

The management of offenders with mental disorders within the criminal justice system in Brunei Darussalam

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Conflicts of interest. Dr Hilda Ho is Head of Psychiatry, Raja Isteri Pengiran Anak Saleha (RIPAS) Hospital, 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.

Acknowledgements. The author thanks Dr Rifai Farid for reviewing the initial drafts of the paper.

This paper examines the management of offenders with mental disorders in Brunei Darussalam. The existing legislation, resources and service configuration are discussed in the context of recent developments and the challenges that need to be addressed. An innovative multi-agency approach is suggested to improve the management of a group of people with complex needs.

Background and existing legislation

Brunei Darussalam is a small country (population 406 000) in South East Asia, which scores highly on economic, health and social indicators (United Nations, 2015). His Majesty the Sultan is both its head of state and head of government. Before this, it was a British protectorate from 1884 until independence in 1984. Many of its civil laws pre-date independence and are based on English common law. Healthcare services are predominantly provided by the government free of charge to all citizens. There are two coexisting legal systems in the country: civil law and Islamic Syariah law. Recently, the country has implemented new mental health legislation in the form of the 2014 Mental Health Order (Ho, 2016). The management of offenders with mental disorders within the criminal justice system is guided separately by sections of the 1951 Criminal Procedure Code addressing the management of 'persons of unsound mind'.

Criminal Procedure Code sections 315–325: 'persons of unsound mind'

A person charged with an offence and suspected to be of 'unsound mind and consequently incapable of making his defence' can be remanded to a hospital for assessment for up to 3 months. The 'medical officer' or psychiatrist in the hospital is obliged to produce a report for the court to certify whether or not the person is 'of unsound mind and incapable of making his defence'. This effectively means stating an opinion regarding the person's fitness to stand trial within the Bruneian criminal court system. There is very limited legal aid provision in the country. Defendants are expected to make their own arrangements but many appear in court without legal representation.

The assessment process

The assessment of an offender suspected of having a mental disorder usually starts in the emergency

department of a general hospital. Thereafter, the person is transferred to one of two general psychiatric wards in the country. The actual numbers are small. For example, in 2016 there were only five people who were remanded by court for psychiatric assessment after being charged with a criminal offence. Police escorts are asked to remain with the person throughout admission, as the wards are not designated as secure facilities. There are no local case law examples or definitions provided to inform the test for 'unsound mind and incapable of making his defence'. There is therefore little legal guidance available locally in the preparation of a psychiatric report. Psychiatrists depend on the clinical assessment and their own professional experience.

'Unsound mind' and 'insanity'

After a finding of unsound mind, the court may approve bail or remand the person to a suitable place of safe custody and report the case to the Permanent Secretary of the Prime Minister's Office. The Permanent Secretary may then order the accused to be 'confined in a lunatic asylum or prison or other suitable place of safe custody'. There being no psychiatric facility designated as a place of safe custody, the default place of confinement is prison for an indefinite period. A defence of insanity is available during trial. If successfully made, the accused could similarly be confined in prison for an indefinite period. Thereafter, persons confined under the provisions of unsound mind or insanity are required to be visited by two medical officers at least every 12 months for the purpose of the preparation of a report to the Permanent Secretary. These arrangements are similar to those elsewhere, for example in the UK, where the review of such persons falls under the responsibility of the Home Secretary in England or the First Minister in Scotland. Unfortunately, there is no opportunity for the psychiatrist to recommend a disposal for psychiatric treatment due to the lack of legislative provision and the absence of a secure psychiatric treatment facility designated as a place of safe custody.

Conditional discharge

There are several routes to conditional discharge. Should the person subsequently be certified by a medical officer to have become 'capable of making his defence', the public prosecutor is required to determine whether or not a trial is in the public interest. Therefore the person would either face

trial or be given conditional discharge. Similarly, a medical report or recommendation may be submitted to His Majesty the Sultan stating that the person 'may have recovered his sanity and that his discharge may be warranted'. Finally, a relative or friend may make an application to the Permanent Secretary to have the person delivered into their care. All three routes require significant and potentially lengthy legal enquiry. There are no legal provisions for leave or testing out in the community prior to conditional discharge. Upon discharge, conditions may be imposed, such as a requirement to have further medical treatment. Although the contravention of discharge conditions is considered an offence punishable with a fine, this is a potentially difficult situation to manage given the lack of an approved multi-agency structure to mandate continued treatment and supervision.

Provisions added in the 2014 Mental Health Order

The 2014 Mental Health Order makes reference to the relevant sections of the Criminal Procedure Code, but does not make any significant amendments. Amending the Criminal Procedure Code was considered to be beyond the remit of the drafting committee, which primarily sought to urgently replace the outdated 1929 Lunacy Act and ensure the care of people in healthcare facilities and in the community. However, the Mental Health Order provides that a government psychiatric facility may be designated as a place of safe custody for the admission or confinement of persons found to be of 'unsound mind'. This would divert them from prison into a therapeutic facility. A 'board of visitors' may be appointed and given the authority to review and make recommendations for discharge. These recommendations would be processed according to the sections of the Criminal Procedure Code dealing with applications for conditional discharge, as described above. No psychiatric facility has yet been given this designation.

The prison system

There are two prisons in Brunei, with a total capacity of approximately 260 prisoners. The government provides good access to an in-house general practitioner and practice nurse clinics. Prisoners kept under 'unsound mind' provisions are usually held in single-occupant cells, separated from the general prisoner population. Regular meals are provided and pre-scheduled family visits are allowed. There is limited opportunity for outdoor exercise. Medication is administered by prison officers. Prisoners are taken for external hospital or clinic treatment upon the recommendation of the visiting general practitioner. Some offenders with mental disorders who are convicted of certain drug offences can be diverted to a residential drug rehabilitation programme in lieu of a prison sentence. The psychosocial morbidity and psychiatric treatment of these residents has been previously described (Ho *et al*, 2015).

In 2012, an in-reach prison psychiatric clinic was started by a newly arrived UK-trained forensic psychiatrist and psychiatric nurse. Prior to this, prisoners were brought in handcuffs and footcuffs to the busy general hospital psychiatric clinic. The establishment of a prison forensic psychiatric clinic has enabled the delivery of psychiatric care directly within the prison setting, with the advantage of engaging with prison staff in the care of prisoners. This has provided early detection and timely treatment for prisoners with mental disorders. Medication compliance has improved. There have been opportunities for inter-agency training. However, treatment options are limited as there are no current psychology, occupational therapy or social work services within the prison system.

Challenges

Mental healthcare services have recently undergone a period of significant expansion and development (Ho, 2014). The priorities have been the improvement of general in-patient services and the development of community services nationally, in order to benefit the wider population. There is no experience of providing secure psychiatric treatment within the health sector. There is limited wider expertise in the management of offenders with mental disorders and there are significant human resource constraints. The provision of specialist forensic psychiatric services also faces the challenge of low patient base rates, particularly in a small population. The number of people held in prison under 'unsound mind' provisions is low, currently at single figures. Therefore, the provision of an expensive designated secure facility has limited cost-effectiveness in a developing health sector with multiple competing demands.

The existing criminal procedural legislation is inflexible and dated. The country needs a comprehensive structured approach for the management of offenders with mental disorders through the criminal justice pathway. Supportive social and community services are significantly underdeveloped. There are currently no independent advocacy services for this group of service users. Conditional discharge is highly dependent on the availability of a family member who is able to provide long-term care and accommodation.

Proposed solutions

The effective and compassionate management of offenders with mental disorders is a complex and challenging task in any country, particularly a young developing country. Much depends on legislation, policy, service provision, resource priorities, societal awareness and attitudes. The most feasible approach would be to strengthen and build upon existing services in prison and within the community. Although there is new legislative provision to designate psychiatric facilities as places of safe custody, an amendment of the Criminal Procedure Code is likely to be necessary in order to provide more specific psychiatric treatment

disposals. These strategies are interlinked and require significant structural investment, human resource development and multi-agency commitment. It may be helpful to consider the examples of offender management in other countries, where mental health programmes are run jointly by criminal justice and health services, for example the development of psychiatric treatment facilities within a secure prison perimeter.

A way to stimulate a multidisciplinary approach is to have regular dialogue between mental health, community and criminal justice services. This has started to some extent, as case discussions have been extended to include broader, systemic issues. There has been a good response from stakeholders such as the police, the prison service, public prosecutors, the Attorney General's chambers and the magistrate's court. This could develop into more comprehensive and strategic planning. A case management system would be particularly helpful for individuals with complex multiple needs such as management of a chronic illness and/or substance misuse, and provision of housing,

occupational rehabilitation and carer support, in order to best manage the risk of reoffending.

Conclusions

There have been recent improvements in the treatment of offenders with mental disorders in Brunei, an area that had not received much attention previously. There are opportunities for further advancement. Structural investment, human resource development, multi-agency commitment and strategic planning are essential.

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Mental health and psychosocial support in Calais: a reflection on research in a challenging environment

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This reflection focuses on research conducted in 'The Jungle' in Calais, an informal camp of approximately 6000 refugees (Help Refugees, 2016). My self-designed qualitative study aimed to assess the availability and nature of mental health and psychosocial support (MHPSS) by interviewing service providers about their role in MHPSS. The research questioned whether MHPSS was evidence-based (Tol *et al*, 2011), what types of MHPSS was available, what service providers envisaged to be the most immediate needs, and barriers and enabling factors in MHPSS.

I interviewed 13 service providers – paid professionals employed by non-governmental organisations (NGOs) or the French clinic situated in the camp, professionals who volunteered in the camp – mostly UK National Health Service (NHS) psychiatrists, nurses and doctors who used their annual leave to volunteer – and longer-term volunteers. The semi-structured interviews followed a topic guide based on my observations and field notes from the camp and a literature review on MHPSS in similar settings. Ethical approval for the research was gained from the Leeds Institute of Health Sciences Research Ethics Sub-Committee (FMHREC-16-1.1) and all participants gave informed consent.

The longer-term volunteers had lived and worked in the camp for over 9 months, but had no previous experience of working in mental health and lacked qualifications in this area. All participants expressed their shock at living conditions in the camp and described a population of stressed and frustrated refugees, whose mental health seemed to worsen the longer they stayed in the camp. Participants described a lack of trained and experienced service providers and an inability to deliver high-quality sustainable MHPSS.

Living conditions

It is difficult to understand how a makeshift camp like 'The Jungle' (which was nominally closed in October 2016) existed in Calais for so long and easy to forget that this pocket of refugees were only a small proportion of those living in Europe. There are doubtless many other unsafe, unsanitary and inhumane camps. One of the first things that participants told me was to not to call it a refugee camp. Instead, they described it as a *favella*, or a slum, and asked me to talk about toddlers playing in faeces when I wrote up my findings. Calling the camp 'The Jungle' felt dehumanising, but in retrospect it epitomises the sense of danger, an unspoken hierarchy and a lack of law and order.