

psychiatric hospital. The patient may be taken into custody by any police officer or social welfare officer or any person authorised in writing by the medical director.

Community care

The 2010 Mental Health Regulations specifically state that a psychiatric hospital or community mental health centre shall ensure establishment of a community mental health team for community mental healthcare services. The community mental health team shall be multidisciplinary, preferably led by a psychiatrist.

Any involuntary patients discharged or granted leave of absence from a psychiatric hospital may undergo community treatment if required by the medical director or the visitors. The Act permits compulsory community treatment but, practically, this does not work at present.

Patients' rights

The Regulations place a specific duty on the medical director of every psychiatric hospital to ensure all patients are provided with statements of

their rights that shall be in a manner and language understood by the patients. Statements of patients' right shall be exhibited in a conspicuous part of the psychiatric facility.

Conclusion

It has been suggested that the turning point for the provision of mental healthcare in Malaysia was the introduction of the Mental Health Act in 2001 (Chong & Mohamad, 2013). The Act's support for community treatment should promote the growth of community mental health services, with a reduction in the number of beds at mental health hospitals, resulting in a more effective and comprehensive service which better suits the needs of patients.

References

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An overview of mental health legislation in Singapore

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This article summarises the development of mental health legislation in Singapore in three distinctive periods: pre-1965; 1965–2007 and 2007 onwards. It highlights the origin of mental health legislation and the relationship between mental health services and legislation in Singapore. The Mental Health (Care and Treatment) Act 2008 and Mental Capacity Act 2008 are described in detail.

History

The Republic of Singapore is a city state with a population of 5.3 million, mainly of Chinese, Malay, Indian and Eurasian background. Singapore was a British colony from 1819 to 1963, was briefly part of Malaysia and then became an independent nation in 1965. The legal system in Singapore is based on the English common law. As a result, the mental health legislation originated from England and there have been parallel developments. The first local mental health law, the Lunacy Act 1858, was implemented in 1863 (Bewley, 2008, pp. 1–9) and the lunatic asylum was established. Several officials

from the colonial government were appointed as visitors to ensure the safe treatment of the asylum's residents. Police officers but not medical professionals were empowered to apprehend 'lunatics' and commit them to the asylum.

In 1935, the Mental Disorders and Treatment Ordinance was introduced. It allowed the compulsory detention of persons of unsound mind. In 1960, the government of Singapore made an amendment to the Ordinance which empowered medical practitioners to send a person with a mental illness to the mental hospital (Woodbridge Hospital) for assessment. The Mental Disorders and Treatment Act 1965, modelled on the UK Mental Health Act 1959, was the only mental health law governing involuntary admission from 1965 to 2007.

Mental health services

In Singapore, mental health services are provided by: the government general hospitals; the Institute of Mental Health (IMH), a state mental health hospital; out-patient poly-clinics; and private psychiatric services. The IMH has 50 psychiatric wards and has around 2000 in-patient beds. There

Table 1

Summary of the Mental Health (Care and Treatment) Act 2008 with cross-reference the UK Mental Health Act 1983/2007

Form	Maximum duration of involuntary hospitalisation	Order requirements	Equivalent section of the UK Act
1	72 hours	A designated medical practitioner working at the Institute of Mental Health (IMH) applies the Act based on the risk posed by patients to themselves or others	Section 4
2	1 month	A designated medical practitioner working at the IMH applies the Act if the risk posed by patients to themselves or others is still present	Section 2
3	6 months	Two independent designated medical practitioners, one of whom is a psychiatrist working at the IMH, apply the Act if the risk posed by patients to themselves or others is still present	Section 3

are three general hospitals in Singapore which have non-gazette psychiatric wards, with around 60 in-patient beds in total (gazette wards are those gazetted by the government as having the legal power to detain psychiatric patients deemed to be at risk to themselves under the terms of the Mental Health Act). The IMH is the only psychiatric hospital which provides involuntary admission because there is a shortage of psychiatric beds in other general hospitals.

The Mental Health (Care and Treatment) Act 2008

The Singapore Mental Health (Care and Treatment) Act 2008 is similar to its older version, the Mental Disorders and Treatment Act 1965. Under the new Act (see Table 1), a designated medical practitioner at the IMH may sign Form 1, which allows the involuntary admission of an individual suffering from a mental illness into the IMH for treatment, for up to 72 hours.

This Act is helpful for patients who are mentally ill and at significant psychiatric risk but who decline voluntary treatment. Currently, Form 1 is available only at the IMH and not at general hospitals or clinics. This implies that only medical practitioners working at the IMH can formally apply this Act and make the final decision on involuntary admission. This arrangement has led to the following situations in general hospitals. First, the general hospital doctors may not be able to admit psychiatric patients who are at risk but who insist on discharge, as they are unable to sign Form 1 in their hospitals. Second, carers may challenge the decision made by general hospital doctors to transfer a patient to the IMH, as that cannot be a formal process. Third, general hospital doctors often have to sedate or apply physical restraints to patients when sending them to the IMH via ambulance. These treatments are initiated before Form 1 is signed. The current legal defence is based on earlier legislation and the common law, which allows general hospital doctors to send patients to the IMH for assessment in good faith. Fourth, the 2008 Act may not apply to patients with significant psychiatric and medical risks because the IMH is a psychiatric hospital without medical and surgical departments.

The above situations would not occur if the mental health legislation empowered doctors to sign legal documents in medical settings prior to a patient's involuntary admission to psychiatric facilities, as happens in other countries. In

Singapore, the extension of the power of detention to general hospitals has been discussed, but the need for more secure psychiatric facilities and gazette wards within general hospitals would be required. The Mental Health Act in Singapore does not have civil treatment orders, in contrast to the UK Mental Health Act 1983, section 5(2) of which allows urgent detention of voluntary in-patients and section 135 of which allows entry to a patient's home and removal of the patient to a place of safety.

The Mental Capacity Act 2008

The Mental Capacity Act 2008 came into operation in March 2010 in response to the ageing population and parallel developments in other jurisdictions. This Act safeguards vulnerable members of society. When assessing the capacity of a person, the doctor needs to determine two things: first, whether the person suffers from an impairment in the functioning of the mind; and second, if an impairment is present, whether the impairment impedes the person from making decisions. The Act provides five guiding principles, summarised in Box 1, modelled on the Mental Capacity Act 2005 in the UK.

Under this Act, a person who is older than 21 years is allowed make an advanced medical directive if the decision relates to refusal of treatment or lasting powers of attorney (LPA) if the decision relates to personal assets. Under the LPA, a person ('the donor') can appoint a proxy ('the donee') to act or make decisions on his or her behalf for matters relating to personal welfare, property and finances when the person loses his or her capacity.

Box 1. Guiding principles of the Mental Capacity Act 2008

- 1 Every individual possesses the capacity to make a decision, unless proven otherwise.
- 2 A person cannot be assumed to lack capacity unless all steps are taken to help him or her to make a decision but the process is unsuccessful.
- 3 A person cannot be assumed to lack capacity merely because he or she makes an unwise decision.
- 4 Any decision made on behalf of an individual who lacks capacity must be in the person's best interest.
- 5 There must be consideration as to how a decision made on behalf of an incapacitated person can be achieved in a way that is less restrictive to his or her rights.

Box 2. Definition of incapacity under the Mental Capacity Act 2008

A person lacks mental capacity if impaired in one of the following areas:

- communicate his or her decision by any means
- remember specific information required for decision-making
- understand the information relevant to the decision-making
- use or weigh relevant information as part of the decision-making process.

Box 2 summarises the definition of incapacity. The donee is expected to make decisions based on the best interests, wishes, beliefs and values of the donor. The Act requires an independent certificate issuer, such as a lawyer, psychiatrist or accredited general practitioner, to explain the terms of the LPA and ensure that the donor understands the implications before the LPA is signed voluntarily. There is a 6-week period before the LPA can be registered and this provides opportunities for other parties to raise objections and concerns if there is a violation of the Act. The LPA does not cover areas such as decision to resuscitate, consent to treatment, advanced medical directives, execution of wills or consent to marriage or divorce.

The Act allows a court to appoint a deputy to make decisions on behalf of an individual. As a result, parents of children with intellectual disability can apply to the court and appoint themselves as deputies for their children and another person

as a successor deputy when the parents themselves lose capacity or pass away.

The Act follows the British Mental Capacity Act and requires the establishment of the Office of Public Guardian. This office appoints a board of visitors to protect donors by monitoring donees and court-appointed deputies. Visitors are registered health professionals who can provide independent advice to donors, donees and deputies.

Conclusions

The mental health legislation in Singapore and the UK share a common root. There are still some aspects of the Mental Health Act which require ongoing consultation and refinement, such as supervised treatment in community settings, clear legal and clinical criteria for fitness to drive and the establishment of gazette wards in general hospitals. Recent improvements to education in forensic psychiatry in the undergraduate and post-graduate curriculum will certainly beget a better cadre of doctors and psychiatrists for the future.

References

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Legislation

Both the Mental Health (Care and Treatment) Act 2008 (No. 21 of 2008) and the Mental Capacity Act 2008 are available (via alphabetical listing or search) at <http://statutes.agc.gov.sg> (accessed 5 January 2014).

SPECIAL
PAPER

Access to community-based mental healthcare and psychosocial support within a disaster context

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After a large-scale humanitarian disaster, 30–50% of victims develop moderate or severe psychological distress. Rates of mild and moderate mental disorders increase by 5–10% and severe disorders by 1–2%. Those with such disorders need access to mental healthcare. Primary care clinics are appropriate due to their easy accessibility and the non-stigmatising environment. There is a consensus among experts that the mental health effects of disaster are best addressed by existing services, that is, through capacity building rather than by establishing parallel systems. Mental health interventions in emergencies should begin with a clear vision for the long-term advancement of community services.

Mental health and psychosocial support (MHPSS) services are often inadequate before a disaster (Saxena *et al*, 2007). Worldwide, disaster settings are challenged to provide appropriate access to mental healthcare. Haiti had a severe shortage of mental health institutions and professionals prior to the 2010 earthquake. In Sri Lanka, two general practitioners provided MHPSS in tsunami-affected Kalmunai and Hambantota districts with populations over 400 000, because district general hospitals had no departments to treat mental health patients. In Pakistan, two psychiatrists and one mental health hospital in Mansehra provided services to the North-West Frontier, with a population over 1 million, before it was hit by a major earthquake in 2005. In Jordan, 150 000 Iraqi refugees from the 2003 war sought costly mental