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National survey of training of psychiatrists on advance directives to refuse treatment in relation to bipolar disorder.

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Abstract

Aims and Methods: To determine features associated with better perceived quality of training for psychiatrists on advance decision-making in the Mental Capacity Act (MCA), and whether the quality or amount of training were associated with positive attitudes or use of advance decisions to refuse treatment (ADRTs) by psychiatrists in people with bipolar disorder (BD). An anonymised national survey of 650 trainee and consultant psychiatrists in England and Wales was performed.
Results: Good or better quality of training was associated with use of case summaries, role-play, ADRTs, assessment of mental capacity and its fluctuation. Good or better quality and two or more sessions MCA training were associated with more positive attitudes and reported use of ADRTs, although many psychiatrists would never discuss them clinically with people with BD.
Clinical implications: Consistent delivery of better quality training is required for all psychiatrists to increase use of ADRTs in people with BD.

149 words

Key words: Advance directives; advance health care planning; bipolar disorder; health legislation.

Introduction

The Mental Capacity Act 2005 (MCA) in England and Wales provides a legal framework for personal welfare and financial decisions to be made in advance by individuals, who later due to an impairment or disturbance of functioning in the mind or brain, may be unable to make these decisions for themselves (1). If capacity is not present, a decision can be made on behalf of the person based on what is in their best interests taking consideration of their wishes using three specific provisions of the MCA for advance decision-making:

1. Advance Decision to Refuse Treatment (ADRT), a legally binding provision preventing specific treatment ;
2. Statement of Wishes and Feelings (ASWF), a non-legally binding statement of preferences for treatment, and/or personal and financial affairs;
3. Lasting Power of Attorney (LPA), a legally binding direction identifying who will look after the person's personal and financial affairs.

Clinicians and their employers, especially psychiatrists, are legally required to "have regard to" MCA guidance and, if later asked, prove that they did (1, 2). Therefore there is an expectation that psychiatrists receive training in the MCA. However, the methods and amount of training that psychiatrists should receive are not specified, nor has the quality or amount of training been related to attitudes or use of ADRTs in practice. We chose to examine the attitudes to and use of ADRTs by psychiatrists as these may be seen as restrictive in terms of treatment offered by psychiatrists to people with BD. In a national survey of general adult and old age psychiatrists in England and Wales, we wished to explore how the quality and amount training they have received may be associated with their implementation of ADRTs in people where capacity is lost e.g. mania, severe depression and regained e.g. bipolar disorder (BD) to complement a survey of service user experience in BD (3).

Methods

Objectives and design

1. To determine what aspects of training in the MCA were associated with higher or low perceived quality of training in the view of psychiatrists.
2. To examine whether the quality and amount of training were associated with reported attitudes or use of Advance Directives to Refuse Treatment (ADRT) in people with BD.

We anticipated that high quality training may be required to overcome professional resistance to the use of ADRTs should any be present.

Participants

Inclusion/exclusion criteria:

a) Participants practice within England and Wales i.e. the jurisdiction of the Mental Capacity Act 2005;
b) Specialise in either general adult or old age psychiatry;
c) They were consultant psychiatrists or in training grades (CT1-CT3, ST4-ST6).;

Procedure:

We aimed to recruit a national sample of 500 psychiatrists in a 12 month period for the survey. No data were available for a formal power calculation. The study was advertised with the help of the National Institute of Health Research funded Mental Health Research Network (MHRN) and the Royal College of Psychiatrists. The Royal College of Psychiatrists agreed to publicise the study by tweeting the link to the survey, and the study team also attended a national conference organised by the Royal College of Psychiatrists to publicise the study. Consultants, senior and junior trainees in general adult and old age psychiatry were selected from different regions to ensure maximum variance of practical clinical experience. To maximise the participation rate of psychiatrists and the frankness of their responses, we anonymised the survey, not asking for personal information such as age, gender or workplace, and placed it on line or if they preferred we administered it face to face, by telephone or posted it.

Measures.

The survey was divided into nine sections that addressed the following topics:

- Section A: Preliminary information - position, years since qualification, place of work (e.g. inpatient, crisis team), geographic location.
- Section B: Mental Capacity Act Training - how many sessions attended, whether mandatory, how recent, whether training considered advance decision-making that included ADRTs, nature of training, quality of training e.g. in your opinion how much of the training focused on advance decision-making (including ADRTs) – a significant amount, a reasonable amount, a minimal amount, none?
- Section C: ADRTs and bipolar disorder - whether they had experience of patients making ADRTs, whether they had advised on making ADRTs, content of ADRTs, factors influencing their decision to advise regarding ADRTs.
- Section D: ADRTs and other conditions - Content of ADRTs.
- Section E: ADRTs and the Mental Health Act 1983 - whether they had encountered ADRTs in context of patients admitted to psychiatric units or sectioned under the MHA.
- Section F: ADRTs in clinical practice - how often should they be discussed e.g. in your opinion how often do you feel that discussion of ADRTs should take place – at every consultation, every six months, at care programme approach (CPA) meetings, only when I think I might be relevant, only when another health or social care professional raises the topic, only if the patient or carer raises the topic or never?
- Section G: Advance statements of wishes and feelings - whether had experience of patients using these; what was contained, whether frequency changing among people with bipolar disorder.
- Section H: ADRTs and implementation of the Mental Capacity Act - whether they had experience of patients using ADRTs and their contents;
- Section I: Lasting powers of attorney - whether they had experience of patients making LPAs, who advised on these.

Analysis.

Descriptive statistics were employed in the survey to explore the professional characteristics of psychiatrists and their experience of training. Univariate analysis indicated that several demographic or service provision factors may be associated with the use of the MCA. Binary logistic regression was applied to three separate analyses: 1. the quality of training (dependent variable) perceived by psychiatrists was explored in relation to the methods, site and content of training; 2. the quality of training (dependent variable) was then related to attitudes and experiences of psychiatrists to

implementing ADRTs in their clinical practice; 3 the amount of training (dependent variable) was related to their attitudes and experiences of implementing ADRTs. Checks for collinearity were applied by exploring the Spearman correlations between the independent variables that might enter the logistic regression. None of the independent variables were excluded because of collinearity. Odds ratios (ORs) and 95 per cent confidence intervals (CIs) are presented for any significant variables.

Results

A total of 650 psychiatrists were recruited for the survey. Table 1 shows the grade, work setting, country of medical training, and duration of time since medical qualification of this sample. Within the sample, there were 374 (57.5%) consultants in general adult or old age psychiatry, and the remainder were trainees, with a slight majority qualified in medicine outside the UK. Psychiatrists were recruited for the study between May 2011 and June 2012. Of 607 respondents who identified the geographic location of their work, 133 (21.9%) were from the West Midlands, 116 (19.1%) from the East Midlands, 80 (13.2%) from the Southwest, 116 (19.1%) from the South East, 74 (12.2%) from the East of England, 46 (7.6%) from London and 10 (1.6%) from the North West of England.

Table 1 about here

Table 1 shows the number of training sessions, methods used for training, source of the training, quality of training and reasons for attending the training: 595 (91.5%) had attended at least one training session on the MCA; 465 (71.5%) had attended two or more sessions; and 326 (50.1%) had been to a training session in the previous year. Of the 595 psychiatrists trained in the MCA, 489 (75.2%) had been trained by their local NHS Trust. The quality of the training was perceived to be high, with 446 (75.0% receiving training) rating it as good, very good or excellent (see Table 1). However, 209 (35.1% receiving training) psychiatrists stated that either minimal or no attention was paid to ADRTs in the training sessions.

Table 2 about here

Table 2 examines the binary multiple logistic regression associations between the quality of training and the methods of training, the site of training, the number of training sessions and topics covered in the training. Compared with average or poor training, good or better (very good or excellent) training was associated positively with the use of case summaries, role play, coverage of advance decision making (including ADRTs) and assessment of capacity. Video feedback was only carried out in good or better quality of training (44 or 9.9%, Fisher's exact 2-tailed test $p<0.001$). Average or poor training was associated with training in their own NHS Trust compared to good or better training (Table 2). In relation to the specific use of advance decision-making including ADRTs and the need to be able to assess fluctuating capacity in conditions such as BD with highly variable severity and therefore capacity, it is notable that even good or better quality training covered these issues in only just over 45% and 37% of cases respectively.

Only 94 (14.5%) of surveyed psychiatrists had encountered a patient with BD who had made an ADRT; 136 (20.9%) had encountered a patient with BD who had made an oral or written statement

of wishes and feelings; and 91 (14.0%) had encountered a patient with BD who had made an LPOA relating to health or personal welfare. Of the 259 psychiatrists expressing an opinion, 208 (80.3%) considered that the number of people with BD making ADRTs had remained the same since the implementation of the MCA in 2007, and 41 (15.8%) considered that it had increased by less than 10 per cent. Of the 252 psychiatrists expressing a view regarding statements of wishes and feelings by people with BD, 187 (74.2%) thought that the frequency remained the same since the MCA came into force, and 46 (18.3%) that it had increased by less than 10 per cent.

Table 3 about here

Table 3 displays the binary multiple logistic regression associations between the quality of training and the discussion of ADRT with patients with BD or other patients who may lose mental capacity but then regain it. Compared with average or poor training, good or better training was associated with fewer psychiatrists who never discuss ADRTs with patients, and fewer psychiatrists who believed that they had insufficient time to discuss ADRTs with patients. Table 3 also shows that compared with only receiving one training session on the MCA, receiving two or more training sessions was associated with more psychiatrists discussing ADRTs at Care Programme Approach meetings and fewer psychiatrists who believed that they had insufficient training to discuss ADRTs with patients. There were no other associations between the quality of MCA training or number of MCA training sessions and reported practice or beliefs about implementing ADRTs.

However, 206 (46.3%) psychiatrists would not discuss ADRTs even if the person with BD or carer raised it, and even after good or better training 96 (21.5%) would never discuss ADRTs. Furthermore, 177 (39.7%) and 178 (38.3%) of psychiatrists still believed they had insufficient training and time to discuss ADRTs in clinical practice despite good or better training and two or more training sessions respectively.

Discussion

Although the need for training of psychiatrists and other clinical health staff in the MCA is often recommended or even required (1,2,4,5), and clinical guidelines also support the importance of considering the MCA in people with bipolar disorder (6), there is an assumption that all training is likely to help clinicians become more familiar with the MCA and that such training will improve attitudes and use in practice of the MCA by psychiatrists. We found that there was plenty of training in the MCA being offered to and taken up by psychiatrists at trainee and consultant level; 92 per cent of trainee and consultant psychiatrists had received at least one training session on the MCA with 50 per cent receiving the training in the last year. Although 75 per cent of psychiatrists rated their training in the MCA as good or better, ADRTs were only covered in 65 per cent of the MCA training.

Psychiatrists preferred MCA training that was not didactic and merely information giving, rating training as good or better that utilised discussion of the MCA in relation to case summaries, used role-play, and covered topics such as advance decisions to refuse treatment, the assessment of capacity and the assessment of fluctuating capacity. Although the assessment of mental capacity was usually covered in MCA training, the topic of fluctuating capacity was rarely discussed while the potentially challenging issue of ADRTs was discussed in only 39 per cent of MCA training attended by

psychiatrists. Therefore in the view of the authors, training of psychiatrists was rarely of sufficient quality to meet the needs of people with BD under the MCA. Training arranged by NHS Trust was not perceived to be as good as training provided by the Royal College of Psychiatrists, law firms or other external agencies. The reasons for this view are unclear.

There was some evidence that good or better quality MCA training received by psychiatrists was associated with fewer psychiatrists reporting that they would never discuss ADRTs under any circumstances. Receipt of two or more sessions of MCA training was associated with an increased likelihood that ADRTs would be discussed routinely in multidisciplinary Care Programme Approach meetings. Both better quality and more training sessions were associated with a reduced likelihood that psychiatrists had insufficient time to address ADRTs. While these data are associations and not a comparison of interventions delivered in a randomised controlled trial, there was some evidence that higher quality training and more than one training session may be helpful in both improving the attitudes to and use in clinical practice of ADRTs by psychiatrists in patients with BD or other patients who lose and then regain mental capacity. Another alternative explanation is that psychiatrists who are interested in helping people with BD through the MCA attend more than one session of training and find better quality training.

Nevertheless offering training in the MCA that psychiatrists perceive as good or better quality seems insufficient to improving their attitudes to ADRTs and their use in practice in people with BD. Even after good or better training, 22 per cent of psychiatrists would never discuss ADRTs under any circumstances, 46 per cent would not discuss ADRTs even if the person with BD or carer raised it, and 39 per cent believed they had insufficient training and time to discuss ADRTs in clinical practice. These findings chime with the experience of people with BD in a national survey we carried out (3) where neither knowledge nor use of ADRTs were associated with seeing a psychiatrist, although knowledge and use of ADRTs were associated with seeing other mental health professionals and attendance at peer support groups.

A strength of the survey was that to our knowledge it is the first of its sort inquiring into quality of training of psychiatrists and relating it to their attitudes and use of ADRTs with people with BD. The survey was large, national and deliberately anonymised so psychiatrists would feel able to comment frankly without any possible constraint. We judged that this advantage of the methodology outweighed the disadvantage that we do not know how many psychiatrists had the opportunity to take part in the survey but decided not to. We also do not know much about the characteristics of psychiatrists in terms of the demographic characteristics of who did or did not take part in the survey. A further limitation was that this survey was completed four years ago so the quality of training and use of ADRTs in clinical practice may have improved. Furthermore by concentrating on MCA training in relation to ADRTs in BD, we cannot comment on other aspects of MCA training on other forms of advance decision-making, application of ADRTs in people who are less likely to regain mental capacity and deprivation of liberty.

The findings confirm those of a four year reaudit study where increases in MCA training and improved documentation had a minimal impact on the recording of the MCA by psychiatrists in patient records (7). There seems to be some consistency in studies of advance planning that the therapeutic relationship between mental health professionals, including psychiatrists, and their

patients is improved with advance planning (8, 9). The House of Lords (2014) heard much evidence that the implementation of the MCA had failed to make much of an impact on clinical practice in the way that was intended, and made 39 recommendations to improve the implementation of the MCA (4). We have not had the opportunity to study the effects of these recommendations but note that none of these relate to the quality or amount of training that psychiatrists or other health professionals receive in relation to the MCA. The Academy of Royal Medical Colleges were asked to report on measures to improve the uptake of the MCA (4, 5). So far it has organised educational events on the MCA of its own but has not made recommendations on the content, form, amount or frequency of training that psychiatrists or other health professionals should receive in relation to the MCA (10).

Therefore we conclude that there is a need to improve the quality of training that psychiatrists receive on the MCA so that fluctuating capacity and ADRTs are covered, and that techniques such as case summaries and role-play are employed to improve confidence and competencies of psychiatrists in its use. There may be a case for adding training in the MCA to mandatory training under the 1983 Mental Health Act section 22 training regulations. There is a need for further implementation research on ways to improve the knowledge and use of the MCA, including ADRTs, by people with BD or other conditions where capacity is lost and then regained, and also on how to improve the attitudes of psychiatrists and assist them further to discuss ADRTs with people who have BD or similar conditions.

2,974 words

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Declaration of Interests.

The authors report no conflict of interests.

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336 **Table 1: Professional characteristics and nature of MCA training of psychiatrists (n=650)**

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	Work characteristic	Number	%
Grade	Consultant general adult psychiatry	283	43.5
	Consultant old age psychiatry	91	14.0
	ST4-6 trainees	111	17.1
	CT1-3 trainees	130	20.0
	Missing	35	5.4
Main work setting	Community mental health team	349	53.7
	In-patient	216	33.3
	Crisis team/EIP/ACT	77	11.9
	Missing	8	1.2
Years since medical qualification	0-10	210	32.3
	11-20	241	37.1
	21-30	146	22.5
	30+	51	7.8
	Missing	2	0.3
Country of medical qualification	United Kingdom	306	47.1
	European Union	51	7.8
	Outside European Union	288	44.3
	Missing	5	0.8
Number of training sessions	0	55	8.5
	1	128	19.7
	2	183	28.2
	3	113	17.4
	>3	169	26.0
	Trained but missing data	2	0.3
Method of training[1]	Case examples	491	75.5
	Role play	82	12.6
	Watch video	44	6.8
	None of these	86	13.2
Source of training[1]	Local NHS Trust	489	75.2
	Royal College of Psychiatrists	133	20.5
	Legal or Solicitor	48	7.4
	Pharmaceutical company	35	5.4
	Other	89	13.7
Perceived quality of training	Excellent	24	4.0
	Very good	153	25.7
	Good	269	45.2
	Average	134	22.5
	Below average	12	2.0
	Missing	58	8.9
Primary reason for attending	Mandatory NHS Trust training	172	28.9
	Approved Clinician training	194	32.6
	Educational event	128	71.5
	Personal interest	79	13.3
	Other	22	3.7
	Missing	55	8.4

338 [1] Categories are not mutually exclusive

339 **Table 2: Content and method training related to perceived quality of training in MCA (n=588)**

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Training characteristic	Quality of training				Multivariate statistics		
	Good or better (*n* = 444)		Average or worse (*n* = 144)				
	No.	%	No.	%	Odds Ratio	95% CI for Odds Ratio	*P*-Value
Used role play	76	17.1	26 6	4.1	3.32	1.37,8.07	0.008
Training in advance decision-making[1]	203	45.6	26	17.8	2.58	1.54, 4.31	< 0.001
Capacity assessment	410	92.3	107	74.3	2.80	1.56, 5.02	0.001
Training in their NHS Trust	355	80.0	132	91.7	0.39	0.20, 0.77	0.007

341 55 psychiatrists received no MCA training, 7 missing responses.

342 [1] including Advance decision to refuse treatment

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Table 3. Relationship between quality and amount of training on MCA and barriers to implementing ADRTs.

Training characteristic	Quality of training				Multivariate Statistics		
	Good or better (*n* = 444)		Average or worse (*n* = 144)				
	No.	%	No.	%	Odds Ratio	95% CI for Odds Ratio	P-Value
Never discuss ADRT[1]	96	21.5	48	32.9	0.53	0.35, 0.79	0.010
Insufficient time to do ADRT[1]	177	39.7	79	54.1	0.57	0.37, 0.88	0.002
	Amount of Training						
	≥2 sessions (*n* = 465)		1 session (*n* = 127)				
Discuss ADRT[1] routinely at Care Programme Approach meetings	77	16.6	11	8.7	2.372	1.17, 4.83	0.017
Insufficient training to do ADRT[1]	178	38.3	80	63.8	0.41	0.27, 0.63	<0.001

[1] ADRT = Advance Decision to Refuse Treatment;

55 psychiatrists received no MCA training, 7 missing responses on quality of training and 3 missing responses on amount of training.