Competence in mental health care: philosophical theory and medical practice

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ObjectiveThe objective of this research is to formulate a better and more useful definition of the term competenceand to write a guideline which can be used by mental health professionals and more widely, in medicine.It will result in a...

Ethical review	Approved WMO
Status	Recruitment stopped
Health condition type	Psychiatric disorders NEC
Study type	Observational non invasive

Summary

ID

NL-OMON35687

Source
ToetsingOnline

Brief title
Competence in mental health care

Condition

- Psychiatric disorders NEC

Synonym
Competence

Research involving
Human

Sponsors and support

Primary sponsor: Vrije Universiteit Medisch Centrum
Source(s) of monetary or material Support: ZonMW,GGZ inGeest

Intervention

Keyword: Capacity, Competence, Empirical Ethics, Psychiatry

Outcome measures

Primary outcome

N/A

Secondary outcome

N/A

Study description

Background summary

Introduction
Competence, or capacity, is an important topic in health care in general and in mental health care in
particular. However, competence is still an unclear concept which is not well defined in law and about
which there is still no consensus as to how exactly it should be tested or determined and by whom
(Welie, 2008). In the Netherlands, competence as a term is especially relevant in the Act of Agreement
on Medical Treatment (WGBO). Although the word *competence* is not used, the Act states that patients
who are to make decisions concerning diagnostics or treatment must have "a reasonable appreciation of
their interests in the case". The Royal Dutch Society for the Promotion of Medicine (KNMG) 2004
describes competence in its guideline as " the capacity to make informed decisions in response to specific
questions concerning care and treatment". It is seen as a broad and normative term with medical,
ethical, cognitive, emotional and personal factors. In the Act on Exceptional Admissions in Psychiatric
Hospitals (Bopz), competence seems to be far less important. The last evaluation commission of this Act
(Commission third evaluation BOPZ 2007) finds this unacceptable: *competence/ incompetence must be
given a substantially larger role within the Act or within new legislation. The

principle should be (*) that
more value is attached to competent resistance than to incompetent resistance*.
The main motive for this study is the introduction of the successor to the Bopz Act, the Act on Obligatory
Mental Health Care. The central issue in this Act is treatment rather than forced admission. This raises
the urgency to study the term competence more closely. This study attempts to provide a contribution by
clarifying the moral meaning of the term in daily life and in care practice, and translating this into a
guideline for medical staff.

Subject
The subject of this study is to discover how competence in mental health care can be determined.
Appelbaum (2007) has distinguished four aspects of the term: the ability to communicate a choice, the
ability to understand the relevant information, the ability to appreciate the situation and its
consequences and the ability to reason about treatment options (compare with Klippe 1999). There are
also questionnaires and other tests available which have been developed to assess competence such as
the international MacCAT-T (Grisso and Appelbaum 1997) and in the Netherlands, the *vignetmethode* of
Vellinga (Vellinga 2008) and the KNMG guideline (2004). Almost all of these tests focus on cognitive
skills. This can lead to a unilateral approach to the concept when explicit testing is concerned because
the practical knowledge of the patient and his emotions are then missing from the examination. On the
one hand, discussions concerning competence raise questions about the moral meaning of the term and
on the other hand, about the legal meaning and the medical/psychiatric practice for all actors involved.
The study focuses on patients with obsessive-compulsive disorder (OCD). Competence in OCD is less
disputed than competence in, for example, psychotic disorders or dementia. However, the thinking and
acting of OCD patients is highly influenced by their disorder. This group is therefore particularly suitable
for studying the nuances of competence.

Knowledge already available
Competence is regarded as a normative, task-specific, variable and dynamic concept which is related to
the decision-making process and is only reviewed if there is a reason to do so.

Formally, incompetence
means that the patient himself cannot meet the legal requirement of informed consent and a
representative must be involved. The decision-making capacity of the person in question has been
assailed (KNMG 2004, Welie 2008ab, Vellinga 2008). The seriousness of OCD can differ greatly between
individuals and over time, but for a certain group the impact is quite severe and these patients are thus
invalidated for longer periods. And yet for this group, legal action is seldom used to force admission or
treatment. Quite a lot of research on competence has been carried out with regards to psychiatric
disorders in general and psychoses and dementia in particular (Vellinga and Ederveen 2008, Owen e.a.
2008, Fazel e.a. 1999, Moye e.a. 2007), and recommendations are available but these are aimed mainly
at care for the elderly and psychogeriatric care (see also Vellinga 2008, KNMG 2004). Some qualitative
studies have recently been performed on eating disorders and competence (Tan e.a. 2003, Tan e.a.
2006). These showed that anorexia nervosa patients could be considered as incompetent; not because of
problems with cognitive functions but because their *values' became pathological. For example, they
gave a higher priority to being thin than to happiness or contact with friends and family.

Study objective

Objective
The objective of this research is to formulate a better and more useful definition of the term competence
and to write a guideline which can be used by mental health professionals and more widely, in medicine.
It will result in a conceptualization of the term competence which is transparent for the professionals who
test competence and which is useful in mental health care, particularly for disorders other than dementia
or psychosis. It does not focus primarily on cognitive functions and will be embedded in a practical
insight about how to manage competence in obsessive-compulsive disorder (OCD). This will result in a
definition of competence which is well thought out in a conceptual, philosophical analysis; one which is
not merely a collection of loose criteria but a sharp examination of the interrelationships of these criteria

and one which can form a basis for significant recommendations in a guideline.

To reach this objective, the following research questions have been formulated:
1. How is the concept of competence used in practice by mental health professionals and patients with
OCD and their family? What meaning do they give to the concept, both formally and substantively? What
meaning does the term have for medical practice?
2. What are the current insights regarding the term competence?
2a. What are the current legal and medical-technical insights regarding competence, informed consent
and legal representation?
2b. What are the current philosophical and medical-ethical insights regarding the term competence in
general and regarding non-psychotic patients with poor insight such as chronic, untreated OCD patients
in particular?
3. Which discussion points are raised by the current debate in the run-up to a new mental health act
concerning competence in OCD and more generally, in mental health care?
4. How can the outcomes of this study be related to the current debate concerning the Dutch situation
and legislation? What guideline for mental health professionals could be formulated hereby?

Study design

Action plan
In order to answer the questions and sub-questions, several methods will be used. These are mainly
qualitative methods as is usual in empirical ethics (Widdershoven e.a. 2008). The study aims at a
conceptual clarification of the term competence to be reached by means of researching the role of
competence in the practice of care using responsive methodology (Guba and Lincoln 1989, Abma and
Widdershoven 2006, Abma et al. 2009). The study will result in a guideline.

Responsive methodology
The overall method of this study is responsive methodology (Abma and Widdershoven 2006, Abma e.a.
2009). A main objective of responsive research is to inventorise the issues of several stakeholders and to
start a dialogue concerning these issues in order to raise mutual understanding. Stakeholders* issues
include questions and dilemmas about the application of the term competence in the care of OCD

patients. Stakeholders are patients with OCD, their families, doctors and other mental health care professionals. By consulting with the stakeholders, issues are mapped out and these are then deepened in focus groups to be finally presented and discussed in heterogeneous groups. The working method is iterative and cyclic. This means that during the process the data from earlier phases is presented and validated in the following phases. This so-called hermeneutic dialectical process prevents unilaterality and bias. There will be a constant check as to whether stakeholders recognize themselves in the analyses of their material (member checks). Additionally, the data will be related several times to literature to achieve further deepening. Literature is to be found in such fields as ethics and philosophy, law and mental health care. During the research several qualitative methods will be used such as semi-structured interviews, focus groups and literature research. The topic lists for the interviews are inspired by earlier research which has been carried out on competence in anorexia nervosa by Tan et al. (2006). A separate topic list will be made for each group. The first step will be to translate and refine the topic lists.
Secondly, the topic lists must be tested in a pilot setting. After testing and adapting the topic lists, they will be ready for use. An advisory board of approximately six people will be formed in which all stakeholders are represented. The professional association and the patient association will be approached to recruit participants for this advisory board. This board will be involved in the implementation during the study; they will ensure embedding in practice. When a phase is completed, the board will give its feedback and input for the following phases.

Construction
After the preparatory phase, the study is made up of three projects. In the preparatory phase, the topic lists for semi-structured interviews will be designed. These are based on interviews which have been developed in Oxford for research on competence in anorexia nervosa patients and involve an interview for patients and their families (Tan e.a. 2006). The Oxford researchers have performed this interview on ten girls and their mothers in order to reflect on competence. The

issues for the Dutch version have also been obtained from an exploratory literature study and interviews
with policy makers, judges, lawyers and researchers.
Empirical ethical research is a constant cycle in which theory and empirical knowledge inspire each other.
Hermeneutic ethics practice is used as the starting point because experiences, acting knowledge and
insights are all available for examining the concept of competence. The construction is such that firstly
the nature of the phenomenon will be mapped and thereafter, justification and external validation will be
considered. Besides obtaining empirical knowledge, it is important that a study of the literature be made
in all phases. Literature offers more formal and abstract knowledge which can help interpret the
information and insights gained from the empirical knowledge more sharply and accurately.
(Widdershoven and Abma 2007) Extra attention will be given to literature research between the projects.

Study burden and risks

The burden will be minimal, since only semi-structured interviews and the OVIS and the MacCAT are used. Patients and familymembers might experience the interviewing as disturbing because questions are asked about the biography and choices in life. There are no risks associated with participation.

Contacts

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Trial sites

Listed location countries

Netherlands

Eligibility criteria

Age
Adults (18-64 years)
Elderly (65 years and older)

Inclusion criteria

- Diagnosis obsessive compulsive disorder according to DSM IV or ICD 10
- Age: 18-65
- Dilemma's concerning patients competence about treatment or admission
- A family member and thee doctor are included too

Exclusion criteria

- Language difficulties
- A diagnosis in the psychotic of amnestic spectrum

Study design

Design

Study type: Observational non invasive

Masking:	Open (masking not used)
Control:	Uncontrolled
Primary purpose:	Other

Recruitment

NL

Recruitment status:	Recruitment stopped

Start date (anticipated):	12-04-2010
Enrollment:	40
Type:	Actual

Ethics review

Approved WMO Date:	12-04-2010
Application type:	First submission
Review commission:	METC Amsterdam UMC

Study registrations

Followed up by the following (possibly more current) registration

No registrations found.

Other (possibly less up-to-date) registrations in this register

No registrations found.

In other registers

Register	ID
CCMO	NL28852.029.09