

an “incomplete” view, as Szmukler says, but it is shocking and unacceptable.

We should dare to express that. Exaggerations may be sometimes necessary to achieve political goals, but exaggerations in morality and medicine can have deadly consequences. Nonetheless, the UN

CRPD itself, as Szmukler emphasized, is highly welcome, and deserves high efforts to be realized in a reasonable manner.

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The CRPD Article 12, the limits of reductionist approaches to complex issues and the necessary search for compromise

The United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD)¹ was received with high expectations by all those concerned with the protection of the human rights of people with mental disorders and psychosocial disabilities. For most sectors of the mental health community, it appeared to be a unique opportunity to take a leap forward in the development of laws promoting the rights of this group of people and facilitating the development of community-based and human rights-oriented mental health care.

Is it possible that the UN Committee's General Comment No. 1 on Article 12 of the Convention² has created a situation in which all these expectations are in danger? Unfortunately, the danger is real. A large number of States Parties that have ratified the Convention have also expressed their disagreement with the Committee's interpretation, in particular regarding the absolute prohibition of substitute decision-making. An increasing number of human rights experts, scholars and clinicians have stated their conviction that this interpretation, if accepted, would result in serious adverse consequences for people with mental health disorders and psychosocial disabilities, and would undermine some of the hard-won critical rights of these people³. Although many mental health service users' organizations support the prohibition of involuntary admission and treatment, there are indicators showing that this view is not shared by all people with mental disorders nor by the majority of family members. In this context, we have to conclude that the possibility that gov-

ernments will change their mental health laws in accordance with the directives of the Committee seems rather remote.

How did we get into this situation? The limited involvement of some relevant sectors (e.g., clinicians) in the drafting of the Committee's Comment, and an insufficient debate about the implications and the implementation of the CRPD, were important factors. However, in my opinion, the ambiguity of the text of clause 4 of Article 12, pointed out by Szmukler⁴, has certainly had a very strong influence in this process. It was this ambiguity, in which it is difficult not to see an imperfect compromise between conflicting approaches, that the Committee has tried to overcome, alas, at the cost of a radical and reductionist interpretation, that is not compatible with the complexity of the issue at stake.

According to the Committee's interpretation, any form of substitute decision-making is considered a violation of the Convention's guarantee of legal capacity on an equal basis. This means that, faced with a person with a mental disorder who does not accept a treatment considered indispensable and has a severe lack of decision-making skills, a psychiatrist would not be allowed to resort to involuntary treatment in any circumstance. Because, in order to preserve legal capacity, it is necessary to respect the person's rights, will and preferences, in such a situation the psychiatrist would have to rely solely on the support that the State is obliged to provide for the person to become able to express his/her will and preferences.

This approach suffers from several fragilities and contradictions. One of these

has to do with the arguments used by the Committee to justify why the lack of decision-making skills cannot be the basis for any form of substitute decision. In fact, one of these arguments – that the assessment of these skills would be impossible – is not confirmed by the available evidence⁵, while the other – that its determination would be discriminatory – has been refuted by several experts, who have argued that the assessment of decision-making capacity does not need to be discriminatory in nature and can be applied to all people equally^{4,6}.

Another example is the idea according to which, with the appropriate support, most persons with disabilities will be able to express their will and preferences, a presumption which ignores the fact that, in many situations, it is not possible to guarantee this support, while in many other situations this support will not be effective. Finally, denying persons with severe mental disorders the treatment they need, in cases where it has been proved that they lack the ability to make decisions regarding their treatment needs, and doing so in the name of “the freedom to take risks”, is, in my opinion, highly debatable from the ethical point of view.

Despite all the objections that may be leveled against the Committee's Comment, we should not forget, as Szmukler⁴ rightly underlines, that the publication of this Comment has had several important merits. It has stimulated a debate, although this has been manifestly insufficient so far. It has called attention to the fact that, for many people with mental disorders and psychosocial disabilities,

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-