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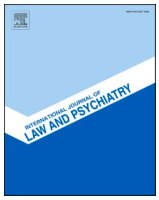

Decision-making capacity law developments in Aotearoa New Zealand☆

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ABSTRACT

New Zealand, as well as other jurisdictions, are revisiting their decision-making capacity law regimes. Currently several strands of New Zealand capacity law are under review. Reforms could impact many people across many domains of decision-making. Focussing on adult decision-making, we describe features of New Zealand's approach to decision-making capacity law that resemble other jurisdictions. We then summarise unique features of New Zealand law and explain the urgency of reform, in light of our obligations under the United Nations Convention on the Rights of Persons with Disabilities, research funded by the Human Rights Commission and the findings of New Zealand's Royal Commission of Inquiry Abuse in Care. Analysis of New Zealand's capacity law is timely, given the current review of the two key statutes governing adult decision-making and mental health legislation.

1. Introduction

New Zealand has enjoyed a burst in scholarship dedicated to capacity law. Why? Professor John Dawson suggested multiple reasons (Dawson, 2019). The rapid growth in New Zealand's aged population has illuminated the gaps in legal protections for people with impaired cognition. When New Zealand reduced the number of large institutions where people with mental, intellectual or learning disabilities resided, guardianship legislation was passed but is no longer fit for purpose. New Zealand has experienced a transformation in family structures and geographic dispersal of people who customarily made decisions for, and with, people with impaired capacity. Also, New Zealand's law requires review for compliance with the United Nations Convention on the Rights of Persons with Disabilities (CRPD) as analysed below.

Two additional factors in New Zealand provide impetus for capacity law reform. First, research commissioned by the Human Rights Commission illuminated the deficiencies in protections for residents of aged care facilities related to capacity law. Second, a void in legal protections for vulnerable people in care settings resulted in gross abuses from 1950 to 1999, according to the Royal Commission Inquiry Abuse in Care (the Inquiry) (Royal Commission of Inquiry Abuse in Care, 2024a, 2024b, 2024c). The findings from both reveal why it is necessary to establish robust law to protect people in positions of dependence, many of whom have compromised decision-making capacity.

Multiple jurisdictions have recognised that protections are essential for people who are deprived of autonomous decision-making and liberty. To some extent, New Zealand has recognised the importance of decision-making capacity as a cornerstone of protections of autonomy and self-determination, as described in legislation and regulations below. However, due to ambiguity regarding the concept of capacity and its application, several reviews are underway. Also, like other States that have ratified the CRPD, New Zealand grapples with its interpretation and practical implementation in relation to supported decision-making. The time is ripe to examine: a summary of features of decision-making capacity law that New Zealand shares with similar jurisdictions; New Zealand's unique legislation and regulations; and the compelling need for reform.

2. Legal capacity and mental capacity

Legal capacity and mental capacity can be distinguished. The Council of Europe's Commissioner for Human Rights defines "legal capacity" as a "person's power or possibility to act within the framework of the legal system" (Council of Europe Commissioner for Human Rights, 2012:7). Legal capacity has been portrayed as being both a sword and a shield (Quinn & Artsein-Kerslake, 2012). If applied as a sword, the exercise of legal capacity provides for individuals' right to make their own decisions and have them honoured by others. Examples include the right

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to marry, make a will, be employed and enter into contracts. If used as a shield, legal capacity provides individuals with the power to halt others from making their decisions.

"Mental capacity" is defined by the United Nations Committee on the CRPD as the decision-making skills of a person (United Nations Committee on the Rights of Persons with Disabilities (11 April 2014). Historically, there have been two dominant approaches to determining whether individuals have legal capacity. The status approach hinges on whether individuals have a particular condition, for example a diagnosed mental illness or intellectual disability; the result is "an automatic loss of legal capacity in both terms of legal standing and legal agency" (McSherry, 2012: 23). In contrast, the cognitive approach focuses on individuals' decision-making abilities; this approach includes the concept of "mental capacity" and the term "decision-making capacity" which is the CRPD Committee's definition (McSherry, 2012). One can envision circumstances where a person with an intellectual disability, for example, exhibits decision-making ability to choose to marry but is prevented because a statute categorically prevents people with this condition from entering into marriage. In this circumstance, the person would have decision-making capacity but not have legal capacity to marry in that jurisdiction.

In relation to the concept of mental capacity, the United Nations Committee on the Rights of Persons with Disabilities held that "'perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity" (2014, at [13]). The ramifications of Article 12 have been studied by many (for example, Bartlett, 2020; Bartlett, 2023; Craigie et al., 2019; McSherry & Wilson, 2015). There is a position that the CRPD "separates a person's legal capacity from the person's decision-making abilities (and) requires governments to abandon laws authorising guardianship and substitute decision-making for people with impaired capacities" (Dresser, 2022). This is the international, human rights backdrop of New Zealand's proposed reform of several strands of decision-making capacity law.

3. Background to decision-making capacity law in New Zealand

New Zealand recognises the fundamental principles of decision-making capacity in many respects. A person's ability to make decisions (or take actions) about their own future is viewed as the foundation of their autonomy (Dawson, 2019; Douglass, 2016). From England, Gunn (1994: 9) explained: "Respect for autonomy is the guiding principle in health care law. It is, therefore, essential that a test for capacity sets a standard which allows as many people as possible to take their own treatment decisions".

An assessment of a person's decision-making capacity is, at its core, a determination of whether that person's right to self-determination should prevail over others' desire to protect them from harm. Assessment, whether by a clinician or non-clinician, therefore has serious potential consequences and has been portrayed as a normative judgement:

> …(The assessor) must decide *how well this person ought to perform*, in the circumstances, to pass the test. This has an evaluative element. *How much understanding of the information*, for instance, must the person show to pass the test? Judging such a matter is never wholly a 'science', so some controversy is bound to remain around the application of such tests (Dawson, 2019: 15).

An assessor's declaration of incapacity may have significant impacts because it potentially restricts or removes a person's fundamental freedoms. To protect liberty, capacity assessments evaluate whether the person meets the minimum threshold required for a specific decision (Dawson, 2019).

In New Zealand, there is no single, universal decision-making capacity test. Several tests apply, dependent on the specific decision under consideration. For example, similar to some other Commonwealth countries, the legal test for *testamentary* capacity is set out in the English case of *Banks v Goodfellow* (1870) LR 5 QB 59; this test has been endorsed in *Woodward v Smith* [2009] NZ CA 215. For some other decisions, legislation sets out the legal tests, as discussed below.

4. Presumption of capacity

There is a general presumption that all adults have decision-making capacity unless there are good reasons to think otherwise. An example is contained within New Zealand's adult guardianship statute, the Protection of Personal and Property Rights Act 1998 (PPPRA):

Section 5 Presumption of capacity

…every person shall be presumed, until the contrary is proved, to have the capacity—

(a) To understand the nature, and to foresee the consequences, of decisions in respect of matters relating to his or her personal care and welfare; and
(b) To communicate decisions in respect of those matters.

However, this presumption may be set aside by evidence that the person is unable to make the decision in a manner that is viewed as valid. On occasion, this presumption is rebutted by law, for example by a rule that deems a class of people to lack capacity for certain purposes (Douglass, 2016). An example would be a young child who is deemed to lack mental capacity to make medical decisions. Further detail of the PPPRA and critiques are explained below.

We note that the questions of *why* we presume competence in the medical context, and whether we should, have been raised by scholars (Herring, 2016; Skegg, 2011). The critical analyses are thought provoking and highly recommended reading, although outside the scope of our current analysis.

5. Gravity of the decision and sliding scale

There is a common recognition that the greater the gravity of the decision, the higher the threshold of capacity required. According to Lord Donaldson in *Re T*: "What matters is that doctors should consider whether at the time [the patient] had a capacity which was commensurate with the gravity of the decisions which he purported to make. The more serious the decisions, the greater the capacity required" (*Re T (Adult Refusal of Treatment)* [1993] Fam 95 at 112, 115). Examples at the grave end of the spectrum include decisions that involve a risk to life or irreversible damage to health (Herring, 2016).

Some people may lack capacity for all legal purposes (e.g. a comatose person); this is often described as global incapacity. Other people may be able to make some, but not all, decisions which is referred to as partial capacity within the PPPRA.

6. A summary of sources of New Zealand decision-making capacity law

6.1. Parens patriae

New Zealand adopted several legal arrangements from England during the colonial period (Dawson, 2019). These included the parens patriae powers and duties of the Crown to intervene for people who required care and protection, including adults who lacked the ability to manage their own affairs. "Historically, it referred to the king as father and protector of his people" with "sovereign prerogative" of the "state being a protective guardian" (Curtis, 1975: 895).

More recently, New Zealand enacted legislation and regulations to protect vulnerable individuals with compromised decision-making capacity, namely the PPPRA and the Code of Health and Disability Services Consumers' Rights (Code), which are discussed below. The result was "to leave the higher courts with residual parens patriae jurisdiction, which they might occasionally exercise when no other solution seemed

available, while permitting the bulk of the state's authority to be exercised through (these) specific statutory schemes" (Dawson, 2019: 12).

6.2. Common law

In New Zealand, a person is generally considered to have decision-making capacity when they can: understand the information relevant to the decision or task; retain that information; use or weigh it, in the process of making a decision; and communicate their decision (*KR v MR* [2004] 2 NZLR 847, [2004] NZFLR 797(HC) (also reported as *X v Y (Mental Health: Sterilisation)*[2004] 23 FRNZ 475(HC). This was derived from the English case of *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 WLR 290(Fam); [1994] 1 All ER 819).

6.3. Legislation: Two recent examples

Two statutes demonstrate New Zealand's inclusion of decisional capacity, meaning that a person should be assessed regarding their ability to make the relevant, specific decision. Both were relatively recently enacted and may suggest that future legislation will embed a specific definition of decision-making capacity. The following discussion compares New Zealand's recent "modern" approach to integration of the concept within legislation, to New Zealand's historic legal approach.

6.3.1. Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (SACATA)

Within SACATA, the criteria for compulsory intervention includes that "the person's capacity to make informed decisions about treatment for that addiction is severely impaired" (s 7(b), PPPRA). For the purposes of s 7(b), s 9 provides:

a person's capacity to make informed decisions about treatment for a severe substance addiction is severely impaired if the person is unable to—.

(a) understand the information relevant to the decisions; or.

(b) retain that information; or.

(c) use or weigh that information as part of the process of making the decisions; or.

(d) communicate the decisions.

Thus, the focus is on *impaired* capacity and can be compared with the assisted dying legislation.

6.3.2. End of Life Choice Act 2019 (EOLCA)

Within the EOLCA, the focus is on the *presence* of capacity, which is a fundamental eligibility criteria for assisted dying. Although the term "competence" is used in this statute, the elements significantly mirror the SACATA's definition of capacity. Section 6 of EOLCA provides that:

a person is competent to make an informed decision about assisted dying if the person is able to—.

(a) understand information about the nature of assisted dying that is relevant to the decision; and.

(b) retain that information to the extent necessary to make the decision; and.

(c) use or weigh that information as part of the process of making the decision; and.

(d) communicate the decision in some way.

Thus, these two New Zealand statutes *do* detail the elements of capacity, derived from the English case of *Re C (Adult: Refusal of Medical Treatment)* [1994] 1 WLR 290(Fam); [1994] 1 All ER 819). However, that specificity is lacking in other existing sources of capacity law.

6.4. Legislation: Two older sources of decision-making capacity law

The two older, fundamental sources of capacity law in New Zealand have been criticised as lacking sufficient detail and clarity (Dawson & Reuvecamp, 2019; Diesfeld & Fisher, 2019; Douglass, 2016; Fisher & Anderson-Bidois, 2018).

6.4.1. Protection of Personal and Property Rights Act 1988 (PPPRA)

The PPPRA's intention is to protect incapacitated people from exploitation and to preserve their rights to appropriate care and treatment through alternative decision-making. It is the guardianship statute for adults aged 18 or over who lack the capacity to make financial, care and welfare decisions. Enacted during an era of deinstitutionalisation, the statute was initially applied to many people with intellectual or learning disabilities who relocated from institutions to community residential facilities (Dawson, 2019). However, the provisions also apply more broadly to adults with diverse conditions who have compromised capacity.

The PPPRA provides no single test for incapacity and is complex to apply (Reuvecamp & Dawson, 2019). References to diverse levels of capacity within the statute have been viewed by medical practitioners, lawyers and academics as challenging to understand and apply in practice (Ammundsen, 2022a; Atkin & Skellern, 2013; Douglass, 2016; Douglass, Young, & McMillan, 2020; Fisher & Anderson-Bidois, 2018; Reuvecamp & Dawson, 2019). This included empirical evidence of New Zealand general practitioners' difficulties and training needs regarding capacity assessment (Vara et al., 2020). The summary below demonstrates this complexity.

In essence, the PPPRA covers four topics with corresponding levels of decision-making capacity:

- the appointment of managers to deal with property;
- the appointment of welfare guardians in relation to personal matters;
- Family Court orders relating to a range of issues from health to accommodation; and
- enduring powers of attorney.

The PPPRA is guided by three principles. There is a presumption of capacity (s 5, PPPRA). Also, there are express requirements for the least restrictive intervention and to maximise the person's participation in decisions (s 8(a) and (b), PPPRA). Furthermore, welfare guardians (s 12 (5)(b), PPPRA), property managers (s 18(3), PPPRA) and enduring attorneys (s. 97 A (2) and s 98A2, PPPRA) are required to act in the person's best interests. The goal is to enable and encourage the subject person to exercise and develop such capacity to the greatest extent possible (s 8(b) and s 28(b), PPPRA).

These provisions can be understood as progressive and autonomy promoting. The statute then allows for substitute decision-making if, in any of the specified circumstances, the threshold regarding capacity has been met.

Four tests need to be explored to establish if a person is capable or incapable of making decisions:

1. "partly" lacks capacity: for making a personal order or appointing a property manager (s 6, PPPRA; personal order, s 10, PPPRA; order for administration of property, s 11, PPPRA; and order for the appointment of a property manager, (wholly or partly), s 25 (2)(b), PPPRA).
2. "wholly" lacks capacity: for appointing a welfare guardian (s 6 and s 12, PPPRA).
3. "not wholly competent": for activating a property Enduring Power of Attorney (EPOA) (s 94(1), PPPRA).
4. "lacks the capacity": for activating a care and welfare-related EPOA (s 94(2), PPPRA).

Jurisdiction is not established simply where a decision is viewed as "imprudent" (s 6(3) and s 25(3), PPPRA). Nor is capacity determined by a diagnosis or the score on a screening test (Lellman & Malone, 2019: 59).

Courts probe whether the person partially or wholly lacks capacity and examine which is the least intrusive option. "Partly" lacks capacity has been interpreted in *PS as Litigation Guardian for SV and CL* [2016] NZFC 3003, [2016] NZFLR 890 at [83]. PS was a woman with autism for whom orders were sought to enable her ongoing accommodation and

care in a residential facility. According to a psychologist, PS was "too bright" to justify welfare guardianship which requires the subject person to "wholly" lack capacity. PS was deemed to "partially" lack capacity and the Family Court selected the narrower, less intrusive option of a personal order specifically for her accommodation.

In contrast, the interpretation of "wholly" lacks capacity was provided in respect to man's personal care. In *R v R*, FC Christchurch FAM 2007–054-472, 7 October 2010 [35], the Court held that a man with a head injury "wholly" lacked the ability to understand the nature, and foresee the consequences, of a wide spectrum of activities. The Court appointed a welfare guardian with powers to make a wide array of decisions.

The application of these concepts of "wholly" or "partly" are nuanced. The "wholly lacks" criteria applies to the donor of an enduring power of attorney regarding the person's ability to manage their property (s 94(1), PPPRA). But provisions for activation of a *care and welfare* EPOA are more detailed; the threshold pursuant to s 94(2) is where the person:

(a) lacks the capacity—

(i) To make a decision about a matter relating to his or her personal care of welfare; or
(ii) To understand the nature of decisions about matters relating to his or her personal care of welfare; or
(iii) To foresee the consequences of decisions about matters relating to his or her personal care and welfare or of any failure to make such decisions; or

(b) lacks the ability to communicate the decisions relating to his or her personal care and welfare.

Understandably, these diverse tests produce considerable confusion, especially for those who perform capacity assessments (Dawson & Reuvecamp, 2019; Douglass, 2016). Attempts to apply these diverse terms, particularly for family members and advocates in urgent or distressing circumstances, can be difficult.

Since the PPPRA came into effect in 1988, there has been little substantive change (Reuvecamp, 2018). The law relating to adult-decision-making capacity is under review by Te Aka Matua o te Ture Law Commission (Law Commission) and submissions closed in July 2024 (Law Commission, 2024). It focused on: how the law matched Māori perspectives and recognised Te Tiriti o Waitangi / the Treaty of Waitangi; how the law promotes human rights; the potential for supported versus substitute decision making; and safeguards for people who are deprived of the right to make decisions. Importantly, the review focuses on how capacity should feature, and be assessed, in future legislation regarding adult decision-making. Reform of capacity law in one domain has significant, complex repercussions across New Zealand law.

6.4.2. The Code of Health and Disability Services Consumers' Rights (Code)

The second key source of capacity law is the Code that was established under the Health and Disability Commissioner Act 1994. It gives ten legally enforceable rights to all consumers of health and disability services, and places corresponding obligations on providers of those services. When the Health and Disability Commissioner (HDC) receives complaints, she may investigate and issue opinions regarding whether rights' breaches occurred. The Code is "pivotal" to many areas of New Zealand health law (Paterson, 2015: 28), particularly for consumers with fluctuating or compromised capacity.

Of note, a critical analysis by Wall (2016) queried the concept of "rights" within Code. He suggested that the rights exist in isolation from a conception of justice (Wall, 2016). While breaches may result in a remedial response, he argued that the Code does not fully engage with the principles of justice. One example of this gap is that there is no Code *requirement* for the person who breached the rights to then remedy or directly "correct" the consumer's loss caused by the breach. In Wall's view, the Code and complaints system can be understood as a health promoting regime, designed to improve services, rather than a rights regime that holds service providers fully accountable (Wall, 2016).

The Code applies the word "competence" but it is undefined (and the corresponding term capacity will be used below). The Code does not contain a legal test for decision-making capacity to consent to medical treatment, health care or disability services. This is problematic because capacity is central to the Code's right to make informed decisions, and to give or refuse consent.

Right 7(3) does provide that where a person has "diminished competence", they retain the right to make informed decisions and give informed consent, to the extent appropriate to their level of competence. Also, Right 7(4) provides an exception to the general rule that services should only be provided to a person who has made an informed choice and given informed consent. According to Right 7(4):

Where a consumer is not competent to make an informed choice and give informed consent, and no person is legally entitled on behalf of the person is available, the provider may provide services where—.

a. it is in the best interests of the consumer; and.

b. reasonable efforts have been made to ascertain the views of the consumer; and.

c. either,

(i) if the consumer's views have been ascertained and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or.

(ii) if the consumer's views have not been ascertained, the provider takes into account the view of other suitable persons who are interested in the welfare of the consumer and available to the provider.

In essence, Right 7(4) integrates the common law doctrine of necessity as it relates to health and disability services (Douglass, 2016). It provides a legal justification for delivering services without consent. As summarised by Reuvecamp (2018: 40):

> Right 7(4) only applies where a person is not competent to make an informed choice and give informed consent; where there is no valid and applicable advance directive; and where (in relation to adults) there is no personal care and welfare EPOA or welfare guardian (or they do not have the power to make the decision in question).

Reuvecamp, who practices medical law, reported that a large number of practitioners are not aware of Right 7(4) and do not routinely apply its criteria (Reuvecamp, 2018). She observed that multiple Health and Disability Commissioner opinions regarding Code breaches expressed concerns about the "lack of requirements for consent and the legal basis for proceeding in the absence of consent" (Reuvecamp, 2018: 40). She noted that there was substantial national variation regarding the interpretation whether Right 7(4) provides adequate legal authority to provide long-term care or for detention in residential facilities and this is explored below.

The HDC completed her review of the Code and the Health and Disability Commissioner Act 1994 in December 2024 (Health and Disability Commissioner, 2024). The HDC Recommendations Report was submitted to the Minister of Health and then tabled in Parliament 3 March 2025 (Health and Disability Commissioner, 2025).The key topics under review were: supporting better and equitable complaint resolution; making the Act and Code more effective for, and responsive to the needs of Māori; making both work better for tāngata whaikaha/disabled people; considering options for a right to appeal of HDC decisions; and minor and technical improvements (Health and Disability Commissioner, 2025). Given that the HDC found the Act and Code were "working well", she recommended "small changes so (they) align with modern expectations, help shift practice in the sector, and improve the way the HDC operates (Health and Disability Commissioner, 2025).

The HDC recommended that any reforms regarding capacity should be aligned with the Mental Health Bill, as well as publication of the Law

Commission regarding adult decision-making, and the Ministry of Health and Whaikaha/Ministry of Disabled People with regards to supported decision-making. More specifically, incorporating a capacity test within the Code was viewed as "too prescriptive" (Health and Disability Commissioner, 2024: 48). The HDC did acknowledge that application of mental capacity tests was inconsistent and often those who assess are unaware of existing guidance. Also, it was accepted that Right 7(4) does not address long-term decision-making for persons who do not have decision-making capacity or a legal representative to make such decisions. The Report concluded that this dilemma is best resolved through changes to the PPPRA. In short, no significant recommendations were made to reform the capacity-related factors within the Act or Code. The HDC did note that her office will have a role in providing support and guidance to people to make informed choice and to express their will and preferences.

Thus, a multi-level response, with corresponding revision of multiple statutes, is needed. The legal confusion, and real life impact, of incoherent approaches to capacity is significant. In New Zealand, the absence of a definition of capacity within the Code, and the inconsistent interpretation of Right 7(4) in practice, is highly problematic and attracted substantial critique. Aged care facilities are a site of particular concern (Fisher & Anderson-Bidois, 2018).

7. Aged care settings and decision-making capacity law

In 2018 it would be predicted that thousands of adults who lack capacity are subject to long-term care on the legal authority of Right 7 (4) alone (Reuvecamp, 2018). Research commissioned by New Zealand's Human Rights Commission estimated that possibly 3000 mentally incapable residents were detained in secure facilities and approximately 11,000 mentally incapable people resided in rest home settings solely on the basis of Right 7(4) (Fisher, 2018). They did not have welfare guardians, enduring powers of attorneys or court orders related to their personal care decisions. Many were subject to coercive care in the absence of their informed consent, often over their objections and without legal protection (Fisher, 2018).

Importantly, the research highlighted that the *scope* of Right 7(4) is undefined and thus may critically intrude upon residents' freedom. There are no stated restrictions on the types of health or disability services that can be provided in reliance on Right 7(4) or clarity regarding the *duration* of its application. Historically, advocates suggested alternatives:

> In cases where a proposed treatment is particularly risky, controversial, has long-term consequences or is contrary to the wishes of those interested in the person's welfare, there will be a legitimate question about whether Right 7(4) is appropriate to rely upon. In these cases, it may be more appropriate to appoint a welfare guardian or obtain a specific court order (Gavaghan & Hedley, 2014: 126).

Yet this did not routinely occur, when people were admitted to residential facilities (Fisher & Anderson-Bidois, 2018).

The 11 contributors to a Human Rights Commission research project revealed shortcomings in the legal protections for the thousands of aged residents who are admitted under Right 7(4) rather than under the PPPRA regime (Fisher & Anderson-Bidois, 2018). An audit of the records of Auckland's aged care facilities reported that often no clear record existed of any legal authority or justification for residents' detention (Fisher, 2018). In these circumstances, the informal arrangements under Right 7(4) do not afford residents the protections that are granted under other coercive care legislation, such as the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA). These safeguards include: specific patients' rights (Part 6, MHA); routine clinical review and access to judicial inquires (Part 7, MHA); independent monitoring by a District Inspector (s 96, MHA); and the right to legal advice (s 70, MHA).

Thus, the problems surrounding the concept of decision-making capacity in New Zealand are linked with a web of additional legal concerns. Indeed, "denying opportunities for choice or decision-making" has been portrayed as a form of elder abuse (Ammundsen, 2022b: 433). This claim may be applicable to many people contained in aged care facilities under Right 7(4). Abuse often occurs behind closed doors, without witnesses (Groves, Thomson, McKellar, & Proctor, 2017). Sometimes abuse *is* observed but ignored or normalised. When people are isolated and segregated from the community, they do not have the benefit of external scrutiny. These settings have been described as closed environments (Naylor, Debeljak, & Mackay, 2014). Also, deprivation of liberty occurs when people are "not permitted to leave at will by order of any judicial, administrative or other order… (including in) closed mental health or disability units" (Naylor et al., 2014: 1).

Thus, the repercussions of reliance on Right 7(4) are vast, particularly for many aged care residents. Their legal vulnerability can be viewed in light of recent revelations from New Zealand's national inquiry into abuse in state care.

8. Royal Commission Inquiry Abuse in care (the inquiry)

Abuse in care is at the forefront of New Zealand advocates' minds, given the release in July 2024 of Whanaketia, the report of the Royal Commission of Inquiry regarding historical abuse in state care and faith-based institutions (the Inquiry) (Royal Commission of Inquiry Abuse in Care, 2024a, 2024b). The Inquiry revealed extensive, severe abuse and neglect of children, young people and adults. Reportedly there were between 113, 000 and 253,000 victims between 1950 and 1999. Over 2300 people spoke to the Inquiry, according to the 3000-page report. The people most likely to be placed in care were those who had adverse personal, health or social circumstances, or disabilities, including members of the Deaf community and Māori.

The Inquiry's findings and recommendations are relevant for the reform of capacity law because many victims were contained in closed environments, without the protection of the law or independent advocates. The State often used legal powers to enforce placement in care, regardless of the person's decision-making capacity. Decision makers, including legal professionals, social workers, teachers, clinicians and police, often had little connection with, or understanding of, the communities most affected (Royal Commission of Inquiry Abuse in Care, 2024c).

In many instances, the abuse was extreme, including: the administration of electric shocks; injections to various parts of the body; and solitary confinement. As a result of the abuse, people died, including by suicide (Royal Commission of Inquiry Abuse in Care, 2024d). Unmarked graves exist at several psychiatric hospital sites (Royal Commission of Inquiry Abuse in Care, 2024d). The Inquiry proclaimed:

> Aotearoa New Zealand must do everything in its power to make sure that our care system is safe for every child, young person and adult. This will require political leadership on preventing and responding decisively and effectively to abuse and neglect in care (Royal Commission of Inquiry Abuse in Care, 2024a).

The findings provide vital lessons for safeguarding people in positions of dependence, across the lifespan. Whilst the majority of the recommendations related to practical and organisational policies, human rights protection is viewed as essential. The Inquiry called for zealous promotion of legal protections to ensure that:

> the human rights of Deaf and disabled people, and people who experience mental distress, are fully realised through standalone legislation that protects and strengthens these rights, including though giving effect to the United Nations Convention on the Rights of Persons with Disabilities (Royal Commission of Inquiry Abuse in Care, 2024e, no page).

The Inquiry's report was published amidst the review of the PPPRA and Code, providing a fertile basis for reform of capacity law and

corresponding legal safeguards. One remaining statute is under review and the concept of capacity is central to current debates.

9. Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA)

When Douglass called for reform of New Zealand's decision-making capacity law, she claimed it was out of step with progressive developments in countries that had similar laws to New Zealand (Douglass, 2016). She, and other commentators (Dawson & Gledhill, 2013), suggested reforms need to encompass additional legislation where capacity is, or should be, relevant. An example is reform of the MHA, which currently does not incorporate incapacity in the legal test for compulsion (Dawson & Gledhill, 2013; Douglass, 2016). This is an anomaly, given that the legislation for compulsory assessment and treatment of substance addiction (SACATA) *does* refer to capacity.

Notably, "New Zealand law does not appear to recognise the right of a patient under the MHA to refuse general psychiatric treatment, irrespective of their capacity to do so" (Skipworth, 2013: 222). The criteria for compulsory treatment under the MHA do not address the "proposed patient's" capacity to decide about treatment. Section 2(1) asks whether the person's "capacity…to take care of himself or herself" has been seriously diminished. However, there is no test for this and no opportunity for a proposed patient who has the decision-making capacity to make an informed decision to live with risk and refuse treatment.

A core reform proposal for the MHA is to include the lack of capacity to make decisions about mental health treatment as a third criterion for compulsory treatment. In principle, this would support the rights of proposed patients to make decisions about, and in some cases refuse, mental health care. Considerable work will need to be done to train the workforce to ensure that the criterion is applied consistently and in the way it is intended. It also raises the question of how a clinician would balance risk and capacity, for example, where a person is assessed as being at imminent risk of suicide but has the capacity to refuse care.

Reforms of the MHA may address this decision-making capacity issue. In December 2022, Cabinet reported that a pillar of new mental health legislation would include "placing a person's ability to make decisions about their own care at the centre of decision-making, through embedding supported decision-making approaches" (Ministry of Health, 2024b, no page). After the Bill's first reading on 24 October 2024, the Health Committee unanimously supported all amendments and recommended that it be passed (New Zealand legislation, no date; Mental Health Bill, Government Bill 87–2). The Bill is awaiting its second reading, where Parliament will debate the Bill and considers the Select Committee's report; it will then be open to amendments from any member of Parliament during the next process before the Committee of the Whole House (Ministry of Health, 2024b).

Currently, the Bill's Clause 3 is to provide for compulsory mental health assessment and care in a manner that:

- promotes a person's decision-making capacity, including while they are subject to compulsory care
- improves equity in mental health outcomes by striving to eliminate mental health care disparities, in particular for Māori
- protects rights
- protect safety and well- being.

Clause 6 is to provide supportive and responsive application. "This means encouraging capacity and choice; reflecting the person's needs; being guided by their will and preferences; and recognising their ties to family, whānau, hapū, iwi, and family group" (Mental Health Bill, Government Bill 87–2, As reported from the Health Committee). Of note, this approach integrates the notion of "will and preference" from the CRPD, while not abolishing compulsory mental health assessment and treatment. Although abolishment has been widely debated by international scholars and advocates (Gooding, 2017; Minkowitz, 2017; Wilson, 2021; Wilson, 2023) the Bill does not reflect this approach.

The Discussion document (Ministry of Health, 2024b) reported that there is a strong desire for new legislation to be founded on Te Tiriti o Waitangi and uphold rights in alignment with international conventions:

> Taken together, the proposals shift legislation towards a more rights-based and recovery approach and will enable care in line with a te ao Māori world view. New legislation will ensure we better meet the needs of people when they need urgent intervention, and that legislation is only used as a last resort" (Ministry of Health, 2024b).

The Ministry of Health reported its commitment to transformation regarding the mental health legislation. A logical progression in New Zealand capacity law would be for constructive reforms in the PPPRA (for adults) and the Code (for consumers of health and disability services) to correspond with reforms of the MHA. A recurring proposal across sectors is that New Zealand capacity law be compliant with its obligations under the CRPD (Douglass, 2016; Reuvecamp & Dawson, 2019).

10. Incorporating a Te Ao Māori worldview in decision-making capacity law

In the New Zealand context, respect for Māori rights and perspectives is vital when considering decision-making capacity law and associated practice. Māori are New Zealand's indigenous people and at 30 June 2024 were approximately 17.1 % of the national population (Stats New Zealand, no date). They have particular rights under te Tiriti o Waitangi, which recognises the duties and relationship between the Crown and Māori. Te Tiriti of Waitangi "upholds a set or rights Māori ought reasonably to expect to exercise" (Baxter, 2020: 156 and see Durie, 2002).

Acknowledgement of the importance of tikanga Māori when applying capacity concepts in practice and in law is essential:

> There is a need to recognise cultural diversity, and particularly the rights of Māori as tangata whenua (people of the land), in all aspects of clinical practice in New Zealand. This remains true when assessing capacity; culture, language and religion are integral factors in how a person makes decisions and what decisions they make (Douglass et al., 2020: 25).

As observed by Professor Baxter (2020), all practitioners involved in capacity assessment have a duty to ensure that they are culturally competent, to promote beneficial outcomes for Māori. As a physician and senior academic, she illuminated the role of whaka-whanaungatanga, making meaningful connections. Baxter explained how te ao Māori guides best practice with Māori, through the description of the medical needs and capacity assessment of "Mareana", a beloved whanau member and 71 year old widow with moderate dementia. At all stages, communication with Mareana and her whanau was supportive of their world view as Māori. Early in the process, Māori services were engaged. Mareana's spiritual and cultural values were identified to understand how they informed her decisions. The importance of whanau and relationship building with practitioners was honoured by all involved. Care was taken with correct pronunciation of te reo Māori. Providers worked in tandem with whanau, knew when to gain knowledge from cultural experts and engaged with for Māori services. Based on Mareana's circumstances, clear guidance on the optimum practice for decision-making capacity assessment was offered, with respect to Māori values, beliefs and experiences (Baxter, 2020).

11. United Nations Convention on the Rights of Persons with Disabilities (CRPD)

Across sectors there has been a call for New Zealand's capacity law to more strongly embed international human rights. People with

disabilities are entitled to the protections of the CRPD, which was entered into force in Convention on the Rights of Persons with Disabilities 2515 UNTS 3 (opened for signature 30 March 2007, entered into force 3 May 2008) and ratified by New Zealand on 25 September 2008. In 2016, New Zealand also signed the Optional Protocol to the CRPD, thereby allowing individuals who claim to be victims of a breach to complain directly to a United Nations Committee. This expresses New Zealand's commitment to ensuring its laws, policies and practices complied with the CRPD.

People subject to (or potentially subject to) the MHA and PPPRA are entitled to the CRPD protections. Also, the CRPD applies to disability service consumers under the Code and to aged care residents who are said to lack capacity (Fisher & Anderson-Bidois, 2018; White, 2018).

Article 12 addresses equal recognition before the law and the question of legal capacity. Article 12(2) provides "States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life". The first General Comment produced by the CRPD Committee provided guidance on the Article 12 obligations regarding equal recognition before the law (Convention on the Rights of Persons with Disabilities, 2014). The General Comment emphasised that legal capacity—the right to make decisions about oneself—is fundamental, and that an assessment of perceived or actual impaired decision-making skills should result in the provision of the support necessary to enable people to make decisions in accordance with their will and preferences. This is also known as supported decision making. (The discussion of mental capacity in relation to legal capacity is discussed above, at section 3).

Thus, CRPD compliance requires vigorous attention to individuals' ability, and support, to make decisions. It also requires a shift by practitioners and service providers away from a focus on "best interests". Recommendations on how supported decision-making should be interpreted and applied in New Zealand have been published by many self-advocates (Gordon, Gardiner, Gledhill, Tamatea, & Newton-Howes, 2022), academics and practitioners (Dawson & Reuvecamp, 2019; Douglass, 2016; Fisher & Anderson-Bidois, 2018; Snelling & Douglass, 2019). One suggestion is creation of a supported decision-making statute (Karetai Wood-Bodley, 2023).

In a similar vein, there was a proposal to undertake a "full restructuring of the legal framework" that could "fuse" statutory and common law principles into one statute (Dawson & Reuvecamp, 2019: 392). These authors suggested that the strategy could encourage supported decision-making as the first option but provide for substitute decision makers for personal care or property decisions. Their proposals include: a deprivation of liberty regime for people detained in residential settings with legal protections that are currently provided by the MHA; and an office of the Public Guardian with an independent advocacy service.

Debates continue regarding how to implement the CRPD's supported decision-making provisions (Douglass, 2016; Dawson, 2019; Snelling & Douglass, 2019). Clearly, a comprehensive response to the shortcomings of New Zealand's current decision-making capacity law will require substantial resources and effort across sectors.

12. Key principles for reform

Principles to guide the future of New Zealand's decision-making capacity law may apply across the legislation and regulations that are described above, under review or enacted in the future. Douglass' seminal report (Douglass, 2016) identified key features for legal reform, including: legal recognition of supported decision-making; a single test of capacity; best interests as a standard for decision-making; and research with people who lack capacity.

Integration of te ao Māori, with respect for Māori beliefs and experiences, is central to the integrity of New Zealand's decision-making capacity law and implementation (Baxter, 2020). More broadly, a capacity law regime that is fully consistent with human rights law, including the CRPD, is vital (Reuvecamp & Dawson, 2019).

Decision-making capacity legislation and regulation requires clear, accessible, and consistent definitions, with practical guidance for health, disability and legal providers (Diesfeld & Fisher, 2019; Douglass et al., 2020).

Stakeholders from the full spectrum of legal fields need to be involved in the discussions of reform; change "must take account of the real situations in which people find themselves: abstract thought is fine, but human rights are about what actually happens to real people" (Bartlett, 2020: 5).

New Zealand is poised for reform, in light of the findings of the Human Rights Commission, Inquiry into Abuse in State Care, review of the Code and adult decision-making law in tandem with the progress of the Mental Health Bill.

13. Challenges in implementing capacity law reforms

Integrating the above principles brings challenges. Decision-making capacity law encompasses multiple, diverse areas of law. Change across these domains is complicated, requires additional fiscal and human resources, and sustained training. Introduction of additional legal safeguards requires accountability, with corresponding costs:

> Designing these mechanisms is not straightforward. For them to be acceptable to all parties, they must come at a reasonable cost—a cost that most families and the state can afford. They must not produce an over-burdened or inaccessible system of administration that risks becoming fossilised over time, or subverted by budgetary cuts, with the result that it generates more problems than those it is trying to solve. In total, this is a demanding set of aims for any jurisdiction's laws to achieve (Dawson & Reuvecamp, 2019: 378).

With regards to integrating the CRPD, meaningful change is not simply about reforming mental health legislation and guardianship regimes but encompasses a spectrum of law with "the involvement of those knowledgeable in other legal areas" (Bartlett, 2020: 1). Other jurisdictions, such as England, have had difficulties in incorporating the CRPD reforms into the broad framework of its existing law (Bartlett, 2020). New Zealand may face these, too.

Like Douglass (2016), Bartlett called for systematic data on how the law is functioning in practice but he also observed that it is difficult to see how this data would be effectively collected (Bartlett, 2020). Additionally, implementation of reforms is affected by other social factors, such as the current ethos of a "risk society" (Bartlett, 2020: 9). Finally, reforms to integrate the CRPD will require a substantial cultural shift:

> The reality is that for CRPD compliance to be achieved in anything like the form envisioned by the CRPD Committee, fundamental political change is going to be necessary, within the political classes, amongst the relevant professional groups and within society as a whole (Barnett, 2020: 12).

While the challenges are substantial, New Zealand is experiencing a potent groundswell of advocacy for reform.

14. Conclusions

One form of abuse is failure to provide legal protections, for example through deprivation of liberty without safeguards. A key safeguard is clarity and consistency regarding the definition and application of decision-making capacity, within a rights-promoting regime. The legal gaps associated with ambiguous, or overly complex, decision-making capacity law have been abundantly researched in New Zealand. There are zealous calls for reform regarding how capacity is defined across legislation, legal protections for people with compromised capacity and promotion of supported decision-making. Now is the time is for reform, given New Zealand's current review of the relevant legislation, the many critiques of the current regime, and vigorous efforts by advocates to ensure New Zealand upholds its commitment to human rights.

CRediT authorship contribution statement

Kate Diesfeld: Writing – review & editing, Writing – original draft, Investigation, Formal analysis, Data curation, Conceptualization. **Greg Young:** Writing – review & editing, Writing – original draft, Investigation, Formal analysis, Data curation, Conceptualization.

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References

Ammundsen, H. (2022b). Elder abuse. In V. Ammundsen (Ed.), *A practical guide to legal issues for older people* (pp. 431–468). CCH New Zealand Limited.

Ammundsen, V. (2022a). *A practical guide to capacity*. Wolter Kluwer.

Atkin, B., & Skellern, A.-M. (2013). Adults with incapacity: The protection of personal and property rights act 1988. In J. Dawson, & K. Gledhill (Eds.), *New Zealand's Mental Health Act in Practice* (pp. 337–352). Victoria University Press.

Bartlett, P. (2020). At the interface between paradigms: English mental capacity law and the CRPD. *Frontiers in Psychiatry, 11*, 1–13.

Bartlett, P. (2023). Benefitting from hindsight: What the mental capacity act and its implementation can teach us about CRPD implementation. In K. Wilson, Y. Maker, P. Gooding, & J. R. Walvisch (Eds.), *The future of mental health, disability and criminal law* (pp. 54–69). Routledge.

Baxter, J. (2020). Māori perspectives. In A. Douglass, G. Young, & J. McMillan (Eds.), *Assessment of mental capacity: A New Zealand guide for doctors and lawyers* (pp. 153–172). Victoria University of Wellington Press.

Convention on the Rights of Persons with Disabilities. (2014). *CRPD Committee 'General Comment No 1 (2014) Article 12: Equal Recognition before the Law' UN Doc CRPD/C/GC/1*. Retrieved from https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement. Accessed September 8, 2024.

Council of Europe Commissioner for Human Rights. (February 2012). *Who gets to decide? Right to legal capacity for persons with intellectual and psychosocial disabilities*. https://rm.coe.int/who-gets-to-decide-right-to-legal-capacity-for-persons-with-intellectu/16807bb0f9. Accessed June 15, 2025.

Craigie, J., Bach, M., Gurbai, S., Kanter, A., Kim, S. Y., Lewis, O., & Morgan, G. (2019). Legal capacity, mental capacity and supported decision-making: Report from a panel event. *International Journal of Law and Psychiatry, 62*, 160–168.

Curtis, G. B. (1975). The checkered career of parens patriae: The state as parent or tyrant. *DePaul Law Review, 25*, 895.

Dawson, J. (2019). General principles and sources of mental capacity law. In I. Reuvecamp, & J. Dawson (Eds.), *Mental capacity law in New Zealand* (pp. 3–16). Thomson Reuters.

Dawson, J., & Gledhill, K. (2013). Introduction. In J. Dawson, & K. Gledhill (Eds.), *New Zealand's mental health act in practice* (pp. 17–25). Victoria University Press.

Dawson, J., & Reuvecamp, I. (2019). The future of mental capacity law. In I. Reuvecamp, & J. Dawson (Eds.), *Mental capacity law in New Zealand* (pp. 377–394). Thomson Reuters.

Diesfeld, K., & Fisher, M. (2019). Capacity assessment. In V. Ammundsen (Ed.), *A practical guide to legal issues for older people* (pp. 25–48). CCH New Zealand Limited.

Douglass, A. (2016). *Mental capacity: Updating New Zealand's law and practice*. New Zealand Law Foundation.

Douglass, A., Young, G., & McMillan, J. (Eds.). (2020). *Assessment of mental capacity: A New Zealand guide for doctors and lawyers*. Victoria University of Wellington Press.

Dresser, R. (2022). The UN challenge to guardianship and surrogate decision-making. *Hastings Center Report, 52*(2), 4–6.

Durie, M. (2002). Universal provision, indigeneity and the treaty of Waitangi. *Victoria University of Wellington Law Review, 33*(3–4), 591–602. https://doi.org/10.26686/vuwlr.v33i3-4.5833

Fisher, M. (2018). 'This is not my home': An audit of legal authorities in aged residential care. In M. Fisher, & J. Anderson-Bidois (Eds.), *This is not my home: A collection of perspectives on the provision of aged residential care without consent (pp.11-20). New Zealand Human Rights Commission Te Kahui Tika Tangata*. https://cfnhri.org/resources/new-zealand-human-rights-commission/ Accessed August 1,2024.

Fisher, M., & Anderson-Bidois, J. (2018). *This is not my home: A collection of perspectives on the provision of aged residential care without consent. New Zealand Human Rights Commission Te Kahui Tika Tangata*. https://cfnhri.org/resources/new-zealand-human-rights-commission/ Accessed 15 June, 2025.

Gavaghan, C., & Hedley, H. (2014). Death and dying: Legal issues elders may encounter. In K. Diesfeld, & I. McIntosh (Eds.), *Elder law in New Zealand* (pp. 111–144). Thomson Reuters.

Gooding, P. (2017). *A new era for mental health law and policy: Supported decision-making and the UN convention on the rights of persons with disabilities*. Cambridge University Press.

Gordon, S., Gardiner, T., Gledhill, K., Tamatea, A., & Newton-Howes, G. (2022). From substitute to supported decision-making: Practitioner, community and service-user perspectives on privileging will and preferences in mental health care. *International Journal of Environmental and Public Health Research, 19*(10), 6002. https://doi.org/10.3390/ijerph19106002

Groves, A., Thomson, D., McKellar, D., & Proctor, N. (2017). *The Oakden Report*. Retrieved from https://apo.org.au/sites/default/files/resource-files/2017-04/apo-nid76130.pdf. Accessed July 28, 2024.

Gunn, M. (1994). The meaning of incapacity. *Medical Law Review, 2*, 8–29.

Health and Disability Commissioner. (2024). *Recommendations report | HeTuhinga Taunaki. Review of the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumers' Rights*. https://www.hdc.org.nz/media/lv4dkzyl/recommendations-report.pdf Accessed June 15, 2025.

Health and Disability Commissioner. (2025). *Review of the Act Code*. https://www.hdc.org.nz/your-rights/review-of-the-act-and-code-2024/ Accessed June 15, 2025.

Herring, J. (2016). Peter Skegg and the question no-one asks: Why presume capacity? In M. Henaghan, & J. Wall (Eds.), *Law, ethics, and medicine: Essays in honour of Peter Skegg* (pp. 32–51). Thomson Reuters.

Karetai Wood-Bodley, F. (2023). *Enabling disabled people to live good lives: Embedding supported decision-making into disability law in Aotearoa, New Zealand*. Retrieved from Open Access Te Herenga Waka-Victoria University of Wellington. Thesis. https://doi.org/10.26686/wgtn.22985234 Accessed August 30, 2024.

Law Commission. (2024). *Law Commission review of adult decision-making capacity law: Second Issues Paper*. Retrieved from https://www.lawcom.govt.nz/our-work/review-of-adult-decision-making-capacity-law/tab/second-issues-paper. Accessed July 24, 2024.

Lellman, K., & Malone, D. (2019). *Intensive mental capacity forum: Readings* (pp. 57–74). New Zealand Law Society Continuing Legal Education.

McSherry, B. (2012). Legal capacity under the convention on the Rghts of Persons with Disabilities. *Journal of Law and Medicine, 20*, 22–27.

McSherry, B., & Wilson, K. (2015). The concept of capacity in Australian mental health law: Going in the wrong direction? *International Journal of Law and Psychiatry, 40*, 60–69.

Ministry of Health. (2024). *Repealing and replacing the Mental Health Act*. Retrieved from https://www.health.govt.nz/regulation-legislation/mental-health-and-addiction/repealing-and-replacing-the-mental-health-act#toc-0-5. Accessed August 3, 2024.

Minkowitz, T. (2017). CRPD and transformative equality. *International jJournal of Law in Context, 13*(1), 77–86.

Naylor, B., Debeljak, J., & Mackay, A. (2014). Introduction: Implementing human rights in closed environments. In B. Naylor, J. Debeljak, & A. Mackay (Eds.), *Human rights in closed environments* (pp. 1–11). Federation Press.

New Zealand Legislation (n.d.), Mental Hhealth Bill, Government Bill 87–2, as reported from the Health Committee. https://legislation.govt.nz/bill/government/2024/0087/latest/whole.html Accessed 15 June 2025.

Paterson, R. (2015). The code of patients' rights. In P. Skegg, & R. Paterson (Eds.), *Health Law in New Zealand* (pp. 27–66). Thomson Reuters.

Quinn, G., & Artsein-Kerslake, A. (2012). Restoring the 'human' in 'human rights': Personhood and doctrinal innovation in the UN Disability Convention. In G. A. G. CA, & C. Douzinas (Eds.), *Cambridge companion to human rights law* (pp. 36–55). Cambridge: Cambridge University Press.

Reuvecamp, I. (2018). Plugging the gaps: Strengthening the rights of mentally incapacitated adults pending substantive law reform. In M. Fisher, & J. Anderson-Bidois (Eds.), *This is not my home: A Collection of Perspectives on the Provision of Aged Residential Care without Consent* (pp. 37–50). New Zealand Human Rights Commission Te Kahui Tika Tangata. https://cfnhri.org/resources/new-zealand-human-rights-commission/ Accessed August 1, 2024.

Reuvecamp, I., & Dawson, J. (Eds.). (2019). *Mental capacity law in New Zealand*. Thomson Reuters.

Royal Commission of Inquiry Abuse in Care. (2024a). *Whanaketia: Through pain and trauma, from darkness to light*. Transcript. Retrieved from https://www.abuseincare.org.nz/reports/whanaketia/transcript/. Accessed August 2, 2024. No page.

Royal Commission of Inquiry Abuse in Care. (2024b). *Whanaketia: Through pain and trauma, from darkness to light*. Report. Retrieved from http://www.abuseincare.org.nz/reports/whanaketia. Accessed August 2, 2024.

Royal Commission of Inquiry Abuse in Care. (2024c). *Whanaketia: Preliminaries*. Retrieved from https://www.abuseincare.org.nz/assets/Whanaketia/PDF-downloads/Whanaketia-preliminaries.pdf.Accessed August 2, 2024.

Royal Commission of Inquiry Abuse in Care. (2024d). *Whanaketia: Chapter 7 Impacts*. Retrieved from https://www.abuseincare.org.nz/reports/whanaketia/part-5/chapter-7-impacts/. Accessed August 2, 2024.

Royal Commission of Inquiry Abuse in Care (2024e) Whanaketia: Chapter 3 Vision for the future. Retrieved from https://www.abuseincare.org.nz/reports/whanaketia/part-9/chapter-3/. Accessed August 2, 2024.

Skegg, P. D. G. (2011). Presuming competence to consent: Could anything be sillier? *University of Queensland Law Journal, 30*, 165–187.

Skipworth, J. (2013). Should involuntary patients with capacity have the right to refuse treatment? In J. Dawson, & K. Gledhill (Eds.), *New Zealand's mental health act in practice* (pp. 213–228). Victoria University Press.

Snelling, J., & Douglass, A. (2019). Legal capacity and supported decision-making. In I. Reuvecamp, & J. Dawson (Eds.), *Mental capacity law in New Zealand* (pp. 163–178). Thomson Reuters.

Stats New Zealand (n.d.) https://www.stats.govt.nz/information-releases/maori-population-estimates-at-30-june-2024/ Accessed June 15, 2025.

Te Aka Matua the Ture Law Commission (n.d.) Nga Huarahi Whakatau: Review of adult decision-making capacity law. Retrieved from https://huarahi-whakatau.lawcom.go

vt.nz/#:~:text=We%20published%20our%20Preliminary%20Issues,Issues%20Paper%20in%20April%202024. Accessed July 16, 2024.
United Nations Committee on the Rights of Persons with Disabilities. (2014a). *General Comment No 1 (2104) Article 12: Equal Recognition Before the Law, 11th Sessd, UN Doc CRPD/C/GC1 (11 April 2014) at [12]*. https://digitallibrary.un.org/record/812024?ln=en&v=pdf Accessed June 15, 2025.
United Nations Committee on the Rights of Persons with Disabilities. (2014b). *General Comment no.1, article 12: Equal recognition before the law, CRPD/C/GC/1*. https://digitallibrary.un.org/search?f1=author&as=1&sf=title&so=a&rm=&m1=e&p1=UN.+Committee+on+the+Rights+of+Persons+with+Disabilities+%2811th+sess.+%3A+2014+%3A+Geneva%29&ln=en Accessed June 15, 2025.
Vara, A., Young, G., Douglass, A., Sundram, F., Henning, M., & Cheung, G. (2020). General practitioners and decision-making capacity assessment: The experiences and educational needs of New Zealand general practitioners. *Family Practice, 37*(4), 535–540. https://doi.org/10.1093/fampra/cmaa022 Accessed on September 9, 2024.
Wall, J. (2016). In what sense 'rights'? Principles of justice and the code of patients' rights (pp. 293-309). In M. Henaghan, & J. Wall (Eds.), *Law, ethics, and medicine: Essays in Honour of Peter Skegg (pp. 293–309)*. Thomson Reuters.
White, M. (2018). Aged residential care without consent: A human rights perspective. In M. Fisher, & J. Anderson-Bidois (Eds.), *This is not my home: A collection of perspectives on the provisions of aged residential care without consent* (pp. 51–58). Human Rights Commission. https://cfnhri.org/resources/new-zealand-human-rights-commission/ Accessed August 1,2024.
Wilson, K. (2021). *Mental health law: Abolish or reform?* Oxford University Press.
Wilson, K. (2023). The CRPD and mental health law: The conflict about abolition, the practical dilemmas of implementation and the untapped potential. In F. Felder, L. Davey, & R. Kayess (Eds.), *Disability law and human rights* (pp. 171–197). Springer International Publishing.

Legislation (New Zealand) and convention

Health and Disability Commissioner Act 1994.
Mental Health (Compulsory Assessment and Treatment) Act 1992.
Protection of Personal and Property Rights Act 1988.

Cases

New Zealand

KR v MR [2004] 2 NZLR 847, [2004] NZFLR 797(HC) (also reported as X v Y (Mental Health: Sterilisation)[2004] 23 FRNZ 475(HC).
R v R, FC Christchurch FAM 2007–-054-472, 7 October 2010 [35].
PS as Guardian for SV and CL [2016] NZFC 3003, [2016] NZFLR 890 at [83].
Woodward v Smith [2009] NZ CA 215.

England

Banks v Goodfellow (1870) LR 5 QB 59.
Re C (Adult: Refusal of Treatment) [1994] 1 WLR 290; [1994] 1 All ER 819 (Fam).
Re T (Adult Refusal of Treatment) [1993] Fam 95(CA).