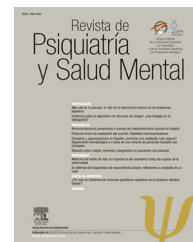




# Revista de Psiquiatría y Salud Mental

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## LETTER TO THE EDITOR

### United Nations Convention on the Rights of Persons with Disabilities: The effects of the debate<sup>☆</sup>



### La Convención de Naciones Unidas sobre los Derechos de las Personas con Discapacidad: los efectos del debate

Dear Editor,

The International Convention on the Rights of Persons with Disabilities<sup>1</sup> is a tool approved by the United Nations in 2006. It aims to bring about a change of paradigm in the conception of disability from a medical capacity/incapacity model to a social model based on supports and founded on human rights. Spain signed and ratified this convention in 2009 and this body of law now forms part of the Spanish legal system. The Committee on the Rights of Persons with Disabilities is the body entrusted with supervising the application of the convention which, in the year 2014, carried out an interpretation of articles 12 (equal recognition of persons before the law)<sup>2</sup> and 14 (freedom and security of the person) that have been the object of discussion.

The debate, a mirror of the unavoidable political dimension of our clinical work, has been emerging in different spaces (volumes of academic journals, national and international). The latest body to state its position is the Spanish Society of Psychiatry.<sup>3</sup>

Taking a look at this problematisation, the debates so far have focused mainly on the committee's interpretations of the convention's articles, which in turn suggest an array of issues, some of which spring up from old themes and others which are newer. Mental illness as a constraining element inhibiting freedom and treatment as the restorer of it; the confusion between care and coercion claimed by those in favour of the abolition of article 763; the possible forensic implications of the issue; the conceptual ambiguity of some terms (capacity, will, preference); the lack of clinicians and users on the committee; the need to shift the paradigm of substitution towards support in decision-making... are just a few examples. At the core of the debate lie the tensions between recognition of the subject's vulnerability to protect him or her (care) versus the exaltation of autonomy and emancipator normalisation,<sup>4</sup> arguments which are in turn

flagged up by some, misrepresented when used in isolation, but as conflictive as they are necessary to one another.

In the midst of such old but also such new pitches, is the lack of the presence of discussion on what aspects we need to include in our clinical practice and what the effects of the debate are. No one knows better than we do (and the users of our services) that the transformative potential of some reforms may be accompanied by the persistence or aggravation of coercive practices, be they existing or newly emerging. Clarifying concepts is and will remain necessary, but some elements of the debate seem to be irreconcilable. Ensuring participation in the discussion of a wider range of stakeholders and promoting debate in all of its forms is vital, but maybe the time has come to focus on deciding which measures, strategies and interventions are effective and have been developed to reduce coercion. There are still landmines ahead: the literature is disperse and complex, the impact of population or environmental issues are difficult to assess (although this does not mean that are ineffective) and we do not know the impact of other mental health interventions such as peer care, home-based interventions or other alternative approaches in community care.

Despite these research limitations, efforts made to reduce, prevent and terminate coercion are effective in the majority of studies.<sup>5</sup> Interventions to reduce involuntary admissions, such as shared decision-making (which in turn includes advance directives and other ways of providing the patient with greater information), or staff training to reduce the use of physical restraint, have shown the greatest effectiveness.<sup>6</sup> Other consensual issues to be considered are that the guidelines usually emphasize the rights of peoples to be involved in their treatment as a general principle but not as a structured group of specific interventions, which would be easier to establish by means of specific recommendations. To consolidate and sustain these interventions not only individual and independent measures are needed, but also a change in organization culture that places greater emphasis on human rights-based recovery and care. To conclude, now is the time to think about and establish what the preservation and enhancement of the rights of persons with disabilities with mental health conditions should imply, without leaving them unprotected along the way.

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## Psychiatric patients are more vulnerable to the Spanish euthanasia law?<sup>☆</sup>



### ¿Los pacientes psiquiátricos son más vulnerables ante la ley de la eutanasia española?

Dear Editor,

Active euthanasia and assisted suicide (EAS) are legal in Luxemburg, the Netherlands, Colombia, Germany, New Zealand, Belgium, Canada, Switzerland and several states in the United States and in Australia.<sup>1</sup> Spain has recently become one of the countries where EAS is legal after approval of the law on 17<sup>th</sup> December 2020 by the Congress of Deputies (BOE-122/000020). The people eligible to benefit from this law would be those of full legal age and full capacity to act and decide, who suffer from a severe, chronic and debilitating condition or a severe and incurable disease causing intolerable levels of physical or mental suffering. This law empowers patients who may be living under intolerable circumstances, providing them with the option to die. However, it also opens the door for psychiatric patients with a mental disorder (many of them considered chronic, disabling and causing mental pain) to be able to request EAS. One recent systematic review confirmed an increase in psychiatric patients requesting EAS in the countries where it has been legalized.<sup>1</sup> The authors found that the clinical characteristics of the patients who requested or who were cases of EAS were similar to those psychiatric patients who commit completed suicide: a history of prior intent; isolation; depressive disorder; personality disorder. Another population vulnerable to the application of this law is the geriatric population. There is growing demand for EAS in patients with geriatric syndromes in the countries which are less restrictive regarding the law.<sup>2</sup> The

problem is that these syndromes are usually accompanied by mental and emotional problems, as well as cognitive ones.

This law invites reflection in the 3 previously mentioned points: 1) full capacity to act; 2) severe, chronic and incapacitating/incurable; and 3) causing intolerable mental pain.

Firstly, the law on euthanasia requires that the patient takes the conscious decision to request EAS, is able to understand the consequences of requesting EAS versus the available treatment alternatives. Decision-making ability is linked to the abilities of taking in relevant feedback, understanding the consequences of their decisions and issuing and communicating a verdict based on the analysis of that information.<sup>3</sup> Although suffering from a mental disorder does not incapacitate the patient in taking decisions, it may limit their capacity. In fact, cognitive impairments in taking decisions are a sign of vulnerability in suicide patients.<sup>4</sup> Patients with these impairments take decisions based on short-term rewards (e.g. pain relief) without bearing in mind the long-term consequences (e.g. death), leading to riskier decisions. Previous studies in Holland have shown in over half of EAS cases that the assessing physician made an overall judgment about the patient's decisional capacity, instead of this being based on validated cognitive tests.<sup>5</sup> Furthermore, a large number of psychiatric patients withdraw their request to commit EAS midway.<sup>1</sup> This proves that the desire to die is not stable over time, and is related to state of mind variables that can be treated. The law provides for these possible changes since the patient has to repeat their desire to request EAS, thus impeding impulsive behaviour. However, in order to protect psychiatric patients it would be recommendable to establish a structured and multidisciplinary assessment of their ability to decide and of the risk of suicide with a EAS request, so that the neurocognitive capacities of the patient are assessed, along with their general mental state based on valid and reliable tests, with follow-up and re-assessment after a certain period of time.

Regarding the terms chronic and incurable, the actual definition of psychological distress includes feelings of desperation, impotence and irreversibility of the pain, with a prolonged duration over time.<sup>6</sup> In a recent study, Lengvenyte et al.<sup>7</sup> analysed the clinical records of 66 patients who had requested EAS in the Netherlands using the data abstraction

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