

# Exploring training, involvement and confidence: a study of healthcare professionals in decision-making capacity assessments

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## ABSTRACT

**AIM:** To explore the training, involvement and confidence of healthcare professionals involved in decision-making capacity (DMC) assessments, and to compare any differences between those conducting and those involved in, but not conducting DMC assessments.

**METHOD:** A 10-minute anonymous, online survey was conducted with both closed and open questions. A total of 78 participants completed the survey.

**RESULTS:** Training was lacking in quantity and adequacy. Only 14.1% received formal training during and post their qualification and only 38.5% reported the right amount of training. Just over 55% reported having the right amount of involvement, with 18% having too much and 27% having not enough involvement. A significantly higher response was given for having too much involvement by those conducting DMC assessments ( $p=0.006$ ), while those not conducting felt they do not have enough involvement ( $p<0.001$ ). Only 25.6% ( $n=20$ ) were very confident in being able to explain DMC to a patient.

**CONCLUSIONS:** Healthcare professionals working in this area urgently require support in the form of formal training and defined roles. Given what can be at stake for an individual undergoing a DMC assessment, it is imperative that improvements are made to upskill the workforce and utilise expertise of all healthcare professionals.

Decision-making capacity (DMC) assessment is a complex task that requires both clinical skills and knowledge of legal and ethical bounds.<sup>1</sup> DMC is legally measured by the ability to understand the nature and purpose of a decision, retain relevant information for the required time, use or weigh this information as part of a reasoning process, including consequential thinking, and communicate their decision.<sup>2</sup> DMC assessments can vary in depth substantially.<sup>3</sup> They can take the form of informal and formal assessments.<sup>4</sup> Informal assessments occur frequently within the process of gaining informed consent for treatment, while formal assessments occur following a trigger that puts an individual's DMC into question.<sup>2</sup> An opinion is then required under the *Protection of Personal and Property Rights Act (PPPR) 1998* to support legal proceedings such as the activation of enduring power of attorney (EPOA) or an application in the family court.<sup>2</sup>

The demand for DMC assessments is likely to rise in an ageing world,<sup>5</sup> with corresponding increases in neurodegenerative diseases and the passing of assisted dying laws.<sup>6,7</sup> A highly skilled and knowledgeable healthcare workforce is required to meet

this demand. However, previous research has highlighted a lack of training and knowledge among healthcare professionals involved,<sup>8-11</sup> and confusion around who is best placed to conduct these assessments.<sup>10,11</sup> As reported in a New Zealand-based qualitative study, none of the 12 general practitioners (GPs) who participated had received formal undergraduate training in DMC assessments and many lacked confidence in conducting these assessments.<sup>11</sup> In addition, 19% of GPs and 18% of hospital doctors who completed a New Zealand survey incorrectly answered the question on what to do when a patient lacks capacity.<sup>10</sup> Alam et al. found in a qualitative study in Australia that most GPs struggled to identify whether a patient with dementia was competent to make the decision in question.<sup>8</sup> Additionally, Lamont et al. concluded from a survey involving healthcare professionals of multiple disciplines that there is a lack of understanding that capacity is a legal construct, and knowledge gaps were found in understanding the legislative frameworks.<sup>9</sup> There is also disagreement and confusion around *who* can and should assess capacity. Some studies found GPs mostly considered DMC assessments to be part of their

responsibility due to their ongoing relationship with the individual.<sup>11</sup> Conversely, it has been found that 24% of GPs and 30% of hospital doctors did *not* believe it was their responsibility to conduct DMC assessments.<sup>10</sup> Involvement of other healthcare professions appears to be varied. Recent studies have highlighted the contribution of occupational therapists and social workers in DCM assessments,<sup>12,13</sup> but it was nearly 10 years ago when research was conducted to explore the roles of clinical psychologists/neuropsychologists<sup>14,15</sup> and speech-language pathologists.<sup>16</sup> In some jurisdictions, social workers and speech-language therapists are recognised for undertaking DMC assessments, for example under the *Mental Capacity Act 2005* in England and Wales.<sup>17</sup> Allied health professionals have a valuable contribution to make in DMC assessments; however, it is unclear how often and to what extent each discipline is involved.

In New Zealand, formal DMC assessments are within the scope of all doctors.<sup>10</sup> Clinical psychologists and neuropsychologists can also complete formal DMC assessments,<sup>18</sup> and more recently, nurse practitioners have a range of formal assessments

included in their scope of practice.<sup>19</sup> Clinical neuropsychologists are often involved in more complex, formal assessments where a more in-depth assessment is required.<sup>3</sup> These assessments usually consist of objective testing from different sources of information and clinical judgement.<sup>3</sup> Nurses and allied health professionals (e.g., social workers, occupational therapists, speech-language therapists) are often involved in, or contribute to, DMC assessment as part of their clinical role.<sup>19</sup> However, the Australasian literature on DMC assessment by non-medical health professionals is very limited.<sup>20</sup>

The aim of the current study was to explore whether there are any differences in the *training*, *involvement* and *confidence* between healthcare professionals involved in DMC assessments. A second aim was to compare the differences between healthcare professionals conducting DMC assessments and those involved, but not formally conducting them. The findings could also uncover the role and training needs of multidisciplinary healthcare professionals in DMC assessment. The survey also included questions on how healthcare professionals are conducting

**Table 1:** List of organisations included for distribution of survey.

Type of organisation	Organisation name
Professional colleges	The Royal New Zealand College of General Practitioners
	The Royal Australian and New Zealand College of Psychiatrists (sent to New Zealand members only)
	New Zealand College of Clinical Psychologists
Associations	Nurse Practitioners New Zealand
	New Zealand Speech-language Therapists' Association
	Occupational Therapy New Zealand
	Aotearoa New Zealand Association of Social Workers (ANZASW)
	New Zealand Special Interest Group in Neuropsychology (NZ SIGN)
	New Zealand Psychological Society
Private/community organisations	Age Concern
	Dementia Auckland/Wellington/Canterbury
	Alzheimers New Zealand
	Third Age Health

DMC assessments, but the results will be presented in a separate publication due to the large volume of data.

## Methods

### Survey design

The survey was developed by the first author following a comprehensive review of relevant literature and detailed discussions with the other three authors around key topics to include. The draft survey was discussed until a consensus was reached on the questions and flow. The survey questions are listed in Table 2.

A descriptive cross-sectional anonymous survey was designed and created through Qualtrics<sup>XM</sup> (a web-based survey tool). Data were collected between January 2022–April 2022. Ethics approval was granted from The University of Auckland Human Participants Ethics Committee (UAHPEC: 23678). Upon completion of the survey, participants were given information about a second

stage of the research that involved training in DCM assessment and qualitative interviews, and if interested they could provide their contact details for that. Results of the second stage of the research will be presented in a separate publication.

### Participants

Eligibility and inclusion involved self-reported positive responses to three screening statements; a healthcare professional in Aotearoa New Zealand involved with DMC assessments, have read and understood the information describing the study in the participant information sheet (PIS) and consent to participate in the survey as detailed in the PIS. Participants were recruited via a number of organisations shown in Table 1, with the use of monthly newsletters, generic emails or specific member-only emails.

### Data analysis

Anonymised data were downloaded from Qualtrics into Microsoft Excel (2022) and descriptive

**Table 2:** Survey questions reported by healthcare professionals and the response codes.

Topic	Responses	Re-coding for analysis
<b>Training</b>		
Which of the following best describes the training you have completed to perform your current role in the assessment of a patient's decision-making capacity?	A. Formal training during my qualification B. Formal training post qualification C. Informal/on-the-job training D. No training	1 = A 2 = B 3 = C 4 = D
How would you rate the amount of training you have received in training you to perform your current role in the assessment of a patient's decision-making capacity?	A. Far too much training B. Too much training C. The right amount of training D. Too little training E. Far too little training	1 = A & B 2 = C 3 = D & E
How adequate was the training you have received in preparing you to perform your current role in the assessment of a patient's decision-making capacity?	A. Very adequate B. Somewhat adequate C. Not very adequate D. Not adequate at all	1 = A 2 = B 3 = C 4 = D
Please explain the reasons for your answer on the adequacy of training you have received to perform your current role	N/A Open ended	

**Table 2 (continued):** Survey questions reported by healthcare professionals and the response codes.

Which of the following best describes your knowledge of the Goodfellow Unit Capacity Assessment training*?	A. Completed both modules B. Completed one of the modules C. Aware of it and intending on completing it D. Aware of it but not intending to complete it E. I have not heard of this training before	1 = A & B 2 = C & D 3 = E
<b>Involvement</b>		
How would you rate your current level of involvement in the assessment of a patient's decision-making capacity?	A. Far too much involvement B. Slightly too much involvement C. The right amount of involvement D. Not quite enough involvement E. Not at all enough involvement	1 = A & B 2 = C 3 = D & E
Please explain the reasons for your answer	N/A Open ended	
<b>Confidence</b>		
How do you rate your confidence in performing your current role(s) in the assessment of a patient's decision-making capacity?	A. Very confident B. Quite confident C. Not very confident D. Not at all confident	1 = A 2 = B 3 = C 4 = D
How confident would you be to describe decision-making capacity to a patient requiring an assessment?		
How would you describe decision-making capacity to a patient requiring an assessment?	N/A Open ended	

\*An online training consisting of two modules on the principles and requirements of capacity assessment, available from: <https://www.goodfellowunit.org/courses/assessing-decision-making-capacity-clinical-basics>.

analysis was undertaken at a total sample and individual profession level. Participants were classified into either Group one: healthcare professionals conducting DMC assessments (medical practitioners, nurse practitioners and clinical psychologists/neuropsychologists), herein referred to as the “conducting” group, or Group two: healthcare professionals involved in, but not conducting, DMC assessments (social workers, occupational therapists and speech-language therapists, nurses), herein referred to as the “contributing to” group. Data were entered into IBM SPSS Statistics for Windows, Version 29<sup>21</sup> for

statistical analysis. Fisher's exact tests were used to determine any significant difference between the two groups (significance was set at 5%). Responses to the open-ended questions were analysed using inductive content analysis as informed by Elo and Kyngas<sup>22</sup> and are presented alongside the quantitative data, where appropriate.

## Results

Given the nature of the survey distribution and advertisement we are unable to calculate a response rate. Of the 171 participants who agreed

**Table 3:** Participant demographic characteristics.

Characteristics	Response	N=78 n (%)
Gender	Male	13 (16.7)
	Female	65 (83.3)
Age	Under 30 years	7 (9.0)
	30–44 years	21 (26.9)
	45–55 years	23 (29.5)
	Over 55 years	27 (34.6)
Ethnicity	European	69 (88.5)
	Māori	6 (7.7)
	Asian	4 (5.1)
	Other	2 (2.6)
	Prefer not to say	1 (1.3)
Profession	Medical practitioner	25 (32.1)
	Clinical psychologist/ neuropsychologist*	12 (15.4)
	Social worker	12 (15.4)
	Occupational therapist	11 (14.1)
	Nurse practitioner	10 (13.8)
	Speech-language therapist	4 (5.1)
	Other	4 (5.1)
DMC assessment role	Conducting DMC assessments	47 (60.3)
	Contributing to DMC assessments	31 (39.7)
Years of professional experience	Less than 6 years	13 (16.7)
	6–10 years	13 (16.7)
	11–20 years	20 (25.6)
	Over 20 years	32 (41.0)
Work setting	Public hospital	46 (59.0)
	Private practice (group/solo)	12 (15.4)
	Other	20 (25.6)

\*All psychologists held the neuropsychology scope of practice; 4 of the 12 also stated holding the clinical psychology scope of practice.

DMC=decision-making capacity.

to the three initial screening statements, 125 (73.1%) remained after the first content question, 118 (69%) after the second question and 78 (45.6%) went on to complete the survey, resulting in a 45.6% completion rate. We only analysed the results of these 78 participants. Table 3 summarises the participant demographics. Of the 25 medical practitioners who completed the survey, there were five (20.0%) GPs, five (20.0%) geriatricians and four (16.0%) psychiatrists, with the remaining medical practitioners from a broad range of specialties. Public hospital (n=46, 59.0%) and private practice (n=12, 15.4%) were the most common workplace settings; “other” settings included university/polytechnic, government department/agency, non-government organisations (NGOs), Kaupapa Māori non-government organisation, primary care, aged care and commercial companies. The majority (66.7%, n=52) had worked in their profession for over 10 years.

## Training

### Format

Table 4 shows that training is generally lacking among our survey participants. Only 14.1% (n=11) reported receiving formal training during and post their qualification, 35.9% (n=28) receiving formal training during their qualification and 28.2% (n=22) receiving formal training post qualification. However, none of the 10 nurse practitioners reported receiving formal training post qualification. Most participants (80.8%, n=63) had received training in the form of on-the-job learning. For 43.6% (n=34) this was the only type of training they had received, and 6.4% received no training at all. No significant difference was found between the “conducting” and “contributing to” groups and the types of training they received (refer to Table 5).

### Quantity

Although most of the participants had received some training, it was commonly found to be lacking in amount and adequacy. Only 38.5% (n=30) of all participants felt they had received the *right amount* of training, with the majority (60.3%, n=47) stating they had received *too little* training in order to perform their current role in DMC assessments. No significant difference was found between the “conducting” and “contributing to” groups and the amount of training received. Descriptively, however, reports of receiving *too little* training rose to 80.0% (n=8) and 66.7% (n=8) for nurse practitioners and social workers, respectively.

## Adequacy

Only 14.1% (n=11) of all participants rated the adequacy of training received as *very adequate*. Participants in the “contributing to” group reported a significantly higher response for their training being *not at all adequate* (25.8%, n=8 compared to 4.3%, n=2) ( $p = 0.012$ ). Those in the “conducting” group observed a significantly higher response for the adequacy of training received being *somewhat adequate* (51.1%, n=24 compared to 25.8%, n=8) ( $p = 0.035$ ), as seen in Table 5.

Social workers reported the lowest level of adequacy. None selected *very adequate*; instead, 75.0% (n=9) reported that their training was either *not very* or *not at all adequate*. Open-ended responses supported that formal training is lacking, and learnings have come from individual active research and observing experienced colleagues. The valuable experience gained from observing the nuances in individuals with diminished capacity was recognised. However, it was also felt there was little in the way of defining their role in DMC assessments: “*There is very little training regarding how my role functions in relation to the capacity assessment, yet I am often tasked with explaining this assessment to patients and their families.*” Most (72.0%, n=18) medical practitioners felt their training was *very* or *somewhat adequate*. The remaining 28% (n=7) felt it was *not very* or *not at all adequate*, which was due to learning being “*mostly self-directed*” and a result of receiving no training, stating that “*We need to be formally taught how to do this rather than on the job ... there is too much at stake for the patient*” and that at present the situation is “*shambolic.*”

Nurse practitioners appeared to rate adequacy better than the amount of training they had received, which was consistent with reports of receiving training in more informal ways (for example, supervision and years of experience, which involved self-learning). For those occupational therapists rating their training as *not adequate at all* (27.3%, n=3), they reported that training is overlooked and only on the job; however, 36.4% (n=4) rated their training as *very adequate* due to the provision of expert facilitators and postgraduate training for assessment tools.

## Goodfellow e-learning

One source of freely available online training for DMC is the two Goodfellow Unit Capacity Assessment Training<sup>17</sup> modules. This online training is based on the Toolkit for Assessing Capacity<sup>2</sup> and is designed to train those involved in DMC

assessments. A question in the current survey captured rates of completion and awareness of the Goodfellow Training. Results showed that only 26.9% (n=21) of participants had heard of this training and only 4.0% (n=3) had completed it.

### Involvement

As shown in Table 4, only 55.1% (n=43) of all participants said their current level of involvement was at the right level and 26.9% (n=21) felt they did not have enough involvement, with the remaining 17.9% (n=14) reporting they had too much involvement. Participants in the “contributing to” group had a significantly higher response for not having enough involvement ( $p<0.001$ ), while those in the “conducting” group had a significantly higher response for having too much involvement ( $p=0.006$ ), as seen in Table 5.

Clinical psychologists/neuropsychologists had the highest response for having the right level of involvement (91.7%, n=11). Open-ended responses highlighted reasons such as the receipt of appropriate referrals and shared responsibility across a team. Medical practitioners had the highest response for having too much involvement (40.0%, n=10). The responsibility often sits with them due to a lack of training, confidence and skills of other healthcare professionals (including junior doctors). Occupational therapists and social workers deemed they did not have enough involvement, 72.7% (n=8) and 25.0% (n=3), respectively. Occupational therapists commonly reported a lack of recognition for their potential value with their opinions, specialised knowledge and abilities often being overlooked:

*“I feel occupational therapists have specialist understanding in cognition, as well as advocacy, and thus feel we could be more involved in this role. I have often been in multidisciplinary meetings where doctors have been talking about decisions re: capacity that I feel are unjustified and require further assessment, which I will start a conversation about. Often doctors will make a ‘capacity in general’ decision, whereas I feel capacity should be decision specific.”*

Both occupational therapists and social workers reported that wider team consultations are often not happening, with reports that senior doctors complete assessments without talking to anyone, not even a patient’s family, and often don’t consider

the functional assessments or the psycho-social aspects of a patient’s life. The need for DMC assessments is sometimes questioned and doctors can be reluctant to complete these assessments:

*“I’ve had medical practitioners refuse to do a capacity assessment on someone who is really struggling. They will not activate a power of attorney because the person has agreed to go into residential care. When I talk with the patient and discuss residential care, it is clear that they have no idea what they have agreed to.”*

They can find themselves persisting with their concerns for a medical practitioner to complete a DMC assessment.

### Confidence

As shown in Table 4, most participants (88.5%, n=69) felt either *quite* confident or *very* confident performing their role in DMC assessments. No significant difference was found in confidence levels between the “conducting” and “contributing to” groups (see Table 5). Nurse practitioners were the least confident, with only 10.0% (n=1) stating they were *very* confident performing their current role in DMC assessments.

Only 25.6% (n=20) of all participants felt *very* confident in being able to describe DMC to a patient, while 16.7% (n=13) stated they were *not very* or *not at all* confident. Of those reporting to be *very* confident, when asked *how* they would explain it, only 15.0% (n=3) spontaneously noted the four legal elements of capacity. A further 10.0% (n=2) named at least two of the elements. The remaining 85.0% (n=15) included reference to an individual’s ability to *understand*, with very few naming the ability to communicate their decision, and in some cases appearing to misunderstand the concept of DMC, stating that it is an ability to make a “reasonable decision.” Descriptively, social workers showed the highest percentage of those who were *very* confident (41.7%, n=5), while only 32.0% (n=8) of medical practitioners were *very* confident.

### Discussion

As the world’s population ages and assisted dying is becoming legalised in Australasia,<sup>6,7</sup> the need for DMC assessments is growing. This cross-sectional survey highlighted several current issues within the assessment of DMC in New

**Table 4:** Training, involvement and confidence in decision-making capacity assessment by total sample and individual healthcare profession.

	<b>Total sample</b> n=78 n (%)	<b>Medical practitioner</b> n=25 n (%)	<b>Clinical psychologist/ neuropsychologist</b> n=12 n (%)	<b>Nurse practitioner</b> n=10 n (%)	<b>Social worker</b> n=12 n (%)	<b>Occupational therapist</b> n=11 n (%)	<b>Other*</b> n=8 n (%)
<b>Training**</b>							
Formal training during qualification	28 (35.9)	12 (48.0)	5 (41.7)	2 (20.0)	3 (25.0)	5 (45.5)	1 (12.5)
Formal training post qualification	22 (28.2)	9 (36.0)	4 (33.3)	0 (0.0)	4 (33.3)	5 (45.5)	0 (0.0)
Informal/on-the-job training	63 (80.8)	17 (68.0)	12 (100.0)	9 (90.0)	11 (91.7)	9 (81.8)	5 (62.5)
No training	5 (6.4)	1 (4.0)	0 (0.0)	0 (0.0)	1 (8.3)	0 (0.0)	3 (37.5)
<b>Training amount</b>							
Too much training	1 (1.3)	1 (40.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
The right amount of training	30 (38.5)	12 (48.0)	6 (50.0)	2 (20.0)	4 (33.3)	5 (45.5)	1 (12.5)
Too little training	47 (60.3)	12 (48.0)	6 (50.0)	8 (80.0)	8 (66.7)	6 (54.5)	7 (87.5)
<b>Training adequacy</b>							
Very adequate	11 (14.1)	3 (12.0)	2 (16.7)	2 (20.0)	0 (0.0)	4 (36.4)	0 (0.0)
Somewhat adequate	32 (41.0)	15 (60.0)	5 (41.7)	4 (40.0)	3 (25.0)	2 (18.2)	3 (37.5)
Not very adequate	25 (32.1)	5 (20.0)	5 (41.7)	4 (40.0)	8 (66.7)	2 (18.2)	1 (12.5)
Not adequate at all	10 (12.8)	2 (8.0)	0 (0.0)	0 (0.0)	1 (8.3)	3 (27.3)	4 (50.0)



**Table 4 (continued):** Training, involvement and confidence in decision-making capacity assessment by total sample and individual healthcare profession.

<b>Involvement</b>							
Too much involvement	14 (17.9)	10 (40.0)	0 (0.0)	3 (30.0)	0 (0.0)	1 (9.1)	0 (0.0)
Right amount of involvement	43 (55.1)	13 (52.0)	11 (91.7)	6 (60.0)	9 (75.0)	2 (18.2)	2 (25.0)
Not enough involvement	21 (26.9)	2 (8.0)	1 (8.3)	1 (10.0)	3 (25.0)	8 (72.7)	6 (75.0)
<b>Confidence to perform role</b>							
Very confident	21 (26.9)	9 (36.0)	3 (25.0)	1 (10.0)	5 (41.7)	3 (27.3)	0 (0.0)
Quite confident	48 (61.5)	14 (56.0)	8 (67.7)	7 (70.0)	7 (58.3)	7 (63.6)	5 (62.5)
Not very confident	9 (11.5)	2 (8.0)	1 (8.3)	2 (20.0)	0 (0.0)	1 (9.1)	3 (37.5)
Not at all confident	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)
<b>Confidence to explain DMC</b>							
Very confident	20 (25.6)	8 (32.0)	3 (25.0)	1 (10.0)	5 (41.7)	3 (27.3)	0 (0.0)
Quite confident	45 (57.7)	14 (56.0)	9 (75.0)	8 (80.0)	6 (50.0)	5 (45.5)	3 (37.5)
Not very confident	10 (12.8)	2 (8.0)	0 (0.0)	1 (10.0)	1 (8.3)	2 (18.2)	4 (50.0)
Not at all confident	3 (3.8)	1 (4.0)	0 (0.0)	0 (0.0)	0 (0.0)	1 (9.1)	1 (12.5)

\*\*“Other” group consisted of the following professionals: speech-language therapist (n=4), advocate/advocacy manager (n=2), nurse (n=1), pharmacist (n=1).

\*\*Multi-response question percentages do not add up to 100% (“No training” exclusive answer).

**Table 5:** Statistical comparison of the “conducting” decision-making capacity group to the “contributing to” group.

	<b>Conducting</b> n=47 n (%)	<b>Contributing to</b> n=31 n (%)	<b>Overall Fisher's exact test*</b>	<b>P-value for comparing two groups</b>
<b>Training**</b>			p=0.290	
Formal training during qualification	19 (26.8)	9 (19.1)		ND
Formal training post qualification	13 (18.3)	9 (19.1)		ND
Informal/on-the-job training	38 (53.5)	25 (53.2)		ND
No training	1 (1.4)	4 (8.5)		ND
<b>Training amount</b>			p=0.463	
Too much training	1 (2.1)	0 (0.0)		ND
The right amount of training	20 (42.6)	10 (32.3)		ND
Too little training	26 (55.3)	21 (67.7)		ND
<b>Training adequacy</b>			p=0.020	
Very adequate	7 (14.9)	4 (12.9)		p=1.000
Somewhat adequate	24 (51.1)	8 (25.8)		p=0.035
Not very adequate	14 (29.8)	11 (35.5)		p=0.627
Not adequate at all	2 (4.3)	8 (25.8)		p=0.012
<b>Involvement</b>			p<0.001	
Too much involvement	13 (27.0)	1 (3.2)		p=0.006
Right amount of involvement	30 (63.8)	13 (41.9)		p=0.067
Not enough involvement	4 (8.5)	17 (54.8)		p<0.001
<b>Confidence to perform role</b>			p=1.000	
Very confident	13 (27.7)	8 (25.8)		ND
Quite confident	29 (61.7)	19 (61.3)		ND
Not very confident	5 (10.6)	4 (12.9)		ND
Not at all confident	0 (0.0)	0 (0.0)		ND
<b>Confidence to explain DMC</b>			p=0.089	
Very confident	12 (25.5)	8 (25.8)		ND
Quite confident	31 (66.0)	14 (45.2)		ND
Not very confident	3 (6.4)	7 (22.6)		ND
Not at all confident	1 (2.1)	2 (6.5)		ND

\*For the overall 3/4-by-2 table.

\*\*Multi-response question percentages do not add up to 100% (“No training” exclusive answer).

ND = not done because overall test not significant.

Zealand and adds to the literature previously exploring this area of clinical practice. Firstly, training was found to be lacking, particularly the provision of formal training and reports from those contributing to DMC assessment, which suggest a desire for greater involvement in these assessments. Additionally, participants, while mostly confident in their role within DMC assessments, did not feel confident in being able to explain DMC to a patient.

Two thirds of the participants involved in this survey had more than 10 years of experience. It appears that they gained the knowledge through experience and their learning being mostly on-the-job,<sup>11</sup> with formal qualifications being largely devoid of training in this area. A small number of our participants underwent formal training as part of their qualification, possibly because some of them completed their training many years ago when formal training in DMC assessments was likely less prevalent than it is today. What was somewhat surprising was that the amount of training received did not vary between those conducting DMC assessments and those not conducting, suggesting that training may be accessible to a wider range of healthcare professionals. However, this finding likely reflects the responses of the nurse practitioners who were part of the “conducting” group but commonly reported that the quantity of training received was too little. Adequacy of training was significantly lower among those who were part of the “contributing to” group, a potential reflection of the small proportion who had received formal training. There is a consistent message across all healthcare professions, and identified in prior research,<sup>10,11,24</sup> that more formal training is needed for those working in this space. It appears that the workforce would greatly benefit from an increased awareness of the training that is freely available (e.g., Goodfellow Unit Capacity Assessment Training).

Responses from medical practitioners support findings from previous studies. Namely, time constraints<sup>25</sup> and concerns about the responsibility sitting with them.<sup>11</sup> Additionally, in this study there were reports of too much involvement from those conducting DMC assessments, while those contributing to DMC assessments reported not enough involvement. Given that disagreements in DMC are common when the assessment involves more than one healthcare professional,<sup>26</sup> it is of concern that wider team consultation is not always happening and the knowledge and input from occupational therapists and social workers

was reported to being overlooked. While wider team consultation may not always be practical in certain settings due to specialist availability, this finding supports a shift in professional dynamics, with room for greater multidisciplinary team involvement in DMC assessment processes.<sup>24</sup> Discipline-specific DMC support roles in the form of a “go-to” DMC expert may be beneficial to increase involvement of multidisciplinary healthcare professionals, having previously been shown to increase learning, development and engagement among occupational therapists in DMC assessments.<sup>13</sup>

Although most participants were confident in their role in DMC assessments, this may be due to the overall high experience level of participants who completed this survey. Importantly, nurse practitioners did not display the same confidence levels, potentially reflective of their change in role from nurse to nurse practitioner and subsequent change of scope.<sup>27</sup> This would suggest that nurse practitioners in particular require greater support and training when the responsibility of assessing DMC becomes a greater part of their clinical practice. Participants reported a lack of confidence in their ability to explain DMC. Very few spontaneously identified the four legal elements required of someone to have DMC, suggesting that this is not top of mind for clinicians, and the competencies expected of patients are potentially not explicitly discussed or explained to them. This is consistent with prior research showing distinct gaps in knowledge of what DMC is and what is involved when assessing it, which has been found to coincide with low confidence levels.<sup>9,10</sup>

Interestingly, there were no significant differences between the “conducting” and “contributing to” groups for confidence in performing their role and confidence to explain DMC to a patient. This may be a reflection of the involvement multidisciplinary healthcare professionals are already having in DMC assessments, commonly referring patients for DMC assessments<sup>12</sup> and liaising with families, potentially providing them with confidence in this area of their clinical practice. Given the well-researched links between confidence and performance,<sup>28,29</sup> it would be advised to focus attentions on improving clinicians’ confidence.

### Strengths and limitations

This is the only study in New Zealand to include non-medical practitioners and their viewpoints on DMC assessment. The use of both quantitative questioning and qualitative analysis of open-ended

comments allowed for an in-depth perspective, providing both a snapshot of the current issues and detailed reasons for the issues, offering clear guidance on a way forward in this complex area. The main limitation of this study is the small sample size. This is particularly relevant for results analysed by profession, which should only be taken as indicative. This study also has a sampling bias, as only professionals already engaged in this topic, or having a particular salience with DMC assessments, were eligible to complete the survey. Neither the Royal Australasian College of Physicians nor the New Zealand division of the Australian & New Zealand Society of Geriatric Medicine were invited to participate in this study; however, despite this, five geriatricians completed the survey, which was the largest medical practitioner group (along with GPs). Additionally, demographics were not collected for those that did not complete the survey, so it is not possible to analyse any differences between those who completed and those who did not complete the survey. Differentiation between informal and formal DMC assessments was not provided to participants, limiting the ability to draw conclusions by assessment type. Additionally, participants were not given detailed explanations of formal versus informal training, but we trusted the participants' judgement on this measure. The study was only conducted with healthcare professionals located in New Zealand, which means the results are only relevant to this country. These limitations mean the generalisability of the results is limited.

### Future research

Closed- and open-ended comments highlighted a lack of formal training available. It would be beneficial to understand more about the training needs of multidisciplinary healthcare professionals involved in DMC assessments. Additionally, it would be recommended to conduct similar research among nurses, a significant healthcare workforce that was not well represented in this study but often has involvement in DMC assessments, particularly mental health nurses in regards to the *Mental Health (Compulsory Assessment and Treatment) Act 1992*.<sup>30</sup> Research is also needed to understand this complex topic among Māori and other non-European groups, and the potential adaptations and considerations required to conduct a safe and culturally comprehensive assessment.

### Conclusion

Our findings suggest there is an urgent need for considerable attention and efforts to help professionals working in this area of clinical practice feel better equipped to perform their role. Given what can be at stake for an individual undergoing a DMC assessment it is imperative that improvements are made to upskill the workforce, particularly those newly entering the field. The Law Commission recently opened for submissions on DMC assessment, and so any changes in approaches to these assessments should be aligned with the legal changes and vice versa.

**COMPETING INTERESTS**

Nil.

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