RESOURCE CONSTRAINTS AND THE RIGHT OF THE MENTALLY DISORDERED TO RECEIVE APPROPRIATE TREATMENT

Sacha Wallach*

This article explores the right of mentally disordered patients to appropriate treatment after the Mental Health (Compulsory Assessment and Treatment) Act 1992. It then examines the detrimental impact of resource constraints on this right, especially the undermining of the presumption in favour of community treatment. It concludes that resource constraints are not an appropriate justification for denial of the right to appropriate treatment.

> [S]omeone always vetoes; someone normal; someone beautiful; someone blessed by normality; someone administering the rusty mind's rules of yesteryear; someone male - cigar-smoker perhaps; someone ruddy-faced with health; someone female - a skeleton in her cupboard, never gave a sucker an even break ... someone genuine not able to bend the rules to match the need; ... someone who had too many nos in their childhood; ... someone always says no.[1]

I INTRODUCTION

It is often all too easy to say "no" to those who are in a position of vulnerability. For those suffering from mental illness, history bears disturbing witness to this fact. The history of the treatment of the mentally ill is characterised by an abusive arrogance, embodied in benevolent paternalism, with an underbelly of public distrust and fear.

Amidst all the baggage of a designation of social abnormality, the mentally disordered have long endured a system which has neglected their rights. Not only the rights which

---

* This paper was submitted in fulfilment of the LLB (Hons) requirements at Victoria University in 1999. It was awarded the Robert Orr McGechan Prize in 1999 for legal writing at Victoria University.

1 Christopher Nolan *Under the Eye of the Clock: The Life Story of Christopher Nolan* (Weidenfeld & Nicholson, London, 1987) 12-13.

are shared by reason of humanity, but also specific rights which acknowledge the need to redress vulnerability. Fundamental among the rights of the mentally disordered is the right to receive appropriate treatment. Despite a move in the current philosophy of mental health legislation toward upholding the rights of patients and promoting the autonomy of those suffering from mental illness, the lack of resources available to support this shift allows the position of vulnerability of the mentally disordered to be perpetuated.

This paper considers the right of a mentally disordered patient to treatment appropriate to his or her condition. Among the issues explored is the meaning to be attached to "appropriate treatment"; what standard of treatment should be available; the question of treatability and whether treatment must have a therapeutic effect if it is to constitute anything other than preventive and arbitrary detention. The paper then looks at the detrimental impact of resource constraint on the right to appropriate treatment, particularly with regard to the undermining of the presumption in favour of community treatment.

The conclusion of this paper is that resource constraint is not an appropriate justification for denial of the right to appropriate treatment. The law must not also be seen to say "no" to the mentally disordered and effective remedies must be available when a patient's fundamental rights are breached. Ultimately, a principled commitment to the rights of the mentally disordered requires resources to be made available to uphold these rights. Without adequate resources to provide appropriate treatment, the abuse of the vulnerable position of those suffering mental illness continues and claims to a system which promotes patients' rights and autonomy present a hollow and deceptive victory.

II THE CHANGING PHILOSOPHY OF MENTAL HEALTH TREATMENT

With the enactment of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA92) a fundamental shift in the underlying philosophy of mental health treatment was introduced. The Act explicitly pronounced concern for protecting the rights of the mentally disordered and for promoting patient autonomy.[2] It also confirmed a change in the setting of mental health treatment from a hospital-based service to a community-based model of care.[3] Pegged as the best and most cost-effective form of mental health care provision,[4] treatment within the community was seen to give those

---

2 Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 64-75.

3 Ministry of Health *Looking Forward: Strategic Directions for the Mental Health Services* (Wellington, June 1994) 3 *[Looking Forward]*. Section 28(2) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 provides a presumption in favour of making a community treatment order when compulsory treatment is required.

4 *Looking Forward*, above n 3, 8.

suffering from mental illness the freedom to lead fulfilling and productive lives.[5] In-patient services were for acute cases and for those requiring secure care.[6]

Under the MHA92, the mentally disordered were also seen to be a more narrowly defined group than they had been when previously classed as crazy, lunatic, mad or mentally defective.[7] As defined by the Act, "mental disorder" is evidenced by an abnormal state of mind (whether of a continuous or an intermittent nature) characterised by delusions, or by disorders of mood, perception, volition or cognition.[8] The definition is then restricted to those persons whose mental abnormality poses serious danger to the public or to the person themselves, or seriously diminishes the individual's capacity for self-care.[9]

There is little concern for the use of diagnostic labels in the construction and application of the Act.[10] Whether the legal definition of mental disorder is met will be influenced by medical opinion based on psychiatric history and clinical reports,[11] but discrete psychiatric diagnosis is not fundamental to the decision whether treatment should occur under the Act.[12] It may however, be relevant to establishing the type of treatment considered "appropriate" for that condition.[13]

Specifically excluded from the assessment and treatment provisions of the MHA92 are those who might be classified as suffering an abnormal state of mind by reason only of their political, cultural or religious beliefs, their sexual preferences, criminal or delinquent

---

5 Sylvia A Bell and Warren J Brookbanks *Mental Health Law in New Zealand* (Brooker's Ltd, Wellington, 1998) 183 *[Mental Health Law]*.

6 *Looking Forward*, above n 3, 8.

7 *Mental Health Law*, above n 5, 13. Some commentators have disputed this point, suggesting that the definition remains broad, particularly with reference to the contentious inclusion of disorders of cognition and volition, vague terms in a psychiatric context. See Jeremy Anderson "Psychiatric decision-making in the compulsory assessment process" in John Dawson, Jeremy Anderson and Stephen McCarthy (leaders) *The Mental Health (Compulsory Assessment and Treatment) Act 1992* (New Zealand Law Society Seminar, Wellington, February-March 1993) 50-58.

8 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 2.

9 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 2.

10 *Mental Health Law*, above n 5, 1-3, 12.

11 John Dawson "The New Mental Health Act 1992" in John Dawson, Jeremy Anderson and Stephen McCarthy (leaders) *The Mental Health (Compulsory Assessment and Treatment) Act 1992* (New Zealand Law Society Seminar, Wellington, February-March 1993) 21, para 5.10 ["The New Mental Health Act 1992"].

12 *Re H [mental health]* (1996) 14 FRNZ 523, 527-528 per Inglis J.

13 *Re H [mental health]* above n 12, 529, 530.

behaviour, or substance abuse.[14] These exclusions emphasise the fact that mental disorder "must derive from the patient themselves, rather than result from conflict with a social system".[15] Intellectual handicap is also removed from the ambit of the Act,[16] severing a long-standing and often contentious association between the mentally disordered and the intellectually disabled.[17]

The philosophy underlying the MHA92 represents a positive and significant shift from past abusive, though often well-intentioned, social and systemic attitudes toward the mentally ill. It recognises that to involuntarily detain and treat an individual constitutes a significant invasion of personal rights and freedoms. The construction of "mental disorder" in the Act goes some way to provide a barrier to the exercise of coercive power in this context. It ensures a balancing of interests that considers the seriousness of interfering with the liberty of a mentally disordered person against the seriousness of any threat posed by that individual. Ultimately however, the Act is not directed toward the general promotion of good mental health but rather to the management of those whose dysfunction presents a social risk.[18] Once a person is held to come under the ambit of the Act and is made subject to a compulsory treatment order, the rights provisions and other procedural safeguards exist to make sure that respect for the dignity and autonomy of that individual is maintained.

III THE RIGHT TO APPROPRIATE TREATMENT

With the exercise of social control comes a corresponding duty of social responsibility. The MHA92 provides significant powers of social control in that it allows for involuntary detention and treatment conducted against the wishes of the patient. Although persons made subject to the provisions of the Act may present a social risk, the aim of the legislation is not punitive.

The foundation of the Act is treatment, to improve the condition of an individual and reduce the likelihood of harm to self or others. This endeavour requires that proper deference be paid to the human rights of mentally disordered patients. The specific statement of rights of patients in Part VI of the MHA92 reflects this concern and

---

14 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 4.

15 *Mental Health Law*, above n 5, 23.

16 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 4(e).

17 Sylvia Bell "Defining Mental Disorder" in Warren Brookbanks (ed) *Psychiatry and the Law: Clinical and Legal Issues* (Brooker's Ltd, Wellington, 1996) 81 ["Defining Mental Disorder"]. The untreatability of intellectual handicap makes it inappropriate to include the intellectually disabled in the scope of legislation that has a fundamental emphasis on treatment.

18 *Mental Health Law*, above n 5, 13.

consolidates international opinion that mental health legislation should reinforce the autonomy of those made subject to the powers of compulsory treatment provisions.

Among the rights provided to those made subject to the MHA92 is the entitlement in section 66 "to medical treatment and other health care *appropriate* to [the patient's] condition".[19] This right is a corollary to the compulsory nature of assessment and treatment.[20] The premise on which compulsory treatment is exercised under the Act is to therapeutically intervene so as to improve the mentally disordered person's condition and quality of life and thereby reduce or eliminate the risk of self-harm or serious danger to others. What is appropriate treatment in any given case would then be determined according to this goal. This appears a reasonably straightforward proposition but, as with all dealings with the human mind, much is assumed, little is known and even less is understood.

What is "appropriate treatment" for a particular mentally disordered individual will inevitably be decided upon by the responsible clinician,[21] reviewed by a judge,[22] and bound by the constructs of culture and time.[23] These factors themselves highlight issues about the interpretation and application of section 66 of the Act but various other questions also surface when the boundaries of this right are explored. Among these is the meaning to be attached to "appropriate treatment"; whether this constitutes best possible, best available, or reasonable, suitable and on-hand treatment; the question of treatability; and whether treatment must have a therapeutic effect if it is to constitute anything other than preventive and arbitrary detention.

A "Appropriateness" of Treatment to the Patient's Condition

The right in section 66 of the MHA92 provides for the patient to receive treatment "appropriate to his or her condition". "Appropriate" treatment would be that which is clinically suitable and proper for the condition with which the patient presents. Such a

---

19 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 66, emphasis added.

20 Ministry of Health, Mental Health Services *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (Wellington, June 1997) 32, para 19.3 [Ministry of Health Guidelines].

21 Ministry of Health Guidelines, above n 20, 22 - provide that the responsible clinician should include in their report to the Court a proposed course of treatment. The strength of the responsible clinician's opinion in determining treatment is conveyed in the case of *In the matter of E* [1994] NZFLR 328, 334, where it is stated that the Court could not compel a psychiatrist to treat someone who is unaccepting of treatment in the way the psychiatrist thinks appropriate.

22 Mental Health (Compulsory Assessment and Treatment) Act, ss 17-18, 27-28.

23 Mason Durie "'Te Taha Hinengaro': An Integrated Approach To Mental Health" (1984) 1 *Community Mental Health in New Zealand* 5.

determination is limited by medical and psychiatric knowledge, but should be appropriate so far as is known and not subject the patient to medical or scientific experimentation.[24]

The right of the detained person to be treated with "humanity and respect for the inherent dignity of the person",[25] the right not to be subjected to "cruel, degrading, or disproportionately severe treatment",[26] and the various requirements that there be respect for the patient's culture and beliefs,[27] add a further gloss to the determination of appropriateness. Essential also in the present philosophy of mental health care is that the appropriateness of treatment is impacted by the setting in which it occurs and more often than not this should mean treatment occurs in the community.

1 Clinical appropriateness

In the case of *Re MP*,[28] a complaint was brought under section 75 of the MHA92 on the basis that the complainant's right to appropriate treatment had been breached. The woman who was subject to a compulsory treatment order under the MHA92 had been treated with various psychiatric drugs, including lithium carbonate, whilst she was pregnant. She later miscarried. It was argued that the prescription of lithium carbonate had been inappropriate to her condition, based on the body of medical theory that suggested the administration of lithium during pregnancy could cause defects to the unborn child.[29]

The Tribunal found in this case that the right to appropriate treatment had not been breached. The responsible clinician had given careful consideration to the use of lithium and was fully aware of its potential implications when administered to a pregnant individual. It was said that: "From a clinical perspective he was appropriately cautious in introducing Lithium".[30] It had also been found that there was nothing to indicate that the

---

24 New Zealand Bill of Rights Act 1990, s 10. This section of the Bill of Rights provides that "Every person has the right not to be subjected to medical or scientific experimentation without that person's consent". The MHA92 should be read consistently with this right and despite authority under the Act to treat without consent it can not be said that experimentation is treatment appropriate to a patient's condition. The very nature of experimentation is that the outcome is the subject of conjecture and not knowledge that could establish something as appropriate or not.

25 New Zealand Bill of Rights Act 1990, s 23(5).

26 New Zealand Bill of Rights Act 1990, s 9.

27 Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 5 and 65.

28 *Re MP* [1997] NZFLR 978.

29 *Re MP,* above n 28, 982, 983.

30 *Re MP,* above n 28, 983.

prescription of lithium caused the miscarriage, the potential risk being one of heart abnormality to the unborn foetus.[31]

This decision demonstrates the power mental health professionals have over the decision as to what is clinically appropriate. Whether the prescription of lithium caused the miscarriage would seem to have little to do with the appropriateness or otherwise of the treatment. The test as stated should require that a "medical practitioner acts in accordance with the practice accepted at the time by a responsible body of medical opinion skilled in the particular form of treatment in question".[32] The medical knowledge available at the time advised against the prescription of lithium to a pregnant patient because of the high incidence of birth abnormalities associated with its use.[33]

That a clinically unattributable miscarriage occurred and not the birth of a child suffering abnormalities fails to take away from the fact that the prescription of lithium to a pregnant patient appeared on the facts to be inappropriate. Such action could also be in potential breach of the New Zealand Bill of Rights Act 1990 (NZBORA) guarantee against cruel, inhuman and degrading treatment,[34] and the right of every person detained under any enactment to be treated with humanity and respect.[35]

2 *Cultural appropriateness*

The powers conferred under the MHA92 should be exercised "with proper respect for the patient's cultural and ethnic identity, language, and religious or ethical beliefs".[36] This includes an entitlement to receive treatment which accords with the spirit and intent of this statement.[37]

Whether a particular treatment is "culturally appropriate" may not be fundamental to its appropriateness to the patient's condition as such. It is however, a relevant

---

31 *Re MP,* above n 28, 983-984.

32 *Re MP,* above n 28, 982. See *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, and the later House of Lords decision that applied this test, *F v West Berkshire Health Authority* [1989] 2 All ER 545.

33 Harold I Kaplan and Benjamin J Sadock (eds) *Synopsis of Psychiatry* (7 ed, Williams & Wilkins, Baltimore, 1994) 872 in *Re MP*, above n 28, 982-983. It is suggested that antipsychotic drugs or electro-convulsive therapy are preferable to lithium when treating a pregnant patient. The evidence surrounding the use of lithium was presented as an undisputed fact at the hearing.

34 New Zealand Bill of Rights Act 1990, s 9.

35 New Zealand Bill of Rights Act 1990, s 23(5).

36 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 5.

37 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 65.

consideration in attempting to provide services that are consistent with the will of the patient so as to promote a positive therapeutic effect and to maintain a philosophy of respect for that individual. Such a consideration might mean that for a Maori patient the use of electro-convulsive therapy would be decided against because of the tapu status of the head in Maori culture.[38] The right to culturally appropriate treatment is also reinforced in the Code of Health and Disability Consumers' Rights,[39] and in the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care which state that "every patient shall have the right to treatment suited to his or her cultural background".[40]

Various inquiries into mental health services have highlighted the cultural insensitivity that has been present in the system in the past.[41] Responding to these failures requires that particular attention be given to the needs of Maori and to other cultural groups who are over-represented in the mental health setting.[42] Treatment that is "appropriate" from a Maori perspective would recognise the inter-related aspects of te taha wairua (spiritual well-being), te taha hinengaro (mental well-being), te taha whanau (family well-being) and te taha tinana (physical well-being).[43]

The importance of recognising extended family ties and their contribution to the patient's well-being is acknowledged in section 5(b) of the MHA92. The influence of this provision is evident in decisions such as *Re PT*,[44] where proximity to whanau and services appropriate to the patient as a Maori were taken into account in considering a request for transfer from one facility to another. The attempt to provide culturally appropriate

---

38 *Mental Health Law*, above n 5, 151.

39 Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, cl 2, right 1(3).

40 United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, princ 7.

41 See RG Gallen (chairperson) *Report of the Commission of Inquiry into Procedures at Oakley Hospital and Related Matters* (Government Printer, Wellington, January 1983) [The Gallen Inquiry]; KH Mason (chairperson) *Report of the Committee of Inquiry into Procedures used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients* (Government Printer, Wellington, August 1988) [The Mason Report 1988]; and JA Laurenson (committee) *Report of the Committee of Inquiry into the Death at Carrington Hospital of a Patient Manihere Mansel Watene, and Other Related Matters* (Wellington, July 1991).

42 *Mental Health Law*, above n 5, 150.

43 The Mason Report 1988, above n 41, 227.

44 *Re PT* (19 July 1995) unreported, Mental Health Review Tribunal, Southern Region SRT30/95.

services must however, be balanced with the need to ensure that the overall goal of proper care for a patient is not unnecessarily impeded.[45]

3 Setting appropriateness - in-patient or community treatment order?

The MHA92 acknowledges that in most cases the most appropriate setting for mental health care and treatment is in the community. The Act creates a presumption in favour of making a community treatment order and it is only where a patient cannot be treated adequately in the community context that an in-patient order should be imposed.[46] Such may be the case where outpatient care is inappropriate to the needs of the patient or the social circumstances of the patient are inadequate for his or her care and treatment within the community.[47]

The emphasis put on community care reflects the underlying philosophy of the Act, which is directed toward encouraging patient autonomy through the use of the least intrusive treatment option.[48] It is also consistent with an attitude that promotes the various rights of the patient, particularly the right to freedom of association,[49] and the right not to be arbitrarily detained.[50] In making the determination the primary focus should be on the needs of the patient and not the potential danger that person might pose to the community if released.[51] Concern that the person presents such special difficulties would have to be dealt with by investigating whether the patient could be declared a restricted patient under section 54 of the MHA92.[52]

An appropriate placement should also take into account the various characteristics of the mentally disordered individual. It would not be appropriate to place an adolescent in a facility for mentally disturbed adults as this could undermine his or her treatment programme.[53]

---

45 Ministry of Health Guidelines, above n 20, 18.

46 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 28(2).

47 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 28(4).

48 *Re IC* [1996] NZFLR 562, 576.

49 New Zealand Bill of Rights Act 1990, s 17.

50 New Zealand Bill of Rights Act 1990, s 22.

51 *Mental Health Law*, above n 5,192.

52 See *Re Decision 273* (13 July 1994) unreported, Mental Health Review Tribunal, Northern Region NRT273/94.

53 *Trapski's Family Law* Vol III (Brooker's, Wellington, 1992) para MH28.06 (updated 18 August 1999). See *Re LF* (28 August 1998) unreported, Mental Health Review Tribunal, Southern Region SRT61/98.

B The Treatability of the Patient

The nature of the clinical condition presented by a mentally disordered person is highly relevant to determining what is appropriate treatment in the circumstances. The inclusion of the right to treatment appropriate to the patient's condition can be seen to establish a "treatability" criterion under the MHA92.[54] As outlined in the Mason Report 1988:[55]

> The treatability criterion is founded on the principle that no person should be hospitalised against his or her will who does not present a condition which is susceptible to treatment in hospital. Unless the disorder of the person detained is treatable, his or her confinement is little more than preventive detention, as there is no prospect of benefit from treatment.

Those who will not benefit from treatment should not then be made subject to a compulsory treatment order.[56] At the core of this issue is the fact that "[t]o deprive a citizen of his or her liberty upon the altruistic theory that confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process".[57] This is true when treatment is not possible as much as when the provision of treatment is denied or neglected.

One of the reasons intellectual handicap is said to have been removed from the scope of the MHA92 is because it constitutes the usual state of the disabled individual and as such, is not treatable.[58] A lack of treatability may also apply to some mental disorders that are covered by the Act, for example, various personality disorders where it is said that "antisocial or maladaptive behaviour is the result of unusual personality traits rather than mental disturbance or malfunction".[59] The inclusion of personality disorders in the definition of mental disorder under the MHA92 is contentious.[60] The focus in the

---

54 For a full discussion of issues pertaining to treatment and treatability see *Airedale NHS Trust v Bland* [1993] AC 789, 856.

55 The Mason Report 1988, above n 41, 222-223.

56 *Mental Health Law*, above n 5, 153. This statement is affirmed in the decision of *Re RR* (9 July 1993) unreported, Mental Health Review Tribunal, Southern Region SRT 37/93 where it was said that: "The Act itself, read as a whole, makes it abundantly clear that a compulsory treatment order can only be made under the Act if the patient suffers from a condition that is treatable".

57 *Wyatt v Stickney* (1971) 325 F Supp 781, 785 (ND Ala); (1972) 344 F Supp 373, 377 (ND Ala).

58 *Mental Health Law*, above n 5, 153.

59 "Defining Mental Disorder", above n 17, 82.

60 For discussion see WJ Brookbanks "Defining Personality Disorder" [1996] MHL 87, 87-90 ["Defining Personality Disorder"].

legislation on threshold indices however, directs attention to fulfilment of the relevant criteria under the Act rather than to the inclusion of a generic category of mental illness.[61]

C Treatment

The argument that one should not be made subject to a compulsory treatment order because of a lack of "treatability" is to some degree anaesthetised by the broad interpretation that is readily applied to "treatment". In addition, the reality of psychiatric knowledge is such that treatment is often expressed in terms of maintenance or containment rather than improvement or cure of a condition.[62]

1 The meaning of "treatment"

Treatment is not defined in the MHA92 but it is generally accepted that it is not a narrow concept.[63] Treatment is certainly not limited to effective drug intervention as was indicated in the decision of *Re RR*:[64]

> [The suggestion] that a person whose mental condition cannot be treated by drug therapy does not fall within the parameters of the Act is, in the view of the Tribunal, a misguided view. It would mean that mental disorder would effectively be defined by the ability of pharmacists to invent and market treatment drugs. It would mean that at the end of the day international drug companies would define mental disorder.

In the mental health context, treatment must include "all the remedies which mental health professionals ... have available to them to manage mental illness".[65]

In assisting the patient to achieve their best level of functioning and encouraging them to develop insight into their illness, discussion and counselling, social interaction and medication, may all be used and viewed as valid forms of treatment,[66] as can exercise and education.[67] Interventions directed at the symptoms of mental disorder, such as the tube-

---

61 See *Re H [mental health]*, above n 12, 528-530. Here a bulimic patient was found to be mentally disordered under the MHA92. Personality disorders are capable of constituting "mental disorder" but are not generically classifiable as such. In any given case it will depend on whether the patient's condition satisfies the relevant threshold criteria under the Act.

62 A Eldergill *Mental Health Review Tribunals: Law and Practice* (Sweet and Maxwell, London, 1997) 1130.

63 See *Capital Coast Health Ltd v R* (1995) 13 FRNZ 294, 300; [1995] NZFLR 838, 844.

64 *Re RR*, above n 56.

65 *Capital Coast Health v R*, above n 63, 300; 844.

66 *Capital Coast Health v R*, above n 63, 300; 844

67 *Mental Health Law*, above n 5, 112.

feeding of an anorexic patient,[68] are also considered treatment as much as those aimed at addressing the root of the problem.[69]

2 *Must treatment have a beneficial effect?*

Despite significant advances in psychiatric knowledge over the last half century, the treatment of mental disorder continues to be characterised by uncertainty. The intrusive nature of compulsory treatment under the MHA92 nevertheless requires that a patient be entitled to a prospect of therapeutic success that significantly outweighs the detrimental impact occasioned by the invasion upon their liberty and autonomy.[70] What constitutes a "beneficial outcome" under a particular treatment regime will inevitably be shaped by the broad definition that is applied to "treatment".

In general terms the desired outcome of treatment is to provide the patient with a "realistic opportunity to be cured or to improve his or her mental condition",[71] or to alleviate or prevent deterioration of the patient's condition.[72] Ultimately however, the goal of mental health services is "recovery" which encompasses such outcomes as the reduction of symptoms and disability, the development of personal resourcefulness,[73] the increase in control over and improvement of mental health and well-being and the enabling of mental health consumers to fully participate in society.[74]

It is not necessary that in subjecting a mentally disordered person to the compulsory control of the MHA92 they be guaranteed "successful" treatment.[75] This proposition was affirmed in the recent case of *Re FAH*:[76]

> Treatment must be available, the treatment given must be appropriate, there must be some reasonable prospect of it helping to alleviate the patient's condition, [but] there is no

---

68 *Re KB (adult) (mental patient: medical treatment)* (1994) 19 BMLR 144, 146.

69 *Mental Health Law*, above n 5, 112.

70 *Mental Health Law*, above n 5, 107.

71 *Wyatt v Stickney*, above n 57, 785; 374.

72 *Mental Health Law*, above n 5, 153.

73 Mental Health Commission *Blueprint for Mental Health Services in New Zealand: How Things Need to Be* (Wellington, December 1998) 6 *[Blueprint for Mental Health Services]*.

74 *Blueprint for Mental Health Services*, above n 73, 16.

75 *Director of Mental Health Services v RH* (30 April 1998) unreported, District Court, Auckland, MH 49/98.

76 *Re FAH* [1999] NZFLR 615, 623.

requirement of successful treatment, a phrase which itself could be given a multiplicity of meanings ranging from holding deterioration in abeyance to total remission.

Recovery for a person suffering from a mental disorder does not always mean a return to full health or a regaining of what might have been lost, but it does mean that the individual should be able to live well in spite of their illness.[77] As such, treatment should be directed to this end.

3 *Standard of services to be available*

As an adjunct to the question of whether treatment that is appropriate should have a positive therapeutic effect, is the issue of the standard of services to be available to the person being treated under the MHA92. Compulsory treatment under the Act should promote "recovery", but is it necessary that it provide the "best" likelihood of such an outcome?

The MHA92 itself provides little guidance as to the level and standard of services to be expected. The Ministry of Health guidelines to the Act state that the right to appropriate treatment means patients should be offered the same level of treatment and care that would be available to any other hospital patient.[78] The Consumers' Rights Code frames this as a right to services of an "appropriate standard".[79] This includes the right to have services provided which are consistent with the mental health consumer's needs and in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.[80] It also places a duty on service providers to work in co-operation so as to ensure quality and continuity of services.[81]

Various international agreements point to the positive duty on government agents to provide health care, expressing the standard to be achieved in "optimum" rather than "adequate" terms. Article 12(1) of the International Covenant on Civil and Political Rights (ICCPR) recognises "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". The 1975 Declaration of the Rights of Disabled

---

77 *Blueprint for Mental Health Services*, above n 73, 1.

78 Ministry of Health Guidelines, above n 20, 32, para 19.3. For example, this standard should apply to the treatment of health conditions unassociated with the mental disorder.

79 Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, cl 2, right 4.

80 Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, cl 2, rights 4(3) and 4(4).

81 Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, cl 2, right 4(5).

Persons, which includes mentally disordered persons, also recognises the right to receive "any treatment, rehabilitation, education, training and other services to develop skills and capabilities to the maximum",[82] and the right not to be subjected to more restrictive conditions of residence than necessary.[83] The United Nations Principles for Mental Health outline the standard of treatment as an absolute, it being the right "to the best available mental health care".[84] Although it is unlikely that action could be taken to enforce these standards,[85] domestic litigation concerning mental health issues is increasingly emphasising the need to consider the impact of various international instruments on the provision of mental health services.[86]

When it comes to the standard of service provision, mental health services in New Zealand are fundamentally directed toward similar goals to those that have been internationally pronounced. Specifically, the aim is to secure the best health care.[87] What is aimed for and what is guaranteed are however, quite different. The right to "appropriate" treatment is generally accepted as conveying something less than the requirement that the treatment to be provided indicate the "best" therapeutic outcome.

This approach has been taken in the United States in cases such as *Eckerhart v Hensley*.[88] Here the Court held that the patient should be guaranteed only that "treatment as is minimally adequate to provide him a reasonable opportunity to be cured or to improve his mental condition".[89] The fact that there is the possibility of a better alternative treatment does not necessarily prove that the one provided is inappropriate or

---

82 The Declaration of the Rights of Disabled Persons 1975, princ 6.

83 The Declaration of the Rights of Disabled Persons 1975, princ 9.

84 United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, princ 1.1.

85 Janet McLean "Forensic Psychiatry and the Constitution" in Warren Brookbanks (ed) *Psychiatry and the Law: Clinical and Legal Issues* (Brooker's, Wellington, 1996) 119, 120-122. Due to New Zealand's accession to the Optional Protocol [NZTS 1989 No 12 AJHR 1993 A 103] it may however be possible for a person who believes his or her rights under the ICCPR have been breached to take a petition to the United Nations Human Rights Committee.

86 See *Innes v Wong* (10 April 1996) unreported, High Court, Auckland CP152/95; *Police v M* (24 April 1996) unreported, District Court, Henderson CRN5090029191. The latter case involved a disability hearing under Part VII of the Criminal Justice Act 1985 where the Judge held that the relevant statutory discretions must be exercised "with a weather eye to the internationally recognised norms for the human rights of ... mentally disabled person[s]".

87 Health and Disability Services Act 1993, s 4.

88 *Eckerhart v Hensley* (1979) 475 F Supp 908 (WD Mo).

89 *Eckerhart v Hensley*, above n 88, 915.

inadequate.[90] Nevertheless, an interpretation consistent with the statutory right to appropriate treatment would suggest that health funding authorities have an obligation to provide a comprehensive range of services, for both in-patient and community-based care.[91]

In the United Kingdom there is a statutory obligation to provide a range of after-care services to certain classes of patients.[92] In the case of *R v Ealing District Health Authority, ex p Fox*, the relevant provision of the Mental Health Act 1983 (UK) was held to impose a mandatory requirement on the district health authority to make practical arrangements for after-care prior to a person's release from committed status as a condition of the discharge imposed by a mental health review tribunal.[93] There is no specific equivalent requirement in New Zealand.

The range and standard of services to be made available to patients is inevitably impacted by resource constraint. The Health and Disability Services Act 1993 specifically contemplates the effect of economic restrictions in that it couches its stated purposes of securing the "best health", "best care" and "greatest independence for people with disabilities", with the qualifier that these aims be fulfilled only to the extent "that is reasonably achievable within the amount of funding provided".[94] The Consumers' Right Code also contemplates the implications of resource constraint on the ability of providers to give effect to patients' rights.[95] Though resource constraint may constitute a justifiable impediment to the degree or standard of services made available, it is questionable whether such a justification should hold weight against the requirement that substantively appropriate services be provided in meeting the right of those made subject to the MHA92 to receive appropriate treatment.

---

90 *Rouse v Cameron* (1966) 125 US App DC 366; 373 F 2d 451, 457.

91 See *Re H* (16 March 1994) unreported, Mental Health Review Tribunal, Southern Region SRT8/94. In this case it was held that the regional health authority had an obligation to provide the necessary services. See also *Mental Health Law*, above n 5, 152.

92 Mental Health Act 1983 (UK), s 117(2).

93 *R v Ealing District Health Authority, ex p Fox* [1993] 3 All ER 170, 181, 183.

94 Health and Disability Services Act 1993, s 4(a). The same statement of purpose also constitutes the Long Title of the Act.

95 Under the Code, action by a provider is not in breach if actions taken are reasonable in light of the provider's resource constraints. Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, cl 3(3).

D Preventive and Arbitrary Detention

It has been said that "unless adequate and appropriate treatment is provided, [a] person's confinement [under the MHA92] amounts to little more than preventive detention".[96] Maintaining a compulsory treatment order simply for the purposes of detaining a person who might otherwise pose a risk of serious danger to the public is an unjustifiable action.[97] Without the provision of appropriate treatment, such detention, as well as being preventive, could also be classed as arbitrary and contrary to section 22 of the NZBORA.[98]

Those who are categorised as mentally disordered under the MHA92 by definition pose a threat, either of serious danger to themselves or others, or of harm to their own health and safety through self-neglect. Although detention may function to "protect a patient from himself or herself and to protect the public",[99] the purpose for detention should not be directed toward punishing an individual for their potential to commit harm as a result of their abnormal state of mind. This contention becomes more hazy in the case of special patients who are concurrently serving a criminal sentence, or with regard to restricted patients who may be subjected to stricter terms of detention because of the danger they pose to others,[100] but for the ordinary patient subject to a compulsory treatment order "any question of punishment is entirely inappropriate".[101] Fundamentally, the exercise of compulsory powers under the Act requires legitimisation through the provision of appropriate treatment to those made subject to its control.[102]

The issue of detention is clearly relevant in the case of in-patient care where the person is physically confined, but it may also be seen as applicable to a community treatment order. A community treatment order requires the patient to attend a specified place and to accept treatment.[103] Powers are also given to duly authorised officers and police called to

---

96 *Trapski's Family Law*, above n 53, para MH66.04 (updated 18 August 1999).

97 *Re RR*, above n 56.

98 The question of arbitrary detention similarly arises in relation to the denial of bail to accused persons because of the possibility of offending on release. See Andrew S Butler "The Law of Bail under the New Zealand Bill of Rights Act: A Note on *Gillbanks v Police*" [1994] NZ Recent LR 314.

99 McLean, above n 85, 126.

100 McLean, above n 85, 127.

101 *Re M* [1992] 1 NZLR 29, 38.

102 *Re IC*, above n 48, 576. Also see *Trapski's Family Law*, above n 53, para MH30.04 (updated 18 August 1999).

103 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 29(1).

assist, to apprehend and take unco-operative patients to the required place for assessment and treatment, or if necessary, to return them to hospital.[104] Under the Mental Health Act 1969 the application of the NZBORA to conditions of detention was recognised as being relevant even where a patient was on leave in his own home.[105]

The question whether arbitrary detention had occurred under the Mental Health Act 1969 arose in the case of *Re M*.[106] Counsel for the applicant submitted that grounds for indefinite detention under the Act were so lacking in specificity as to be arbitrary.[107] The Court found however, that detention cannot be arbitrary when it is according to law and is within the confines of the principles that are statutorily imposed.[108] In a later case by the same name,[109] Judge McElrea pointed out that the statement that detention is not arbitrary if it is authorised by law is only of assistance where the law provides specific criteria for the exercise of power.[110] In order to comply with an individual's right not to be arbitrarily detained the detention "must be principled, or justifiable according to objective grounds laid down by the law, i.e. not according to the whim or convenience of the detainer".[111]

Under the present statutory regime the legal and principled justification for detention is to provide treatment to those who are defined as mentally disordered under the MHA92. "The purpose of involuntary hospitalization for treatment purposes is *treatment* and not mere custodial care or punishment."[112] This purpose is developed further by the statement that the patient is entitled to appropriate treatment and by the definition of mental disorder, which informs of the motivation for which this power is conferred; that is, to remove the serious danger an individual poses to himself or herself, or to others.

---

104 Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 40, 41.

105 *Re S* [1992] 1 NZLR 363, 370.

106 *Re M*, above n 101.

107 *Re M*, above n 101, 38, 40. The applicant was seen as being in a worse position than if they were a violent criminal subject to the controls of the criminal justice system: "In the one case a person who has behaved with considerable violence could be accepted as able to return to the community with all the potential to carry out repeat offences and a person who has never committed any violent offence at all should be detained indefinitely because of the potential risk assessed by psychiatrists."

108 *Re M*, above n 101, 41, 42.

109 *Re M* [1993] DCR 153.

110 *Re M*, above n 109, 175.

111 *Re M*, above n 109, 175.

112 *Wyatt v Stickney*, above n 57, 784, 390.

Action based on a protective motivation however, is justified as non-arbitrary by the fulfilment of the purpose of treatment.

The Law Commission has said that: "The justification [for detention] must rationally relate to the purpose ... Any limit on liberty should be the least restrictive alternative needed to achieve its purpose".[113] The MHA92 should be read consistently with the NZBORA where possible and detention without treatment appropriate to the detained person's condition would not only present a situation which appears factually arbitrary, it would also constitute a detention inconsistent with the stated principles and the purpose of the MHA92 itself.

E Summary

Honouring the right to appropriate treatment is fundamental to the integrity with which action can be taken under the MHA92. Doing so requires that a person detained for the purposes of treatment must first of all be treatable. In a context where treatment is framed as anything from education programmes to specific drug intervention the question of treatability is largely subdued and a determination of what is appropriate treatment lies primarily in the hands of professionals. Treatment which is provided must nevertheless be clinically suitable, be respectful of an individual's culture and beliefs, and must promote "recovery".

To deny someone subject to the powers of the MHA92 their right to receive appropriate treatment perpetuates the vulnerable position of the mentally disordered and constitutes a serious breach of that individual's rights. It also sustains a system which allows for the restraint of the liberty of an individual because of what they "might" do. This type of punitive approach goes against the philosophy of the MHA92. It breaches the patient's entitlement to appropriate treatment and also various rights provided by the NZBORA, including the right not to be arbitrarily detained.

An ongoing dilemma in seeking to provide appropriate treatment to the mentally disordered is the issue of resource constraint. A lack of resources acts as a serious impediment, not only to providing the best possible standard of treatment, but also to accessing treatment which is appropriate to the patient's condition in a given case.

---

113 New Zealand Law Commission *Community Safety: Mental Health and Criminal Justice Issues* Report No 30 (Wellington, 1994) 2.

V THE IMPLICATIONS OF RESOURCE CONSTRAINT ON THE RIGHT TO APPROPRIATE TREATMENT

The lack of resources available for mental health treatment is a reality that has been highlighted by a number of reviews of mental health services.[114] Resource constraint poses a serious and ongoing threat to the right of a patient to receive treatment appropriate to his or her condition. This is an issue in relation to accessing pharmaceutical interventions but has particular significance in relation to the provision of community-based treatment.

A Access to Pharmaceuticals

Resource constraint inevitably impacts on the availability of appropriate pharmaceutical intervention for mental illness. Increasingly pharmaceutical treatments are being developed which achieve greater levels of acceptability because of the decrease in unwanted side effects that accompany therapeutic outcomes.[115] The superior nature of these products comes however, at a higher cost than treatments developed a number of decades ago.[116] Effective treatments also have the tendency to tap into the pool of potential consumers, increasing the number of individuals to be treated.[117]

Provision of effective modern pharmaceuticals to those subject to compulsory treatment under the MHA92 could be viewed as an issue of the standard rather than the appropriateness of services to be available. The line to be drawn is arguably however, a very fine one. These new drugs have fewer unwanted effects,[118] enable greater improvements in people's health and lives, and reduce the wider economic and other costs of severe mental disorder.[119] The Mental Health Commission has stated that these "[n]ew anti-psychotic drugs should be prescribed for all those for whom they are clinically indicated."[120] The right to be treated with humanity and dignity,[121] and to receive the

---

114 See *Looking Forward*, above n 3, 6.

115 Wayne Miles "The Right to Treatment: Access to Pharmaceuticals" (Spring 1995) Mental Health News 23, 24.

116 Miles, above n 115, 26.

117 Miles, above n 115, 26.

118 Miles, above n 115, 26.

119 *Blueprint for Mental Health Services*, above n 73, 33. See also Miles, above n 115, 25. The wider socio-economic costs associated with mental health may include the loss of productivity of a mentally disordered person through to the costs that fall on families and caregivers in looking after such an individual.

120 *Blueprint for Mental Health Services*, above n 73, 33.

121 New Zealand Bill of Rights Act 1990, s 23(5).

least intrusive treatment,[122] also supports a finding that the provision of such medication is "appropriate" when the patient's condition indicates such a prescription, regardless of resource constraints.

B Adequate Resources for Community Care?

The impact of resource constraint is particularly significant in relation to community treatment. The MHA92 creates a presumption in favour of community-based care and yet the "insufficient and unsuitable resources available" for the care of patients readily undermine this presumption.[123] On a global scale the shift from institutionalised care to community treatment has resulted in situations where:[124]

> [P]atients are being transferred in large number from the hospitals which allegedly caused their condition to deteriorate, back into the community. But the community rarely cares, and the facilities provided have proved sadly inadequate ... [highlighting] the evils of "incarceration" and the even greater iniquities of "decarceration" that is, the release of patients in large number into unprepared communities.

For those made subject to compulsory treatment under the MHA92 this failure to provide adequate resources stands as a significant barrier to receiving appropriate treatment in the community context.[125]

1 The impact of resource constraints on the presumption of community treatment

In deciding whether to make a community treatment order the court must be satisfied that care and treatment appropriate to the needs of the patient are available and that the social circumstances of the patient are adequate for his or her care within the community.[126] If inadequate community facilities are available then the presumption of community treatment is rebutted and an in-patient order must be made.[127] This situation allows for a result which is entirely inconsistent with the right to appropriate treatment

---

122 *Re IC*, above n 48, 576. A treatment option that produces significantly less debilitating side-effects could certainly be seen as a less intrusive intervention.

123 *Looking Forward*, above n 3, 6.

124 Martin Roth "The Historical Background: The Past 25 Years since the Mental Health Act of 1959" in Martin Roth and Robert Bluglass (eds) *Psychiatry, Human Rights and the Law* (Cambridge University Press, Cambridge, 1985) 4.

125 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 28(2).

126 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 28(4).

127 Mental Health (Compulsory Assessment and Treatment) Act 1992, s 28(2).

under the MHA92, this being a right to treatment appropriate to the patient's condition and not to the condition of the community.

The lack of resources to support community care may also have the effect of frustrating mental health professionals so that they conform their clinical judgments to what is available rather than what is appropriate.[128] A responsible clinician may then promote the making of an in-patient order because of their knowledge of the inadequacies of community facilities. It has been argued that this phenomenon is unlikely because of the requirement that treatment be appropriate to the patient's needs,[129] and also the suggested practice that the recommended treatment is identified before the court makes its order.[130] Responsible clinicians are likely however, to be well aware of the services available to support the patient if a community treatment order is made.[131] They may also be familiar with the patient's social circumstances and support networks in the community. On this basis it is feasible that they may propose treatment which is "appropriate in the circumstances", but not fundamentally "appropriate to the patient's condition".

In the alternative, a responsible clinician may be adamant that a community treatment order is appropriate, but the court may then direct an in-patient order because of a lack of resources. This scenario presents an anomalous situation where the responsible clinician could subsequently discharge the patient from hospital under section 30 of the MHA92 on the basis that the patient can be treated adequately as an outpatient. This would have the effect of making the hearing under section 28 redundant and would allow a decision to be imposed that is contrary to the findings of the judicial monitoring process.[132]

2 *The rights of the patient as the principal concern*

There is much ambiguity over the existence or otherwise of an obligation on the part of health funding authorities and other purchasers of health services, to provide necessary services for effective community care. It has generally been said that a definitive statement of a human right of the mentally ill to appropriate services is frustrated by the inability to

---

128 Stacy E Seicshnaydre "Community Mental Health Treatment for the Mentally Ill - When does Less Restrictive Treatment become a Right?" (1992) 66 Tulane Law Rev 1971, 1983.

129 Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 28(4)(a) and 66.

130 *Mental Health Law*, above n 5, 193. The practice of identifying proposed treatment before the court makes an order is suggested in the Ministry of Health Guidelines, above n 20, 24, para 11.3.

131 It is envisioned that a responsible clinician will contemplate the services and support available to meet the needs of the patient when they determine a proposed treatment plan. See Ministry of Health Guidelines, above n 20, 24, para 11.3.

132 See *Trapski's Family Law*, above n 53, para MH28.12 (updated 18 August 1999).

require an absolute level of resources that could apply across national boundaries.[133] The inclusion of a right to appropriate treatment in the MHA92, supported by various other domestic and international provisions, does however suggest, that a lack of resources should not justify the lack of provision of appropriate community treatment.[134]

A number of decisions of the Mental Health Review Tribunal reflect an approach consistent with this focus on patients' rights.[135] In the case of *Re H*,[136] the Tribunal concluded that a lack of resources to support a community placement meant the only proper course was to order the patient be discharged from compulsory status. It was said that:

> Treatment cannot include the prolonged detention of a patient in hospital simply because of the failure of the Regional Health Authority to provide other resources ... when one examines the issue of the health of the patient, a factor that must be taken into account is the psychological effect upon a patient of enduring a serious curtailment of personal liberty. This may engender animosity and antagonism towards the mental health system, destroying any reasonable prospect of establishing a healthy therapeutic relationship between caregiver and care receiver.

To allow a compulsory treatment order to continue in the circumstances was tantamount to condoning the improper disregard for the patient's rights because of a failure to provide adequate resources. Although this approach has been viewed as somewhat radical,[137] it accords with an attitude that has the rights of the patient as the principal concern.[138]

On the international stage the United Nations Economic and Social Committee which monitors compliance with the International Covenant on Economic Social and Cultural

---

133 Larry Gostin "Human Rights in Mental Health" in Martin Roth and Robert Bluglass (eds) *Psychiatry, Human Rights and the Law* (Cambridge University Press, Cambridge, 1985) 152.

134 See *Trapski's Family Law*, above n 53, para MH28.07(1) (updated 18 August 1999).

135 See *Re H*, above n 91; *Re PTP* (29 June 1994) unreported, Mental Health Review Tribunal, Southern Region SRT40/94; *Re AG* (11 August 1995) unreported, Mental Health Review Tribunal, Northern Region NRT334/95.

136 *Re H*, above n 91.

137 *Trapski's Family Law*, above n 53, para MH28.07(2) (updated 18 August 1999).

138 *Trapski's Family Law*, above n 53, para MH28.07(1) (updated 18 August 1999). This approach is also consistent with cases in the United States where the inadequate resources defence has been rejected as a justification for denial of the right to community treatment. See for example *Thomas S v Morrow* (1986) 781 F 2d 367 (4th Cir). The applicability of such decisions to the New Zealand situation has been questioned however because of the constitutional basis of these rights in the United States.

Rights has also stated that economic pressures are an unacceptable excuse for the failure to uphold rights such as that to health care.[139] This is particularly important in the case of mental health patients subject to compulsory treatment, where a lack of appropriate treatment could constitute an arbitrary detention under the NZBORA.

3 A practical response?

The difficulty with the approach taken by the Tribunal in *Re H* is that a person who can be categorised as mentally disordered and in need of compulsory treatment under the MHA92 may then fall outside its scope because of a lack of resources. This presents serious implications in regard to the implicit motivation of the Act, that is to intervene so as to reduce the likelihood that the person affected by mental illness will cause harm to himself or herself, or to others. Non-compulsion in these circumstances may act to uphold in the negative the right to not receive inappropriate treatment and to guard against a breach of the patient's broader rights to liberty and dignity, but its practical effect is to do the person little good.[140]

An alternative approach which is directed at this fundamental concern is evidenced in the decision of *In the matter of E*.[141] In this case the implications of resource constraint were felt in the denial of a community treatment order. Judge Carruthers held that the words used in section 28(4)(a) of the MHA92 require the Court to investigate the resources that are available to support a patient in the community. He stated that: "The services must be there in fact and available for the proper care of the patient".[142] In this case the lack of resources available meant that community-based treatment could not be monitored adequately because of staffing deficiencies. As a result an in-patient order was made. This has been seen as a logical application of the provisions of the MHA92.[143] It has been said that:[144]

> If the Court is convinced that the requirements of s 27 are satisfied, and therefore compulsory status arises, but is not satisfied that a patient is able to be adequately treated on a community treatment order because the necessary resources are not available, then, with respect, it is difficult to see how a Review Tribunal, applying the same tests when reviewing a patient's

---

139 *Mental Health Law*, above n 5, 142.

140 Stephanie Dyhrberg "The Approach of the Mental Health Review Tribunal to Community Treatment Orders and Unavailable Resources" [1995] MHL 60, 61.

141 *In the matter of E*, above n 21.

142 *In the matter of E*, above n 21, 335.

143 Dyhrberg, above n 140, 61.

144 Dyhrberg, above n 140, 61 (emphasis in the original).

condition, could order that the patient be released from compulsory status, on the grounds that community treatment *should* be made available.

Intervening and providing assistance of some form to those deemed mentally disordered under the MHA92 is seen as more important than upholding the patient's rights so as to deliver a rebuke to the funding authorities.[145]

4 So where should the balance lie?

The approach taken by the court in *In the matter of E* may represent a practical response to the deplorable state of community mental health care resourcing, but it does serious damage to the integrity of the MHA92. When an in-patient order results because of a lack of resources to support appropriate community care, the patient's rights are undermined. Such an outcome is inconsistent not only with the right to receive appropriate treatment, but also to be subject to the least restrictive intervention and to be free from arbitrary detention.

Judicial ambivalence to interfering in funding issues is understandable in view of the stretched resources of the health system,[146] but should not justify a neglect of the court's role in upholding the patient's rights. The anticipated effects of resource constraints identified by statutes such as the Health and Disability Services Act may be relevant to the standard of treatment that can be expected but should not justify the compulsory imposition of treatment that is inappropriate to the patient's condition. Patients should not be detained unnecessarily because of a lack of resources. In making an in-patient order because of the deficiencies of community care, the balance is tipped in favour of protecting the public from what the mentally disordered individual "might" do, over and above the rights of the patient. This has the tendency to promote a punitive attitude toward the mentally ill and to perpetuate the historically vulnerable and stigmatised position of this group of individuals.

C Summary

Resource constraint acts as a serious and seemingly inevitable barrier to the patient's right to receive treatment appropriate to his or her condition. This is a reality in the

---

145 Dyhrberg, above n 140, 61.

146 The Courts have shown a reluctance to intervene where there is a question of deciding between conflicting medical opinions or determining how a health authority's limited budget should be allocated when there are competing claims on its resources. See for example *R v Cambridge District Health Authority, ex p B* [1995] 2 All ER 129 (CA), and locally, *Shortland v Northland Health Ltd* (20 September 1997) unreported, High Court, Auckland M75/97. Often these decisions surround the provision of care to those with terminal conditions and implicitly convey value judgments about the worth of treating such individuals.

accessing of appropriate drug treatments and more particularly in relation to the availability of community care facilities for appropriate out-patient treatment. Though the lack of available resources represents a very real impediment to upholding the rights of the patient, it should not be accepted as an appropriate justification for the denial of appropriate treatment.

Those made subject to the intrusive powers of the MHA92 should be able to access pharmaceuticals which offer effective outcomes, and which have least unwanted side-effects. Patients should also be entitled to community-based treatment where it is indicated that this is appropriate for their condition. If inappropriate treatment or detention are the inevitable alternatives where resources are inadequate then the integrity of the system comes into question and patients should not be left without an effective remedy.

Complaints made under the MHA92 itself have been said to be "a notoriously circular and toothless remedy for an alleged breach, which may, at the end of the day, result in no action being taken".[147] Broader avenues for relief may then need to be explored, such as a complaint to the Health and Disability Commissioner under the Consumers' Rights Code, a public law action for a breach of the NZBORA, or various private law or equitable remedies.[148]

The right to appropriate treatment is integral to the purpose of the MHA92. Unless efforts are made to recognise the importance of this right and to implement it with integrity then the heralded change in philosophy of mental health treatment from protection and control to an emphasis on patients' rights and autonomy is seriously undermined.

VI CONCLUSION

As a whole the MHA92 is said to represent a comprehensive reform of mental health law.[149] The affirmative statement of patients' rights in the Act marks a significant philosophical shift from the abusive constructs of mental health "treatment" that dominated in the past. Rather than being driven by fear and a motivation to control the mentally disordered, the Act is heralded as seeking to intervene in the least restrictive form and to promote recovery so that these individuals can live productive and fulfilling

147 *Mental Health Law*, above n 5, 165.

148 See *Mental Health Law*, above n 5, 165-182 for discussion of available remedies and the likelihood of their successful application.

149 "The New Mental Health Act 1992", above n 11, 3, para 1.7.

lives in the community. The presumption in favour of community-based treatment is fundamental to this endeavour.

Among the rights provided in the MHA92 and supported by various international agreements and domestic enactments, the right of the patient to receive treatment appropriate to his or her condition is of key concern. This right goes to the heart of the purpose of the MHA92, that is, to provide treatment so that concerns about the danger posed by a mentally disordered individual are addressed and appeased. Without the provision of appropriate treatment the intrusive and coercive powers of the MHA92 promote a punitive attitude toward the mentally disordered and perpetuate the vulnerable position of these individuals.

Appropriate treatment should be clinically suitable for the person's condition, be respectful of an individual's culture and beliefs, and should occur in a setting that is consistent with the needs and characteristics of the patient. Treatment need not guarantee success in the sense of cure, but should provide a therapeutic benefit, which outweighs the detrimental effect of the compulsory intervention. When appropriate treatment is not provided to a person made subject to the Act the exercise of a compulsory treatment order becomes tantamount to preventive and arbitrary detention. This is particularly relevant in the situation where a community treatment order is denied and supplanted with an in-patient order simply because there is no adequate facilities to support the patient in community care.

The impact of resource constraint on the integrity of the MHA92 is an issue of grave concern. It poses serious threat to the recognition and observation of a patient's right to treatment appropriate to his or her condition. As has been said:[150]

> [T]he mere enactment of "rights" related legislation, while securing the legal rights of patients in hospital, may be a hollow victory if, as is reported to be the case in other jurisdictions, little is done to enhance the social and material needs of patients either in hospital or in the local community.

Ultimately, resource allocation represents a question of values and priorities. If the right of a patient to receive appropriate treatment is to be accepted as a matter of priority then resources need to be made available so that those made subject to the provisions of the MHA92 can be treated with the dignity and respect to which they are entitled.

---

150 *Trapski's Family Law*, above n 53, para MHPtVI.02(2) (updated 18 August 1999).