

# Review of the implementation of Brunei Darussalam's New Mental Health Order in a psychiatric ward in RIPAS Hospital.

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## ABSTRACT

**Introduction** The Brunei Darussalam New Mental Health Order was implemented on 1<sup>st</sup> November 2014, replacing the 1929 Lunacy Act. The aim of this study was to evaluate the implications of the new Mental Health Order on admissions to the psychiatric ward in Raja Isteri Pengiran Anak Saleha (RIPAS) Hospital in the first year of implementation. **Method** All new psychiatric in-patient admissions and readmissions between 1<sup>st</sup> November 2014 and 31<sup>st</sup> October 2015 were included in the study. Each new admission or readmission was regarded as a "case". Admission, demographic, diagnostic data and length of stay were collected from the ward admission register, hospital electronic records and completed involuntary treatment forms. Comparisons were made between voluntary and involuntary "cases". **Results** One hundred and fifty-eight patients were included in the study. There were 179 cases in total, of which 21(11.7%) were readmissions for 15 patients. 105 (58.7%) cases were involuntary and 74 (41.3%) were voluntary. There were higher proportions of schizophrenia, acute and transient psychotic disorder, schizoaffective disorder and primary diagnosis of mental and behavioural disorder due to psychoactive substance abuse in the involuntary group. The mean length of admission was 26.11 (sd= 29.69, range = 1 - 170) days for all cases, 28.24 (sd = 31.41, range = 1-170) days for involuntary cases and 23.09 (sd = 26.97, range = 1-156) days for voluntary cases. Long term (six month) involuntary treatment orders were used only for 16 (6.1%) of cases. **Conclusions** Involuntary admissions make up the majority of admissions for patients admitted with a diagnosis of mental disorder. Those presenting with a psychotic disorder or substance abuse disorder were more likely to be involuntarily admitted. Long-term involuntary treatment orders were not commonly used.

**Keywords:** Involuntary Admission, Involuntary Treatment, Mental Health Services, Mental Health Legislation

## INTRODUCTION

Brunei Darussalam is a small country (population 406,000) in Southeast Asia, which scores highly in economic, health and

social indicators.<sup>1</sup> Mental health care services have undergone a period of expansion and development.<sup>2</sup> The new Mental Health Order was implemented on 1<sup>st</sup> November 2014, replacing the 1929 Lunacy Act.<sup>3</sup> The development and contents of this legislation have

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been described elsewhere.<sup>4</sup> The new legislation was drafted to replace the previously inefficient system for involuntary detention and a growing awareness of the need to improve protection for mentally disordered people. Strengthening governance in mental health care and developing a national law to protect the rights of people with mental disorders is a key objective of the World Health Organization's Mental Health Action Plan 2013 – 2020 which was endorsed by Brunei at the 66<sup>th</sup> World Health Assembly.<sup>5</sup> The previous Lunacy Act did not acknowledge the patient's right to make decisions about his own care and did not require a medical recommendation for involuntary treatment. Medical practitioners could not initiate involuntary treatment but had to direct relatives to the Magistrate's Court to apply for an order under the Lunacy Act. This was an inefficient system which did not safeguard the treatment or welfare of mentally disordered people. It was difficult to identify involuntary or voluntary in-patients as the documentation was often poorly recorded. There were no statutory review requirements. With the new legislation, the responsibility for making decisions regarding involuntary treatment has been shifted from the Magistrate's Court to the examining medical practitioner and a Board of Visitors.

#### **"Voluntary" and "involuntary" admissions**

A voluntary admission into a psychiatric facility occurs when the person consents to their admission and is assessed as having the capacity to give informed consent. An involuntary admission occurs in two ways. Under Section 8(1), an involuntary admission occurs when a person who is suspected to be suffering from a mental disorder is admitted upon application by a relative or carer and a recommendation by a medical practitioner that *"he is suffering from a mental disorder of a nature or degree which warrants his admission into a psychiatric facility for the purposes of assessment or treatment; or he ought to*

*be detained in the interest of his health or safety or for the protection of other persons"*. Involuntary admission under Section 12(1) occurs when any suspected mentally disordered person sent to a psychiatric facility by the police or a medical social worker for examination by a designated medical practitioner is found to be *"suffering from a mental disorder and in need of care and treatment"*.

Involuntary admissions start with a 72 hour assessment that may progress to a one month treatment order. Thereafter, a treatment order for six months can be used. This is renewable for up to one year by the Board of Visitors, an independent review body tasked to review psychiatric facilities. Upon discharge, patients can be placed under a community treatment order for up to two years. There are three levels of appeal against involuntary treatment. Practical guidance and application forms are published in the Code of Practice.<sup>6</sup>

#### **Preparation for implementation**

The proper implementation of new legislation requires much preparation. The pre-implementation plan included national roadshows and training sessions for key stakeholders such as the police, prison officers, the Courts, welfare agencies, village heads, community groups, school counsellors, nurses and allied health professionals. Information was released through radio, television, newspapers and the distribution of information leaflets. This was found to be a good opportunity to educate the public about mental health and the services available. 501 (85%) of the 590 registered medical practitioners and 11 (85%) of the 13 medical social workers in the country received a half-day training session. More in-depth training was provided to health professionals working in psychiatric facilities. An administrator was appointed to oversee the processes involved and to ensure adequate data collection for audit.

There were concerns that it would be "easier" for medical practitioners to detain more people for longer periods, and that the police would bring large numbers of people to hospital for detention. Medical social workers wondered if they would be inundated with requests to apprehend people in the community. In order to manage these concerns, multi-agency protocols were agreed and distributed. Liaison work was done with agencies such as the police, public prosecutors and the Courts.

### **Challenges in practice**

Brunei did not have a history of modern mental health law. This task required the introduction of new concepts and processes into the mental healthcare system and wider society. It required willingness from health professionals and stakeholders to adapt and take responsibility for its use. The use of standardised forms and protocols required careful attention to details such as the use of different section numbers, review requirements and dates of expiry.

### **AIMS AND OBJECTIVES**

This study aims to evaluate the implications of the new Mental Health Order on admissions to the psychiatric ward in Raja Isteri Pengiran Anak Saleha (RIPAS) Hospital in the first year of implementation. The experience of implementing the new legislation is also described, with suggestions for future improvement.

### **METHOD**

#### **Patients and Study setting**

RIPAS hospital is the national tertiary medical centre with the largest psychiatric admission ward in the country with a catchment area covering more than three-quarters of the population. The ward is a 20 bed mixed gender facility that provides acute in-patient psychiatric treatment for patients aged 14 years and above. All psychiatric in-patients admitted between 1<sup>st</sup> November 2014 and 31<sup>st</sup> October 2015 were included in the study. This

study was conducted as part of our departmental audit.

#### **Inclusion criteria**

All admissions during the study period above were included. The length of admission was calculated as the number of days stayed in the ward, from the date of admission until the date of discharge, or until 31<sup>st</sup> October 2015 if the patient was still an in-patient. An admission was defined as "involuntary" if the person was involuntarily admitted or treated in hospital at any point during their stay. Multiple admissions for the same person were recorded as separate admissions. As we were interested in the characteristics of each admission in its own right, every readmission was regarded as a separate "case" and comparisons were made between voluntary and involuntary "cases".

#### **Exclusion criteria**

A small number of patients admitted voluntarily for elective maintenance electroconvulsive therapy were excluded. Patients who were admitted into hospital for assessment of fitness to stand trial were also excluded. These patients are detained under separate legislation for the management of mentally disordered offenders.<sup>7</sup>

#### **Data collection**

Admission and demographic data were routinely collected for all in-patients from the ward admissions register and Bru-HIMS (Brunei Health Information Management System), which is the hospital's electronic patient records system. Diagnostic data was obtained from the recorded ICD-10 diagnosis and checked with the patients' written electronic case-notes. Completed mental health order forms are routinely recorded and filed. The data for this study were obtained from these existing sources.

#### **Quality of paperwork**

A sample of used Mental Health Order forms

was selected to examine the quality of completed paperwork during the study period.

### Statistical analyses

Data were entered into a database using the Statistical Package for Social Sciences, version 16.0. Continuous data were presented as mean (SD) and analysed using Student t-test. Categorical data were analysed using Pearson's Chi-Squared test.  $p < 0.05$  was taken as statistical significance. Demographic data were presented for the study sample, whilst diagnostic and admission data were compared between voluntary and involuntary "cases".

## RESULTS

### Sample size and number of "cases"

One hundred and fifty-eight patients were included in the study. There were 179 cases in total, of which 21(11.7%) were readmissions for 15 patients.

### Patient demographics

One hundred and eight (68.4%) patients were male and 50 (31.6%) patients were female. Of the involuntary patients, 66 (68.0%) were male and 31 (32.0%) were female. Of the voluntary patients, 42(68.9%) were male and 19(31.1%) were female. The mean age at admission was 37.2 years (sd=11.84) for the whole sample, 36.45 years (sd=11.78) for involuntary patients and 38.59 (sd=11.91) for voluntary patients. Comparison of means using Student's t-test found no significant difference in mean age between involuntary and voluntary patients, although involuntary patients tended to be slightly younger ( $p = 0.272$ ,  $t = -1.103$ ). Demo-

graphic data is demonstrated in Table 1 below.

### Length of admission

The mean length of admission was 26.11 (sd= 29.69, range = 1 - 170) days for all cases, 28.24 (sd = 31.41, range = 1-170) days for involuntary cases and 23.09 (sd = 26.97, range = 1-156) days for voluntary cases. No statistical difference was found between involuntary and voluntary cases ( $p=0.242$ ,  $t=1.173$ ), however voluntary admissions tended to be shorter.

### Diagnoses

Schizophrenia was the most common primary diagnosis recorded in cases, followed by bipolar disorder (Table 2). Mental and behavioural disorder due to substance abuse was the third most common diagnosis. The use of crystal methamphetamine, locally known as "syabu", was reported in all but one case with a substance abuse diagnosis. Pearson's chi-squared analyses showed statistically significant differences between voluntary and involuntary cases (Table 2). There were higher proportions of schizophrenia, acute and transient psychotic disorder, schizoaffective disorder and diagnosis of mental and behavioural disorder due to psychoactive substance abuse in involuntary cases compared with voluntary cases.

### The use of involuntary treatment

Seventy-seven (43.0%) cases were admitted involuntarily through co-application by a medical practitioner and relative. Sixteen (8.9%) cases were involuntarily admitted after appre-

**Table 1. Demographic data of patients admitted into RIPAS hospital psychiatric ward.**

	Number (%), n=158 Total patients	Number (%), n=97 Involuntary pa- tients	Number (%), n=61 Voluntary pa- tients	p- and t-value
<b>Males</b>	108 (68.4%)	66 (68.0%)	42 (68.9%)	
<b>Females</b>	50 (31.6%)	31 (32.0%)	19 (31.1%)	
<b>Mean Age on Admission</b>	37.2 years (sd=11.84)	36.45 years (sd=11.78)	38.59 years (sd=11.91)	$p=0.272$ , $t=-1.103$

**Table 2. Diagnoses of cases admitted into RIPAS psychiatric ward.**

Diagnosis	Total cases, n=179 (%)	Voluntary cases, n=74 (%)	Involuntary cases, n=105 (%)
Schizophrenia	69 (38.5%)	27 (36.5%)	42 (40.0%)
Bipolar affective disorder	35 (19.6%)	21 (28.4%)	14 (13.3%)
Mental and behavioural disorder due to psychoactive substance abuse	22 (12.3%)	5 (6.8%)	17 (16.2%)
Depressive episode	15 (8.4%)	10 (13.5%)	5 (4.8%)
Acute and transient psychotic disorders	12 (6.7%)	2 (2.7%)	10 (9.5%)
Schizoaffective disorder	8 (4.5%)	2 (2.7%)	6 (5.7%)
Mental retardation	4 (2.2%)	2 (2.7%)	2 (1.9%)
Personality disorder	3 (1.7%)	1 (1.4%)	2 (1.9%)
Anxiety disorders	2 (1.1%)	0	2 (1.9%)
Reaction to severe stress and adjustment disorders	2 (1.1%)	0	2 (1.9%)
Delusional disorder	1 (0.6%)	0	1 (1.0%)
No recorded ICD-10 mental disorder diagnosis*	6 (3.4%)	4 (5.4%)	2 (1.9%)

\*(4 "brought by the police for assessment"; 1 Z63.0 "marital conflict"; 1 Z03.2 "observation for suspected mental disorder")

Pearson's chi-square value = 22.161, df = 12, p = 0.036, 17 cells (65.4%) have expected count less than 5.

hension to hospital by the police or medical social worker. Most involuntarily admitted cases proceeded to be placed under one month treatment orders. Fourteen (7.8%) cases that had been initially admitted voluntarily were subsequently placed on one-month involuntary treatment orders (Table 3). Long term (six month) involuntary treatment orders were used only in 11 (6.1%) cases. Upon discharge from hospital, six patients were placed under a community treatment order.

### Appeals

Only one appeal against detention was lodged. This appeal went through the first level of the appeal process and was declined. The patient was eventually discharged before the appeal was heard at the next level.

### Quality of paperwork

Of the 93 recorded 72 hour involuntary admissions, 92 forms were copied to the department's administrator. Of these, 16 (17.4%) contained errors. These often led to similar

**Table 3. Sections of the 2014 Mental Health Order used for involuntary treatment in RIPAS hospital psychiatric ward.**

Type of detention	Total cases, n=179 (%)
<b>Section 8(1)</b> <u>Involuntary admission for up to 72 hours</u> : medical practitioner + family member application.	77 (43.0%)
<b>Section 12(1)</b> <u>Involuntary admission for up to 72 hours</u> : police / medical social worker apprehension to hospital under Section 9 and subsequent admission by a designated medical practitioner.	16 (8.9%)
<b>Section 8(4)</b> <u>Involuntary treatment for up to one month</u> : determined by a designated medical practitioner after detention under Section 8(1).	54 (30.2%)
<b>Section 12(4)</b> <u>Involuntary treatment for up to one month</u> : determined by a designated medical practitioner after detention under Section 12(1).	8 (4.5%)
<b>Section 7(4)</b> <u>Involuntary treatment for up to one month</u> : determined by a designated medical practitioner after voluntary admission and a subsequent request for discharge.	14 (7.8%)
<b>Section 13(3b)</b> <u>Involuntary treatment for up to six months</u> : determined by a designated medical practitioner and a psychiatrist before expiry of Section 8(4), 12(4) or 7(4). Renewable by the Board of Visitors.	11 (6.1%)
<b>Section 32</b> <u>Community treatment for up to 2 years</u> upon discharge of an involuntary patient from a psychiatric facility: determined by a designated medical practitioner.	6 (3.6%)

errors filling in the subsequent one month involuntary treatment forms. When the medical practitioners affected were asked for feedback, there appeared to be confusion regarding the different sections of legislation to use and the design of the forms. Multiple errors were made by a small number of practitioners.

## **DISCUSSION**

This study has found that adequate data on involuntary treatment is being kept in the country's main psychiatric facility. This is encouraging as it is vital to continuously evaluate the use of involuntary treatment. The length of admission was similar between involuntary and voluntary groups. Long-term involuntary treatment was not commonly used. Patients given involuntary treatment are not being held in hospital for significantly longer periods than voluntary patients. The majority of involuntary admissions were initiated by co-application between medical practitioners and a relative. Only a minority of admissions occurred through the apprehension powers of the police or medical social workers.

Although this study found statistically significant differences in diagnoses between voluntary and involuntary cases, these results should be viewed with caution as the numbers present in each group were small and often less than 5. There appeared to be an increased likelihood of those with acutely disturbed presentations such as acute psychosis or the effects of substance abuse, being admitted involuntarily. Involuntary patients also tended to be younger than voluntary patients. Although this study did not evaluate this specifically, these findings may reflect the increased likelihood of involuntary admissions to be first presentations of younger and more acutely disturbed patients. Older patients with a history of previous psychiatric treatment are arguably more likely to seek voluntary treatment due to having better insight and a pre-

existing therapeutic relationship with mental health staff. This study also found that a proportion of patients were readmitted within the 12-month period of the study, some being readmitted more than once. The factors related to these frequent readmissions may be related to diagnoses, severity of illness, insight, co-morbid substance abuse and social circumstances. These are factors that should be explored further in future studies.

This study found that mental and behavioural disorder due to substance abuse, specifically crystal methamphetamine, was a common diagnosis. Our findings are consistent with previous research that found crystal methamphetamine to be the apparent substance of choice in Brunei.<sup>8</sup> The management of substance abuse and its overlap with the criminal justice system is an area that requires improvement. The use of illicit substances is an offence in Brunei which falls under the purview of the Narcotics Control Bureau.<sup>9</sup> Those found guilty of drug related offences can be diverted to residential drug rehabilitation or community supervision programmes. However the processes involved are lengthy and lack the ability to respond to acute individual needs. This often results in an over-reliance on the psychiatric system, resulting in recurrent acute admissions.

Patients rarely exercised their right to appeal against involuntary treatment. This may reflect the culture where there is high compliance to authority and reluctance to challenge authority figures such hospital staff. There are no advocacy or service-user organizations. Patients are not routinely informed of the procedures for appeal and there is no legal requirement for hospitals to display this information. Therefore there is little support available for patients, should they wish to appeal. It is hoped that patient-led services will develop with improved public and service-user awareness surrounding the implementation of the Mental Health Order. Community Treat-

ment Orders were not frequently used by clinicians. Many clinicians felt that this part of the legislation had little robustness. Other sections of the legislation not directly initiated by health professionals have not yet been used, for example court powers to order mental health assessments in civil cases regarding the management of assets, or investigations into neglect or abuse.

The introduction of the Mental Health Order has enabled the collection of data to monitor the use of involuntary treatment and to make comparisons between voluntary and involuntary treatment groups. Development in wider areas associated with patient welfare, advocacy and criminal justice systems, could further enhance the improvements initiated by the implementation of this new legislation.

### **Strengths and limitations**

The strengths of this study include the examination of a complete cohort of in-patients affected by the new legislation. There were limitations to this study, which depended on the accuracy of records kept by clinical and administrative staff. Missing details were retrospectively sought, which could have affected the accuracy of data. The author was also involved in the drafting and implementation of the new law, which could have caused bias its evaluation. Nevertheless, it remains important to evaluate any change in practice. This study compared basic demographic and diagnostic variables between involuntary and voluntary admissions. Other factors which could have influenced the decision to use involuntary treatment such as age, mental state, insight, first presentation or previous mental disorder diagnosis, previous engagement with psychiatric services, social circumstances and risk of violence or self-harm, were not evaluated. These are areas that could be explored further in future studies. The use of a larger cohort of patients would allow more detailed statistical analyses.

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### **References**

- 1: United Nations. World Statistics Pocketbook Country Profile: Brunei Darussalam. [Online].; 2015. [Assessed on 2017 April 3. Available from: <http://unstats.un.org/unsd/pocketbook/PDF/2013/brunei%20Darussalam.pdf>.
- 2: Ho, H. Mental healthcare in Brunei Darussalam. *Int Psychiatry*. 2014; 11(4): 100-102.
- 3: Mental Health Order. Laws of Brunei. [Online].; 2014. [Assessed on 2017 April 3. Available from: [http://www.agc.gov.bn/AGC%20Images/LAWS/Gazette\\_PDF/2014/EN/S025.pdf](http://www.agc.gov.bn/AGC%20Images/LAWS/Gazette_PDF/2014/EN/S025.pdf).
- 4: Ho, H. Brunei Darussalam's new Mental Health Order. *BJPsych International*. 2016; 13(2): 38-40.
- 5: Mental Health Action Plan 2013 – 2020, World Health Organization. Geneva, Switzerland. [Online].; 2013. [Assessed on 2017 April 3. Available from: [http://www.who.int/mental\\_health/publications/action\\_plan/en/](http://www.who.int/mental_health/publications/action_plan/en/).
- 6: Ministry of Health. Code of Practice, Mental Health Order, Brunei Darussalam. Government Printing Department, Prime Minister's Office. 2014. Print copy available upon request from the department of Psychiatry, RIPAS Hospital.
- 7: Criminal Procedure Code. Laws of Brunei. [Online].; 1951. [Assessed on 2017 April 3. Available from: <http://www.agc.gov.bn/AGC%20Images/LOB/PDF/Cap7.pdf>.
- 8: Ho, H, Maz Adanan A, Omar, R. 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*. 2015; 39 (5): 213-217.
- 9: Misuse of Drugs Act. Laws of Brunei. [Online].; 1978. [Assessed on 2017 April 3. Available from: [http://www.agc.gov.bn/AGC%20Images/LAWS/ACT\\_PDF/cap027.pdf](http://www.agc.gov.bn/AGC%20Images/LAWS/ACT_PDF/cap027.pdf).