

Introduction

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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

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Brunei Darussalam's new Mental Health Order

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Declaration of interest:
Dr Hilda Ho is currently Head of
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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