

# Introduction

George Ikkos

Consultant Psychiatrist in Liaison  
Psychiatry, Royal National  
Orthopaedic Hospital, London,  
UK, email ikkos@doctors.org.uk

Brunei Darussalam and New Zealand, the first north-west and the other south-east of Australia, both sit to the south-east of the Asian continent. Fiji is to the north of New Zealand and a popular destination for Australian, New Zealand, US and other tourists.

Different in size and cultural history and history of mental health services, they share the legacy of the British empire and its laws, although not in identical ways. New legislation in Brunei and Fiji and established legislation in New Zealand, as described in this issue, are principles-based, open to scrutiny and quality assurance, and applicable to both those detained in hospital and those in the community, although the problem of implementation of this is highlighted in the Fiji paper. Authorised healthcare professionals (AHCPs) feature prominently in Fiji's legislation and the strong role of nursing staff in New Zealand is noteworthy, as is the statement by Soosay & Kidd in their paper on New Zealand that assessment for compulsory detention by a medically qualified clinician is 'ideal', rather than mandatory. However, they do not inform us whether the 'ideal' of medical assessment arises out of historical precedent or is based on evidence that medical assessors perform better with respect to risk assessment, compliance with law or patient satisfaction.

Comparing the decisions of mental health nurses and psychiatrists in their paper on risk assessment following self-harm, Murphy *et al* (2011) found:

There was strong agreement on factors associated with high risk assessment by both professions. Following assessment of high risk, psychiatrists were much more likely than nurses to admit people for inpatient treatment.

Commenting on this research, McAllister (2011) suggested that divergence with respect to treatment decisions may reflect length of professional service and experience rather than divergence between the two professions. Comparative research regarding the performance of different professions in specific tasks merits further research, as it has implications for workforce development in the application of mental health law worldwide.

## References

- McAllister, M. (2011) Assessment following self-harm: nurses provide comparable risk assessment to psychiatrists but are less likely to admit for in-hospital treatment. *Evidence-Based Nursing*, 3, 83–84 (doi: 10.1136/ebn1163).
- Murphy, E., Kapur, N., Webb, R., *et al* (2011) Risk assessment following self-harm: comparison of mental health nurses and psychiatrists. *Journal of Advanced Nursing*, 67, 127–139 (doi: 10.1111/j.1365-2648.2010.05484.x).

# Brunei Darussalam's new Mental Health Order

Hilda Ho

Head of Psychiatric Services,  
Ministry of Health, Brunei  
Darussalam, email hilda.ho@  
moh.gov.bn

Declaration of interest:  
Dr Hilda Ho is currently Head of  
Psychiatric Services, Ministry of  
Health, Brunei Darussalam. The  
views expressed in this paper are  
her own and do not necessarily  
represent those held by the  
Ministry of Health.

**Brunei's new mental health legislation was implemented on 1 November 2014. This is a much needed and long overdue development which has required significant multi-agency consultation and commitment. This paper describes how the 2014 Mental Health Order was prepared and provides a summary of its contents. The future direction and challenges facing its full implementation are discussed.**

Brunei Darussalam is a small country (population 406 000) in South East Asia, which scores highly on economic, health and social indicators (United Nations, 2013). Mental healthcare services have recently undergone expansion and development

(Ho, 2014) but until 2014 the only mental health legislation in use was the 1929 Lunacy Act. For many years, it was recognised that this archaic legislation was inadequate and previous attempts to draft new legislation had been made. This difficult task was finally accomplished after a significant collaborative effort between the Ministry of Health and the Attorney General's Chambers. There was vital leadership commitment from the Honourable Minister of Health.

## The need for a new law

In 2011, a mental health legislation drafting committee was formed. The precipitant for this was the appointment of the first Bruneian consultant psychiatrist. There was frustration regarding

the inefficient system for involuntary detention and a growing awareness of the need to improve protection for people with mental disorders. Strengthening governance in mental healthcare and developing a national law to protect the rights of people with mental disorders are key objectives of the current Mental Health Action Plan of the World Health Organization (WHO, 2013), which was endorsed by Brunei at the 66th World Health Assembly.

### **The drafting process**

In the first year, the committee drafted the key components of the proposed law. Brunei's civil law is historically based on British law. Therefore legislation from the UK, Malaysia and Singapore, two neighbouring countries with similar legal structures and cultures, was used to inform the process. Resources from the WHO (2005) were used in order to ensure that the new legislation was consistent with international standards. Thereafter, a comprehensive consultation and re-drafting exercise was carried out with key agencies, including the Attorney General's Chambers, Prime Minister's office, the Royal Brunei Police Force, the Department of Prisons, the judiciary, the Ministry of Home Affairs, the Ministry of Education and the Ministry of Culture, Youth and Sports. Unfortunately, there were no local independent patient or carer groups to consult.

The Ministry of Religious Affairs and the Islamic Religious Council were consulted to ensure compliance with Islamic Syariah principles, given the coexistence of civil and Syariah legal systems. This process took a further year and a half.

Two final versions were prepared: in English and standard Malay. In March 2014 these were presented to His Majesty the Sultan and Yang Di-Pertuan of Brunei Darussalam (who is both head of government and head of state). The legislation was gazetted into law in June 2014 and came into effect on 1 November 2014.

### **The new legislation**

The 2014 Mental Health Order (available at <http://www.agc.gov.bn>) provides the backbone for a significant change in the approach towards mental healthcare. The guiding principles include the preservation of individual autonomy, acting in the best interests of patients, using the least restrictive alternative for treatment, reciprocity and beneficence, promoting equality and non-discrimination, and ensuring multi-agency management. It is designed to be pragmatic and straightforward to apply given the local context of services still in early development. Nevertheless, the legislation emphasises the shared responsibilities of stakeholders and the importance of carer involvement. Previously undefined terms such as 'lunacy' and 'lunatic asylum' have been replaced with modern terminology such as 'mental disorder' and 'psychiatric facility'.

The previous Lunacy Act did not acknowledge patients' rights to make decisions about their own care and did not even require a medical

recommendation for involuntary treatment. There were no requirements regarding statutory review. Now, the duties to obtain consent and offer voluntary treatment are explicitly stated. The criteria for involuntary treatment are clearly defined. The responsibility for making decisions regarding detention has shifted from the magistrate's court to the examining medical practitioner and the Board of Visitors.

The specific parts of the 2014 Mental Health Order are as follows.

#### **Part I. Preliminary provisions and definitions**

This describes the purpose of the law and the definitions used. Mental disorder is defined as 'any mental illness, arrested or incomplete development of the mind, psychiatric disorder or any other disorder of disability of the mind, however acquired'.

#### **Part II. Admission to and detention in and discharge from psychiatric facilities**

Voluntary admission is encouraged where possible. A recommendation from a medical practitioner and the consent of a relative or carer are required for an initial involuntary admission (72 hours), with assistance from social workers and police officers where consent from a relative is not available. Further detention (1 month and 6 months) requires the involvement of designated medical practitioners. Longer detentions require the involvement of the Board of Visitors.

#### **Part III. Discharge, leave of absence and transfer of involuntary patients from psychiatric facilities**

This contains provisions for the discharge of involuntary patients on application or appeal, leave of absence and patient transfer between facilities.

#### **Part IV. Persons admitted or confined in psychiatric facilities under the Criminal Procedure Code**

Provisions for offenders with a mental disorder are contained in another piece of legislation, the 1951 Criminal Procedure Code, where the term used is 'person of unsound mind' – a concept which is not explicitly defined but which implies that the person is unable to stand trial. Part IV of the Mental Health Order is supplementary to the Criminal Procedure Code, and is mainly concerned with medical assessment, review by the Board of Visitors and conditional discharge. The management of offenders with a mental disorder is an area which needs future development.

#### **Parts V and VI. Community psychiatric residence and community mental health centre**

These two parts of the Order contain new provisions for community care, including compulsory community treatment. The aim is to promote social inclusion, continuity of care and the integration of mental healthcare into community healthcare settings.

## Part VII. Board of Visitors

The Board of Visitors is an independent body created to inspect the quality of care provided in psychiatric facilities, examine involuntary patients and make decisions regarding applications for long-term involuntary treatment.

## Part VIII. Quality of psychiatric healthcare facilities and services

This part emphasises the therapeutic purpose of psychiatric treatment and contains provisions for ensuring the quality of services.

## Part IX. Proceedings in inquiries into mental disorders

This part details the process of inquiry into the ability of persons with mental disorders to manage their own affairs and matters relating to their financial estate.

## Part X. General provisions

The general provisions include the process of obtaining consent for 'life-sustaining medical and surgical procedures', for psychosurgery and for electroconvulsive therapy. Further provisions include penalties for the neglect, ill-treatment or unlawful detention of anyone with a mental disorder. Administrative matters such as the payment of government welfare allowances are included. Finally, a Code of Practice (Ministry of Health, 2014) is introduced.

## Challenges

Mental healthcare had been a neglected area in Brunei for many decades. The stigma attached to mental disorders is both pervasive and strong. Beliefs regarding spirit possession predominate over scientific understanding. Often people are ashamed that there is a mental illness and turn to spiritual treatment. Sadly, the trigger for seeking medical help is usually aggressive or suicidal behaviour, or carer burn-out. To address this, in recent years public mental health education programmes have been implemented throughout the country.

There was no precedent for modern mental health law in Brunei. Other legislation affecting the treatment of those with comorbid substance misuse has been previously discussed (Ho *et al.*, 2015). The task required an unprecedented effort in terms of research, multi-agency engagement and overcoming a complicated bureaucracy. In order to ensure that important stakeholders were adequately informed, a national road-show and training programme was conducted prior to implementation. Many resources were available to download on the Ministry of Health's website.

## Future direction

It will require some years of practice to fully operationalise this new legislation. Research and audit are required to examine its use and impact. The national health, social welfare and criminal justice systems all face significant challenges in terms

of improving processes, recruiting and training staff and developing services. The absence of independent representation of service users in the implementation process is a disadvantage which will affect the system's ability to respond to patients and carers. It is hoped that increased public engagement will encourage the emergence of vital service user organisations.

## Conclusion

The 2014 Mental Health Order is a comprehensive law which aims to address the complex needs of people affected by mental disorder. The full realisation of its principles will require long-term multi-agency investment and community engagement. Despite the many challenges ahead, this is a significant stride forward and is likely to have far-reaching effects.

## References

- Ho, H. (2014) Mental healthcare in Brunei Darussalam. *International Psychiatry*, 11, 100–102.
- Ho, H., Maz Adanan, A. & Omar, R. (2015) Psychiatric morbidity and socio-occupational dysfunction in residents of a drug rehabilitation centre: challenges of a substance misuse management in a Bruneian context. *BJPsych Bulletin*, 39, 213–127.
- Ministry of Health (2014) *Code of Practice, Mental Health Order, 2014*. Ministry of Health.
- United Nations (2013) *World Statistics Pocketbook. Country Profile: Brunei Darussalam*. UN. Available at <http://unstats.un.org/unsd/pocketbook/PDF/2013/brunei%20Darussalam.pdf> (accessed October 2014).
- WHO (2005) *WHO Resource Book on Mental Health, Human Rights and Legislation*. World Health Organization. Available at [http://www.who.int/mental\\_health/policy/who\\_rb\\_mnh\\_hr\\_leg\\_FINAL\\_11\\_07\\_05.pdf](http://www.who.int/mental_health/policy/who_rb_mnh_hr_leg_FINAL_11_07_05.pdf) (accessed October 2014).
- WHO (2013) *Mental Health Action Plan 2013–2020*. World Health Organization. Available at [http://www.who.int/mental\\_health/publications/action\\_plan/en](http://www.who.int/mental_health/publications/action_plan/en) (accessed October 2014).

### BJPsych International's online presence

#### Blog

<http://www.bjpinternationalblog.org>

#### Issue 4: eHealth

ViveLibre And The Emerging Properties

Mr Ignacio Aizpún Viñes, Director General de ATAM

#### Issue 3: The role of front-line staff in process of change

Review of addiction services at Al Amal Psychiatric Complex in Riyadh, engaging frontline staff in the review and process of change

Dr Abdelaal Ahmed and Dr Faisal Al Zakari

#### Facebook

<https://www.facebook.com/>

BJPsychInternational

#### Twitter

@BJPsychInt