

Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

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The test for decision-making capacity in common law countries is not the test outlined by Zhong *et al*

In the UK and common law countries the legal test for decision-making capacity is not the test outlined by Zhong *et al*.¹ That test is derived from literature that emanates from the USA.

In common law jurisdictions, adults are presumed to have decision-making capacity, but this presumption can be rebutted for particular decisions if the person has some impairment or disturbance of mental functioning that renders him or her either: unable to comprehend and retain the information that is material to the decision, or; unable to use and weigh the information as part of the process of making the decision.² This common law test was codified into the Mental Capacity Act 2005 (UK) s3(1).

Contrary to Zhong *et al*'s rendering, the common law test does not incorporate an ability to 'appreciate' information. Indeed 'appreciation' was specifically rejected by the UK Law Reform Commission.³ To the extent that appreciation might be relevant it should be considered as part of the ability to comprehend. The 'use and weigh' arm of the common law test does not require that information be 'rationally manipulate[d]'.¹ A competent person must have their decision respected even if his or her reasons are 'irrational'.^{2,4} Choices need not be 'consistent' over time, although if a person were to constantly change his or her mind that might be reason to question the usual presumption of decision-making capacity.^{2,5} The bar for decisional ability does not rise as the risk of harm or complexity of the decision rises – it remains as described in the second paragraph above. However: as the risk increases, the more we should be concerned that the person has capacity, and; as the complexity increases, the more difficult it will be to attain the understanding of the relevant information required to demonstrate capacity.⁵

It is also worth highlighting that although the USA has not ratified the United Nations Convention on the Rights of Persons with Disabilities, almost all other countries, including the UK, have. Article 12 of the Convention places a duty on those who are assessing capacity to assist the person as much as possible to attain that capacity. This changes the process from one of objectively assessing

the patient's abilities to one that determines whether the assessor can assist the patient to achieve those abilities.

- 1 Zhong R, Sisti DA, Karlawish JH. A pragmatist's guide to the assessment of decision-making capacity. *Br J Psychiatry* 2019; **214**: 183–5.
- 2 *Re MB (Medical Treatment)* [1997] EWCA Civ 3093.
- 3 Law Reform Commission (UK). *Report No 231: Report on Mental Incapacity*. HMSO, 1995.
- 4 Ryan C, Szmukler G, Large M. Kings College Hospital Trust v C: using and weighing information to assess capacity. *Lancet Psychiatry* 2016; **3**: 917–9.
- 5 Ryan CJ, Callaghan S, Peisah C. The capacity to refuse psychiatric treatment – a guide to the law for clinicians and tribunal members. *Aust N Z J Psychiatry* 2015; **49**: 324–3.

Christopher James Ryan, Clinical Associate Professor and Consultation-Liaison Psychiatrist, Disciple of Psychiatry and Sydney Health Ethics, University of Sydney and Department of Psychiatry, Westmead Hospital, Sydney, Australia. Email: christopher.ryan@sydney.edu.au

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Authors' reply

Dr Ryan's comparison of UK and Commonwealth jurisdictions versus American jurisdictions highlights important differences in the letter of the law. He rightly states that the 'four abilities model' arises from American case law.¹ The UK and Commonwealth nations have independently developed tests of capacity. Fortunately for medical practitioners who must navigate the difficult waters of comparative jurisprudence, the underlying concepts remain essentially the same.

In the 'four abilities model,' understanding is the ability to 'grasp the fundamental meaning of information communicated by [the] physician'.² It is analogous to the Mental Capacity Act's test of 'comprehend[ing] and retain[ing] the information' that is material to the decision.³ Indeed, the Oxford English Dictionary gives 'to comprehend' as one definition of grasp.⁴

Appreciation is the ability to 'acknowledge [the] medical condition and likely consequences of treatment options'.² Another common description of appreciation is that the person must be able to apply information meaningfully to his or her own situation.⁵ Although it is true that the UK Law Reform Commission specifically rejected the word 'appreciation', the Commission went on to say that a person lacks capacity if 'he or she is unable to make a decision based on the information relevant to the decision, including information about the reasonably foreseeable consequences of deciding one way or another'.³ Making decisions based on relevant information and foreseeable consequences is equivalent to acknowledging a condition and the consequences of treatment and applying that information to oneself when making a choice. Whether this ability is termed 'appreciation' or 'knowing' or some other synonym is less significant.

Reasoning or rational manipulation refers not to the idea that decisions must appear rational to outside observers but that the patient has the ability 'to compare treatment options and consequences and to offer reasons for selection of [an] option'.² Furthermore, 'this criterion focuses on the process by which a decision is reached, not the outcome of the patient's choice, since patients have the right to make 'unreasonable' choices'.² In short, individuals who exhibit the ability to reason in this way are using and weighing information as part of the process of making the decision.

We agree with Dr Ryan, who, together with colleagues, has rightly argued that 'Decision-making capacity is decision- and time-specific'.⁶ Their example was a person with mania who simultaneously has capacity to choose between different mood stabilisers but lacks the capacity to decline mood stabilisers altogether.⁶ The decision-specific nature of capacity gives rise to a sliding scale

because without a variable threshold, the standard for capacity would be the same for all decisions (and not decision-specific).

Finally, although the US government has not ratified the United Nations Convention on the Rights of Persons with Disabilities, American physicians certainly agree that their ethical duty when assessing capacity is to assess the patient's abilities and, where possible, assist incapacitated patients in regaining capacity. The American psychiatric literature is replete with exhortations to restore capacity or enhance decision-making abilities following a finding of incapacity.⁷ We hope that our editorial provides guidance on one aspect of that process of assessment and assistance.

- 1 Berg JW, Appelbaum PS, Grisso T. Constructing competence: formulating standards of legal competence to make medical decisions. *Rutgers Law Rev* 1996; **48**: 345–71.
- 2 Appelbaum PS. Assessment of patients' competence to consent to treatment. *N Engl J Med* 2007; **357**: 1834–40.
- 3 Law Reform Commission. *Report No 231: Report on Mental Incapacity*. HMSO, 1995.
- 4 Oxford English Dictionary. Grasp. Oxford University Press, 2019 (<http://www.oed.com/view/Entry/80878?rskey=S8Bacb&result=2&isAdvanced=false>).
- 5 Appelbaum PS, Grisso T. Assessing patients' capacities to consent to treatment. *N Engl J Med* 1988; **319**: 1635–8.
- 6 Ryan C, Callaghan S, Peisah C. The capacity to refuse psychiatric treatment: a guide to the law for clinicians and tribunal members. *Aust N Z J Psychiatry* 2015; **49**: 324–33.
- 7 Kim SYH. *Evaluation of Capacity to Consent to Treatment and Research*. Oxford University Press, 2010.

Rocksheng Zhong, Lecturer, Department of Psychiatry, Yale School of Medicine, USA; **Dominic A. Sisti**, Assistant Professor, Department of Medical Ethics and Health Policy, University of Pennsylvania; and Director of the Scattergood Program for Applied Ethics of Behavioral Health Care, Perelman School of Medicine, University of Pennsylvania, USA; **Jason H. Karlawish**, Professor, Departments of Medicine, Medical Ethics and Health Policy, and Neurology, University of Pennsylvania; and Co-Director of the Penn Memory Center, Perelman School of Medicine, University of Pennsylvania, USA. Email: rocksheng.zhong@yale.edu

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CORE study: different interpretation of the results

Lloyd-Evans *et al*¹ published results from a cluster-randomised trial looking at the effect on patients of an improvement programme for mental health crisis resolution teams, in which the aim was to increase fidelity with the crisis resolution team model. In the intervention group, the authors found a reduction in admissions and in-patient bed days but no increase in average patient satisfaction. We have two comments about interpretation of their results.

First, the authors report that there was no difference in average patient satisfaction score between the intervention and the control group. They offer a ceiling effect as a possible explanation, given that average patient satisfaction was already high before the intervention. We wonder whether this ceiling effect can be at least partially explained by the timing of their assessment? The authors measured patient satisfaction around the time of discharge from the home treatment team. Patient satisfaction, however, tends to be lower if the time interval between intervention and measurement is larger.² The Mind report, *Listening to Experience*³ – cited by the authors – suggests that patients are far more critical about crisis care, when questioned at a much later date following discharge. Studies reporting patient satisfaction 6 months or longer after the crisis episode are desperately needed.

Second, there remains the question of whether the observed reduction in admissions and in-patient bed days found in the intervention group is related to an increase in the fidelity scores. The crisis resolution teams in the intervention group received additional support to increase both their fidelity to the model and their scores

on the fidelity scale. And yet despite this, the authors also mention in the article, and in the supplementary material (pp. 47–50), that there is no relationship between the fidelity scale scores and the reduction in admissions and in-patient bed days.

This makes us wonder about what are the causal factors in reducing admissions and in-patient bed days? It seems that an increase in scores on the fidelity scale is not necessarily essential to achieving this. This observation is important for us as practicing clinicians. The results here suggest that we ought to be aiming to secure the actual intervention itself, namely the access to a facilitator, the opportunity to discuss team improvement at a specially arranged day and the development of a service improvement plan and not be focusing on getting higher scores on the fidelity scale.

- 1 Lloyd-Evans B, Osborn D, Marston L, Lamb D, Ambler G, Hunter R, et al. The CORE service improvement programme for mental health crisis resolution teams: results from a cluster-randomised trial. *Br J Psychiatry* 2019; **xx**:xx–xx.
- 2 Jensen HI, Ammentorp J, Kofoed PE. User satisfaction is influenced by the interval between a health care service and the assessment of the service. *Soc Sci Med* 2010; **70**: 1882–7.
- 3 Mind. *Listening to Experience: An Independent Inquiry into Acute and Crisis Mental Health Care*. Mind, 2011.

Pang Loong Wong, Specialty Registrar in Psychiatry, South West London and St George's NHS Trust, UK; **Robert Bertram**, Psychiatrist, South West London and St George's NHS Trust, UK; **Dieneke Hubbeling**, Psychiatrist, South West London and St George's NHS Trust, UK. Email: Adrian.Wong@swlstg.nhs.uk

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Authors' reply

We agree with the thoughtful letter by Wong and colleagues up to a point. The Crisis team Optimisation and RElapse prevention (CORE) Fidelity Scale for crisis resolution teams (CRTs) was based mainly on stakeholders' opinions rather than robust empirical evidence regarding components of effective crisis care.¹ Some fidelity items may be more important than others, and some items may not constitute critical ingredients of effective CRTs.

The CORE service improvement programme evaluated in our trial² built in a lot of flexibility and ownership for teams to choose their own goals for improving their service and plan how these would be achieved, in their local context, given their available resources. This flexibility in the programme was valued by the teams. We agree that giving CRT teams dedicated time and space to reflect on their team's performance and how this could be improved, and offering support from an experienced clinician (the CRT facilitator), are both important components of the programme.

We do not recommend that practitioners should ignore CRT model fidelity, however, for two reasons. First, the CORE CRT Fidelity Scale specifies many aspects of CRT service organisation and delivery, and the total fidelity score is a fairly blunt measure. Although our trial found no relationship between CRT total fidelity score and hospital admission or CRT patients' readmission rates, we did find relationships between these outcomes and fidelity scale subscale scores, as reported in our paper.² Our results suggest that to avert hospital admissions requires rapid, easy access to CRT care (the access and referrals subscale); while to help CRT patients recover and avoid readmissions to acute care requires provision of good quality CRT care (the content of care, and timing and location of care subscales). This makes intuitive and clinical sense. Different fidelity items may be most important for different outcomes but are diluted in the total fidelity score.

Second, seeking to improve model fidelity was an integral part of our trial's successful CRT service improvement programme. CRT teams' whole-team scoping day and their service improvement