

## Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

## Contents

- Avoiding hard capacity assessments will not help
- Authors' reply
- A contextual approach to routinely elicit a trauma-oriented history
- Conclusions in Gryglewski et al may not be warranted
- Response letter to the article by Killackey et al (2019) 'Individual placement and support for vocational recovery in first-episode psychosis: randomised controlled trial'

## Avoiding hard capacity assessments will not help

We read with interest Zhong et al's editorial outlining a 'pragmatist's guide' to assessment of decision-making capacity.<sup>1</sup> The authors argue that a subset of 'grey area' capacity cases cause 'moral distress' in clinicians and propose that 'capacity is only practically important when the treatment team is willing to proceed with forced treatment. Absent this condition, the outcome would be the same as simply honouring the patient's choice, and there is no need (apart from intellectual satisfaction) to assess capacity'. In our view, this is problematic advice.

Some capacity assessments are easily resolved, and Zhong et al give helpful examples of cases where time, education, treating illness and negotiating with the person negate capacity questions. Indeed, in England and Wales, the Mental Capacity Act (MCA) lays out the imperative to do this.<sup>2</sup> Yet to collapse all hard capacity questions into a coercion test fails to grapple with the range of clinical sources of 'moral distress' and the legal doctrine of informed consent.

First, the question 'would we force treatment?' is not necessarily an easy one. Decisions about coercion generated moral discomfort in clinicians long before capacity emerged as a legal construct,<sup>3</sup> and discomfort can arise when forced treatment is not at issue: consider a person with depression assenting to electroconvulsive therapy because she feels that she deserves punishment. Furthermore, the question 'would we force treatment?' is all too easily reduced to its sibling: 'can we force treatment?' The authors raise the issue of whether adequate resources are available to restrain a person who refuses antibiotic treatment, arguing that if not, the capacity question is moot. However, even with such resources readily available, the ethical question persists: is forcing treatment the right thing to do in this case? This holds in all capacity cases, not merely grey area cases.

Several Court of Protection determinations have upheld the wishes of a person found to lack capacity, ruling out coercion, through a careful 'Best Interests' process (see for example *Wye Valley NHS Trust v B*).<sup>4</sup> This involves recognition of current and prior wishes of the person, advance directives and views of family. Zhong et al's alternative model is a risk-benefit analysis carried out by clinicians. It is telling that they consider medical risks only (pressure sores, prolonged hospital stay) and pay little import to the perspective and lived experience of the person facing coercion. The MCA also provides a defensible process for clinicians, with

capacity assessments providing legal clarity on where decisional authority lies.

The authors contrast a scenario in which a patient who is hypomanic faces imminent death by sepsis with a scenario in which the infection is mild and out-patient antibiotics will suffice. Yet such vastly different facts, contexts and consequences of a decision can be legitimately incorporated into a capacity assessment as a component of the 'relevant information' that a person must 'understand, retain, use or weigh' under the MCA.

Avoidance is not the best approach to moral distress. More research on hard capacity cases and on education and training to improve approaches to them is a healthier path.<sup>5</sup>

## Declaration of interest

The authors are all core researchers in the 'contested capacity' workgroup, part of the Mental Health and Justice Project funded by a grant from the Wellcome Trust (203376/2/16/Z). N.K.'s MD(res) degree is supported by a grant from Mental Health Research UK and the Schizophrenia Research Fund.

- 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 Department of Health. *The Mental Capacity Act 2005, Section 1(3)*. Stationary Office, 2015.
- 3 Austin WJ, Kagan L, Rankel M, Bergum V. The balancing act: psychiatrists' experience of moral distress. *Med Health Care Philosophy* 2008; **11**: 89.
- 4 *Wye Valley NHS Trust v B* [2015] EWCOP 60.
- 5 Mental Health and Justice Project. Contested assessment [Internet]. London UK: Mental Health and Justice Project; 2019. Available from: <https://mhj.org.uk/workstreams/6-contested-assessment/>

**Nuala Kane**, ST4 Psychiatry, Mental Health Research UK MD(Res) Scholar, King's College London, UK; **Alex Ruck Keene**, Barrister, Wellcome Research Fellow and Visiting Senior Lecturer, King's College London, UK; **Gareth Owen**, Psychiatrist, Reader and Lead, Mental Health, Ethics and Law Research Group, King's College London, UK. Email: [nuala.1.kane@kcl.ac.uk](mailto:nuala.1.kane@kcl.ac.uk)

doi:10.1192/bjp.2019.229

## Authors' reply

Kane et al claim that we 'collapse all hard capacity questions into a coercion test [which] fails to grapple with the range of clinical sources of "moral distress" and the legal doctrine of informed consent.' We do not take this position. We identify a narrow set of circumstances that permit capacity evaluators to look past the overt question – does this patient have capacity? – and address the covert but more practically meaningful question – what should clinicians do when the patient declines the treatment recommendation? If it turns out that all parties actually agree that involuntary treatment is not available, feasible or appropriate, then the apparent conflict dissolves.

Nevertheless, Kane and colleagues rightly point out that the determination of whether a treatment is available or 'medically indicated' can itself pose an ethical dilemma. Forced treatment is almost always contentious, as it infringes upon people's liberty and autonomy interests. But even voluntary treatments can provoke moral distress if the validity of consent is in doubt or if clinicians regard a requested intervention as futile. Kane et al. seem to suggest that our approach avoids these issues.

On the contrary, we believe that our method puts the focus right where it belongs: on the practical problem of providing involuntary treatment. Capacity status can be an important consideration, but in the most difficult cases, it is seldom determinative on its own. In proposing that capacity evaluators 'collaborate closely with treatment providers', we do not advocate that evaluators should abdicate their responsibility to engage in moral discussion about a patient's situation. Nor do we encourage practitioners to make unilateral

moral judgements based only on 'medical risks.' Instead, capacity evaluators play the vital role of helping treaters recognise the true source of their moral distress. In those cases, referral to broader decision-making bodies such as ethics committees or the courts is appropriate.

**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

doi:10.1192/bjp.2019.230

### A contextual approach to routinely elicit a trauma-oriented history

Thanks to Dr Ingrassia for her recent editorial on the Independent Inquiry into Child Sexual Abuse in the UK with an emphasis on the need for the sensitive and well-informed clinician to proactively and routinely ask about sexual abuse.<sup>1</sup>

In our study of child sexual abuse (CSA) history among psychiatric consultations in a general hospital emergency room, we found that 38% of individuals (adults and minors) referred for psychiatric consultation over a 2-year period described having experienced sexual abuse during their childhood.<sup>2</sup>

We used a semi-structured questionnaire with language that was appropriate to age and cultural background in order to routinely enquire whether the patient had experienced physical, emotional or sexual abuse during their childhood in accordance with a widely accepted definition of sexual abuse.<sup>3</sup> This approach is consistent with the research that multiple forms of adverse childhood experiences may coexist.<sup>4</sup> We believe that a contextual approach like this is more likely to promote a discussion of the person's trauma narrative. Using this paradigm, with appropriate training, it is hoped that medical and paramedical clinicians will be able to sensitively and routinely take a comprehensive trauma-oriented history in every patient. In this way, the patient's presenting problem may be understood and treated with an understanding of 'what has happened to this person'.

It is worth mentioning that adverse childhood experiences including sexual abuse is not only associated with an increase in lifetime prevalence of mental illness but also of physical illness. There is evidence linking early-life stress to reduced telomere length in a study of physically and psychiatrically healthy adults with or without a reported history of childhood trauma. These early experiences may affect adult health in two ways: either by cumulative damage over time or by the biological embedding of adversities during sensitive developmental periods.<sup>4</sup> Mediating factors between CSA and physical illness include neuroendocrine dysfunction, metabolic syndrome and chronic inflammation.<sup>5</sup>

To the best of our knowledge our study is the first to investigate CSA history during hospital emergency room psychiatric consultations. It is hoped that there will be an increased awareness of CSA during psychiatric consultations in a general hospital setting.

Interventions for past CSA should include the nature of early-life trauma and its effects on psychobehavioural factors. When healthcare providers counsel victims of childhood abuse, they should consider the long-term psychological and physical well-being necessary to counter adverse responses to abuse such as disordered eating, lack of exercise, sleeping problems and depressive symptoms. They should also promote healthier ways to cope with trauma. Such psychological interventions would have the potential to prevent or reduce physical health problems in later life.<sup>4</sup>

- 1 Ingrassia A. The Independent Inquiry into Child Sexual Abuse in the UK: reflecting on the mental health needs of victims and survivors. *Br J Psychiatry* 2018; **213**: 571–3.
- 2 Jaworowski S, Golmard JL, Morag Engelberg M, Priejs S, Lital Twizer L, Gropp C, et al. Case-control retrospective study of child sexual abuse history among psychiatric consultations in a general hospital emergency room. *IMAJ* 2019; **21**: 77–81.
- 3 Finkelhor D, Hotaling GT. Sexual abuse in the National Incidence Study of Child Abuse and Neglect: an appraisal. *Child Abuse Negl* 1984; **8**: 23–32.
- 4 Shonkoff JP, Boyce WT, McEwen BS. Neuroscience, molecular biology, and the childhood roots of health. Disparities building a new framework for health promotion and disease prevention. *JAMA* 2009; **301**: 2252–9.
- 5 Anda RF, Felitti VJ, Bremner JD, Walker JD, Whitfield C, Perry BD, et al. The enduring effects of abuse and related adverse experiences in childhood: a convergence of evidence from neurobiology and epidemiology. *Eur Arch Psychiatry Clin Neurosci* 2006; **256**: 174–86.

**Sol Jaworowski**, Shaare Zedek Medical Centre, Israel; **Cornelius Gropp**, Psychiatrist, Shaare Zedek Medical Centre, Israel. Email: solj@szmc.org.il

doi:10.1192/bjp.2019.231

### Conclusions in Gryglewski et al may not be warranted

A number of issues not addressed in Gryglewski et al require comment and clarification.<sup>1</sup> First, the authors show that a significant increase in volumes in amygdala nuclei, hippocampus, putamen and cortical thickness occurred following a course of electroconvulsive therapy (ECT) in 12 patients. However, it is not stated whether these patients' brain structures average size at baseline is significantly different to what we would expect to find in a healthy cohort, or what percentage of the sample fall below the norm. If this is not clarified, we need to understand why brain structure sizes that may fall within a normal distribution would require enlarging.

Second, patients had two scans before ECT and the authors present the average of the two scans as baseline measures. The authors omit to say how different the measurements were between the two pre-ECT scans, which would inform the reader as to the accuracy of each magnetic resonance imaging reading. This is important since the same procedure was not employed at termination of treatment.

Third, the authors attribute the increase in volume to a process of neurogenesis, which they consider a positive outcome. However, they do not seem to take into account the possibility that the neurogenesis may not be benign but be the result of the electrical insult inflicted on the brain, and that the proliferation and morphology of the newly created neurons may not be normal. Neurogenesis has also been observed to occur in similar areas of the brain following intake of lithium and other mood stabilisers, but it was found that the number and morphology of the cells were abnormal, with 'increasing growth of cone formation, leading to the spreading of the neuron and a shorter neuronal axon'.<sup>2</sup> If such cellular proliferation in the areas connected with memory is a positive outcome, rather than a pathological reaction to a brain insult, then widespread memory and cognitive impairment found in a large percentage of patients who have had ECT<sup>3</sup> needs explaining.

Fourth, and related to the last point, there is no data presented on the incidence of adverse effects following ECT (disorientation, confusion, memory loss, concentration, impairment in abstract reasoning, overall level of cognitive functioning, docility, lethargy and apathy), which may impact on the ability to perform a post-treatment test.

Finally, the authors bemoan the difficulty with recruiting 'suitable patients' and ended up with a very small sample. In an era of antidepressant-induced treatment-resistant depression,<sup>4,5</sup> I suspect