

involuntary admission and treatment may be a very painful and traumatic experience. Finally, it has represented a strong challenge to be met by the development of new contributions that may help to build a much-needed consensus.

The proposal of Szmukler and Dawson^{4,7} goes in that direction and proves that it is possible to formulate a law that is generic, non-discriminatory towards people with mental health disabilities, based on decision-making ability in relation to a particular treatment decision at a particular time, and that permits involuntary treatment when all attempts at support have failed in helping the person to make a decision that could be considered autonomous.

The proposal of a more subjective approach to both the concept of best interests and the assessment of the person's decision-making ability could also help to ensure that the deep beliefs and values (in other words, the will and preferences) of the person are taken into consideration⁴. Although differing from this approach in several specific aspects, the proposals put forward by Freeman et al³

and Scholten and Gather⁸ share some of its principles.

Important differences remain between these proposals and the Committee's view. However, they all represent valuable contributions to the construction of a formulation that will take into account the complexity of what is at stake and will have real chances of being incorporated into the mental health laws of most countries.

For this to happen, several things are necessary: a) to promote all forms of debate that may help to build a new consensus; b) to ensure the participation in the discussion of a much broader range of stakeholders (e.g., different groups of people with mental disabilities, family members, mental health professionals with clinical experience, and experts in mental health legislation and policy); c) to clarify the definition of and the relations between relevant concepts (e.g., mental disorders, disabilities, psychosocial disabilities); d) to admit that, rather than concentrating our efforts on "an absolute prohibition on involuntary treatment (that) is, at least at present, not credible"⁴,

we should "devote more time to thinking about how to make the essential practice of substitute decision-making as respectful as possible"⁹; and e) to invest more on the reform of services and practices, without which no meaningful change in protection of the human rights of people with mental disorders will ever occur.

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The UN Convention on the Rights of Persons with Disabilities: great opportunities and dangerous interpretations

G. Szmukler's paper¹ provides an in-depth analysis of some critical aspects of the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) that make its implementation problematic in mental health care laws and provisions.

Out of 177 States Parties that ratified the Convention, only 92 signed the Optional Protocol, and several of them expressed reservations on the Convention or explicitly put forward their interpretation of some articles².

Actually, as correctly pointed out in Szmukler's paper¹, the most critical aspects do not stem directly from the text of the Convention, but from the interpretations provided by the UN Committee set up to monitor the implementation of the Convention (CRPD Committee)³.

Articles 12 and 14 represent the best examples. The text of these articles requires appropriate measures by States Parties to guarantee persons with disabilities the support they may require in exercising their legal capacity. However, in the interpretation provided by the Committee, these articles would preclude all non-consensual treatment and substitute decision making on behalf of persons with mental disorders.

Szmukler focuses on three concepts likely to underlie misinterpretations of several articles of the Convention and generate problems in its implementation in mental health laws: legal capacity, will and preferences.

The position taken by the Committee on the issue of legal capacity is a challenge for common sense. It is based on

the assumption that mental capacity and legal capacity are independent from each other, though both of them (in particular, legal capacity in terms of legal agency) involve decision making processes. As a result, a person may lack the capability of making decisions, but will be considered able to do so from a legal point of view, in order to avoid discrimination and denial of human rights.

This assumption entails multiple risks for multiple entities. The recognition of full legal capacity would deprive the person with mental disorder of any right to benefit from the acknowledgement of a mental condition as a source of defense. In the absence of decisional capacity, a person with a severe mental disorder (e.g., psychotic disorder or dementia) may be unable to protect her/his own in-

terests, and may be victim of exploitation by others. Those who care for people with mental disorders know that this happens and, unfortunately, it is not a rare event.

It is also worth reminding all of us that several people are willing to take their own life when deeply depressed. However, when recovered from depression, the same people are very thankful to doctors who treated them (even under a coercive treatment regimen) for being still alive.

Of course, the need to support people in being actively involved in decisions relevant to their treatments, housing or finances is not questioned, and efforts aimed at identifying and disseminating the best relevant practices should be encouraged. Indeed, the shift from a classical welfare approach to one focusing on autonomy and full inclusion in the society of people with disabilities is more than welcome, as demonstrated by the ratification of the Convention by so many States Parties.

However, a rigid approach, as the one advocated by the Committee's General Comment No. 1 on Article 12, would not provide any safeguard in case support fails to enable the person's active and informed participation in the decisional process, and would leave room for exploitation and extreme irreversible decisions. As highlighted in Szmukler's paper, rigid interpretations of the Convention may result in a paradoxical situation in which both the person with mental disability and her/his unofficial carers may experience more disadvantages than advantages.

The reliance on will and preferences of the person in ensuring the exercise of legal capacity suggests a lack of clinical expertise and input in the writing of the Convention. In several neurological, psychiatric and internal medicine conditions, such as those involving quantitative and

qualitative alterations of consciousness, the possibility to assess the person's will and preferences "coherent with a sense of personal identity"¹ is very limited. During a manic episode, for instance, a person may prefer to behave in ways that, outside that episode, would make her/him deeply ashamed, or concerned, or even guilty. When recovered, the person might ask those around her/him why no one did anything to prevent her/him from causing so many troubles. When acutely delusional, a person might wish to donate all her/his goods to someone else, and later on, when no more delusional, feel desperate for having ruined her/himself and the whole family. Conflicts between different wills in different moments, and even among different rights, are clearly present here: in these cases, should, as noted by Szmukler, the right to enjoy freedom from exploitation override the right to act according to one's own current preferences?

In spite of the drawbacks underlined by Szmukler, advance directives might be an important resource. However, an in-depth discussion among all stakeholders is needed in order to identify the best relevant procedures and validate them in different cultural contexts.

In the light of the potentially harmful consequences of rigid interpretations, it is not surprising that several States Parties, while ratifying the UN Convention, expressed reservations on some of its articles (in particular on Articles 12, 14 and 19) and did not sign the Optional Protocol. It is also not surprising that, as highlighted by Szmukler, other UN bodies do not support the interpretations provided by the CPRD Committee⁴. The issue of mental disabilities is very complex, and requires high ethical standards, appropriate training, as well as mental health care services

with adequate structural and human resources.

In spite of the critical aspects highlighted in Szmukler's paper, the Convention has fueled a lively debate on inappropriately neglected hot topics which, at odds with the tendency to shortcuts and oversimplifications characteristic of the CPRD Committee and Special Rapporteur's report, seem to require accurate testing of different models and a neutral evaluation of their outcomes.

For the time being, a general agreement could and should be reached on the following aspects: a) the determination of incapacity should never be based upon diagnosis alone, as no mental disorder impairs the capability of making decisions by definition; b) in each State Party, procedures for advance directives should be identified and included in mental health laws after adequate validation; c) a careful documentation of attempts made to establish a therapeutic alliance and to support the patient in the process of making decisions relevant to her/his treatment, housing, finances, etc., should be provided in patients' clinical records.

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Will and preferences in the overall CRPD project

G. Szmukler's paper¹ needs to be understood in the context of the Convention on the Rights of Persons with Disabilities (CRPD) as a whole, and what the CRPD endeavors to achieve.

The motivation for the CRPD was an acknowledgement that existing legal and policy approaches, both at the international and the national levels, were not delivering human rights for people with

disabilities². As that relates to people with mental disabilities, that is unlikely to be contested by the readers of this journal. We are all aware of institutional systems in which people with mental disabili-