing CTO's and IITO's are to be amended in accordance with this Decree.

Existing Presidential orders

Those patients who have been admitted to the Mental Health Hospital under a Presidential Order can have the Order discharged by applying to the High Court.

Existing applications

Existing applications for review and pending decisions to be completed under the old legislation. Application made after the commencement to be conducted according to the Decree.

Existing Boards of Mental Health Visitors

The Existing Boards of Mental Health Visitors is to complete their term with the new Board to than be appointed under the provisions of this Decree.

Price: $3.90

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附件五、斐濟歷年友好醫事人員訓練計畫學員名單

相關附件資料因涉及個人資料之保護，保留不予公開

附件六、斐濟歷年友好醫事人員訓練計畫學員訪談彙整表

相關附件資料因涉及個人資料之保護，保留不予公開

附件七、斐濟歷年友好醫事人員訓練計畫學員訪談評核資料量性分析彙整表

相關附件資料因涉及個人資料之保護，保留不予公開