Competency in Adolescent Inpatients

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A 15-item questionnaire was used to evaluate competency to consent to hospitalization in 30 adolescent psychiatric inpatients. For competency, 17 percent of the subjects met minimal clinical criteria, 30 percent met broad clinical criteria, and 37 percent satisfied legally oriented criteria. Only 22 percent of the adolescent subjects met combined clinical and legal criteria. When compared with previously studied adult voluntary and adult involuntary inpatients, the data more closely resemble those generated by involuntarily admitted adults. Consistently deficient performance on the minimal clinical criteria indicates that adolescents may have a poor understanding of the most general determinants of their hospitalization. Conversely, adolescents performed more favorably than voluntary and involuntary adults on the legally oriented criteria, demonstrating their better cognitive ability to understand such abstract concepts. Thus, specific types of judgment and insight may be essential components in the evaluation of adolescent competency to consent to psychiatric hospitalization.

A number of clinical studies have been performed within the past two decades examining the capabilities of various psychiatric inpatients to participate meaningfully in the process of informed consent to their hospitalization.[1-4] There are no standardized criteria for competency to consent to psychiatric hospitalization, making objective comparison of research and clinical data difficult. Despite the lack of standardized criteria, until now, there has been only one systematic line of inquiry attempting to define and empirically investigate this particular type of competency.

In 1981 at the Massachusetts Mental Health Center, Appelbaum *et al.*[5] developed a 15-item questionnaire comprised of a number of previously recognized components of competency, grouped into three basic categories: the need for treatment, the roles of physician and medication, and a patient's legal rights following hospitalization. Patients in Appelbaum's study were interviewed within 24 hours of signing voluntarily into the hospital. Only 50 percent of the patients thought they had psychiatric problems that required treatment. Also, 50 percent did not know they had a right to refuse medication and to speak with

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a lawyer. Fully one-half of the patients were not aware that the hospital could not hold them against their will, despite being given all this information at the time of admission.

Norko *et al.*[6] replicated the Appelbaum study at St. Vincent's Hospital and Medical Center of New York in 1986. Looking at 100 consecutive voluntary adult psychiatric admissions, Norko found that 85 percent of these patients knew they had a psychiatric problem that needed treatment, a far better proportion than for Appelbaum's group. The St. Vincent's sample population performed more poorly, however, on legally oriented criteria as compared with the subjects in Appelbaum's study. Furthermore, 20 percent of the St. Vincent's population, who had signed in voluntarily, denied their need to be in the hospital.

Clark and Billick[7] in 1989, also at St. Vincent's Hospital, performed a similar study using involuntary adult psychiatric inpatients. They found that 53 percent of patients thought they had psychiatric problems that required treatment, a percentage comparable to that obtained by Appelbaum *et al.* in 1981. Only 37 percent of patients understood the role of their physician, and 42 percent understood the role of psychotropic medication. In addition, 20 percent of patients were unsure of whether the hospital could keep them against their will, and 16 percent of patients did not know which steps to take to obtain discharge.

The purpose of the current study is to extend the investigation of competency to include a group of patients who have not to our knowledge been previously studied in this context; namely, adolescents, aged 12 to 18 years, admitted to an inpatient psychiatric unit.

Methods

The study was conducted from January 1991 until February 1992 at St. Vincent's Hospital and Medical Center of New York/New York Medical College, on a 23-bed mixed adult/adolescent unit. The unit is part of a 100-bed general psychiatric pavilion within a large general university hospital in the Greenwich Village section of Manhattan. Patients and their parents were approached within 72 hours of admission and asked to participate in the study. The 15-item questionnaire (Table 1) is similar to the one previously utilized by Appelbaum *et al.*, Norko *et al.*, and Clark and Billick, with two minor modifications: The addition of question 7b ("Why do you think that your parents recommended that you come into the hospital?"), and the addition of question 10b ("What procedure would you have to follow if you wanted to leave the hospital and your parents continued to think that you were not ready to go?"). The questionnaire was administered verbally by the principal investigator, and answers were scored immediately on the corresponding three-point scale.

Data from 30 participating adolescent patients were collected. All patients aged 12 to 18 years were approached for the study. Six patients were not tested, because they or their parents declined participation. Written informed consent

Table 1
St. Vincent's Hospital Adolescent Inpatient Competency Questionnaire

1. Do you think that you have psychiatric problems?
2. Do you think that you need some kind of treatment for your problems?
3. Do you think that you need to be in the hospital to get that treatment?
4. What will your doctor do for you while you are in the hospital?
5. What will the medication do for you while you are in the hospital?
6. Are there other things that go on in the hospital that you think will be of benefit to you that can't be done as an outpatient?

7a. Why do you think the doctor you saw recommended that you come into the hospital?
b. Why do you think that your parents recommended that you come into the hospital?

8. Do you think that you will go along with the doctor's suggestions for treatment here in the hospital?
9. What would you do if you were having what you thought were unpleasant side effects from the medication?

10a. What procedure would you have to follow if you wanted to leave the hospital and your doctor continued to think that you were not ready to go?
b. What procedure would you have to follow if you wanted to leave the hospital and your parents continued to think that you were not ready to go?

11. Do you have to take your medication if you don't want to?
12. Do you have access to a lawyer if you need one?
13. Does the hospital have someone you can talk to about your legal rights as a patient?
14. Are there any disadvantages to your being hospitalized?
15. Can the hospital keep you here against your will if you want to leave and your doctor doesn't think that you are ready to go?

was obtained from participants, along with their parents or guardians.

The questionnaire was administered as soon as possible after acquiring consent. The questionnaire was relatively simple to administer, requiring approximately 15 to 20 minutes. Answers were scored on a three-point scale: 0 = completely unacceptable response, 1 = partially acceptable response, and 2 = completely acceptable response. In the event of unclear answers, the investigator followed the formal question with additional clarifying questions to accurately establish the patient's level of understanding. All 30 patients enrolled in the study were tested by the first author.

Demographic and clinical data were noted from each patient (see Table 2). Charts were later reviewed to record the DSM-III(R) discharge diagnoses. These

Table 2
Demographics

Description	Number	
Total subjects	30	
Average age (years/months)	14/01	
Age range (years/months)	12/11–17/0	
Female	22	
Male	08	
White	10	(33.3%)
Hispanic	09	(30.0%)
Black	06	(20.0%)
Other	04	(13.3%)
Asian	01	(3.3%)
Average grade in school	8.37	
Novice (no previous hospitalizations)	18	(60.0%)
Experienced (+previous hospitalizations)	12	(40.0%)
Adjustment disorder	13	(43.3%)
Affective disorder	08	(26.7%)
Conduct disorder	08	(26.7%)
Schizophrenic disorder	01	(3.3%)
Average WISC-R vocabulary scaled score	8.70	

diagnoses were subsequently used to place patients into one of four categories for purposes of data analysis: (1) adjustment disorders, (2) affective disorders, (3) conduct disorders, and (4) schizophrenic disorders.

Data were coded into d-Base format, and statistical analyses performed using the Statistical Packet for the Social Sciences (SPSS/PC+). To compare continuous variables, Pearson product-moment correlation coefficients (r) were obtained. T-tests were used to compare two-group categorical data with continuous data. To test for subgroup differences in scores, one-way analyses of variance were used. Finally, ANOVA was run to test for differences and interactions among the independent variables.

Results

A total of 36 adolescents were approached during the course of the study in order to obtain a sample population of 30 subjects. The mean age was 14 years, 1 month, with a range of 12 years, 11 months to 17 years, 0 months. Average grade in school was 8.37. Overall, 73.3 percent of subjects (n = 22) participating in the study were female, as compared with 26.7 percent (n = 8), who were male. Sixty percent of patients (n = 18) were "novices," or psychiatric inpatients for the first time. The maximum number of previous hospitalizations was six, and 75 percent of subjects who were previously hospitalized had two or fewer admissions. Adjustment disorder was the most common diagnostic category, applicable to 43.3 percent of cases, followed by affective disorders (26.7%) and conduct disorders (26.7%). Only one subject fell into the category of schizophrenic disorder.

Racially, white patients were the largest subgroup, comprising 33.3 percent of the population (n = 10). Hispanic subjects were the next largest subgroup (30.0%, n = 9), followed by black patients (20.0%, n = 6). Patients of mixed race made up 13.3 percent of the population (n = 4). There was one Asian subject (Indian), accounting for 3.3 percent of the total sample population.

The patients' socioeconomic status was categorized using the five-point scale developed by Hollingshead and Redlich.[8] The majority of subjects came from middle and lower-middle class family backgrounds, 50 percent falling into category 3 and 30 percent falling into category 4.

Subjects' intelligence was estimated using the vocabulary subtest of the Wechsler Intelligence Scale for Children—Revised Edition (WISC-R). The overall mean scaled score for all subjects was 8.70, with a standard deviation of 2.74 and a range of from 5 to 15.

Table 3 demonstrates the average scores for individual items on the questionnaire, along with the percentages of patients with each of the three possible scores. The adolescents clearly manifested low scores on the first three items: only 16 percent of patients clearly acknowledged the presence of psychiatric problems. While 40 percent of subjects admitted to needing treatment for their (usually perceived as nonpsychiatric) problems, only 26 percent acknowl-

Table 3
Distribution of Scores and Mean Scores for Individual Questions

	Score (%)			Mean	SD
	0	1	2		
1. (Psychiatric problems)	57	27	16	0.60	0.77
2. (Treatment for problems)	33	27	40	1.03	0.89
3. (Need for hospital)	67	10	23	0.57	0.86
4. (Role of M.D.)	13	37	50	1.37	0.72
5. (Role of medication)	23	03	74	1.50	0.86
6. (Inpatient benefits)	37	20	43	1.07	0.91
7a. (Reason for M.D.'s recommendation)	13	30	57	1.43	0.73
7b. (Reason for parents' recommendation)	17	36	47	1.30	0.75
8. (Anticipated cooperation)	10	23	67	1.57	0.68
9. (Reaction to side effects)	07	27	66	1.60	0.62
10a. (Sign out versus M.D.)	40	40	20	0.80	0.76
10b. (Sign out versus parents)	63	27	10	0.53	0.73
11. (Right to refuse meds)	30	07	63	1.33	0.92
12. (Access to lawyer)	23	17	60	1.37	0.85
13. (Hospital legal service)	40	33	27	0.87	0.82
14. (Disadvantages of hospitalization)	13	13	74	1.60	0.72
15. (Right to retain patient)	33	23	44	1.10	0.88

0 = completely unacceptable response; 1 = partially acceptable response; 2 = completely acceptable response.

edged their need to be in a hospital to obtain their treatment.

In Table 4, the questions are grouped into conceptual categories as first delineated by Appelbaum and Bateman,[2] demonstrating the percentage of subjects obtaining scores in the low (0–33%), middle (34–66%), and high (67–100%)

Table 4
Distribution of Scores for Conceptual Categories with Comparison Data

	Low	Middle	High
Appreciation of nature of conditions (Q1–3)	63	20	17
Norko *et al.*[6]	(11)	(19)	(70)
Clark and Billick[7]	(47)	(11)	(42)
Appreciation of nature of hospital (Q4–6)	27	37	36
Norko *et al.*[6]	(25)	(33)	(42)
Clark and Billick[7]	(32)	(58)	(11)
Comprehension of reason for admission (Q7)	07	43	50
Norko *et al.*[6]	(14)	(19)	(67)
Ability to decide to cooperate with treatment plan (Q8)	10	23	67
Norko *et al.*[6]	(02)	(15)	(83)
Ability to protect self in hospital (Q9)	07	26	67
Norko *et al.*[6]	(13)	(05)	(82)
Awareness of legal rights (Q10–13)	30	53	17
Norko *et al.*[6]	(36)	(27)	(37)
Clark and Billick[7]	(32)	(42)	(26)
Awareness of adverse consequences (Q14–15)	17	20	63
Norko *et al.*[6]	(32)	(36)	(32)
Clark and Billick[7]	(05)	(16)	(79)

Low = 0–33%, Middle = 34–66%, High = 67–100% of total possible score.

range for each category. This table provides a clear illustration of how limited the adolescents' appreciation of the nature of their condition was: 83 percent of patients demonstrate a limited or poor grasp of the fact that they were diagnosable as being mentally ill. In the remaining conceptual categories, the data for adolescent subjects were more similar to data from previous studies of voluntary adults and involuntary adults.

The questionnaire items may also be categorized according to a system of criteria proposed by Appelbaum *et al.*[5] in their 1981 study, as shown in Table 5. Reiterated in this table is the subjects' poor performance on minimal clinical criteria. The adolescents performed better when evaluated on the basis of broad clinical criteria, but 63 percent of the subjects in this study still showed limited understanding of broader clinical issues, such as nature of hospitalization, reason for admission, and decision to cooperate with treatment plan. On legally oriented criteria, although 37 percent of patients performed well, over half of the subjects (53%) demonstrated a limited understanding of legal issues related to their hospitalization. The adolescents' overall incompleteness of understanding was effectively demonstrated by their mediocre performance on combined clinical and legal criteria, where 74 percent scored in the middle range.

To statistically evaluate the relationships between demographic/clinical variables and scores on subcategories of the questionnaire, the Pearson product-moment correlation coefficient (r) was used. These data are provided in Table 6. There was a significant correlation between number of previous psychiatric hospitalizations and total score ($r = 0.3036$, $p < .05$). Social status was significantly negatively correlated with performance on legally oriented criteria ($r = -0.3093$, $p < .05$). The strongest correlation was between performance on the WISC-R vocabulary subtest, calculated using scaled scores, and legally oriented criteria ($r = 0.4733$, $p < .01$). The mean scores for competency criteria categories among various subgroups are shown in Table 7. There were no significant differences between sex or race subgroups by any statistical procedure.

Table 5
Distribution of Scores for Competency Criteria Categories with Comparison Data

	Low	Middle	High
Minimal clinical criteria (Q1–3)	63	20	17
Norko *et al.*[6]	(11)	(19)	(70)
Clark and Billick[7]	(47)	(11)	(42)
Broad clinical criteria (Q1–9)	07	63	30
Norko *et al.*[6]	(07)	(21)	(72)
Clark and Billick[7]	(16)	(47)	(37)
Legally oriented criteria (Q10–15)	10	53	37
Norko *et al.*[6]	(34)	(48)	(18)
Clark and Billick[7]	(11)	(58)	(32)
Combined clinical and legal criteria (Q1–15)	03	74	23
Norko *et al.*[6]	(09)	(40)	(51)
Clark and Billick[7]	(11)	(47)	(42)

Table 6
Pearson Correlations for Competency Criteria Categories with Independent Variables

	Minimal Clinical Criteria	Broad Clinical Criteria	Legally Oriented Criteria	Total (Combined Criteria)
Age in years	.0224	.1852	.1282	.2209
Grade	.0694	.0638	.2218	.1772
WISC-R vocabulary score	.2618	−.0118	.4733**	.2600
Social status	−.1306	−.0227	−.3093*	−.1782
Previous hospitalization	.2514	.2517	.1803	.3036*

*$p < .05$; **$p < .01$.

Table 7
Mean Scores for Competency Criteria Categories by Independent Variable (Comparison with Data from Norko *et al.*[4])

Group (n)	Minimal Clinical Criteria	Broad Clinical Criteria	Legal Criteria	Combined Criteria
Male (8)	2.8/47	12.4/62	8.0/57	20.4/60
	(5.2/87)	(14.4/80)	(5.6/47)	(20.1/67)
Female (22)	2.0/33	11.9/60	7.4/53	19.3/57
	(4.6/77)	(13.1/73)	(5.6/47)	(18.7/62)
White (10)	2.8/46	12.3/62	7.4/53	19.8/58
	(4.8/80)	(13.4/74)	(5.7/48)	(19.0/63)
Hispanic (9)	2.4/40	12.2/61	7.1/51	19.4/57
	(5.6/93)	(15.0/83)	(4.4/37)	(19.4/65)
Black (6)	2.1/35	11.3/57	7.0/50	18.3/54
	(4.8/80)	(14.3/79)	(6.0/50)	(20.3/68)
Other (5)	2.3/39	10.3/52	9.3/67	19.7/58
Novice (18)	2.1/35	11.2/56	7.3/52	18.5/55
	(4.4/73)	(13.1/73)	(5.1/43)	(18.6/62)
Experienced (12)	2.9/48	12.8/64	7.8/56	20.6/60
	(5.2/87)	(14.3/79)	(5.9/49)	(19.8/66)
Adjustment disorder (13)	1.5/25	9.5/48	6.8/49	16.3/48
Affective disorder (8)	3.8/64	14.8/74	7.7/55	22.5/66
	(4.8/80)	(13.6/76)	(6.0/50)	(19.6/65)
Conduct disorder (8)	3.2/53	14.0/74	8.6/61	22.6/66
Schizophrenic disorder (1)	1.0/17	11.0/55	9.0/64	20.0/59
All (30)	2.2/37	12.0/60	7.5/54	19.6/58
	(4.9/82)	(13.8/77)	(5.6/47)	(19.4/65)

An ANOVA revealed a significant two-way interaction between diagnosis and age ($F = 3.752$, $df = 3$, $p = .023$) for total score. The relationship diagnosis and grade for total score is also statistically significant ($F = 4.022$, $df = 3$, $p = .018$). When subsections of the questionnaire are considered, the interaction between grade and DSM-III(R) diagnosis is statistically significant only for broad clinical criteria ($F = 3.262$, $df = 3$, $p = .037$).

Table 8 provides an illustration of mean scores for competency criteria categories by age in years. Although statistical analysis is hampered by the small

Table 8
Mean Scores for Competency Criteria Categories by Age

Age (n)	Minimal Clinical Criteria	Broad Clinical Criteria	Legal Criteria	Combined Criteria
12 (1)	5.0 (83%)	17.0 (85%)	5.0 (36%)	22.0 (65%)
13 (11)	2.1 (35%)	11.2 (56%)	7.4 (53%)	18.6 (55%)
14 (9)	1.8 (30%)	11.0 (55%)	7.6 (54%)	18.6 (55%)
15 (4)	1.8 (30%)	12.3 (61%)	8.5 (61%)	20.8 (61%)
16 (4)	3.8 (63%)	14.8 (74%)	8.3 (60%)	23.0 (68%)
17 (1)	1.0 (17%)	14.0 (70%)	5.0 (36%)	19.0 (56%)

number of subjects in each age category, examination of the data in tabular form provides an indication that performance on minimal clinical criteria is probably least predictable as a function of age. Performance on broad clinical, legal, and combined criteria appears to improve more reliably with increasing age of the patient.

Discussion

The data generated by the present study suggest that a large percentage of the adolescents who entered this psychiatric hospital under minor voluntary status were not competent to consent to their admission. This was true whether competency was defined on general clinical grounds, with more specific clinically oriented criteria, in terms of understanding of legal rights, or with combined clinical and legal criteria. The performance of the adolescents enrolled in this study was not uniformly poor, however. When data from the questionnaire are examined in subsections based on strategically chosen clinical and legal conceptual categories, differences become apparent. This provides evidence that these adolescent patients understood some issues relating to their hospitalization more clearly than they understood other issues.

The study population of 30 adolescents demonstrated a significantly lower level of understanding on minimal clinical criteria (questions 1–3) than on the test's other subsections. The first section of the questionnaire provides a measure of patients' views regarding the presence of psychiatric illness in general, and whether or not hospitalization is warranted. Eighty-three percent of adolescents tested demonstrated poor or limited understanding of their illness and their need for inpatient treatment. These same subjects performed much better on broad clinical criteria (based on more practical issues), legal criteria, and combined clinical and legal criteria.

Comparison of these findings with data from previous studies at St. Vincent's Hospital using voluntary and involuntary adult subjects, as in Table 5, illustrates that adolescents performed similarly to both populations of adults based on broad clinical, legal, and combined criteria. In contrast, patients in our study scored lower than adults on the minimal clinical criteria, with a greater quantitative disparity between adolescent scores and those of the vol-

untary adults. Thus, despite their often being admitted following a family decision, and with one or both parents present to provide legal consent, the adolescents in our study performed significantly worse than involuntary adults on questions relating to basic clinical issues. Because of the often less than democratic power structure of the families involved, the construct of reactance, or negative reaction to coercion, is certainly relevant in such situations. It will thus be necessary for future studies in this area to specifically consider the degree of involvement of adolescents in the decision to seek hospitalization.

It is interesting to note that adolescents fared more poorly than adults on minimal clinical criteria than voluntary and involuntary adults, when one considers the diagnostic complexion of our adolescent population relative to adult inpatient populations. Although percentage-wise far fewer adolescents carried diagnoses of illnesses associated with delirium, dementia, or psychoses than a comparable sample of adult inpatients, their understanding of the presence of psychiatric illness and the need for hospitalization was significantly worse than that of adults. Indeed, it was often the subtlety of pathology, the prominent involvement of other individuals, or the relationship of symptoms to discrete stressors that led an adolescent to identify the problem as existing outside him or herself, and hence to disagree with the need for inpatient hospitalization.

Statistical analysis of our data provides quantitative confirmation of several trends that are intuitively expectable when considering adolescent competency in relation to clinical, demographic, and intellectual variables. Total score on the questionnaire correlates significantly with number of previous hospitalizations and WISC-R vocabulary subtest score. The WISC-R vocabulary scale was chosen as a feasible method of estimating intellectual ability because it is the portion of the WISC-R that is most highly correlated with overall IQ score. Performance on the legally oriented section of the questionnaire is highly correlated with WISC-R vocabulary score (statistically significant at $p < .01$), demonstrating that issues related to legal rights require more abstract reasoning ability than clinically related issues.

In adolescents, as in adults, incompetency may be due to mental illness or mental defectiveness. In the present study, all subjects scored within two standard deviations of the mean vocabulary scaled score as established by WISC-R norms. As the mean vocabulary scaled score is designed to correspond to an IQ of 100, none of the subjects in this study scored in the defective range on this screening measure of intelligence. Consideration of this important relationship between intelligence and competency provides a heuristic imperitive for a more precise measure of intelligence in subsequent studies of adolescent competency.

As expected from Norko's[6] study of voluntary adult patients, ANOVA demonstrates a significant two-way interaction between DSM-III(R) diagnosis and grade for total score. Further analysis of

the data by questionnaire subsection shows that the one portion of the test which significantly contributes to the variance is that relating to the broad critical criteria. It is this portion of the questionnaire which should prove most valuable in testing adolescent competency to consent to psychiatric hospitalization.

The results of this study are relevant to considerations of the process of adolescent psychiatric hospitalization in two essential areas. The first of these is the capacity of adolescents to act as collaborators during the decision-making process proceeding inpatient admission. The low scores of our subjects on minimal clinical criteria raise serious doubts regarding their insight on questions of psychiatric illness and need for hospitalization. Placed in a developmental perspective, the incomplete maturation of the capacity to use secondary process thinking (Freud) and/or concrete and formal operations (Piaget) limits the adolescent during the decision-making process. The intrusion of newly strengthened libidinal and aggressive drives must also be considered when noting the obvious differences in insight and judgment between adolescents and young adults.

The second area pertains to a therapeutic challenge following admission. Most adolescents deny the presence of psychiatric illness and the need to be in the hospital. This must be considered when designing a treatment plan for forging a therapeutic alliance during the initial phase of hospitalization.

Issues such as these have become increasingly relevant in the current legal and economic climate. The emergence of for-profit psychiatric hospitals and the increased ease with which parents may "voluntarily" admit their minor adolescent offspring in some states have rekindled the debate over standards of admission for adolescents. The reader is referred to recent papers by Appelbaum[1] and Weithorn[9] for further discussion of these issues.

In summary, this study provides an effective illustration of the limited level of understanding of basic clinical issues pertaining to inpatient psychiatric hospitalization in a population of adolescents, aged 12 to 18 years. Although their understanding of practical and legal issues relating to their hospitalization was similar to that of previously studied voluntary and involuntary adult psychiatric inpatients, adolescents demonstrated a notable lack of insight regarding presence of psychiatric illness and need for inpatient hospitalization. The competency questionnaire used in the previously cited adult studies was readily applicable to the adolescent population, following minor amendments to allow for the consideration of the relationship of parental opinions to the hospitalization of adolescents. It is expected that further research utilizing this instrument will bolster the theoretical framework of the study of clinical competency, and assist in deriving standards for the evaluation of competency to consent to psychiatric hospitalization.

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