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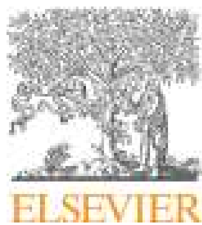

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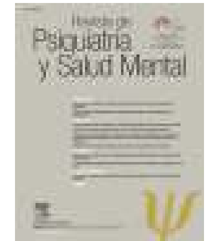

LETTERS TO THE EDITOR

Convention on the rights of persons with disabilities in mental health. A human rights issue☆,☆☆

La Convención sobre los derechos de las personas con discapacidad en salud mental. Una cuestión de derechos humanos

Dear Editor,

The *Convention on the Rights of Persons with Disabilities*[1] is a treaty on human rights in healthcare, social and political matters, focused on the ''long-term'' physical, mental, intellectual or sensory ''disability'' that prevents full participation in society. In mental health, this definition errs in not distinguishing between (and consequently discriminating against), for example, a patient with chronic schizophrenia and a brief psychotic episode. These are both mental dimensions that affect daily life.

This difficulty violates *equal recognition as a person before the law*,[2] given that it excludes patients not encompassed in the definition from legal protection. It is true that the law guarantees equality because it focuses on full participation of the person. However, recognising that the person is not always autonomous, it is stipulated that the member States should ensure appropriate and effective ''safeguards''[2] to prevent abuses. Although this also lacks a definition, the literature[3,4] shows that various approaches have been adopted. In mental health, the focus is on making shared decisions, advance directives and early planning of decisions.

Given that what is desired is protection against abuses, the *Committee* recommended that Spain should revise its laws on deprivation of liberty based on criteria of disability and authorisation of involuntary hospital admissions and treatments, and that it should adopt measures based on informed consent.[5] For that reason, we would have to revise laws such as the Penal Code (Article 156), which allows sterilisation of persons with disabilities without their consent.

Although we should promote social and healthcare policies based on free consent, people do not always have sufficient competence to decide autonomously. ''Legal capacity'' (having rights and obligations) is presumed, but not all individuals have enough ''competence'' (skills to carry out actions based on their convictions). We believe that it is a mistake to hold that mental competence is not something objective, natural y scientific, but rather social and political.[2] Research centres on a functional focus that studies cognitive processes: *reasoning*, *comprehension*, *appraisal and choice*.[6] When this fails, it is hard to apply a model based on *support*, having to apply the ''best interpretation of the wishes''[2] (beliefs, values, desires, etc.) of the person and not the one that decides in his or her name. And all of this based[7] on non-discrimination, equality and dignity (Article 3), protection of integrity (Article 17), right to life (Article 10) and health (Article 26), and enablement and rehabilitation (Article 27).[1]

Consequently, with these premises, without having to be the rule but rather the exception, our legal system would respect the *Convention* and apply involuntary hospital admissions or involuntary out-patient treatments. In both cases, the criteria would not the ''disability'' or ''dangerousness'' involved,[8] they would be the human rights (health, rehabilitation, etc.). As far as involuntary out-patient treatment goes,[9] it should be focused on patients with severe mental disease (frequently psychosis), lacking consciousness of illness, with multiple hospital admissions, abandonment of therapy, physical and psychological deterioration, and self- and/or hetero-aggressive behaviours. Its application is not aimed at a collective of individuals, but at clinical characteristics. Its rationale[10] is endorsed by Articles 3, 10, 17 and 27,[1] and the search for a life with dignity, with quality of life.

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Re-analysis of construct validity of the brief-version of the University of California Performance Skills Assessment (Sp-UPSA-Brief) of García-Portilla et al.☆

Re-análisis de la validez de constructo de la escala breve para la evaluación de la capacidad funcional (Sp-UPSA-Brief) de García-Portilla et al.

Dear Editor,

Validating brief-versions of mental health evaluation tools poses new challenges in terms of the process of their preparation and gaining evidence of validity. Brief-versions are important allies in professional practice when resources and the time required to evaluate by means of a complete test are limited,[1] because they eliminate redundant items and reduce the fatigue, frustration and boredom of repeatedly answering very similar questions.[2] In this regard, we consider the study undertaken by García-Portilla et al. to be valuable,[3] because the evaluation of functional capacity using the UPSA brief-version opens up possibilities of its inclusion in the evaluation of intervention programmes. However, we believe that important methodological aspects were omitted in obtaining evidence of validity, which would call into question the calculations made taking the scores of the brief-version into account and the authors' conclusions.

In the study, in order to obtain evidence of construct validity, the full version of the UPSA was correlated with its brief version (Sp-UPSA and Sp-UPSA-Brief, respectively), which is coherent since a high correlation between them is expected as the same construct is being quantified, but the Sp-UPSA-Brief has items in common with Sp-UPSA which spuriously increase the correlation. In order to mitigate this effect, there is a procedure which enables a correction to be made by correlated errors in order to achieve a more accurate estimate of such an association.[4,5] This procedure is reflected in the following mathematical expression:

$$r'_{tb} = r_{tb} - \left((1 - r_{xx}) \frac{\sigma_b}{\sigma_t} \right) \quad (1)$$

where r'_{tb} is the corrected correlation between the full and the brief version; r_{tb}, the original correlation between the full and brief version; r_{xx}, the internal consistency reliability of the brief version; σ_b, the standard deviation (SD) of the brief version; and σ_t the SD of the full version. However, the SD of the total score of the full version is not given in the manuscript, and this is necessary for this procedure. For this reason, the mean and the SD of the total score was calculated using the data reported in the validation of the full version by García-Portilla et al.,[6] which was possible because they used the same sample for both studies. To be specific, a total mean was considered (summing the means of each subscale separately) and a total SD was calculated from the coefficients of variation of 18.10; 12.78 and 5.90 for the groups *Patients with schizophrenia*, and *Patients with bipolar disorder and Health controls*, respectively. The results for the 3 groups are summarised in Table 1.

The findings indicate that on correcting the initial correlations for spuriousness, the statistics would need to be reinterpreted and the conclusions amended, because changes occurred in the magnitude of the correlations and in the statistical significance, added to which the percentage of change observed in the correlations was high. It is worth mentioning that the coefficients of reliability α are below the minimum accepted as adequate (>0.70),[7] which could have affected the calculations considering the amount of measurement error existing in their scores.

For all of the above, the results with regard to the construct validity of the Sp-UPSA-Brief reported by García-Portilla et al. are questionable due to the lack of empirical equivalence between the full version and the brief version, in addition to the high measurement error presented by their scores.[8] Added to this is the fact that both versions of the Sp-UPSA are principally used in the clinical environment

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