

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.

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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.

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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