"Capacity", "best interests", "will and preferences" and the UN Convention on the Rights of Persons with Disabilities

George Szmukler

Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK

The United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) is the most up-to-date international legal instrument concerning the rights of persons with disabilities. Such persons are taken to include those with serious mental disorders. According to an authoritative interpretation of a crucial Article (Article 12 - Equal recognition before the law) by the UN CRPD Committee, involuntary detention and treatment of people with mental health disabilities are prohibited under the Convention. Both conventional mental health law and "capacity-based" law are deemed to violate the Convention. However, some other UN bodies are not in full agreement (for example, the UN Human Rights Committee and the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment), while others are less explicitly absolutist (for example, the Human Rights Council). Furthermore, strong criticisms of the position of the CRPD Committee have been mounted from a number of academic quarters. These criticisms center on whether the role of a person's ability to make a decision can be ignored, no matter the circumstances. Much of the above debate turns on the concept of "legal capacity" and the now often-repeated precept that one must always respect the "will and preferences" of the person with a disability. However, "will and preferences" remains undefined. In this paper, I offer an analysis of "will and preferences" that can clarify interventions that may be acceptable or non-acceptable under the terms of the UN Convention.

Key words: UN Convention, human rights, persons with disability, UN CRPD Committee, mental disorders, involuntary treatment, mental health law, legal capacity, mental capacity, will, preferences, best interests, substitute decision-making

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The United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD)[1] is the most up-to-date international legal instrument specifically tailored to stipulate the rights of persons with disabilities. Such persons are taken to include those with serious mental disorders.

Recent authoritative interpretations issued by the UN Committee set up to monitor the implementation of the Convention (CRPD Committee) lead to an insistence that involuntary detention and treatment of people with mental health (or "psychosocial") disabilities are prohibited.

For example, the Committee's General Comment No. 1 on Article 12 (Equal recognition before the law) of the Convention[2] includes the following statements:

> "Support in the exercise of legal capacity must respect the rights, will and preferences of persons with disabilities and should never amount to substitute decision-making." (para. 17)

> "States parties must review the laws allowing for guardianship and trusteeship, and take action to develop laws and policies to replace regimes of substitute decision-making by supported decision-making, which respects the person's autonomy, will and preferences." (para. 26)

> "The denial of the legal capacity of persons with disabilities and their detention in institutions against their will, either without their consent or with the consent of a substitute decision-maker... constitutes arbitrary deprivation of liberty and violates articles 12 and 14 of the Convention." (para. 40)

Furthermore, the Committee's Statement on Article 14 (Liberty and security of person) of the Convention[3] argues that:

> "The Committee has called on States parties to protect the security and personal integrity of persons with disabilities who are deprived of their liberty, including by eliminating the use of forced treatment, seclusion and various methods of restraint in medical facilities, including physical, chemical and mechanic restraints." (para. 12)

> "The involuntary detention of persons with disabilities based on risk or dangerousness, alleged need of care or treatment or other reasons tied to impairment or health diagnosis is contrary to the right to liberty, and amounts to arbitrary deprivation of liberty." (para. 13)

These challenging assertions follow from the Committee's position that Article 12 of the Convention entails that all persons, regardless of their decision-making capabilities, must enjoy "legal capacity" on an "equal basis with others". Legal capacity involves the right to be recognized as a person before the law, as well as the right to legal agency, that is, to have one's decisions – for example, concerning health or social care, where and how to live, finances – legally recognized. "Legal capacity" is considered fundamental to personhood, equal human dignity, and full citizenship[4,5].

The Committee's interpretation[2] states that "legal capacity" and "mental capacity" are distinct: the former is a legal concept, the latter a psychological one. Contrary to the virtually universal provisions in mental health law and capacity-based law, the Committee maintains that the existence of a disability (based on a physical, mental, sensory or psychosocial impairment) must never be grounds for denying legal capacity and the imposition of "substitute decision-making" – that is, a decision made by another person in the place of the person with a disability (not appointed by the person, done against his or her will, and not based on his or her own "will and preferences").

The Committee insists that the preservation of "legal capacity" means that we "must respect the rights, will and preferences of persons with disabilities". With the appropriate support (strictly speaking for the exercise of "legal capacity", and that the State is obligated to provide), people with disabilities will be able to express their "will and preferences". Where a person has difficulty in communicating this directly, the Committee states that one should achieve a "best interpretation" of the person's "will and preferences", involving those who know the person.

Article 14 of the CRPD states that "the existence of a disability shall in no case justify a deprivation of liberty"[1]. On the Committee's interpretation[2], even where there is a risk to the person or to others in association with a disability, involuntary measures are nevertheless in breach of the Convention. Thus, conventional mental health law, based on a diagnosis of some form of "mental disorder" plus risk to self or others, is clearly ruled out.

This interpretation of Article 12 (together with that of Article 13 - Access to justice) has also important implications for forensic practice, including a possible prohibition of the "mental condition" defenses – "unfitness to stand trial" and "not guilty by reason of insanity" – on the grounds that defenses must be "disability-neutral"[6-9].

An important background factor in the emphasis on legal capacity in the CRPD is the widespread abuse of the rights of persons with disabilities. In many places this has amounted to a loss of nearly all civil rights, sometimes termed a "civil death".

WHY IS THE CONVENTION IMPORTANT?

The Convention, adopted in 2006, came into force in 2008. Although it does not create rights not already existing in universal human rights treaties, it specifies how the principles of human dignity, equality, non-discrimination, autonomy and full social participation and inclusion apply in the case of persons with disabilities. It aims to ensure that such persons are treated on an equal basis with others.

The Convention can be regarded as representing a "paradigm shift" in the legal concept of "disability"[10,11]. Persons with disabilities are characterized as "including those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others". This is not an exhaustive definition. Most authorities (but not all service users) accept that persons with a mental disorder treated within the mental health system are included. The Convention puts forward a "social model" of disability: it is the level of accommodations made by a society that determines the degree to which a person's impairment becomes a disability. It is in this sense that "supported decision-making" may be necessary for a person with a mental health disability to facilitate the person's expression of his or her "will and preferences".

At the time of this writing, 177 States have ratified the Convention. Ratification signals the willingness of a State to foster the specified legal rights and obligations. Depending on the jurisdiction, the Convention may or may not be automatically incorporated into national law upon ratification. In many common law countries (like the UK), it is incorporated into national law only when directly legislated.

OTHER UN INTERPRETATIONS

The UN currently has ten "treaty-based" bodies set up to monitor specific human rights legal instruments such as the CRPD. There is also the UN "charter-based" Human Rights Council, with its various "special procedures", such as reports by "special rapporteurs", "independent experts", and working groups. A "flat" overall structure means that there may be significant differences in the interpretation of similar issues across these essentially independent bodies.

The CRPD Committee's absolute prohibition on involuntary detention and treatment is supported by the Special Rapporteur on Disability[12], the first Special Rapporteur on the Rights of Persons with Disabilities[13], the UN Working Group on Arbitrary Detention[14], and the UN High Commissioner on Human Rights[15].

However, there are statements from other UN bodies that do not support the Committee's interpretation, at least in its absolutist form.

Some positions are clearly at variance. In 2014, the Human Rights Committee published a General Comment (No. 35) on Article 9 of the International Covenant on Civil and Political Rights, which states[16]:

"The existence of a disability shall not in itself justify a deprivation of liberty but rather any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others. It must be applied only as a measure of last resort and for the shortest appropriate period of time, and must be accompanied by adequate procedural and substantive safeguards established by law. The procedures should ensure respect for the views of the individual and ensure that any representative genuinely represents and defends the wishes and interests of the individual."

A similar position has been taken by the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[17].

Other UN bodies' positions are less explicit about an absolute prohibition on involuntary interventions, but are framed in terms that support a central role for "will and preferences". They call for an urgent need to develop alternatives to coercive interventions.

An important Resolution on Mental Health and Human Rights from the UN Human Rights Council[18] calls upon States to "abandon all practices that fail to respect the rights, will and preferences of all persons, on an equal basis" and to "provide mental health services for persons with mental health conditions or psychosocial disabilities on the same basis as to those without disabilities, including on the basis of free and informed consent".

A report of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health[19] notes the lack of consensus on compulsion within the UN bodies. The Rapporteur offers to work with others to achieve one. He notes that discrimination is still evident in mental health services, for example, in depriving users of the rights to refuse treatment, to legal capacity and to privacy, as well as other civil and political rights. He insists that action is required to radically reduce coercion and to facilitate a move towards an eventual end to all forced psychiatric treatment.

A report from the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment[20] seems ambiguous on whether involuntary measures can ever be justified.

Worth noting at this point is a recent decision by the European Court of Human Rights[21] which, whilst addressing Article 12 of the CRPD, concluded that it was justified not to accede to the expressed "preference" of a man with an intellectual disability concerning where he should live, since "the disability was of a kind that, in terms of its effects on the applicant's cognitive skills, rendered the applicant unable to adequately understand the significance and the implications of the specific decision he wished to take", and that, therefore, "the applicant's well-being and interests require that the mentor [in effect, a substitute decision-maker] arrangement be maintained". Thus, the Court's interpretation of Article 12 did not concur with that of the CRPD Committee.

CRITICISMS OF THE CRPD COMMITTEE'S INTERPRETATION OF ARTICLE 12

It is no surprise that the absolutist position of the CRPD Committee, so dramatically at odds with centuries of legal acceptance of involuntary detention and treatment, should receive harsh criticism.

An international group of clinicians[22] argues that the Committee's interpretation threatens to undermine hard-won, critical rights of people with mental health disabilities – the right to the highest attainable standard of health, to life, or access to justice. Furthermore, they fear that the rights of others, the family and the public, are similarly threatened, with a consequent increase in mental illness stigma. A central necessary role for a person's decision-making capacity is described (though, of course, in the majority of jurisdictions, capacity plays no formal role in civil commitment regimes). The authors bemoan the Committee's apparent limited expertise in relation to mental illness, the lack of clinician input, and the Committee's failure to consider the views of a broad population of service users, a significant proportion of whom support involuntary treatment, at least as a last resort.

Dawson[23], from a legal perspective, criticizes the Committee's interpretation for failing to offer adequate guidance on how, when situations arise where rights articulated in the CRPD are in conflict, this can be resolved. This is especially important since the relevant text of the CRPD, he maintains, is ambiguous. A key concept in many legal systems, in settling the balance between competing imperatives, is a functional test of decision-making capacity. This points to whether – in a particular instance – autonomy, on the one hand, or protection of the interests of a vulnerable person, on the other, should prevail.

Furthermore, Dawson notes that the law in general is riddled with mental concepts, deprecated by the Committee as not objective, like intention, understanding or foresight. A denial of legal capacity in a specific domain, he argues, is not necessarily a denial of intrinsic human rights. Blind persons are not allowed to drive; the key consideration is whether the person has an impairment of the relevant functions, physical or mental, necessary to act safely in that domain. Dawson criticizes the Committee's understanding of the meaning of "discrimination", arguing that it is not necessarily improper to treat people differently if relevant differences exist between their situations even after adequate support has been provided and reasonable accommodations made.

Scholten and Gather[24] argue that the Committee's standpoint, if accepted, would result in a number of serious adverse consequences for persons with mental health disabilities. Important would be a serious effect on "autonomy" and well-being. By "autonomy" they mean "the ability to live one's life according to one's own conception of the good". They state: "When a person's decision-making competence is substantially impaired, the person is often not in the best position to assess which treatment option will be most conducive to her well-being and consistent with her conception of the good. In such cases, the practice of informed consent loses its point".

They further argue that the Committee's proposals would make it difficult to determine whether "undue influence" had been exerted by a supporter of the disabled person: "It will be more difficult for the medical staff to monitor the actions of support persons because the distinction between the interests of the patient and those of the support person becomes diffuse". Related to this problem, they maintain, would be the formal allocation of responsibility for a decision exclusively to the person with a mental disability. Support persons are presumably to be left without any formal accountability.

All three critiques above have in common a key objection. They ask whether the role of a person's ability to make a decision can be ignored, no matter the circumstances. If all efforts at support have failed, or if the person refuses support, but there is still an inability to understand the facts pertinent to the decision in question, or to appreciate their relevance, or to use, weigh, or reason with that information in terms of what is important to that person, to his or her beliefs and values, to his or her personal life goals or personal conception of the good, is his or her choice to be nevertheless accepted?

Decision-making ability is currently widely constructed as the crux around which justifications are sought for interfering in a person's life in the interests of restoring that person's ability to decide and thus his or her well-being. Or, as Dawson proposes, the basis on which we work to resolve serious situations where rights contradict each other – for example the right to self-determination versus the right to life, or to the highest standard of health care, or to be free of violence and exploitation.

All three critiques also raise the related question of how we are to understand "advance directives". At Time 1, a person with unquestioned decision-making ability may predict that, because of an anticipated future episode involving what that person recognizes as an impairment in that ability (Time 2), he or she will express a different, contradictory preference, which the person states is not to be regarded as what he or she truly or "autonomously" desires. If the feared episode occurs, which preference should be respected? The CRPD Committee provides no explicit guidance on this question. Is it the Time 2 preference, disavowed at Time 1, that is to be followed? If so, what is the point of such an advance directive?

Since significant criticisms of the Committee's interpretation turn on the notion of decision-making ability, I suggest that an examination of how this concept might relate to the CRPD's "respect for rights, will and preferences" may be fruitful. Such a discussion will have a strong bearing on two key principles underlying the CRPD: support for autonomy and the elimination of discrimination.

DECISION-MAKING ABILITY, A DISABILITY-NEUTRAL LAW, AND DISCRIMINATION

Before the CRPD Committee had issued its interpretation, colleagues and I presented an argument that a "disability-neutral" law could be formulated that was non-discriminatory towards people with mental health disabilities[25,26]. Such a law would permit involuntary treatment when all attempts at support had failed in helping the person to make a decision that could be considered autonomous.

Such a law, we proposed – as do the critics discussed above – would be squarely based on decision-making ability. This is not a "blanket" inability but is specific to a particular treatment decision at a particular time. People with mental illness do not have an impairment of such an ability for most, or indeed all decisions, and for most or all of the time. If there was a significant impairment of this ability, involuntary treatment would only be justified if it were in the person's "best interests". We qualified the term "best interests" as "subjective" best interests – that is, one that gives paramount importance to the person's deep beliefs and values, or what might be termed the person's "will and preferences".

We also suggested that decision-making ability itself might be construed in terms of a person's beliefs and values. An assessment of the person's decision-making ability would go beyond the more conventional, so-called "cognitive" elements, by examining the coherence of a person's treatment decision with his or her relevant deep beliefs, values, and commitments. A similarity was noted to Bach and Kerzner's influential account of how "will and preferences" could be assessed in the light of a person's ability to express an intention (or will) and its coherence with a sense of a personal identity through time[27,28].

Further, we argued it was essential that the law be "generic". To avoid discrimination, it had to apply to all persons on an equal basis, no matter the cause of the impairment of their decision-making ability, whether it was a "mental" or "physical" disorder, nor whether they had a "disability" or not. Decision-making ability, we argued, is conceptually distinct from a "disability" and may occur in people with or without a disability.

Dawson and I had earlier proposed such a generic law, which we termed a "fusion law", as a riposte to conventional mental health legislation. We argued that conventional law was unfairly discriminatory against people with a mental illness, in that their autonomy or right to self-determination was not accorded the same respect as given to all other patients in general medicine or surgery.

Some, including the CRPD Committee, criticize capacity-based law – even a generic law applicable to all – as discriminatory, because a disproportionate number of people with mental health disabilities would be judged to lack decision-making capability, even if such a lack is specific to a time and decision. Certainly, this would constitute a "disproportionate effect". However, a disproportionate effect does not automatically entail discrimination – in such cases, "indirect discrimination". For example, a person with an intellectual disability is rarely accepted for training as a doctor. As entry qualifications do not explicitly exclude people with an intellectual disability, there is no "direct discrimination". However, the entry criteria, usually requiring top class examination results in academic subjects, do have a disproportionate impact on people with an intellectual disability. Yet, we do not claim these criteria discriminate unfairly against people with an intellectual disability.

This is because it is accepted, certainly in international law, that a disproportionate effect does not amount to indirect discrimination provided its basis has three attributes: a) it has a legitimate aim, b) the criteria leading to the effect are objective, and c) the criteria are reasonable in the light of that aim[29].

The "aim", in the instances that interest us, should be seen in the terms of the fundamental principles of the CRPD: respect for the "inherent dignity of the person, and individual autonomy, including the freedom to make one's own choices". The aim is essentially to ensure that people experiencing a serious difficulty in making an important decision are supported in acting autonomously (according to their deeply held personal beliefs and values, their personal conception of the "good", or "will and preferences'"), and that those values are given effect through facilitation from others until the person's autonomy is restored.

A substantial body of research on the standard criteria for "decision-making capacity" – as defined, for example, in the work of Grisso and Appelbaum[30] – show a level of agreement between independent assessors, a strong index of "objectivity", that is very high[31].

"Reasonableness" turns on whether the basis of the differential treatment advances the legitimate aim. Is it a reasonable and proportionate means to achieve that aim? A person's "autonomy" – in the sense above – is necessarily related to some kind of decision-making ability. If a person is unable to make a decision reflecting or furthering his or her conception of the good, despite all measures of support, this poses an obstacle to acting autonomously.

Under what circumstances might a person have difficulties in making a treatment decision that is coherent with his or her individual conception of the good, or his or her deep beliefs and values? What the CRPD Committee has not directly considered is a common situation for people with a serious mental illness, such as a psychosis: that is, a significant, often dramatic, change in the person's preferences. Indeed, the same may occur in people without a mental illness, for example, with an organic brain syndrome caused by a brain injury or adverse drug reaction.

An examination of the terms "will and preferences" can perhaps help to clarify the elements entering into such situations; and how we might respond to them in a manner arguably consistent with the CRPD, yet sometimes allowing for an "involuntary" intervention.

THE MEANING OF "WILL AND PREFERENCES": "WILL" VERSUS "PREFERENCE"

According to the CRPD Article 12, Clause 4, "States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body."

There appears to be ambiguity in this text, born of compromise. Some authorities have interpreted this clause as permitting substitute decision-making, but only with the safeguards stated[11]. However, as we have seen, the CRPD Committee maintains that the exercise of legal capacity prohibits substitute decision-making and insists that we must at all times "respect the rights, will and preferences" of persons with disabilities (as we presumably do for everyone else)[2]. The expression "will and preferences", as noted earlier, appears in many UN bodies' statements, even in those that do not explicitly prohibit substitute decision-making.

Though the expression "will and preferences" is frequently repeated, no authority has provided a definition of its meaning. I have not found one in the "travaux préparatoires". Why were these two words, "will" and "preference", chosen? "Preference" has a relatively straightforward meaning: the Oxford English Dictionary defines it as "a greater liking for one alternative over another". On the other hand, the meaning of "will" moves us into a much more difficult territory.

In ordinary language, "will" has a stronger sense of force or resolve to act in a particular way than does a "preference". Furthermore, the "will" has a long history in the philosophy of mind. It is no surprise that the views expressed by philosophers concerning its meaning reveal significant differences. Indeed, in a recent volume dealing with the subject, the author describes the "incomplete demise" of the "modern theory of the will" that held sway from Descartes to the 19th century and came under fierce attack in the 20th century[32].

A 17th century account might see the "will" as occupying a kind of causal role between the desire and the act aimed at fulfilling the desire. A distinction between the "will" and a desire (or wish or "preference") is generally drawn in the philosophical literature. Influential has been Kant's concept of the "will", helpfully summarized as: "The will, then, as distinct from the ability to choose, is the capacity to transform felt urges or desires with causal force into motivating reasons for action with justifying validity. To possess a will is therefore also to be able to test desires to see whether or not they can be validated as reasons"[33]. Kant's "will" forms part of a larger account including the choice of "ends", but this is not relevant for our purposes.

Pertinent to this discussion, and shared with a number of recent accounts, is the idea of the "will" as a kind of higher-order motivating structure that determines which desires are to be translated into acts. It may be seen as having a special "reason-giving force"[34], or as a higher-order self-governing mechanism, one in which "values" play a key role and where desires are subject to forms of deliberation within higher-order "policies" extending over time and expressing commitments towards ends that embody values[35].

Consistent with this framework, we can develop an account of "will" and "preference" that proves helpful in understanding when we may become concerned that a person's decision-making is undermined[36]. A distinction may be drawn between the "will" – as a higher-order, self-governing function – as opposed to desires or inclinations or "preferences", expressed in the present. The "will", on this view, is a manifestation of a person's deeply held, reasonably stable and coherent personal beliefs, values, commitments and conception of the good. It is what we may understand as characterizing personal "autonomy". In this sense, it is not the same as a desire, inclination, or a currently held "preference", even a strongly expressed one.

Normally, "will" and "preferences", by and large, run together. It is when the "will" and a "preference" diverge or are contradictory, and a person needs to make a serious decision, that a problem may arise.

WHERE A "PREFERENCE" IS INCONSISTENT WITH THE "WILL": ALL PREFERENCES ARE NOT CREATED EQUAL

For an instructive model we can return to "advance directives", cited as problematic in the critiques of the CRPD Committee's interpretation of Article 12. Noting the difference between the "will" of the person (and its associated preferences) at Time 1, as against the "preferences" that the person anticipates will be expressed at

Time 2 – and which the person asks to be ignored – it is explained why we generally respect the person's Time 1 "will" and not the Time 2 "preference". If the person were to "will" at Time 1 that treatment on an involuntary basis in the face of a predicted persistent refusal at Time 2 (as a last resort, all attempts at support having failed), the argument is strong that the Time 2 refusal should be overridden. We favor the Time 1 instruction as it reflects the person's "will" – his or her relatively stable, deeply held beliefs and values, and personal conception of the good.

To honor the preference at Time 2 is to undermine the "will" or, in essence, the "autonomy", of the person. It is hard to see how this would be consistent with the first "General Principle" of the CRPD: "Respect for [the] inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons".

If this analysis is accepted, it would follow that we would act similarly if the person had not made a written advance directive, but had expressed, through various statements and life choices, the same values (or "will") and associated "preferences", as evidenced by people who know the person well, for example, relatives and friends. Even if the person had not previously expressed clear treatment wishes, his or her previously manifest "will", as evident from his or her value commitments, life choices and goals, would have to count heavily in deciding whether or not to respect a present "preference".

Consistent with the spirit of the CRPD would be – despite an involuntary intervention – the necessity of developing a relationship aimed at facilitating the person's expression of his or her will as soon as possible[27].

This analysis of "will and preferences" adds a further dimension in the conceptualization of "decision-making capacity" and "best interests", if not a major reformulation. Treatment decision-making capacity is undermined when there is a serious divergence between the person's "will" and a currently expressed treatment "preference"; while a person's "best interests" are served by acting so as to give effect to the person's "will". An advance directive offers the clearest model. The case for an involuntary intervention is stronger, the greater the threat to the person's "will" that would result from the person enacting a contradicting "preference".

How well are we able to determine what are a person's deep beliefs, values or personal conception of the good? The tool we use is called, by philosophers, "interpretation"[37-39], not to be confused with the psychoanalytic version. Interpretation involves a form of "folk" or "common-sense" psychology we use to understand and predict others' behaviour in everyday terms of mental states such as beliefs and desires. Dennett[40] characterized this ability as follows: "For all of its blemishes, warts and perplexities, folk psychology is an extraordinarily powerful source of prediction. It is not just prodigiously powerful but remarkably easy for human beings to use. We are virtuoso exploiters of not so much a theory as a craft". When employed collaboratively with the patient, and with people who know the patient well, one would expect an appropriate degree of "objectivity" in the assessment.

No doubt the reader will have seen some potential difficulties in this "will and preferences" approach. Here, I point to some briefly.

Can a person's "will" (and associated preferences) change without it being a sign of that "will" being undermined? Although there are accounts of a sudden, "quantum" change in a person's deep beliefs and values, these appear to be rare[41]. They are usually in the nature of spiritual revelations, and the result of the change appears to be an overall largely coherent conception of the "good", often of a religious nature. More commonly, a change in the "will" is gradual and understandable, usually involving a working through of value conflicts: "coherence" in an interpretive sense is maintained. Another instance where a new "will" may be seen as "authentic" may occur in a person with a long-standing psychosis, where the person has changed significantly, but where there is a sufficient degree of stability and coherence in the person's new beliefs, values, and conception of the good, with a reasonable correspondence with the real world.

Should one always privilege the "will" over a conflicting "preference"? When the impairment of decision-making is due to a reversible cause, it is usually straightforwardly so. However, when irreversible, for example in dementia, it is arguable that the person now is not the "same person" having the previous "will". Whether that "will" should be respected rather than a strongly held but divergent "preference" in the present, I suggest, should be determined on a case-by-case basis, involving those with a close interest in the well-being of the person[39].

There are situations where it may be impossible to know what a person's "will" might be – for example, a person who is unconscious or is in an organic confusional state where no-one is available who knows the person; or a person with a severe intellectual disability who may not have been able to clearly express a coherent "will" (though there may be fragments of observed behaviour and utterances pointing to what has been important to the person that offer an indication). In such cases, it has been proposed that the default position might be to consider the human rights relevant to the situation as the guide for the decision to be made[42].

RESPECT FOR "RIGHTS" AS WELL AS "WILL" AND "PREFERENCES"?

Just as "will" and "preferences" may point in different directions, so may "will" and "rights". When a "right" should override a clearly formulated "will" constitutes a predicament more familiar to us, usually framed as "protection" versus "autonomy".

An example is whether a right to enjoy freedom from exploitation should override a person's "will" to live alone in a situation where such a right is threatened. Its resolution might depend on a "best interpretation" of whether the person's "will" to live independently – as judged on the basis of his or her beliefs, values and conception of the good – would be consistent with accepting the level of risk to which the person would be exposed (after appropriate support services were provided).

From the previous discussion, it will be evident that the word "respect" in the phrase "one must respect the rights, will and preferences" of the person cannot mean that one must comply or accede to all those three elements. If they point in different directions, that is logically impossible.

CONCLUSIONS

The UN CRPD is an important legal instrument clearly specifying the rights of persons with disabilities. If given effect by ratifying States, it will dramatically transform the standing in society of such persons. This is to be strongly welcome.

However, the CRPD Committee's interpretation of Article 12 prohibiting "substitute decision-making", while supported in some quarters, has not been fully endorsed in statements from some other UN bodies, and has drawn strong criticism from legal and clinical scholars.

An absolute prohibition on involuntary treatment is, at least at present, not credible. Nevertheless, States parties are constantly reminded of the Committee's position in its Concluding Observations, published following regular examinations of each State's progress in implementing the Convention[43]. Almost invariably, States are asked to replace regimes of "substitute decision-making" with regimes of "supported decision-making".

While it is probable that service innovations aiming to reduce coercive measures can substantially reduce their frequency, there will always be cases – for example, due to organic confusional states or neurodegenerative disorders – where ethically persuasive justifications can be made for such measures, at the very least in circumstances carrying grave consequences. Furthermore, surveys reveal that a significant proportion of people who have been involuntarily treated for a mental illness state that such a measure can be appropriate as a last resort[44-46]. This indicates that law reform must involve those most directly affected and take into account the diversity of views in this group[47].

It would be an unhappy state of affairs if regard for the CRPD were undermined by the Committee's interpretation. It should be noted that, while this interpretation is "authoritative", it is nevertheless not "legally binding" in international law[29].

Despite these concerns, the Committee's role in drawing attention to involuntary detention and treatment is welcome. Sadly, this has been a neglected area in mental health care. We prefer not to linger on what can be a profoundly distressing and humiliating experience for patients (and a disturbing one for clinicians). The discrimination against people with a mental illness in conventional mental health law is being increasingly recognized, raising fundamental questions about justifications for compulsion.

The Committee's objective to eliminate the obvious discrimination against persons with mental health disabilities and to pay special or paramount regard to such persons' deeply held beliefs and values (or personal conception of the good, or "will" and "preferences") is to be highly commended. However, by failing to analyze the meaning of the regularly endorsed phrase "respect for will and preferences", especially in cases where there is a radical change in a person's "preferences", the Committee's interpretation is incomplete.

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