ADVANCE DIRECTIVES IN AN AMENDED NEW ZEALAND MENTAL HEALTH ACT

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INTRODUCTION

Introduction:

Advance Directives (ADs) enable people to set out their preferences for health care in advance of becoming unwell and are intended to be effective when a person is no longer competent.[1] Such preferences include refusal of consent. In New Zealand (NZ), the right to use an AD is outlined in Clause 7(5) of the Health and Disability Consumer's Code of Rights which says that "every consumer may use an advance directive in accordance with the common law".[2] The issue with this in relation to mental health is the absence of any reference here to the powers conferred by the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA), or as to the continuing effect an AD may have when a person comes under an inpatient Compulsory Treatment Order (CompTO) under that Act.[3] At present, a person may be treated without consent under the MHA for the first month of the CompTO and thereafter where consent is given in writing or where an independent psychiatrist finds the treatment to be in the interest of the patient.[4] The implication, then, is that ADs, if they exist, need not be followed if their terms are inconsistent with the powers to treat conferred by this Act. As such, the main purpose of this dissertation is to consider the extent to which refusal of psychiatric medication and treatment given in an AD should be honoured in relation to inpatients under a CompTO and to recommend additional safeguards for patient autonomy where ADs are overridden by the responsible clinician (RC). This research might then be considered by Parliament as an example of how ADs can be incorporated into an amended NZ MHA.

The driving force behind ADs is their capacity to promote autonomy and a person's ability to self-direct care by allowing an individual to communicate and seek to protect their own interests.[5] Their moral authority, even in the absence of legal enforceability, is based on the principle of respect for patient autonomy and the value of inherent dignity and worth of every person.[6] ADs are thus valued for their ability to create a broader concept of patient-centredness and a self-determined voice for patients.[7] Nevertheless, this must be balanced with the need to

[1] Jessie Lenagh-Glue and others "The content of Mental Health Advance Preference statements (MAPs): An assessment of completed advance directives in one New Zealand health board" (2020) 68 Int'l J.L.& Psychiatry 1 at 1.
[2] Code of Health and Disability Services Consumers' Rights, Right 7(5).
[3] Mental Health (Compulsory Assessment and Treatment) Act 1992, s 28(1)(b). See appendix.
[4] Ibid, at s 59.
[5] Daniel Ambrosini "Professional perceptions of psychiatric advance directives: a view of multiple stakeholders in Ontario and Quebec" (M.Sc. in Psychiatry Thesis, McGill University Montreal, 2008).
[6] Guy Widdershoven and Ron Berghmans "Advance directives in psychiatric care: a narrative approach" (2001) 27(2) Journal and Medical Ethics 92 at 93.
[7] Ibid.

give effect to the purpose of any MHA, which in NZ is to prevent danger to the health or safety of the patient or others, or prevent the capacity of that person to care for themselves becoming seriously diminished.[8] In addition, we must consider the interests of relatives, the demand on public health resources, the long-term implications of refusing treatment, and doubts about the validity and reliability of ADs, which cumulatively may demonstrably justify placing significant limits on patient autonomy exercised through an AD. Ultimately, where the balance of interests lies will be a decision for Parliament to make, in any law reform process, but this dissertation indicates the position it may take based on the arguments presented and the position adopted in jurisdictions overseas.

A. Key Legal Issues:

The first chapter of this dissertation addresses the arguments for and against honouring advance refusals in all circumstances. Unsurprisingly, the arguments in favour tend to focus on a respect for strong patient autonomy and avoiding discrimination against the mentally disordered. These come up against grave concerns for the physical and mental health of the patient which, as cases from Ontario, Canada, show, can drastically deteriorate in the absence of appropriate psychiatric treatment. Other arguments against honouring advance refusals in all circumstances stem from substantial doubts which may be raised about the reliability and validity of ADs made in the absence of a treating team, as well as from potential burdens on staff, other patients, and public health resources.

Chapter two subsequently addresses an avenue Parliament might take which finds a balance between arguments raised in chapter one. The suggestion here is that the RC may be able to override advance refusals in certain situations, provided they can adequately justify their reasons for doing so. These reasons mostly concern the clinical appropriateness and safety of honouring the advance instructions.

The third chapter questions whether advance consent to a certain form of psychiatric treatment can constitute 'consent' under sections 59 and 60 of the NZ MHA, and thus waive the need for a second opinion to be obtained from an independent psychiatrist when the patient contemporaneously objects (while incapacitous) to the treatment. The discussion focuses on

[8] Above n 3, at s 2(1).

the value of informed consent in NZ and whether a RC can rely on the preconditions for 'informed' consent having been met under the current procedure for making an AD, or whether there is enough doubt to justify hesitation. In addition, the principle of being able to withdraw consent at any time, and whether this can justifiably be waived when consent is given in advance while capacitous, is examined.

Chapter four outlines recommendations for procedural obligations that must be followed by clinicians if Parliament were to find that ADs could be overridden in some situations, as outlined in chapter two. The discussion looks at some example scenarios which might or might not allow the RC to override an AD and examines when, if ever, a second opinion or review by the Mental Health Review Tribunal (MHRT) might be necessary before advance instructions are overruled. It also outlines the procedure to follow when an AD is overridden.

Finally, the fifth chapter of this dissertation looks at how ADs should be made to address some of the substantial doubts raised throughout the dissertation regarding the validity and reliability of ADs. The main question boils down to whether there should be a statutory requirement for ADs to be made in consultation with clinicians, or whether that should merely be a recommendation, and whether ADs made with a treating team should be given a special legal status.

II

ADVANCE REFUSAL OF PSYCHIATRIC MEDICATION AND TREATMENT

Chapter I: Should Advance Refusals Always Be Honoured?

A. Arguments Against Honouring Advance Refusal of Psychiatric Treatment in All Circumstances:

i. Health and Wellbeing of the Patient

Justice Abella, in *Fleming v Reid* (1991), held that "the right to determine what shall, or shall not, be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in our common law".[9] The fact that serious risks or consequences may result from refusal of medical treatment does not vitiate the right of medical self-determination. This is the standpoint of strong patient autonomy. The Canadian legislation from the province of Ontario provides the best example of advance refusal of mental health treatment being honoured in all circumstances. Throughout the 1990s, the Canadian courts began shifting towards a more patient-centred regime, recognising that mentally disordered patients do not leave their right to individual autonomy at the door of psychiatric hospitals.[10] This gradual evolution to advance patient liberties led to the decision to honour advance refusals of psychiatric treatment in three controversial Ontario cases which will be outlined succinctly here for the purposes of showcasing some of the severe consequences which can arise when advance refusal is honoured in all circumstances.[11]

The first is that of *Fleming v Reid*. Mr Reid had been diagnosed with schizophrenia following a criminal trial in which he was found not guilty by reason of insanity.[12] In time, he came under the authority of the Ontario MHA which gives clinicians power to treat in the absence of capacitous refusal.[13] The RC, operating under that Act, held that Reid would benefit from neuroleptic medication, but Reid's welfare guardians, whose consent was required for the treatment to proceed (Reid having lost the competence to decide), refused to consent on Reid's behalf, on the ground that, while he had been mentally competent, Reid had made plain his

[9] Simon N. Verdun-Jones and Michelle S. Lawrence "The Charter Right to Refuse Psychiatric Treatment: A Comparative Analysis of the Laws of Ontario and British Columbia Concerning the Right of Mental-Health Patients to Refuse Psychiatric Treatment" (2013) 46(2) UBC Law Rev 489 at 492.
[10] Daniel L. Ambrosini and Anne G. Crocker "Psychiatric Advance Directives and the Right to Refuse Treatment in Canada" (2007) 52(6) Canadian Journal of Psychiatry 397 at 398.
[11] Ibid.
[12] *Fleming v. Reid* (1991) 28 ACWS (3d) 238.
[13] PsychDB "Introduction to Ontario's Mental Health Laws" (6 July 2021) <https://www.psychdb.com/teaching/on-mha/home>.

refusal to take neuroleptic drugs because they were, to his mind, unhelpful or harmful.[14] So, Reid had given his advance refusal to psychiatric treatment that his RC deemed invaluable to his healthcare, and Ontario law required his welfare guardians to honour this refusal.[15] Over the next several years, Reid's mental condition deteriorated as he became grossly psychotic, hostile and agitated.[16] Moreover, he became increasingly violent and was ultimately detained in a maximum-security facility.[17] For the duration of this extended period (1992 – 1995), the clinicians could do little more than observe the deterioration of Reid's condition, because the law did not permit him to be treated over his advance refusal.[18]

The second case features Mr Starson who had been diagnosed on several occasions as having bipolar disorder and came under the authority of the Ontario MHA.[19] His physicians proposed to administer neuroleptic medication, mood stabilisers, anti-anxiety medication, and anti-Parkinson medication, all of which Starson refused.[20] Starson's case is distinct from Reid's in that, where Reid refused consent in advance, Starson refused treatment at the time it was offered and, despite his illness, was assessed as having the competence to make that decision at the time.[21] However, the consequences arising from honouring such a refusal in all circumstances remain the same. In Starson's case, his mental health deteriorated as he developed paranoid delusions in relation to the consumption of food.[22] He believed eating or drinking would cause his imaginary son (who was also part of his delusion) to be tortured.[23] Since, under Ontario law, the clinicians were legally bound by Starson's refusal, even though he was under the MHA, because the refusal was considered competently made, his weight plummeted, and he became so dehydrated that death was imminent.[24] While he was eventually treated, when he was later considered to have lost the competence to refuse, and then showed marked improvement in both his physical and mental health, in the meantime he had been detained for an extended period.[25] So, while he retained the liberty of choice and autonomy

[14] Above n 11.
[15] Above n 12.
[16] Robert Solomon and others "Treatment Delayed – Liberty Denied" (2009) 87(3) Canadian Bar Review 679 at 704.
[17] Ibid.
[18] Ibid.
[19] Ronald Sklar "Starson v. Swayze: the Supreme Court speaks out (not all that clearly) on the question of "capacity"" (2007) 52(6) Can J Psychiatry 390 at 392.
[20] Above n 8, at 507.
[21] Ibid.
[22] Above n 15, at 680.
[23] Ibid.
[24] Ibid.
[25] Ibid, at 681.

regarding his treatment while considered competent to refuse, he lost for many years the physical liberty of being free.[26]

Finally, a patient by the name of Edwin Sevels suffered from paranoid schizophrenia and came under the Ontario MHA. Like in Reid's case, a relative (whose consent was required under the legislation) refused to consent to the recommended neuroleptic treatment on the basis that Sevels had previously refused consent while competent.[27] An interim court order was sought to medicate Sevels as he had been detained for 400 days, was extremely violent, and had responded well in the past to the proposed medication.[28] The order was denied, but the Court commented that it cannot have been the intended purpose of the Canadian Charter of Rights and Freedoms for mental health patients to be detained or warehoused for prolonged periods without treatment.[29]

These three cases show the principle of strong patient autonomy at work, in relation to the right to refuse psychiatric treatment, namely, that this right is not forfeited when a person becomes an involuntary patient under the Ontario MHA, when the patient has competently refused the treatment, either in advance, via an AD, or at the time the treatment is offered – despite the consequences. In Canada, this right can be grounded in section 7 of the Canadian Charter of Rights and Freedoms which outlines the "right to life, liberty and security of the person".[30] Specifically, "liberty" and "security of the person" have been interpreted to grant a degree of autonomy in making decisions of personal importance, such as those related to medical treatment.[31] Considered in a NZ context, section 11 of the NZ Bill of Rights Act 1990 (NZBORA) can be seen to attribute this same right, albeit more directly, to self-determined medical decisions.[32] However, human rights are not necessarily absolute. NZBORA rights may be limited or breached where it can be demonstrably justified in a free and democratic society.[33] In *R v Hansen*, Tipping J cited the leading Canadian case of *Oakes* which outlined that a limit on fundamental rights and freedoms is reasonable and demonstrably justified where the

[26] Above n 18, at 395.
[27] Above n 15, at 696.
[28] Ibid, at 697.
[29] Ibid.
[30] Canadian Charter of Rights and Freedoms, s 7, Part 1 of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11.
[31] Sarah MacKenzie "Informed Consent: The Right of Psychiatric Patients to Refuse Treatment" (1993) 2 Dalhousie J.Legal Stud 59 at 72.
[32] New Zealand Bill of Rights Act 1990, s 11.
[33] Ibid, at s 5.

purpose of that limit is sufficiently important and proportionate to the aim sought.[34] Considering then the consequences of failing to impose a limit on the right to refuse medical treatment in the mental health context, the three Canadian cases show how failure to treat can lead to significant deterioration of mental and physical health as well as ongoing, indefinite detainment. In each case, medical treatment was only given when the patients' situation became life-threatening or otherwise dehumanising. In the meantime, the patients suffered from debilitating delusions and irrational thoughts. Australian psychiatrists reported in a survey that most would not support a binding advance refusal of psychiatric medication because of the severe implications for the health of the patient.[35] Inherent human dignity is surely diminished and not gained when people are abandoned to the torments of their illness, such as hallucinations, psychotic delusions and suicidal thoughts.

The trend in mental health care has been to move away from a paternalistic approach to one focussed more on the autonomy of the patient. However, aspects of paternalism have existed from the inception of psychiatry and are still alive today.[36] Medical decisions are made on the assumption that professionals can form a reasoned judgement about what is in the best interests of the patient based on science in addition to what the patient would want if they were in an ordinary state of mind.[37] True, these same decisions are not enforced in the context of general medicine, but psychiatric patients are not similarly situated. It is a significantly different scenario. Consider that failure to treat increases the prospect that serious restrictions, like restraint and detainment, may be required for a much longer period because release to the community is untenable due to the nature of the patient's illness and their incapacity to care for themselves. Consider next the loss of life opportunities for those patients such as the option of being well and more functional, and thus more able to positively contribute to society and reap all the benefits of being alive. Returning then to reasonable and demonstrably justified limits on rights and freedoms, the potentially dire and possibly life-threatening consequences of failure to treat have been made plain in relation to the health of the patient. While there are other components which must, and will, be considered, the poor health outcomes and potential need for long-term detainment and physical restraint are persuasive arguments against

[34] *R v Hansen* [2008] NZSC at [103], per Tipping J.
[35] Marcus Sellars and others "Australian Psychiatrists' Support for Psychiatric Advance Directives: Responses to a Hypothetical Vignette" (2017) 24(1) ANZAPPL 61 at 69.
[36] Stephanie du Fresne "The Role of the Responsible Clinician" in John Dawson and Kris Gledhill (ed) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 183 at 184.
[37] Ibid.

honouring advance refusals in all circumstances, which Parliament will no doubt find compelling.

ii. The Responsible Clinician's Confidence in the Advance Directive

To make a valid AD, there are standard legal requirements which must be satisfied.[38] In the context of mental health, the confidence a RC has in these conditions being met may have implications for the perceived reliability of an AD. The existence of substantial doubts, for instance, may provide a justified reason for failing to honour an advance refusal. Firstly, there is no specific requirement as to the form an AD must take.[39] It may be given orally or in writing, though, where given orally, it can be difficult to definitively establish that an AD has been given and that it represents the true intentions of the patient and was not a mere "offhand remark".[40] For example, consider a patient who is suffering from a severe depressive episode for which antidepressant medication is ineffective, or the side-effects or risks associated with the medication would ordinarily make electroconvulsive therapy (ECT) the most appropriate treatment, or the depression is accompanied by other symptoms like a refusal to eat which make it impossible to wait for the slow acting effects of medication to become apparent. Next, consider the suggestion by a relative or friend that the patient had verbally indicated an advance refusal of ECT. There is no way for the RC to definitively say that this was the firm, settled and fully informed choice of the patient, made while they had capacity, and had knowledge of the potential consequences, and were free from undue influence, all of which constitute legal requirements for a valid AD. Serious doubt about the true intentions of the patient is a convincing reason for a RC to hesitate in blindly honouring an advance refusal.

Turning then to the three remaining criteria which form the substantially firmer legal requirements. First, the person must have the relevant capacity to make an AD. In NZ, sections 5 and 93B of the Protection of Personal and Property Rights Act 1988 (PPPRA) express the usual presumption of capacity that operates for all adults unless the contrary is proved on the balance of probabilities.[41] Across jurisdictions there are many and varying definitions of mental capacity, but NZ has opted for the "functional" approach to defining capacity which focuses

[38] Iris Reuvecamp "Advance Decision-Making About Personal Care and Welfare" in Iris Reuvecamp and John Dawson (eds) *Mental Capacity Law in New Zealand* (Thomson Reuters, Wellington, 2019) at 209.
[39] *HE v A Hospital NHS Trust* [2003] EWHC 1017 (Fam), [2003] 2 FLR 408 at [24].
[40] Above n 37.
[41] Ibid.

on the ability to make a particular decision at a particular time.[42] Typically, the degree of capacity required varies depending on the consequences of that healthcare decision. Lord Donaldson confirmed this in *Re T (Adult: Refusal of Treatment)*, saying that the consideration should be whether the degree of capacity corresponds to the gravity of the decision being made.[43] This decision-making capacity goes to the heart of patient autonomy and self-determination. The challenge in relation to ADs in the mental health context is having confidence that the patient did have that decision-making capacity at the time they made their AD. There is no legal requirement in NZ for ADs to be made with the involvement of medical professionals, and, for some clinicians, the implications of chronic mental disorders which "impair thinking, judgement and perception of reality" may cast enough doubt on the patient's capacity at the time they made their AD to believe this justifies overriding an advance refusal.[44]

Second, the person must make their AD free from undue influence.[45] In *Re T*, the Court held that undue influence arises when the degree of external influence is such that the decision is no longer that of the person.[46] Like for capacity, in the absence of any indication of who was involved in the making of the AD, the RC cannot be certain that the advance refusal is the true wish of the patient, which again raises doubts as to whether it should be honoured. This problem is perhaps particularly prevalent where an enduring attorney or substitute decision-maker was involved in making the AD. They would not yet have had legal authority to make decisions for the capacitous person, but they may nonetheless have been highly influential in the contents of the AD given the legal power they will have over the care of the person in the future. This is not to say that similar doubts do not also arise for ADs made for general medical care, but the consequences of refusing psychiatric treatment can be quite different, for example, the long-term detainment or restraint of patients. It is a significantly different scenario, so it is not necessarily unjustified for the State to treat it as such.

The final requirement is that of informed choice which in relation to advance refusal would be the informed choice to refuse consent. Generally, this involves the clinician providing

[42] Jeremy Skipworth "Should Involuntary Patients with Capacity Have the Right 213 to Refuse Treatment?" in John Dawson and Kris Gledhill (ed) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 213 at 216.
[43] *Re T (Adult: Refusal of Treatment)* [1993] Fam 95 (CA) at 113 per Lord Donaldson MR.
[44] Jeffrey W. Swanson and others "Superseding Psychiatric Advance Directives: Ethical and Legal Considerations" (2006) 34(3) J. Am. Acad. Psychiatry Law 385 at 388.
[45] Above n 37.
[46] Above n 42.

information about the treatment such as alternative treatment options, the risks of treatment, the implications of not having the treatment and the treatment methodology and process.[47] As highlighted previously, there is no requirement for an AD to be made with a clinician which means substantial doubt may arise as to whether a patient was sufficiently informed about the implications of their stated preferences. If the assumption is made that most people, once told that refusal of all or some aspects of treatment might result in them being detained for extended periods of time or would cause their health to substantially deteriorate, would agree to give their consent, then one can see how a RC might have cause to hesitate in relying on the idea that the patient has made an informed decision. Finally, there may arise a situation where an advance refusal has been made based on a past negative experience with a specific psychotropic drug. It may be appropriate for a clinician to override this advance directive to provide a newer, more effective treatment which has fewer side effects because the patient's refusal is a distorted preference to forego all medication which is misinformed because it includes medication the patient has never tried.[48]

The lack of verifiability of the person's capacity, true intentions and informed choice cumulatively can raise enough doubt as to the reliability of a patient's AD and thus give justifiable reason to hesitate to honour an advance refusal. Chapter five will address these gaps in the regulations surrounding the making of ADs to recommend how they might be overcome such that these doubts may not arise in the first place. One option, for instance, would be obtaining the signature of a clinician before the AD becomes valid. In the absence of such formal requirements for making an AD, doubts can arise surrounding the validity of advance refusals which may cumulatively justify failing to honour them.

iii. Burden on Relatives, Staff and other Patients

Quite aside from the significant and numerous drawbacks for the health of the patient in honouring advance refusals and the substantial doubts which may arise in relation to whether the legal requirements for a valid AD have been met, the implications for staff, other patients and public health resources must also be weighed in the balance. Consider first that a patient who has refused all or some aspect of psychiatric treatment is less likely to fully recover, and may deteriorate, and thus may be detained for an extended and indeterminate period, denying

[47] Above n 37.
[48] Above n 43, at 390.

other mentally disordered people access to beds and treatment.[49] Second, there are increased system costs as limited clinical resources are redirected to non-therapeutic pursuits such as restraint and other management techniques. This imposes a substantial burden on already scarce resources. Finally, there are the implications of a potentially violent individual who poses a threat to staff and other patients. The imminent risk of harm to others may outweigh safeguarding the autonomy of the patient.

iv. Concluding remarks

In total, these arguments against honouring advance refusals in all circumstances are compelling. Firstly, the three Ontario case examples gave an indication of the type of deterioration in both physical and mental wellbeing that may arise. This is dehumanising and unsafe for the patient and potentially unsafe to other patients and staff. Moreover, it may result in prolonged, seemingly indefinite, detainment. Second, the current lack of statutory requirements regarding the making of ADs raises substantial doubts about the reliability of such advance refusals in relation to capacity, undue influence, and most especially, informed consent. A RC would be right to hesitate to follow instructions which may pose great risk to the patient or others if they cannot be certain that the refusal was fully informed or that it represents what the patient's true intentions were. Finally, there are increased system costs and a drain of resources when patients are detained without intention to treat, limiting the ability for other patients to be treated. While the arguments in favour of honouring advance refusal have yet to be addressed, Parliament is likely to find the arguments against the idea persuasive.

B. Arguments in Favour of Honouring Advance Refusal of Psychiatric Treatment in All Circumstances:

Thus far, this chapter has considered arguments against honouring advance refusals of psychiatric treatment in all circumstances. Independently, each of these arguments may be insufficient to trump the autonomy of the patient, but, when considered cumulatively, they are likely to be convincing for Parliament. However, arguments in favour of honouring advance refusals must also be presented in full. These centre around the self-determined choice of the

[49] "Psychiatric Treatment Authorisation and Refusal" (2018) Canadian Mental Health Law & Policy 197 at 244.

patient, discrimination against the mentally disordered, and the uncertain efficacy of psychiatric treatment.

The obvious starting point is the concept of autonomy. Rights and freedoms act as a sort of shield or barrier which helps to map out a zone of autonomy, that is, a space where an individual can make decisions about how to live their own life according to their own vision about what a good life is.[50] Furthermore, the creation of such zones of autonomy for individuals is essential when it comes to people with different views about what makes a good life living alongside each other. The basic principle is that even when there is disagreement, one should not seek to interfere with the autonomous choices of another because it is only by conceding this freedom of choice that we have autonomy ourselves. The role autonomy plays in Western medicine remains somewhat obscure, but some bioethicists suggest that it is such an important principle that patients ought to be able to make their own choices about treatment even if others would be in a better position to make that decision.[51] For example, if one imagines a person considering whether to refuse a certain psychiatric medication in advance, we can assume that they are not as capable of understanding and evaluating all the medical information relevant to that decision as a clinician would be, but despite the person being aware of these differences between themselves and the clinician, they still wish to make their own self-determined choice. This reflects the intrinsic value placed on individual autonomy.[52] From this standpoint, autonomy is not defeated or reduced by the fact that the choices made may not promote wellbeing.[53] Where a person with full capacity has declined to consent, any interference with their autonomous choice is great indeed, even where serious risk or consequence may arise. In short, strong patient autonomy holds that the choices of another person, no matter how well intentioned, are unlikely to be as good as our own choice because only we can know for ourselves what is best and right for us.

Closely linked to patient autonomy is the argument that to treat the self-determined choices made in an AD by a psychiatric patient as less binding than those made by a non-psychiatric patient is discriminatory. This dissertation has already outlined how psychiatric patients are not similarly situated as compared to general patients and that the consequences of honouring advance refusals can be substantially different, not only for the patient but for staff, resources

[50] Above n 6.
[51] Jukka Varelius "The value of autonomy in medical ethics" (2006) 9(3) Med Health Care Philos 377 at 377.
[52] Ibid, at 378.
[53] Ibid, at 379.

and other patients. It is likely that Parliament will find these points convincing when combined with the numerous other arguments against honouring advance refusals in all circumstances. Nonetheless, concerns about discrimination remain. In *Fleming v Reid*, the Ontario Court of Appeal held that the traditional common law right to determine what shall and shall not be done with one's own body extends to ADs made in relation to psychiatric treatment.[54] If one assumes that a person making an AD is competent (though, as this paper has already outlined, there can be doubts about this assumption), then surely it is discriminatory not to afford them the same entitlement as other competent adults to dictate the course of their future treatment. The Court held that a psychiatric patient may refuse psychotropic medication just as a diabetic patient may refuse insulin.[55] If we allow people to refuse general medical care even when it may be life-threatening, then the same argument could be made for those with mental disorders provided their decisions are made with capacity and they are sufficiently informed. Moreover, the consequences of people issuing advance refusals may not be so problematic as it initially seems. This is because, when a person is later offered the treatment, they may still have the capacity to decide, and, when informed that they may become very unwell, and be required to remain in hospital, or be detained, if they do not receive the treatment, often they will accept it. This may be somewhat coerced consent, but it may nevertheless be informed consent if it involves no more than telling the patient the truth. Nonetheless, the argument here is that mentally ill persons ought not to be stigmatised because of the nature of their illness. Their right to personal autonomy and self-determination is no less significant and is entitled to no less protection.[56]

The final point is in relation to psychiatric treatment itself. To begin with, it cannot be predicted with absolute certainty what effect (whether in terms of side effects or the primary intended effect) a psychotropic drug or other treatment will have in any individual case. One cannot simply assume, for example, that individuals such as Starson or Reid would respond to medications in a manner deemed medically optimal. Next, it ought to be considered that ADs for mental health patients are often made by people who have a long history of psychiatric treatment and concern events that occur repeatedly. It may be assumed then that they will use such experience to make decisions for their future health care and can perhaps convey their preferences quite accurately based on their accumulated personal experience with psychiatric

[54] Above n 11.
[55] Above n 30, at 66.
[56] Above n 8, at 493.

treatment.[57] No one is better placed to explain the internal effects psychiatric treatment has on a person than that individual. Irrespective of how beneficial medication might be for a patient's mental disorder, if the side effects are intolerable, there is an argument to be made that such an advance refusal should be honoured.

C. Concluding Remarks:

This chapter has outlined the key arguments against honouring advance refusals in all circumstances in addition to the arguments in favour. As previously stated, this is a decision which will ultimately be made by Parliament and the intention of this chapter is to outline the key considerations and the position Parliament is likely to find convincing. This dissertation finds the arguments against honouring advance refusals in all circumstances to be the most persuasive. While independently they may not justify overriding the autonomous choice of the patient, cumulatively they suggest there might be severe consequences for the health of the patient. In addition, there may be substantial doubts about the validity of the AD in the first place, and a drain placed on public health resources as a result of honouring it. Of course, these considerations must stand against the arguments in favour of strong patient autonomy and anti-discrimination which find patient autonomy not defeated by how much it reduces wellbeing or by the nature of the patient's illness. These are convincing principles. They highlight the intrinsic value individuals place on their own autonomy, and the idea that it is only by respecting the autonomy of others that we have autonomy ourselves. Nonetheless, when all the arguments against are added together, there are a great many concerns to be reckoned with.

Nevertheless, even if Parliament is convinced by the arguments in opposition and does not accept that advance refusals should be honoured in all circumstances, there are still methods by which the law on ADs can be made more patient-centred and a better safeguard for patient autonomy by creating checks and balances. These recommendations will be outlined from chapters three through five. Before reaching that point, however, chapter two will suggest a position on advance refusals that has been taken by several overseas jurisdictions and which Parliament may find convincing. This is for advance refusals to be honoured except where in the view of the RC the refusal would be clinically inappropriate.

[57] Above n 43, at 387.

Chapter II: The Position Parliament May Take

A. Advance Refusals Overridden when Clinically Inappropriate in View of Responsible Clinician:

It is important here to first recall the general value of ADs within mental health care because it is this which must be balanced against the substantial concerns relating to patient health, the validity of ADs, and use of mental health resources, highlighted in chapter one. Acute mental disorder and the implications it has for capacity and behavioural and cognitive functioning understandably compromise the ability of patients and clinicians to work together towards recovery and rehabilitation.[58] Various overseas jurisdictions have therefore recognised the value in creating a legitimate system whereby people may record their preferences for their future healthcare, oftentimes during a period of intact capacity between episodic periods of incapacity. This facilitates patient participation in medical decisions and promotes feelings of independence and self-determination and subsequently reduces the perception of coercion.[59] These principles, in addition to those considered in chapter one, are not to be abandoned. Even if Parliament stands in opposition to advance refusals being honoured in all circumstances, there remains scope for patients to exert their individual autonomy within defined boundaries. This chapter considers the possibility of overriding advance refusals when the RC finds the instructions to be clinically inappropriate. This proposes a compromise between patient autonomy and the best interests of the patient in the view of medical professionals and considers how ADs can be feasibly implemented in a healthcare system with limited resources and the safety and welfare of others to protect. The specific procedural obligations to protect against subjectivity will be outlined in chapter four. To begin with however, and for completeness, the potential for advance refusals to be honoured except in emergencies will be evaluated.

Most overseas jurisdictions, like Australia and the United States, make specific reference to emergency situations whereby any advance instructions may be overridden if failing to do so would endanger the life of the patient. For example, in the state of Washington, the RC is required to act in accordance with the provisions of an AD unless, in the view of the clinician,

[58] Above n 43, at 388.
[59] Patricia Backlar, Bentson H. McFarland, and Jo Mahler "Oregon's Psychiatric Advance Directive" in Patricia Backlaw and David L. Cutler (ed) *Ethics in Community Mental Health Care: Commonplace Concerns* (Kluwer Academic Publishers, New York, 2002) 157 at 161.

overriding the instructions is immediately necessary to prevent death.[60] As this approach indicates, perhaps advance refusals should only be overridden where death is imminent or where there is an immediate risk of permanent harm to the physical or mental health of the patient. This is a step down from the strong idea of patient autonomy examined in chapter one which would endorse honouring advance refusals in all circumstances, but still stands as robust protection for patient autonomy. The theoretical value in honouring advance refusals except in emergencies is clear. It is saying that the right to self-determination will be respected as far as possible because we recognise that each person should be able to make decisions about their health care, even if those decisions might cause them harm or seem irrational to others.[61] Arguably, there is no great risk to such a provision if one considers that only a small portion of patients are likely to refuse psychiatric treatment while capacitous, particularly when informed of the possible consequences of doing so. If this is the case, emergencies may only arise infrequently. Nonetheless, even if only a few patients refuse treatment, it does not reduce the serious implications of allowing someone who is already in a crisis, given they must meet the statutory criteria of being mentally disordered to come under a CompTO at all, to deteriorate to the point of life endangerment before the emergency exception could be invoked.[62] The consequences of this approach differ very little from honouring advance refusals in all circumstances. Again, the health and safety of the patient, and perhaps other patients and staff, may be at substantial risk, and the realities of a public health care system limit the capacity for clinicians to detain patients in the absence of intention to treat. As such, the remainder of this chapter turns to an alternative approach which has been used in various overseas jurisdictions and finds a better balance between patient autonomy and patient best interests.

The purpose of treating an inpatient under a CompTO is to facilitate recovery so they can be discharged as soon as possible.[63] The system wants to avoid the 'warehousing' of patients where they are detained within inpatient settings without treatment which provides therapeutic

[60] When acting under authority of a directive, a health care provider, professional person, or health care facility shall act in accordance with the provisions of the directive to the fullest extent possible, unless in the determination of the health care provider, professional person, or health care facility: (d) It is an emergency situation and compliance would endanger any person's life or health. See "Washington State Legislature, RWC 71.32.070(2)(d)".
[61] Above n 8.
[62] Above n 3.
[63] SAMHSA *A Practical Guide to Psychiatric Advance Directives* (U.S. Department of Health and Human Services, 2019), at 5.

benefit.[64] This dissertation has laid out several arguments which convincingly demonstrate how honouring advance refusals in all circumstances (or in all circumstances except emergencies) would subvert that purpose. The recommendation presented here then is that clinicians should have discretionary power to override an advance refusal where it would be clinically inappropriate to comply. This is the approach taken by many jurisdictions in Australia and the United States and is recommended in the proposed reforms for England and Wales. In Queensland for example, a health practitioner must follow an AD as far as possible but only if it is consistent with appropriate and safe clinical practice.[65] Their legislation also emphasises that ordinarily a clinician must use the least restrictive means possible for a person to receive treatment but that this principle may be thwarted where an AD does not authorise the administration of psychiatric treatment that is clinically necessary for the patient.[66] In the Australian Capital Territory (ACT) the clinician may administer treatment not specified or consented to in an AD if they believe on reasonable grounds that to comply with the AD would be unsafe or inappropriate.[67] Likewise, in the state of Washington, a RC may decline to honour an AD if doing so would violate medical professional standards.[68] These examples differ slightly in language, but the same theme is reflected across these jurisdictions, that of a statutory power to override advance refusals to prevent unnecessary harm to the patient, including serious harm to their mental health.

Members of the medical profession have a legal and ethical duty of care to their patients in combination with a duty to do no harm, so it subverts this duty to expect them to make treatment decisions which have no clinical benefit.[69] Amongst clinicians there is a strong desire to protect against the devastating effects mental disorder can have on patients in addition to minimising the level of harm posed to others.[70] Chapter one of this dissertation clearly showed by way of example the perilous position that honouring all advance refusals may place the patient in, such as severe malnutrition and debilitating delusional thoughts and hallucinations. The value in giving clinicians flexibility and discretion in the context of mental health care should not be underestimated. While there may be generic symptoms for specific mental disorders, each

[64] Department of Health & Social Care *Joint foreword from the Secretary of State for Health and Social Care and the Secretary of State for Justice and Lord Chancellor* (Government of United Kingdom, 24 August 2021) at Part 1.
[65] Mental Health Act 2017 (Qld), Chapter 1, Part 3, s 13. See appendix.
[66] Ibid.
[67] Mental Health Act 2015 (ACT), Chapter 3, Part 3.3, s 28(5). See appendix.
[68] Above n 59, at (a).
[69] Above n 34, at 68.
[70] Ibid.

patient is an individual and disparities will present themselves which means there must be scope to handle unexpected situations or changes in a patient's condition. As such, ADs ought not overly restrict the scope for clinicians to make decisions based on medical evidence and experience. Statutory power which justifies overriding advance refusals when it would be clinically inappropriate to comply allows for such flexibility and protects against a great portion of the concerns raised in chapter one.

This discretionary power though does not automatically defeat the autonomous decisions of the patient. While overseas jurisdictions have made plain the ability for clinicians to override ADs in some situations, they also iterate that the clinicians must consider the experience and knowledge of the patient, as outlined in their AD, before deciding on treatment.[71] Just as the individuality of each patient is significant for how symptoms may present themselves, it is also important to consider how each patient responds to medication and treatment, which may be reflected in the terms of their AD.[72] Where one schizophrenic patient may respond well to clozapine, another may find the side effects of weight gain and nausea, for example, to be intolerable.[73] This is not to say that the clozapine is not medically effective in lessening that patient's schizophrenic symptoms, rather it is, by personal preference and experience, not acceptable to that patient.[74] What may become significant then in such scenarios is whether the patient has refused a specific medication in favour of another.[75] In that case, even if the medication refused is clinically more effective, the clinician ought not to exercise their discretionary power to administer that treatment where the medication preferred by the patient is still appropriate and safe, albeit less effective. This respects the autonomy of the patient and is the most likely situation to arise as it is only in very rare cases that a patient will refuse all treatment. In such a rare case, where a patient has refused all medication for their mental disorder, perhaps based on a past negative experience with one type of medication, it may be appropriate for a clinician to override that advance refusal and administer an alternative or newer treatment that the patient has never tried and has only refused based on a different experience.[76] The specific procedural obligations needed to minimise subjectivity in the

[71] See generally "Mental Health Act 2015 (ACT), Chapter 3, Part 3.3, s 28(2)" and "Mental Health Act 2017 (Qld), Chapter 2, Part 3, s 43(4)". See appendix.
[72] Sudeep Saraf "Advance statements in the new Victorian Mental Health Act" (2015) 23(3) SAGE 230 at 231.
[73] Health Navigator New Zealand "Clozapine" (24 June 2020) <https://www.healthnavigator.org.nz/medicines/c/clozapine/>.
[74] Above n 71.
[75] Above n 34, at 71.
[76] Above n 43, at 390.

exercise of this discretionary power by the clinician and to safeguard patient autonomy as far as possible will be outlined in more detail in the fourth and fifth chapters of this dissertation. These brief examples, however, have indicated how the self-determined choices of the patient need not always be defeated by the medical opinion of the RC. They can be weighed and balanced against their best interests and alternative treatment options.

Ultimately, the benefits of this approach are substantial and persuasive because it facilitates the active recovery and rehabilitation of the patient and protects against unnecessary long-term detainment which is significant not only for the patient themselves but also for hospital staff and other people who are in desperate need of inpatient psychiatric treatment. Moreover, the preferences of the patient indicated in their AD remain influential such that even if one component of their AD is overridden, the remaining aspects should still be followed or considered as far as possible. Parliament is likely to find this approach convincing as it has been successfully implemented in other jurisdictions and facilitates a system whereby the advance instructions of the patient will always be at the forefront of any treatment decision without necessarily causing any great detriment to the welfare of the patient or others.

III

SAFEGUARDING PATIENT AUTONOMY

Chapter III: Advance Consent

A. Does Advance Consent Waive the Right to a Second Opinion?

As well as including information about psychiatric treatment a person does not want administered in the future, overseas jurisdictions outline that a person may also list, in their AD, medications or procedures they consent to. This is advance consent and is valued especially by people who have experienced mental disorder in the past and wish to consent, while well, to treatment that they know they have a history of refusing when ill.[77] In the ACT, for instance, a person may outline particular psychiatric treatment they consent to in the event of becoming mentally disordered in the future when they no longer have the capacity to make medical decisions.[78] The question for NZ is whether consent given in an AD can constitute 'consent' under the MHA for a treatment that would ordinarily require consent to be given at the time the treatment is proposed or, where consent is not forthcoming, requires approval by a second opinion psychiatrist (SOP). Specifically, this dissertation looks at whether advance consent waives the right to a second opinion if the patient objects (while incapacitous) to treatment at the time it is proposed, despite their having given advance consent. This discussion will be broken down into two components to reflect the two distinct provisions, and thus the distinct requirements for 'consent', outlined in the NZ MHA for ECT and all other treatment.

Both sections 59 and 60 (which govern psychiatric treatment and ECT respectively) outline that no patient shall be required to accept treatment or ECT for mental disorder unless (a) the patient, having had the treatment explained to him or her in accordance with section 67, consents in writing to the treatment; or (b) the treatment is considered to be in the interests of the patient by a psychiatrist (not being the RC).[79] These sections suggest that where a patient has the relevant capacity and has given their written consent, there is no requirement for the additional protective measures to be followed. As such, if advance consent were to qualify as

[77] Magdalena Furgalska "Psychiatric Survivors' Views on Advance Consent and 'Forced' Treatment" (5 November 2020) Open Justice – Court of Protection Project <https://openjusticecourtofprotection.org/2020/11/05/psychiatric-survivors-views-on-advance-consent-and-forced-treatment/>.
[78] Mental Health Act 2015 (ACT), Chapter 3, Part 3.3, s 27. See appendix.
[79] No patient shall be required to accept any treatment unless—(a) the patient, having had the treatment explained to him or her in accordance with section 67, consents in writing to the treatment; or (b) the treatment is considered to be in the interests of the patient by a psychiatrist (not being the responsible clinician) who has been appointed for the purposes of this section by the Review Tribunal. See "Mental Health (Compulsory Assessment and Treatment) Act 1992, ss 59 and 60". See appendix.

'consent' as it is written in sections 59 and 60, this would negate the need for a second opinion by an independent psychiatrist. This becomes controversial when a patient has given their advance consent but then, in the future, at a time when they lack the relevant capacity, the treatment is proposed, and they object. Ordinarily, such an objection would trigger the need for a SOP to review the treatment proposed but as afore mentioned, if advance consent constitutes 'consent' per the requirements of the MHA, this additional protection would be waived. The exception of course is where the patient retains the relevant capacity at the time treatment is proposed, in which case capacitous refusal would trump advance consent, because the AD is only operational when the patient is incapacitous.[80] A patient may also revoke their AD, and thus their advance consent, at any time when they have the relevant capacity.[81]

i. Should Advance Consent Constitute 'Consent' for ECT under s 60 of the MHA?

The fact that ECT is governed by special provisions independently of all other psychiatric treatment under NZs MHA suggests the more serious nature of the treatment and that more care is required to ensure consent is given specifically for ECT or, in the absence of consent, additional protective measures are operational to ensure the necessity and clinical appropriateness of the treatment. The different nature of ECT thus requires an assessment of advance consent independent to that for all other, more general, psychiatric treatment. The importance of consent under NZs MHA is emphasised by Principle 5 of the Royal Australian and NZ College of Psychiatrists (RANZCP) 2010 Code of Ethics which stipulates that a psychiatrist must seek the valid consent of the patient before administering treatment.[82] Principle 5.1 goes further and outlines the requirement for informed consent which includes understanding the purpose, nature, possible side-effects and risks, and expected benefits of the procedure, as well as alternative treatment options.[83] This is like the requirements of section 67 of the NZ MHA.[84] Informed consent is especially important for invasive and more severe procedures like ECT. The emphasis on informed consent for ECT is prevalent in overseas

[80] Aurélie Tinland and others "Psychiatric advance directives for people living with schizophrenia, bipolar I disorders, or schizoaffective disorders: Study protocol for a randomized controlled trial – DAiP study" (2019) 19 BMC Psychiatry 1 at 2.
[81] Above n 63, at 7.
[82] Psychiatrists shall seek valid consent from their patients before undertaking any procedure, treatment or provision of a report for legal or other purposes. See "Royal Australian and New Zealand College of Psychiatrists Code of Ethics, Principle 5".
[83] Ibid, at 5.1.
[84] Every patient is entitled to receive an explanation of the expected effects of any treatment offered to the patient, including the expected benefits and the likely side effects, before the treatment is commenced. See "Above n 3, at 67".

jurisdictions like Queensland, for example, which requires a full explanation about ECT to be given.[85] Like for advance refusal, doubts may arise as to whether the patient's advance consent was sufficiently informed when the AD was made without the inclusion of medical professionals who can witness and verify that all relevant information was provided to the person before they indicated their treatment preferences. In the absence of statutory checks on whether this condition of informed consent has been met, it would seem easier to require written consent at the time treatment is proposed, because it enables the RC to outline all the relevant information directly to the patient. This ensures the true consent of the patient has been obtained and that the clinician is not ignoring contemporaneous objection on the mere assumption that the advance consent was informed. However, chapter five will recommend possible ways to reduce or eliminate this doubt, in which case it is possible that advance consent for ECT could be equal to written consent under section 60 at the time the treatment is proposed. However, for reasons outlined below, this paper suggests that, even where the RC is confident that the legal requirements for making an AD have been satisfied, advance consent should not waive the right to the MHA's additional procedural protections governing the use of ECT.

Principle 5.9 of the RANZCP Code of Ethics states the right of the patient to withdraw their consent at any time.[86] Queensland mental health legislation also requires the patient to be informed of their right to withdraw their consent to ECT.[87] Moreover, in the ACT, while advance consent for ECT may be given under section 27(4) of their MHA, provided this consent is given in the presence of two witnesses and signed by a representative of the treating team, section 28(4) outlines that where an advance consent direction is in force but the person resists being administered treatment, the RC may only administer that treatment with the permission of the ACT Civil & Administrative Tribunal (ACACT).[88] Finally, section 60(b) of the NZ MHA is designed to come into effect when a patient's consent is not forthcoming.[89]

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[85] Queensland Government Department of Health "The Administration of Electroconvulsive Therapy" (September 2018) < https://www.health.qld.gov.au/__data/assets/pdf_file/0028/444763/2018_Guideline-for-the-administration-of-Electroconvulsive-Therapy-v0.7.pdf> at 8.
[86] Above n 82, at 5.9.
[87] Royal Australian and New Zealand College of Psychiatrists "Comparison table: Special provisions governing informed consent to electroconvulsive treatment (ECT) in Australian and New Zealand Mental Health Acts" (30 June 2017) Informed consent to ECT - mental health legislation < https://www.ranzcp.org/practice-education/guidelines-and-resources-for-practice/mental-health-legislation-australia-and-new-zealan/informed-consent-to-ect-mental-health-legislatio>.
[88] Above n 78, at s 28(4).
[89] Jeanne Snelling "A review of the literature, the Acts of Parliament and relevant current practices on regulation of the use of ECT in New Zealand and in other like nations" (Prepared for the ECT Review Group, 2004).

What these various provisions show is a general trend towards promoting the right of the patient to refuse ECT at the time it is proposed and where that right is exercised, a second opinion is sought to ensure the necessity of administering ECT in that case. The provisions relating to consent for ECT are designed to ensure that consent is genuinely informed and free from the influence of coercion. As such, overseas statutes, and the general approach to informed consent in NZ, suggest that any advance consent which clearly outlines the preferences of the patient should be influential, and is a document that must be considered before treatment is administered, but it does not waive the right to a second opinion by an independent psychiatrist for ECT where the patient contemporaneously objects.

The position of this dissertation then is that advance consent to ECT should never waive the right to a second opinion where the patient objects at the time treatment is proposed. Particularly as the guidelines on making an AD currently stand where there are no formal checks in place to ensure the legal requirements have been satisfied, it would seem irresponsible for a clinician to blindly follow consent given in advance when the patient contemporaneously objects. However, it is possible that advance consent for ECT may qualify as written consent at the time the treatment is proposed if the patient does not contemporaneously object and the RC is confident the patient had capacity, was informed, and free from undue influence when making their AD. This will be discussed further in chapter five.

ii. Should Advance Consent Constitute 'Consent' for All Other Psychiatric Treatment under s 59 of the MHA?

One of the key arguments presented here in favour of advance consent constituting 'consent' under the MHA is that a person making an AD may have full capacity where the AD is made before they become unwell.[90] This means they should be in a better position to make decisions about their future health care and treatment compared to when they are classified as 'mentally disordered' under the NZ MHA. While a person may still be deemed by the RC to have enough capacity to either give or refuse consent at the time the treatment is proposed, they will probably have had greater capacity at the time of making an AD and arguably that advance consent should trump any contemporaneous objection. Before becoming unwell, in

[90] Above n 1.

the absence of paranoid delusions, irrational thoughts and the like, a person is more able to effectively consider the benefits and potential necessity of treatment they may need in the future. The crux of the argument is that mental illness is incredibly complex, and we cannot know for certain what goes through the mind of a patient at the time treatment is proposed. Mentally disordered patients may become paranoid and believe, for example, that their RC is trying to poison them, or they may become so severely depressed that they have no desire to go on living and thus, no desire to accept treatment, or a schizophrenic patient may hear voices that tell them to refuse treatment. As such, there is a strong argument to be made that substantially more confidence can be placed in advance consent given at a time when the person was well and fully capacitous. This claim is strengthened where there is evidence that patient's advance consent was adequately informed. Section 67 of the NZ MHA and Right 6(2) of the Code of Health and Disability Services Consumers' Rights outline the right of the patient to be informed about the treatment, before it is administered, to the extent required for a reasonable consumer in that patient's circumstances to be able to make an informed choice or give informed consent.[91] So, if enough information has been provided to the patient when making their AD, in relation to the likely effects of the treatment, possible side effects and risks, alternative treatment options, the implications of not having the treatment, and the treatment methodology and process, then it might feasibly be argued that the patient's autonomy and their right to make their own decisions about treatment should be respected.

There are doubts, however, about whether waiving the right to a second opinion where advance consent has been given is a favourable position. People are liable to change their minds and, as iterated in the first chapter of this dissertation, the autonomy and self-determined choice of the patient is not necessarily reduced because of the nature of their illness. Just because someone has said 'yes' at one point does not mean they are going to say 'yes' forever. If the law is to say that advance consent constitutes 'consent' under the MHA, then it is removing the ability for people to say 'no' later, and have that 'no' taken seriously, because the effect would be to waive their right to the benefit of the additional protection provided by the second opinion. Ordinarily, incapacitous contemporaneous objection does not, of course, mean the patient will automatically be left untreated.[92] Under the powers provided by the MHA, while a review by a second psychiatrist is required, if the treating clinician considers the treatment is in the best interests of the patient and there is no other less

[91] Above n 3, at s 67.
[92] Above n 3, at ss 59(b) and 60(b).

restrictive alternative, then it can be administered. There is little concern then of patients facing great detriment to their medical wellbeing, if advance consent merely remains an indication of the patient's preferences which must be considered by the RC, and a useful guideline to appropriate treatment, but does not have the effect of waiving the right to additional protection as outlined by section 59(b).

In addition, there are other doubts relating to the reliability of the advance consent. These are like those outlined in chapter one in reference to advance refusals, and recommendations to reduce these doubts will be outlined in chapter five. The first of these relates to the capacity of the patient at the time they gave their apparent advance consent. The purpose of an AD, and of being able to consent in advance to specific medication or treatment techniques, is to outline your preference and have a voice while you have the legitimate capacity to do so.[93] If advance consent is to constitute formal consent under the MHA, then it must be assumed that the patient had the required capacity when they gave their advance consent. In the absence of an authorised witness, such as a medical professional, it will be difficult for the RC to be confident that this condition has been met. Likewise, there can be little certainty of the consent being informed, for the same reason as for an advance refusal, that is, the lack of legal requirement for ADs to be made with a treating team.[94] Recall that the strength of the argument for advance consent constituting effective 'consent' under the MHA lies in knowing it was *informed* consent. In the absence of this, the RC must blindly trust that the advance consent is informed as required by section 59 of the MHA and outlined further in section 67. Finally, there may be doubts as to whether the advance consent accurately reflects what the patient really wants, be it for reasons of undue influence and coercion or because the AD is outdated. It is comforting for people who are in a coercive environment, or who may have made their AD several years ago, prior to becoming unwell, to know that they may still refuse treatment at any stage. These factors highlight the value of the second opinion regime.

Ultimately, there is no denying the value advance consent has in outlining the personal preferences of the patient. It facilitates self-governance and enables people to communicate their personal experience with mental disorder and psychiatric treatment to their RC. This can enhance the therapeutic relationship and ensure future decisions are patient-centred.[95] This is

[93] Above n 1.
[94] Health and Disability Commissioner "Advance Directives & Enduring Powers of Attorney" (2021) < https://www.hdc.org.nz/your-rights/about-the-code/advance-directives-enduring-powers-of-attorney/>.
[95] Above n 63, at 7

especially important for people who know they have responded well in the past to a certain medication but are prone to refusing that treatment when they become unwell.[96] However, there is a distinction between outlining one's preferences and an advance consent constituting 'consent' for the purposes of the MHA, with the result that additional protection regimes are waived if the patient's contemporaneous objection is considered incapacitous. There can be doubts in particular about whether the condition for informed consent has been met, which are significant because true consent and autonomous choice are not possible where a person is not fully or correctly informed about the implications of their decision. Moreover, there should be great hesitation in removing the statutory right of patients to have the proposed treatment reviewed where they have objected. The second opinion regime provides an opportunity for an unbiased mind to assess the necessity and appropriateness of the treatment and allows for suggestions of less restrictive or alternative approaches to be made. As such, this dissertation suggests that the arguments against advance consent constituting 'consent' for the purposes of section 59 of NZs MHA are highly persuasive.

B. Concluding Remarks

Chapter three has evaluated whether advance consent should constitute 'consent' under sections 59 and 60 of the NZ MHA, and thus whether a patient's right to additional protection, if they refuse to consent to treatment at the time it is proposed, is waived when they have given that advance consent. For both ECT and all other psychiatric treatment (covered by sections 60 and 59 respectively), this dissertation finds the arguments against this suggestion most compelling. For ECT, NZ and overseas jurisdictions place great emphasis on the patient giving their informed consent and there is limited capacity for the RC to ensure this condition has been met through advance consent. It is more reliable for the RC to explain the relevant information to the patient and collect their written consent at the time treatment is proposed. Chapter five will outline possible ways to overcome the doubts surrounding the validity of the prior informed consent, as well as those surrounding capacity and coercion, in order to ensure that advance consent may be equal to written consent for the purposes of sections 59 and 60 at the time treatment is proposed.

[96] Above n 77.

For both general treatment and ECT, there is an international and domestic desire to promote the right of the patient to withdraw their consent at any time and to have their incapacitous, but nonetheless self-determined, choice to refuse treatment, respected. As stated earlier, this means Parliament should be very hesitant to limit this right by removing the opportunity for them to review their treatment plan. While a mentally disordered person might not have the same capacity that they had when making their AD, and it may not be clear to them why they are refusing treatment that they once consented to, this does not diminish the significant infringement on liberty and autonomous choice that would be involved in waiving their right to a second opinion. The suggestion here therefore is that advance consent should not waive the right to additional protection for patients, provided by the MHA, where they give their contemporaneous incapacitous objection to the proposed treatment.

Chapter IV: Procedural Obligations on Clinicians

A. When Advance Directives are Overridden:

The second chapter of this dissertation outlined the approach Parliament might take in relation to honouring advance refusals. This was for advance refusals to be honoured except where the RC deemed it would be clinically inappropriate to comply. So, if it is assumed that Parliament will endorse the discretionary power of clinicians to override an AD in some situations, the question remains as to what the procedural obligations for clinicians would be, so that subjectivity is minimised, and patient autonomy is respected as far as possible. This discussion will be largely based on the approach taken by overseas jurisdictions and will extend to the influence advance consent and other general treatment preferences have on how the RC approaches the psychiatric treatment of the patient. Ultimately, the purpose is to make recommendations which will outline more clearly to Parliament how ADs can feasibly be implemented into NZ mental health law.

Because these recommendations incorporate the SOP (Second Opinion Psychiatrist) regime, a brief explanatory note regarding SOP's appointment, role, and existing challenges, is provided here for clarity. The MHRT is the mechanism of appointment for SOPs in NZ.[97] This suggests the RC should, at the very least, be prohibited from choosing the SOP who will conduct the review of their treatment plan based on the likelihood that the SOP's opinion will coincide with the treatment. However, in practice, the MHRT does not designate the SOP who will conduct the review in each individual case.[98] Rather, several psychiatrists are appointed in each region to be a SOP and then either (1) the regional administrator of the MHA can devise a roster system; (2) the RC can send out a general enquiry to all approved psychiatrists in their region requesting a review; or (3) the RC may approach an approved SOP directly.[99] The MHA is silent as to the procedure when a SOP does not approve the proposed treatment. Possibly, the RC may be able to appeal the second opinion to the regional Director of Area Mental Health Services (DAMHS) as this is not explicitly prohibited by the NZ MHA as it is in England under

[97] John Dawson and others "Mandatory Second Opinions on Compulsory Treatment" in John Dawson and Kris Gledhill (ed) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 229 at 232.
[98] Ibid, at 232.
[99] Ibid, at 233.

the MHA Code of Practice.[100] The DAMHS might then appoint another approved psychiatrist to review (and possibly approve) the proposed treatment.[101] Alternatively, the RC and SOP may negotiate until a compromise is found.[102] Finally, this dissertation acknowledges the possibility of at least perceived bias on the part of the SOP in favour of the treatment. The number of practicing psychiatrists in each District Health Board is not extensive and, for patients to be treated effectively, cordial, or at the very least, professional, relationships must be maintained. In smaller regions, it is likely that most of the psychiatrists know each other, and perhaps work together regularly, and will each be appointed as a SOP at some stage during their career. All these situations may diminish the degree of independence of the SOP in any individual case.

i. Procedure for Overriding Advance Directives for All Psychiatric Treatment (except ECT)

In recent reforms of MHAs in overseas jurisdictions, the usual approach is to impose a statutory requirement that clinicians, firstly, consider carefully the terms of the patient's AD, before deciding to override it, and then that they explain directly to the patient (and to any substitute decision-maker) the reasons for overriding, if that is what they plan to do, and to record these justifications in the patient's medical records.[103] This is the approach in Queensland, Victoria, and the ACT, for example. Justifiable reasons might include serious threat to the health or life of the patient or any of the other serious implications outlined in chapters 1 and 2 of this paper. This approach ensures the RC is accountable for their decision because they must justify limiting patient autonomy in each case. A further requirement for the AD to be followed as far as possible, irrespective of any decision to override one component, will be discussed later in this chapter.

Regarding the procedure for overriding the AD itself, the unique situation of each patient should be relevant. For instance, if a patient has indicated in their AD a refusal of the most commonly used and most effective psychotropic drug for their mental disorder, based on a past negative experience but have also indicated another psychotropic drug to be used as an

[100] Ibid, at 234.
[101] Ibid, at 235.
[102] Ibid.
[103] See generally: "Mental Health Act 2015 (ACT), Chapter 3, Part 3.3, s 28(6)" and Mental Health Act 2014 (Vic) Part 5, Division 2, s 73(2) and (3)". See appendix.

alternative, then provided the alternative option is appropriate for the mental disorder and is safe, the RC ought not to overrule this advance instruction even if, in their professional opinion, the refused medication would be more effective.[104] Likewise, even if the patient has not indicated an alternative to the medication they have refused, the RC should not administer the refused treatment without striving to find an alternative treatment, within reason. This respects the autonomous choice of the patient which is based on experience. The choice of what to include in an AD must ultimately be made by the person to whom it relates and provided the legal requirements of capacity, informed consent, and a non-coercive environment have been met, there are few grounds that would justify overruling that self-determined choice. If the RC finds that the alternative medication suggested by the patient would be inappropriate for their condition, or that the patient's condition requires the most effective treatment to be administered, the recommendation of this dissertation is for review and approval by an independent psychiatrist to be required before the AD can be overruled. Alternatively, where the AD has special legal status, outlined in chapter five, approval by the MHRT is required. This provides a check to ensure the autonomy of the patient is not too readily overridden, and ensure the objectivity of the RC, but does not necessarily hinder the appropriate treatment of the patient.

ii. Should Advance Refusal of ECT be More Binding than Refusal of Other Psychiatric Treatment?

This dissertation has outlined the distinction between ECT and all other psychiatric treatment in reference to advance consent. The same distinction now applies to whether the procedures for overriding an AD should differ based on the nature of the treatment. The Wesseley Report of the Independent Review of the UK Mental Health Act, for example, recommended that an advance refusal to ECT should only be overturned with permission from the MHRT.[105] This reflects the invasive and more severe nature of ECT which perhaps justifies stricter regulations regarding a RC overruling the advance instructions of a patient. This is perhaps most significant for people who have been administered ECT in the past and would emphasise the position on patient autonomy that no one may be better placed than the patient to know what is best for them. However, a significant drawback to the approach suggested by the Wesseley Report is

[104] Above n 43, at 387.
[105] Simon Wessely "Modernising the Mental Health Act Increasing choice, reducing compulsion" (Government of the United Kingdom, Independent Review of the Mental Health Act, December 2018) at 233.

the time it would take for the MHRT to review the treatment plan.[106] If it is imagined that it takes a month to review a single case, there are serious implications raised for the patient regarding their treatment in the meantime. One option would be to treat them against their wishes until a decision is made by the MHRT. The current NZ MHA confers such a discretionary power to treat with ECT without consent, but the purpose of incorporating ADs into mental health legislation is to facilitate protection of patient autonomy and ignoring an AD entirely while waiting for the MHRT to review the case subverts this. Other approaches might be to administer a form of substitute treatment which is less effective than ECT or to withhold treatment. However, the downfall here is that there are strict criteria which must be met for an invasive treatment like ECT to be administered in the first place, which means oftentimes it is proposed as an emergency, life-saving intervention which cannot be effectively substituted.[107] For example, ECT is used to treat severe depression for which regular psychiatric treatment is ineffective, particularly when accompanied by psychosis, a desire to commit suicide, or refusal to eat.[108] For obvious reasons, in those circumstances, appropriate and effective treatment cannot be delayed for extended periods. This is not to suggest that advance refusal of ECT ought to be taken lightly. This dissertation has already outlined the strong arguments for respecting patient autonomy and self-determined choice which cannot be ignored. While additional measures like tribunal review protect patient autonomy, it may be impractical and unsafe to implement them in this context. The recommendation here then is that the process for overriding an advance refusal of ECT should be the same as that for all other psychiatric treatment to be administered without consent under the MHA: that is, for it to be approved by a second opinion by an independent psychiatrist, in addition to the RC, where the latter thinks it would be clinically inappropriate to honour the advance refusal. This would replicate the second opinion that is required by section 60(b) of the NZ MHA where the refusal of ECT is contemporaneous rather than in advance.

iii. How Influential Should Advance Directives be in Directing the Psychiatric Care of the Patient?

[106] Community Law "Applying to the Review Tribunal" (2021) Mental Health < https://communitylaw.org.nz/community-law-manual/not-rated/reviews-and-appeals/applying-to-the-review-tribunal/>.
[107] Ministry of Health "Electroconvulsive Therapy in New Zealand – what you and your family and whanau need to know" (June 2009) < https://www.health.govt.nz/system/files/documents/publications/ect-booklet.pdf>.
[108] Ibid.

The mental health legislation from Queensland, Victoria, and the ACT indicates a clear requirement for the wishes and preferences of the patient stated in an AD to be considered and followed as far as possible. In Queensland, for example, in determining whether the nature and extent of the treatment to be provided under a treatment authority, the RC must consider the instructions outlined in the patient's AD.[109] Likewise, in the ACT, the RC must administer treatment to the patient in accordance with the preferences expressed in their AD as far as reasonably practicable.[110] These overseas jurisdictions thus express a clear rule that the preferences and self-determined choices of the patient are not to be cast aside lightly and are for more than brief consideration. They must be followed as far as possible and only in limited situations is it lawful for the RC to deviate from those instructions, as indicated earlier in this chapter and in chapter two. Moreover, the deviation from one component of the AD does not release the RC from their duty to follow and apply the remaining aspects of the AD, if they are clinically appropriate.[111] It is recommended here that NZ follows suit and legislates that ADs will be binding instructions in psychiatric care, even when the patient is under the MHA, except where, in the view of the RC and the appointed SOP, it would be unsafe or otherwise clinically inappropriate (as described in chapter two) to comply. Moreover, even if one aspect of an AD is lawfully overruled, all other components remain binding on the RC unless and until those respective instructions are independently reviewed by a SOP.

B. Concluding Remarks:

The primary focus of outlining the procedural obligations for clinicians when overriding an AD is to respect the autonomy of the patient as far as possible without necessarily hindering appropriate care. In relation to general psychiatric treatment and medication falling under section 59 of the MHA, the recommendation is for the personal circumstances of the patient to be always relevant, particularly where their advance instructions are based on their personal experience of certain forms of treatment. A RC should not have the power to override an advance refusal, for example, of one medication where the patient has indicated a preference for an alternative that is also appropriate for their condition. If the RC finds the advance instructions to be somehow clinically inappropriate, as outlined in chapter two, then they ought to seek the approval of a SOP before overriding the AD. Further restrictions for overriding an

[109] Mental Health Act 2017 (Qld), Chapter 2, Part 4, s 53; Chapter 7, part 2, s 201(4)(b).
[110] Mental Health Act 2015 (ACT), s 28(2).
[111] Ibid.

AD are discussed in chapter five. For ECT, while this dissertation recognises the difference between this treatment and all other psychiatric treatment, the recommendation is to follow the same procedure as for all other treatment because of the impracticality of involving the MHRT in every case. So, as for general psychiatric treatment, where the RC finds advance instructions to be clinically inappropriate, a second opinion should be required. Finally, in all cases where ADs are overruled, the RC must justify and explain their reasons to the patient and any lawfully appointed substitute decision-maker and record these reasons in the patient's medical records.

In closing, to reflect the importance of respecting patient autonomy and self-determined decisions, ADs should be followed as far as possible and used to direct the care and treatment of the patient. Where one aspect of the AD is overruled, the recommendation is for the other components to continue to be adhered to, where clinically appropriate.

Chapter V: Making Advance Directives for Psychiatric Treatment

A. Should Advance Directives made with a Treating Team have Special Legal Effect?

A recurring theme in this dissertation for both advance refusal and advance consent are the substantial doubts that can be raised about the reliability of a patient's AD. For both advance refusal and advance consent, these doubts may justify hesitation on the part of the RC to honour those advance instructions. The purpose, then, of this chapter is to review the formal process for making ADs in overseas jurisdictions and assess how a similar approach may be used in NZ to increase the reliability of advance instructions, thereby increasing the likelihood those instructions will be honoured, thus safeguarding patient autonomy as far as possible.

i. General Advantages to making an Advance Directive with a Treating Team

The involvement of psychiatrists in the process of making an AD provides an opportunity to discuss the potential consequences or benefits of a treatment preference, the methodology of treatment, and alternative options.[112] It also creates a dialogue between the clinician and the patient through which the patient may voice any concerns or explain the reasons for certain preferences.[113] This may pre-empt any issues that could arise in the future which might otherwise have reduced the likelihood of the AD being honoured. For example, the courts in England have held that an AD that is too vague or unclear in meaning need not be honoured.[114] Moreover, it allows the treating team to directly assess the capacity of the person at the time they are making their AD. These advantages negate several of the concerns raised throughout this paper regarding the reliability and validity of ADs. Part (ii) and (iii) of this chapter discuss in greater detail the possibility of ADs that are formally approved and signed off by psychiatrists having a special legal status that makes it more difficult to override those ADs as compared to standard ADs.

ii. Applying an Overseas Approach to New Zealand

[112] Above n 5, at 13.
[113] Ibid.
[114] *Healthcare NHS Trust v H* [2004] EWCA Civ 1324, [2005] 1 WLR 834, at 21.

In the ACT, the MHA confers a particular legal effect on an AD made by a person who both had decision making capacity at the time and has obtained the agreement of psychiatric clinicians to its content.[115] Sections 28(3)(c) and 28(4) of the ACT MHA suggest that a tribunal order is necessary to trump an advance refusal included in a properly executed advance consent direction (ACD) of that kind.[116] This contrasts with the position following mere certification of a patient by two doctors under the MHA, which may permit treatment to proceed immediately, without tribunal approval. So, we see here a special legal effect conferred upon ADs made with a psychiatric treating team as opposed to a standard AD. The positions to consider for the NZ MHA then might be categorised as (1) a statutory requirement for ADs to be made with a psychiatric treating team if they are to be valid; or (2) a recommendation that ADs made with a psychiatric team should have a special legal effect.

A statutory requirement for ADs to be made with a psychiatric treating team naturally increases confidence for future RCs in knowing which ADs to consider and removes the need for complicated enquiry and speculation about capacity and informed consent. Chapters one to three have all indicated the substantial doubts which can arise as to whether the formal requirements for making an AD have been satisfied which may in turn give cause for the RC to hesitate in honouring that AD. Making an AD with psychiatrists who have relevant knowledge and understanding of the NZ MHA, and who can certify that the patient did have the relevant capacity at the time and was fully informed in their decision-making obviously negates those doubts. The difficulty with this approach is that imposing such a requirement would result in a discriminatory legal rule. It would place people with mental disorders who make ADs for mental health care in a less favourable position than other people who make ADs because there is no statutory requirement for an AD to be made in conjunction with the treating team when it relates to a person's general medical care.[117] To impose such a requirement would effectively be saying that, if an AD is not completed with, and agreed to by, a psychiatric treating team, then the RC would be under no obligation to consider it, thus deeming the AD to be invalid for this purpose and this rule would only apply in the context of mental health care. Such a statutory requirement might also make it difficult for people to make

[115] Stephen Tang "Advance Consent Directions" (24 July 2018) Making decisions about mental health treatment, care and support < http://austlii.community/foswiki/ACTLawHbk/MakingDecisionsAboutMentalHealthTreatmentCareAndSupport >.
[116] Mental Health Act 2015 (ACT), Chapter 3, Part 3.3, ss 28(3)(c) and 28(4).
[117] Above n 94.

a valid AD for mental health care at all. There are around 400 practising psychiatrists in NZ and perhaps several thousand people wanting to make an AD at any one time.[118] Clearly, it is not feasible for everyone to consult with two or more psychiatrists when making their AD. Such a difficult process, that might require booking an appointment with a psychiatric treating team months in advance, may reduce the likelihood that people will make an AD for psychiatric care at all. This dissertation has outlined the importance of ADs for promoting patient autonomy but making an AD will not be at the top of people's agenda when it is so difficult to achieve. This approach subverts the purpose of having a right to make an AD, and seems discriminatory, is therefore not recommended.

An alternative position, then, is for ADs to have special legal effect when they are made with, and signed off by, a psychiatric treating team. This agreement of the treating team would not be just a verification of the person's capacity but require actual agreement on the part of the clinical team to the content of the AD (otherwise, they will not sign it off). This gives the treating team a veto over its content, which in turn prevents their being later placed in (what they view as) an untenable position: of being unable to provide a refused form of treatment without an order from a tribunal (which might take a month to get). They would not 'sign-off' on such a refusal in the first place. The special AD of this kind, under the ACT MHA, becomes something like a contract between the patient and the clinical team, concerning the agreed care (except that it can be overridden by tribunal order). Arguably, this requirement for their agreement does impose significant limits on the patient's freedom of choice: they are not free to indicate any advance refusal that the clinical team would not accept (if they want the team's sign-off – without which the AD will not have special effect). There may also be the implied or actual threat of involuntary treatment if there is non-compliance with the recommendation of the treating team. The quid pro quo of this is that if the patient does choose content that the clinician's sign off on, then the AD will have heightened effect (the specifics of which are discussed in part iii of this chapter). This is a much less objectionable position than imposing a statutory requirement for all ADs in relation to psychiatric care to be completed with a treating team because it does not invalidate ADs made without a treating team, it merely gives extra benefit to ADs that are made in that way as a reflection of the increased confidence in their validity, and increased clinical support for their content.

[118] New Zealand Government "Psychiatrist" (20 May 2021) careers.govt.nz < https://www.careers.govt.nz/jobs-database/health-and-community/health/psychiatrist/>.

The recommendation of this dissertation is therefore for there to be no formal statutory requirement that ADs be completed with a treating team but, if a patient chooses to make their AD in this way and the contents of the AD are agreed to by the clinicians, that AD should have special legal status when the patient comes under the MHA. The need to obtain the clinical team's agreement will, however, prevent such special legal effect being given to any advance instructions that they do not endorse. In short, the team's involvement can act as a check, not just on the validity of the AD, but on its content. This in no way invalidates ADs made in the absence of a treating team and does not prevent people from including their independent preferences for psychiatric treatment; it just means that ADs signed off by psychiatrists will be more difficult to override. The details of what this special legal effect should be are discussed below.

iii. What is the Special Legal Effect?

The question now then is what this special legal effect ought to be. This dissertation will present three positions which can be thought of as falling along a spectrum of legally binding power. First, the option for ADs signed off by a treating team to be completely binding. This is an unattractive position for the reasons outlined in chapter one of this dissertation and, I would add, for the reason that what is clinically appropriate at the time the AD is made will not necessarily turn out to be so when the treatment is proposed, which makes the possibility of override a necessary precaution. The second position is for ADs to only be viewed as valid for the purposes of the MHA if completed with a clinical team. This was discussed in part ii and was found to be an unfavourable position due to its discriminatory nature and the practical impossibility of spreading the four hundred psychiatrists in NZ across the thousands of people who wish to make an AD for their future psychiatric care. The remainder of part iii discusses a third position which is for ADs signed off by a treating team to be binding except for MHRT override.

This third option finds its roots in section 28(5) of the ACT MHA which requires approval by the ACAT before treatment can be administered if that treatment is contrary to the instructions outlined in the patient's ACD.[119] So, the special legal effect of the ACD, the contents of which have been agreed to by the clinical team, is to impose an additional procedural requirement

[119] Mental Health Act 2015 (ACT), Chapter 3, Part 3.3, s 28(5).

beyond that required by the standard second opinion regime, for an RC to override the advance instructions. In NZ, if the special status scheme was implemented, the RC would apply to the MHRT to overrule the relevant component of the AD. In chapter four, this paper discussed the significant delay in MHRT proceedings as a drawback to requiring review by the tribunal. Reviews are required to start as soon as possible, but not later than 28 days.[120] However, review hearings might occur after this 28-day timeframe has expired for various reasons, such as unavailability of the RC or lawyer.[121] The delay in the MHRT can be somewhat mitigated here though, regarding ADs with special legal effect, by the fact that the treating team has already vetted the AD and approved its contents. So, while there may still be some unforeseen circumstances that cause the RC to make an application to the tribunal, these cases are likely to be few and far between. Another consideration is what to do with the patient pending the hearing of the MHRT. One option is for the RC to request a review by a SOP and, if the SOP also finds that the AD should be overridden, they may authorise an interim override which allows the patient to be treated against their wishes until the MHRT makes their decision. Possibly, this could be combined with a rule that the MHRT must hear the case within 14 days. Again, the likelihood of this situation arising is slim for ADs which have been signed off by a treating team. In terms of the review process itself, in the ACT the lawyer for the patient makes submissions on behalf of the patient, following which the patient is questioned by the tribunal.[122] The RC is then questioned by the tribunal and the lawyer for the patient.[123] The tribunal then deliberates and makes its decision. Ordinarily, there is unanimous agreement but if members of the tribunal remain undecided or disagree, discussion will continue until a unanimous decision is made.[124] Evidently, this is a much more extensive review process than the second opinion regime, and thus offers greater protection for patient autonomy and the instructions outlined in an AD. This indicates the special legal effect given to ADs made with, and signed off by, a psychiatric treating team.

B. Concluding Remarks:

[120] Nigel Dunlop "The Mental Health Review Tribunal" in John Dawson and Kris Gledhill (ed) *New Zealand's Mental Health Act in Practice* (Victoria University Press, Wellington, 2013) 97 at 101.
[121] Ibid, at 102.
[122] Ibid, at 104.
[123] Ibid.
[124] Ibid.

This chapter has discussed methods of making ADs which increases the likelihood that they will be honoured. Generally, making an AD in consultation with a treating team increases confidence in patient capacity and informed consent. However, the discussion has focussed on whether there should be a statutory requirement for ADs to be made in this way or whether it should merely be recommended that ADs signed off by clinicians would have special legal effect compared to standard ADs. A statutory requirement is not recommended because it is discriminatory in nature and may discourage people from making an AD at all due to difficulty in organising a consult with two or more psychiatrists. Instead, it should be outlined in the MHA that if a patient chooses to make their AD with a psychiatric treating team and this team agrees to the content of the AD, then the AD will have special legal effect when the patient comes under the MHA. The nature of this heightened legal effect is that, for RCs to override an AD, they must make an application to the MHRT, which in turn must approve the override. This contrasts with a standard AD, or an AD that has not been signed off by clinicians, which merely requires review and approval by a SOP when the RC wishes to override advance instructions. To enable treatment of the patient pending the MHRT decision, I suggest that a SOP may offer an interim override of the AD, provided the MHRT review the case within 14 days of application. The special legal effect of ADs made in this way should offer greater protection of patient autonomy by increasing the RCs confidence in its validity and content and by elevating the binding nature of the instructions.

IV

CONCLUSION

Conclusion:

The main purpose of this dissertation has been to analyse the extent to which refusal of psychiatric medication and treatment given in an AD should be honoured in relation to inpatients under compulsory treatment and to recommend additional safeguards where ADs are overridden by the RC. While these questions are ones that will ultimately be answered by Parliament, the aim here has been to present various arguments and recommendations which may assist Parliament in the future when amending the NZ MHA.

Regarding advance refusal, persuasive arguments were presented both in favour of and against honouring advance refusals in all circumstances. Ultimately, this dissertation found the arguments opposed to be most convincing, particularly in relation to the health and wellbeing of the patient. While the value of autonomy is not diminished because of mental illness, or because a self-determined choice does not facilitate recovery, the possibility of prolonged, seemingly limitless, detainment, and of significant cost to the mental health care system, and of promoting a risky environment for other patients and staff, means Parliament will most likely find the arguments against honouring advance refusals in all circumstances to be most compelling. I am therefore recommending an alternative approach, whereby the RC could override an AD when it would be clinically inappropriate to comply. There would be strict guidelines and procedures, outlined in chapters four and five, that a RC must adhere to if an AD was to be overruled.

This paper also examined whether advance consent should constitute 'consent' under sections 59 and 60 of the MHA, and thus have the effect of waiving the right to a second opinion if the patient objects to the treatment at the time it is proposed. For reasons relating to the right to withdraw consent at any time, and to ensuring even an incapacitous refusal of medical treatment is respected, this dissertation recommends that advance consent should never waive the right to such additional protections. However, Parliament might provide that, where an AD has been signed off by a treating team, then there may be grounds for this to constitute written consent such that the RC can administer the treatment without seeking the consent of the patient at the time the treatment is proposed. However, in my view, the patient should still be able to object or withdraw their consent at any time, in which case a second opinion by an independent psychiatrist would be required.

In summary, for ADs to be effectively incorporated into an amended NZ MHA, this dissertation recommends that (1) advance instructions should be followed as far as possible but could be overruled in limited circumstances with the agreement of an independent psychiatrist or the MHRT, depending on whether the AD has special legal status; (2) if any component of an AD is overruled, the patient must be informed of the reasons for doing so and these reasons must be recorded in the patient's medical records, and all other components of the AD must still be followed; (3) advance consent should not waive the right to additional protection regimes but may constitute written consent if the AD was made with a treating team; and (4) ADs made with, and signed off by, a psychiatric treating team should have special legal status. In my view, this legal position represents the best compromise, in a demanding situation, between the competing interests involved.

V

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Appendix:

Mental Health (Compulsory Assessment and Treatment) Act 1992:

2 Interpretation

(1) **mental disorder**, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it—

a) poses a serious danger to the health or safety of that person or of others; or
b) seriously diminishes the capacity of that person to take care of himself or herself;—

responsible clinician, in relation to a patient, means the clinician in charge of the treatment of that patient.

Part 2 Compulsory treatment orders

28 Compulsory treatment orders

(1) Every compulsory treatment order shall be either—

a) a community treatment order; or
b) an inpatient order,— and on making a compulsory treatment order the court shall specify the kind of order it is.

(2) Subject to subsections (3) and (4), the court shall make a community treatment order unless the court considers that the patient cannot be treated adequately as an outpatient, in which case the court shall make an inpatient order.

(3) The court shall not make an inpatient order if, at the time of making the order, the patient is undergoing assessment and treatment as an outpatient; but in such a case, the Judge may, instead of making a community treatment order, order that the patient be re-assessed in accordance with sections 13 and 14, and the provisions of those sections, sections 15 to 27, and this section shall apply with any necessary modifications.

(4) Before the court makes a community treatment order, it must be satisfied of the following:

a) the service provides care and treatment on an outpatient basis that is appropriate to the needs of the patient. (The service means the service that the applicant for the order asks the court to specify in the order); and

b) the social circumstances of the patient are adequate for his or her care within the community.

(5) When the court makes an order under this section, it shall give or send a copy of the order to the patient.

Part 5 Compulsory treatment

59 Treatment while subject to compulsory treatment order

(1) Every patient who is subject to a compulsory treatment order shall, during the first month of the currency of the order, be required to accept such treatment for mental disorder as the responsible clinician shall direct.

(2) Except during the period of 1 month referred to in subsection (1), no patient shall be required to accept any treatment unless—

a) the patient, having had the treatment explained to him or her in accordance with section 67, consents in writing to the treatment; or
b) the treatment is considered to be in the interests of the patient by a psychiatrist (not being the responsible clinician) who has been appointed for the purposes of this section by the Review Tribunal.

(3) Where, during the period of 1 month referred to in subsection (1), the responsible clinician is satisfied—

a) that the patient will need further treatment of a particular kind beyond the expiry of that period; and
b) that the patient is unlikely to consent to that treatment,— the responsible clinician may, notwithstanding that the period has not expired, refer the case to the psychiatrist referred to in subsection (2)(b) for consideration, so as to ensure that the opinion of that psychiatrist is available on the expiry of that period.

(4) The responsible clinician shall, wherever practicable, seek to obtain the consent of the patient to any treatment even though that treatment may be authorised by or under this Act without the patient’s consent.

60 Special provision relating to electro-convulsive treatment

Notwithstanding anything in section 58 or section 59, no patient shall be required to accept electro-convulsive treatment for mental disorder unless—

a) the patient, having had the treatment explained to him or her in accordance with section 67, consents in writing to the treatment; or
b) the treatment is considered to be in the interests of the patient by a psychiatrist (not being the responsible clinician) who has been appointed for the purposes of this section by the Review Tribunal.

Part 6 Rights of patients

67 Right to be informed about treatment

Every patient is entitled to receive an explanation of the expected effects of any treatment offered to the patient, including the expected benefits and the likely side effects, before the treatment is commenced.

Mental Health Act 2017 (Qld):

Chapter 1

Part 3 Interpretation

13 Meaning of less restrictive way

(1) For this Act, there is a less restrictive way for a person to receive treatment and care for the person's mental illness if, instead of receiving involuntary treatment and care, the person is able to receive the treatment and care that is reasonably necessary for the person's mental illness in 1 of the following ways – (b) if the person has made an advance health directive.

Chapter 2

Part 3 Assessments

43 Making assessment

(1) An authorised doctor may make an assessment of a person subject to a recommendation for assessment to decide—

a) whether the treatment criteria apply to the person; and

b) (b) whether there is a less restrictive way for the person to receive treatment and care for the person's mental illness.

(2) The authorised doctor who makes the assessment under subsection (1) must not be the authorised doctor who made the recommendation for assessment for the person.

(3) Subsection (2) does not apply if the authorised doctor is an authorised doctor for an authorised mental health service (rural and remote) and is the only authorised doctor reasonably available to make the assessment.

(4) For subsection (1)(b), the authorised doctor must take reasonable steps to find out whether there is a less restrictive way for the person to receive treatment and care for the person's mental illness, including, for example, by searching the person's health records to find out whether the person has made an advance health directive or has a personal guardian.

Part 4 Treatment authorities

53 Nature and extent of treatment and care

In deciding the nature and extent of the treatment and care to be provided to the person under the treatment authority, the authorised doctor must—

a) discuss the treatment and care to be provided with the person; and
b) have regard to the views, wishes and preferences of the person, to the extent they can be expressed, including, for example, in an advance health directive.

Chapter 7

Part 2 Responsibility to provide treatment and care

201 Examination of patient for purpose of providing treatment and care

(1) This section does not apply to a patient subject to a treatment authority, other than a patient subject to a treatment authority who becomes a classified patient.

(2) An authorised doctor must examine the patient and decide the nature and extent of treatment and care to be provided to the patient.

(3) The examination must be made—

a) as soon as practicable after the person becomes a patient to whom this part applies; or

b) if a patient subject to a treatment authority, forensic order or treatment support order becomes a classified patient—as soon as practicable after the patient becomes a classified patient.

(4) In deciding the treatment and care to be provided to the patient, the authorised doctor must—

a) discuss the treatment and care to be provided with the patient; and
b) have regard to the views, wishes and preferences of the patient, to the extent they can be expressed, including, for example, in an advance health directive.

Mental Health Act 2015 (ACT):

Chapter 3

Part 3.3 Advance agreements and advance consent directions

27 Making advance consent direction

(1) A person with a mental disorder or mental illness may make a direction (an advance consent direction) about 1 or more of the following:

a) the treatment, care or support that the person consents to receiving if the mental disorder or mental illness results in the person not having decision-making capacity;
b) particular medications or procedures that the person consents to receiving if the mental disorder or mental illness results in the person not having decision-making capacity;
c) particular medications or procedures that the person does not consent to receiving if the mental disorder or mental illness results in the person not having decision-making capacity;
d) the people who may be provided with information about the treatment, care or support the person requires for a mental disorder or mental illness;
e) the people who are not to be provided with information about the treatment, care or support the person requires for a mental disorder or mental illness.

(2) A person with a mental disorder or mental illness may make an advance consent direction only if the person—

a) has decision-making capacity; and

b) has consulted with the person's treating team about options for treatment care and support in relation to the mental disorder or mental illness.

(3) An advance consent direction that does not include advance consent for electroconvulsive therapy or psychiatric surgery must be—

a) in writing; and
b) signed by the person in the presence of a witness who is not a treating health professional for the person, and by the witness in the presence of the person; and
c) signed by the representative of the person's treating team in the presence of a witness who is not a treating health professional for the person, and by the witness in the presence of the representative.

(4) An advance consent direction that includes advance consent for electroconvulsive therapy must—

a) be in writing; and
b) state the maximum number of times (not more than 9) that electroconvulsive therapy may be administered to the person under the consent; and
c) be signed by the person in the presence of 2 witnesses who are not treating health professionals for the person, and by each witness in the presence of the other witness and the person; and
d) be signed by the representative of the person's treating team in the presence of 2 witnesses who are not treating health professionals for the person, and by each witness in the presence of the other witness and the representative.

(5) An advance consent direction that includes advance consent for psychiatric surgery must be—

a) in writing; and
b) signed by the person in the presence of 2 witnesses who are not treating health professionals for the person, and by each witness in the presence of the other witness and the person; and
c) signed by the representative of the person's treating team in the presence of 2 witnesses who are not treating health professionals for the person, and by each witness in the presence of the other witness and the representative.

28 Giving treatment etc under advance agreement or advance consent direction

(1) A mental health professional must, before giving treatment, care or support to a person with a mental disorder or mental illness, take reasonable steps to find out whether an advance agreement or advance consent direction is in force in relation to the person.

(2) If an advance agreement is in force and the person does not have decision-making capacity, a mental health professional—

a) must, if reasonably practicable, give treatment, care or support to the person in accordance with the preferences expressed in the agreement; and
b) must not apprehend, detain, restrain or use force to give effect to the agreement.

(3) If an advance consent direction is in force and the person does not have decision-making capacity, a mental health professional—

a) may give the person the treatment, care or support if the direction gives consent for the treatment, care or support; and
b) may give a particular medication or procedure if the direction indicates that the person consents to the medication or procedure; and
c) must not give a particular medication or procedure if the direction indicates that the person does not consent to the medication or procedure; and
d) must not apprehend, detain, restrain or use force to give effect to the direction.

(4) If an advance consent direction is in force in relation to a person but the person resists being given treatment, care or support to which they have consented under the direction, a mental health professional may give the treatment, care or support to the person only if the ACAT, on application by the mental health professional, orders that the treatment, care or support may be given.

(5) If a mental health professional believes on reasonable grounds that giving treatment, care or support to a person with impaired decision-making capacity in accordance with an advance consent direction is unsafe or inappropriate, the mental health professional may give the person other treatment, care or support only if—

a) both of the following apply:
    (i) the person is willing to receive the treatment, care or support;
    (ii) the person has a guardian or health attorney under the Guardianship and Management of Property Act 1991, or attorney under the Powers of Attorney Act 2006, and the guardian, health attorney or attorney gives consent to the

treatment, care or support in accordance with the guardian, health attorney or attorney's appointment; or

b) the ACAT, on application by the mental health professional, orders that the treatment, care or support may be given.

(6) The mental health professional must enter in the person's record the reasons for the treatment, care or support given under subsection (5) (a).