

Competence in mental health care: philosophical theory and medical practice

Published: 12-04-2010

Last updated: 06-05-2024

ObjectiveThe 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...

| | |
|------------------------------|----------------------------|
| 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

Public

Vrije Universiteit Medisch Centrum

Van der Boechorststraat 7
1081 BT Amsterdam
NL

Scientific

Vrije Universiteit Medisch Centrum

Van der Boechorststraat 7
1081 BT Amsterdam
NL

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 the doctor are included too

Exclusion criteria

- Language difficulties
- A diagnosis in the psychotic or amnesic 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 |