Capacity to Consent to Voluntary Hospitalization: Searching for a Satisfactory *Zinermon* Screen

Norman G. Poythress, PhD, Michele Cascardi, PhD, and Lee Ritterband, MA

Half a decade ago, the *Zinermon* court announced the need for clinicians to evaluate the competence of people with mental illness to consent to voluntary hospital admission, but the court did not specify the test of capacity that mental health professionals should use. As has occurred in other areas dealing with legal competence, there is a need for the field to develop standardized assessment procedures for evaluating capacity to consent to voluntary hospitalization. Both theorethical and practical considerations suggest that these procedures should be modeled after what S. K. Hoge has termed a "weak" model of consent. This and other studies of the ability of mentally ill persons to understand disclosed information suggest that their level of understanding may be assessed optimally with measures that utilize *recognition* rather than *recall* response elicitation formats.

For the past quarter century, the dominant model for involuntary psychiatric treatment in the United States has been a "legal model," which places greater emphasis on protecting the rights of committed individuals than on their "need" for medical intervention. Involuntary commitment results in the loss of individual autonomy, a right guaranteed by the constitution. To protect this individual right, the civil rights litigation of the 1970s established the policy that "only a compelling state interest could justify the loss of liberty occasioned by commitment" (p 211).[1] The courts and legislatures have determined that such "compelling interests" may be justified through either the "police power" (preventing mentally ill persons from harming themselves or other citizens) or "*parens patriae*" (preventing mentally ill persons from deterioration resulting from severe personal neglect or the inability to meet basic needs) rationales of state intervention.[2] All 50 states have statutory provisions for the

Drs. Poythress and Ritterband are affiliated with the Department of Mental Health Law and Policy, University of South Florida, Tampa, FL. Dr. Cascardi is currently affiliated with Compass Information Services, King of Prussia, PA. Address correspondence to: Norman G. Poythress, PhD, Mental Health Law and Policy, The Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Blvd, Tampa, FL 33621-3899. E-mail address: poythres@hal.fmhi.usf.edu

commitment of mentally ill persons based on one or both of these rationales.

Although all states provide for involuntary treatment, there is often an explicit preference for allowing mentally ill persons to enter treatment on a *voluntary* basis when appropriate. This preference is based on the potential benefits of voluntary hospitalization for both patients and hospital staff.[3–6]

Voluntary admission is congruent with respect for individual autonomy; voluntary status allows patients to retain the legal right to request release and may increase their involvement in and personal responsibility for their treatment. Other benefits may include the reduction of stigma associated with involuntary commitment and the prevention of further deterioration while awaiting hearing. Hospital staff prefer that patients enter the hospital voluntarily because the commitment process (e.g., preparing petitions, conferring with attorneys) is very time consuming. Further, commitment hearings force the doctor and patient into an adversarial relationship that may undermine efforts to establish a therapeutic alliance and thus adversely affect patients' participation in treatment.

Despite the potential benefits of voluntary admission, there are also potential risks. Some patients may be acutely disturbed in ways that impair their capacity to give informed consent to voluntary admission or to make other treatment decisions in a responsible, self-interested manner. The plight of this type of patient was the focus of the U.S. Supreme Court's decision in *Zinermon v. Burch*.[7] The Court suggested that persons with mental illness should be screened, upon admission, regarding their capacity to give informed consent to voluntary hospitalization and that patients unable to give informed consent should be subjected to involuntary commitment procedures. The Court did not specify the screening procedures required to determine competence to admit oneself voluntarily to a psychiatric hospital, nor did the Court opine on the substantive test of capacity to consent. However, the opinion clearly established capacity to give informed consent as the proper and pivotal inquiry in determining whether to permit voluntary admission.[5–6, 8–10]

Informed Consent for Voluntary Admission: Empirical Findings

Both before and since the Court's opinion in *Zinermon*, researchers have investigated psychiatric patients' capacities to consent to voluntary admission. These studies have uniformly yielded results that cast considerable doubt upon the capacity of most psychiatric patients. Olin and Olin[11] interviewed 81 state hospital and 19 private psychiatric hospital patients and solicited narrative responses to four key questions that probed understanding of the voluntary admission contract that all patients had signed upon admission. Researchers rated the subjects' narrative responses on a scale ranging from 1 ("no understanding") to 5 ("complete understanding"). Less than half of the patients in each facility were rated at the higher end of the scale (ratings 4 to 5), leading the authors to characterize their findings as indicating a "massive lack of comprehension by pa-

tients of their voluntary status" (p 940). Poorer scores were associated with more serious diagnoses including schizophrenia and organic disorders.

Appelbaum and colleagues[12] interviewed 50 patients within 24 to 48 hours of voluntary admission to two inpatient services at the Massachusetts Mental Health Center (Boston, MA) in 1979. The experimental measure included 15 items that assessed patients' understanding and appreciation of both clinical and legal parameters of their hospitalization (e.g., appreciation of their clinical condition, comprehension of the reason that admission was recommended, awareness of rights outlined in written admissions material). No more than approximately one-third of patients scored in the upper one-third of possible scores in either the clinical or legal domains. The patients' scores did not appear to be related to either diagnosis or prior treatment history (chronicity), leading the authors to suggest that mental status upon admission may be the more critical variable in determining competency. They concluded that "If the results of this study can be confirmed, it appears that according to any meaningful standard a large number, perhaps a majority, of psychiatric patients may not be competent to sign themselves into the hospital" (p 1175).

In a third study, Levine and colleagues[13] interviewed 62 patients within 72 hours of voluntary admission to two psychiatric inpatient units. Narrative responses were obtained to eight structured questions that explored both clinical and legal information that had been communicated to patients at the time of admission. As in the previous studies, patients understanding of both legal and clinical information was "poor." Elderly patients in particular showed poorer comprehension of legal issues, rights, and procedures related to voluntary admission.

Weak Versus Strong Models of Informed Consent

Were the results of existing studies to form the basis for policy in light of the *Zinermon* opinion, substantially increased numbers of patients, many of whom are now treated on a voluntary basis, might be subjected to involuntary commitment proceedings. However, the absence of specific guidelines regarding the appropriate criteria (either substantive or procedural) for competence to consent in this context leaves open the public policy implications of this body of research. From a social and legal policy perspective, an open question remains: how stringent should the test of capacity be in screenings anticipated by the *Zinermon* dicta?

In a thoughtful and comprehensive analysis of these issues, Dr. Hoge[6] conceptualized both strong (relatively more demanding) and weak (relatively less demanding) models of informed consent, focusing on the type of information that, hypothetically, might need to be disclosed by doctors and satisfactorily understood by prospective patients at the time of admission.

The strong model is characterized as a fairly extensive disclosure that might include, for example, specific legal rights waived by signing the voluntary admission form (e.g., right to contest the hospitalization at a hearing, aided by counsel,

before an impartial decisionmaker), the procedures for discharge from voluntary admission (including possible waiting periods and the initiation or reinitiation of the involuntary commitment process), or the disclosure of adverse social costs (e.g., stigma) potentially attendant to hospitalization. The *ad hoc* tests of competence that investigators have developed to date all appear to reflect the "strong" informed consent model. In each study, patients were questioned about both clinical and legal information, such as the terms and conditions of the "contract between patient and hospital" (p 938)[11]; the nature of clinical problems and anticipated treatments, and procedures for seeking discharge from the hospital (p 302)[13]; or clinical insight, comparative advantages of inpatient versus outpatient treatment, and awareness of potential adverse consequences of admission (p 1171).[12]

Hoge rejects the strong model on a variety of both policy and practical grounds. For example, in no other medical specialty do informed consent procedures require the disclosure of nonmedical, social cost information (e.g., surgeons are not expected to advise prospective patients that a life-saving but disfiguring operation might result in "stigma"). Similarly, given that clinicians are not experts in the law, the inclusion of extensive "legal" information in the informed consent process is rejected. From a more practical perspective, he notes that ". . . acute psychiatric hospitalization predictably involves individuals with significant cognitive impairment whose capacities are further diminished by distress. In these circumstances, an elaborate informed consent process is likely to be ineffective" (p 438).[6]

Having rejected the strong model, Professor Hoge endorses a weaker model that would be limited primarily to the disclosure of information based on medical expertise. A measure recently developed by the Treatment Competence Subgroup of the MacArthur Foundation Research Network on Mental Health and the Law—Measuring Understanding of Disclosure: Voluntary Hospitalization (MUD-VH)—does appear to fit within Dr. Hoge's framework as a weak model. The MUD-VH (described in greater detail below; see *Measures*) is much less comprehensive in scope than the *ad hoc* tests of understanding employed by previous researchers. It discloses (and evaluates patients' understanding of) very limited information, in only two domains: the primary purposes of psychiatric hospitalization (diagnosis, treatment, preventing harm to self/others), and doctors' possible reactions to a voluntary patient's request to leave the hospital (permit or deny the request). The present study investigated psychiatric patients' capacity to understand information relevant to voluntary admission using the MUD-VH as an operational measure of capacity.

The Present Study

Setting This study was conducted at two community mental health centers in west central Florida. These centers operate crisis stabilization units (CSU) that serve as receiving facilities for Florida's Department of Health and Rehabilitation Services (HRS). Receiving facilities are those agencies designated by HRS to con-

duct psychiatric examinations within 72 hours of admission for persons committed via court order to undergo an involuntary evaluation.[14] The statute specifies that the possible dispositions upon examination include release, petition for involuntary placement (treatment), or conversion to voluntary status. These were particularly appropriate settings for this study because the *Zinermon* case took place in Florida and because state statutes encourage psychiatrists to facilitate voluntary admissions ("The patient shall be asked to give express and informed consent to placement as a voluntary patient").[15] The statutes further encourage treatment staff to transfer involuntary patients to voluntary status, again subject to the patients' ability "to give express and informed consent."[16]

Objectives and Hypotheses There were three primary aims to the present study: (1) to evaluate patients' capacity to give informed consent for voluntary hospitalization under a weak model, as operationalized by comprehension of the MUD-VH disclosures; (2) to examine MUD-VH performance separately for patients in voluntary (VOL) versus involuntary (INVOL) commitment status based on psychiatric assessments completed within 72 hours of admission for involuntary evaluation; and (3) to examine patient factors associated with measured capacity to understand disclosed information relevant to the voluntary admission decision.

Although no studies have been published using the MUD-VH, we hypothesized that most patients allowed to sign voluntarily into the CSU would be able to understand the MUD-VH disclosure. This hypothesis was based on the brevity and seemingly undemanding nature of the MUD-VH recall task (see *Measures* below). Firm hypotheses regarding the capacity of patients designated for involuntary hospitalization were more difficult to formulate. One might hypothesize that patients recommended for involuntary placement would display greater impairment in capacity, perhaps as a result of being more acutely disturbed than their voluntary counterparts; however, psychiatrists might recommend involuntary placement for some patients who clearly had the capacity to consent (e.g., those who refused to accept ("assent" to) voluntary placement and who otherwise met commitment criteria, e.g., danger to self or others). Finally, we examined the impact of a number of factors that might explain the variance in patients' capacity to consent, including diagnosis and present mental status, which had been identified as important in previous research.[11–12]

Methods

Participants Research participants were 120 persons initially brought to the CSUs under court order for an involuntary evaluation between October 1994 and July 1995. Approximately half (58 and 62) of the participants were recruited at each CSU; half of the participants at each site were judged by the psychiatrist (upon completion of the 72-hour evaluation) to require involuntary commitment via the court (INVOL), and half were permitted to sign into the CSU as voluntary treatment patients (VOL). All partic-

Table 1
Sample Characteristics: Demographic and Clinical

	Voluntary (n = 60)	Involuntary (n = 60)
Demographics:		
% Male	55.0	53.3
% Caucasian	70.0	75.0
Mean age (yr)	35.2	36.8
Education (%)		
0–11 years	40.0	21.7
High school graduate/ GED	36.7	25.0
Some college	11.7	35.0
College graduate	5.0	5.0
Postgraduate	6.7	13.4
% Unemployed prior to admission (%)	68.3	65.0
Marital status (%)		
Single	38.3	51.7
Married	11.7	8.3
Separated	13.3	11.7
Divorced	36.7	25.0
Widowed	0.0	3.3
Clinical:		
% Receiving outpatient treatment prior to admission	41.7	40.0
Diagnosis (%)		
Schizophrenia and schizoaffective	41.7	48.3
Major affective	43.3	40.0
Other	10.0	8.3
(Missing data)	5.0	3.3
BPRS-A mean scores		
Total	36.6	37.0
Psychoticism	5.6	6.4
Depression	10.5	8.2*
Hostility	5.6	7.0*
Emotional withdrawal	4.8	5.0

* $p < .01$.

ipants were age 16 years or older, and persons of all ethnic backgrounds and both genders were eligible.

The clinical and demographic characteristics of the sample are presented in Table 1. The INVOL and VOL groups were highly similar on most measures; the majority of participants were Caucasian, in their mid-thirties, and male. About 75 percent of persons in each group were either single or divorced, and about two-thirds of each group were unemployed prior to the current admission. The INVOL group, based on self-report, appeared to be better educated than the VOL group. Clinically, the groups were similar in terms of chart diagnosis and involvement in outpatient treatment prior to admission. The groups also had similar total scores on the Brief Psychiatric Rating Scale; VOL patients had somewhat higher scores on the Depression subscale and somewhat lower scores on the Hostility subscale.

Procedure Recruitment of INVOL participants involved monitoring, through frequent telephone contact with social work staff and CSU discharge coordinators, the dispositional decisions made by psychiatrists at the 72-hour evaluation. Unless staff advised that the patient was too aggressive or unstable to participate, all eligible patients were asked to participate. Recruitment procedures for VOL patients were similar to those used with INVOL patients; however, not all potentially eligible VOL patients were recruited. The data reported here are part of a larger study, the design for which called for equal numbers of INVOL and VOL patients; thus we recruited VOL patients (of whom there was a much larger number) at approximately the same pace as INVOL patients. Overall, 4 VOL patients and 11 INVOL patients were screened out of the study by treatment staff as too aggressive or clinically unstable to be in-

terviewed. In total, 30 percent of the patients refused or were excluded from participating. This refusal rate is comparable with rates reported in previous studies by Appelbaum and colleagues (33%)[12] and Levine *et al.* (31%).[13]

Each research participant was recruited into the study using informed consent procedures approved by our institution's human subjects review board.* After a patient was recruited into the study, demographic and social history were obtained and the research protocol was administered. All protocol items were read aloud to the patient while he/she followed along in a participant's manual.

Measures Demographic and social history information was obtained from the patient; with the patient's permission, current diagnosis was retrieved from the hospital chart (five patients refused to give permission to access their hospital charts). A five-item multiple choice measure was administered to assess the patient's understanding of information pertinent to consent to research participation (ConRx),* yielding scores ranging from 0 to 5. An assessment of current mental status was obtained via the anchored version of the Brief Psychiatric Rating Scale (BPRS-A).[17]

The primary research instrument was the MUD-VH.[18] This instrument, developed by the Treatment Competence Subgroup of the MacArthur Foundation Research Network on Mental Health and the Law, is similar in structure to one of their instruments used in assessing competence to make treatment decisions.[19] The MUD-VH consists of two brief paragraphs. The first paragraph articulates three reasons why people may enter a psychiatric hospital: diagnosis, treatment, or preventing harm. The second paragraph explains that discharge from voluntary psychiatric hospitalization is not automatic; doctors may allow the person to leave upon request, but they may not if they think the person may harm themselves or others if released. After these disclosures are read aloud, patients are asked "What are all the reasons that a person might come into a psychiatric hospital?," and their response is scored 2/1/0 for recalling, respectively, two, one, or none of the three reasons in the disclosure. They are then asked "When a person who has come into the hospital for psychiatric treatment asks to leave, how might the doctors respond?," and their response is scored 2/1/0 for recalling two, one, or neither of the ways that the doctors might respond. Thus, the range of possible scores on the MUD-VH is 0 to 4.

Results

Patients' Performance on MUD-VH A score of 4 on the MUD-VH suggests

* In our original recruitment plan, we required that a patient demonstrate capacity to give informed consent to participate in research. Capacity was defined as answering correctly at least four of five multiple choice items that were administered to test their understanding of information communicated about the study during the recruitment process (e.g., purpose and nature of the study, confidentiality of responses, voluntary of participation, compensation ($5.00) for their time, etc.). During the first two months, 31 percent of the patients approached were excluded for failure to pass this informed consent screen. We subsequently altered our recruiting procedure (with approvals of the participating mental health centers and the university's Institution Review Board) such that any patient who assented to participate, with approval from a member of his/her treatment team (e.g., nurse, social worker), was eligible. However, we continued to administer the test of capacity to consent to research participation (ConRx) and included scores on that measure in our analysis.

Table 2
Distribution of MUD-VH Scores for Voluntary and Involuntary Patients

MUD-VH Score	Voluntary N (%)	Involuntary N (%)
0	2 (3.3)	3 (5.0)
1	11 (18.3)	4 (6.7)
2	12 (20.0)	10 (16.7)
3	13 (21.7)	11 (18.3)
4	22 (36.7)	32 (53.3)

that the patient is unimpaired in his/her ability to understand the disclosed information, while scores of 0 to 3 reflect some impairment in this competence-related ability. More than half (65 of 120, 55%) of the patients in this study displayed some impairment as evidenced by a MUD-VH score of less than 4. If a less stringent criterion (MUD-VH $\geq$ 3) is used as an index of capacity, then 65 percent of the sample (78 of 120) attained a "passing" score.[†]

Comparison of the Competence-Related Abilities of Voluntary and Involuntary Patients As noted above, 55 percent of all patients displayed some impairment in capacity to consent as measured by perfect performance on the MUD-VH (Table 2). There is a trend in the data suggesting that VOL patients may be more impaired in capacity, as measured by the MUD-VH, than INVOL patients: 63.3 percent of the VOL patients attained a MUD-VH score <4, compared with 46.7 percent of the INVOL patients. Using a 2 $\times$ 2 Pearson χ^2 analysis, the association between MUD-VH performance and legal status (VOL/INVOL) approaches significance: χ^2 (1) = 3.37, $p < .07$.

Factors Associated with Patients' MUD-VH Performance A backward, stepwise multiple regression analysis was conducted to determine factors that explained unique variance in MUD-VH scores. Table 3 indicates the predictor variables initially entered in the analysis; these include demographic variables (age, gender, ethnicity), diagnosis (schizophrenia/schizoaffective disorder, major affective disorder), current mental status (four BPRS-A subscales and a BPRS-A "residual" (total − subscales)), study site variables (days after admission tested, CSU site), current legal status (VOL/INVOL), and another measure of patients' capacity to understand disclosed information (ConRX, understanding of the informed consent disclosure for participation in this study).

Table 3 indicates the bivariate Pearson correlation for each predictor variable with the MUD-VH. The upper portion of the table indicates predictor variables that contributed unique variance in the MUD-VH scores; 26.5 percent of the variance in MUD-VH scores was explained by five variables, including diagnosis (lower MUD scores for persons with schizophrenia/schizoaffective disorder), present symptoms of psychosis or depression, legal status, and ConRX scores (capacity to understand disclosure for research participation).

Interestingly, and somewhat unexpectedly, the strongest predictor of MUD-VH scores was ConRX. We examined the as-

[†] Results reported here are based on the full sample. We repeated all analyses using only the 94 cases recruited after the change in eligibility requirements. Except for relatively minor changes in the regression analysis, the results were not significantly affected.

Table 3
Results of Regression Analyses to Explain MUD-VH Scores

Predictor	Correlation with MUD-VH	Unique Variance Explained
Variables contributing unique variance		
ConRX	.37****	.107****
VOL/INVOL	−.16**	.042**
BPRS-A: psychoticism	−.25***	.038**
BPRS-A: depression	.16**	.028**
Diagnosis	.18**	.050**
Variables not contributing significant unique variance		
BPRS-A: hostility	.06	Deleted step 2
BPRS-A: emotional withdrawal	−.05	Deleted step 3
Days after admission	.08	Deleted step 4
Age	−.04	Deleted step 5
Ethnicity	.16**	Deleted step 5
Gender	.08	Deleted step 5
BPRS-A: residual	−.23****	Deleted step 6
CSU site	−.09	Deleted step 7

*$p < .10$; **$p < .05$; ***$p < .01$; ****$p < .001$.

sociation between scores on the ConRX screen and MUD-VH using the procedure described above. Both MUD-VH and ConRX scores were collapsed into perfect versus impaired performance categories, creating a 2 × 2 contingency table. The association between these scores was significant (χ^2 (1) = 15.69, $p < .001$. Eighty-nine subjects (74.2%) attained a perfect score on ConRX, compared with only 54 subjects (45%) attaining a perfect score on the MUD-VH. Because our initial recruiting strategy selected for good performance (scores of 4 or 5) on the ConRX, the full sample may have been biased toward persons capable of understanding information relevant to research participation. However, when we excluded from analysis the 26 subjects initially recruited on the basis of ConRX scores, these results were not affected; 75.5 percent of the remaining subjects attained a perfect score on ConRX, while only 41.5 percent attained a perfect MUD-VH score.

Discussion

This study investigated the capacity of persons committed for involuntary psychiatric evaluation to understand information relevant to voluntary hospital admission, using an objective measure of capacity that reflects a weak model of capacity to consent as conceptualized by Hoge. Our hypothesis that most patients would be able to pass the MUD-VH, which we consider a relatively nondemanding challenge to patients' capacity, was not supported. Fifty-five percent of all patients, and 62.3 percent of those permitted to sign into the CSU on a voluntary basis, demonstrated impaired capacity to consent as measured by the MUD-VH. Scores on this measure were influenced by both clinical (diagnosis and current mental status) and nonclinical

(legal status, capacity to understand research participation disclosures) variables. We will consider these findings in reverse order.

Factors Influencing Capacity to Consent The results obtained, at least with respect to clinical variables, are relatively unremarkable. Intuitively, patients with symptoms of more severe disorders (e.g., schizophrenia) or a current mental status that includes psychotic symptoms would be expected to have greater difficulty completing a cognitive comprehension task than other patients; in previous research of capacity to consent to voluntary hospitalization that used more demanding tasks of capacity, investigators have implicated both severity of diagnosis[11] and current mental status[12] as influential.

The strongest predictor of MUD-VH scores, however, was the ConRX. The ConRX was a five-item, multiple choice measure of the patients' capacity to understand information contained in the research participation disclosure. It is perhaps not surprising that two tasks of cognitive comprehension would be positively associated. Somewhat more surprising, however, was the relative performance of subjects on the two measures. A considerably larger number of subjects attained a perfect score on ConRX (74.2%) than on the MUD-VH (45%). The ConRX is a much longer document (approximately 1.3 pages) than the MUD-VH and it contains information that, arguably, would be relatively unfamiliar to these patients (e.g., nature and purpose of research, confidentiality issues); virtually all of these subjects had prior CSU or psychiatric hospital admission experience and, thus, should have had considerable prior exposure to the content of the MUD-VH. However, unlike the MUD-VH, the ConRX utilized a *recognition* testing format, a structural feature that may explain subjects' superior performance on that measure. We will revisit this issue in the discussion below in considering alternative methods of measuring patients' capacity to consent to voluntary hospitalization.

Involuntary Patients' MUD-VH Performance Strong conclusions about the INVOL patients' capacity to consent cannot be reached from our data. On a case-by-case basis, we do not know why the attending psychiatrist recommended involuntary placement upon completion of the 72-hour evaluation, even though more than half (53.3%) of the INVOL patients were unimpaired as assessed by the MUD-VH. As noted earlier, in some instances it may have been simply patients' unwillingness to accept an offer of voluntary admission; if commitment criteria were otherwise met (e.g., danger to self or others), doctors would have had little alternative except to file for involuntary placement on a nonassenting patient.

Anecdotally, however, other factors appear to have been in play more often. As has been described by other investigators,[3, 20] reports from a number of patients and treatment support staff suggest that psychiatrists would not permit an assenting patient to sign a voluntary admission unless (and until) the patient also agreed to take psychotropic medications. Although capacity to consent to treatment (and the right to refuse medications) can be conceptually and legally distinguished

from capacity to consent to voluntary admission, a number of INVOL patients in this study may have been denied the right to voluntary admission because of doctors' concerns about medications. Frequently, when we followed up on these patients 24 hours after the research protocol had been administered, we found that the "involuntary" patient had "agreed today to take his/her medicine, so he/she was allowed to sign voluntary." In fact, only 16 of the 60 INVOL patients in this study remained in that status long enough to get to a court hearing; most were discharged to the community within a few days of agreeing to take medication.[‡]

In most psychiatric settings, copies of medication consent disclosures are kept in patients' charts to document the information disclosed to patients and the result of the doctor-patient discussion about taking medications. Discussions regarding consent to voluntary admission, however, are commonly less formal and medical records may not reveal the specific disclosure and/or screening method (if any) used by the doctor to assess capacity to consent to voluntary admission.

This is problematic when a third party, such as a probate court, may be asked to review and rule upon patients' capacities. Cases involving tension between patient autonomy and hospital staff desires, with respect to both voluntary admission and medication refusal issues, will be difficult to resolve fairly in the absence of clear documentation on whether and how the patient's capacity to consent has been assessed. Patients and hearing officers will have little recourse if a medical record simply indicates a psychiatrist's conclusory judgment that "the patient is unable to give consent (to voluntary admission)." In order to level the playing field with respect to the fair resolution of these issues, one implication of these data is that practioners should be required to assess these capacities systematically and to provide clear documentation of the patient's abilities, however measured. Whether policy considerations ultimately demand that the acceptable measures of capacity are more, or less, demanding than the MUD-VH, efforts to standardize these kinds of assessments is indicated.[§]

Voluntary Patients' MUD-VH Performance Perhaps the most troubling data from our study is the relatively poor performance of the voluntary admission patients on the MUD-VH. If passing the MUD-VH or a comparable measure were determined by the appropriate policy-making body to be necessary to demonstrate capacity to consent to voluntary hospital admission, then our data suggest that involuntary commitment hearings would be required for a considerable number of persons now admitted voluntarily. Significantly increasing the num-

[‡] Less frequently, other "pragmatic" concerns may have influenced psychiatrists' actions. One psychiatrist advised that it is sometimes "necessary" to commit patients to the state hospital because, until they have been committed at least once, they are ineligible for a special, state-sponsored case management program that the doctor thought might benefit them. Thus, denying voluntary admission may be "necessary" to access, ultimately, a preferred type of community treatment.

[§] In this regard, we would oppose the suggestion that the assessment of capacity to consent to voluntary hospitalization ". . . need not involve a formal interview when it is obvious to the psychiatrist that the patient is capable" (p 300).[5] The observation(s) or other data that support the conclusion of "obvious" capacity should be noted in the record.

ber of required involuntary placement hearings would not likely be seen as a favorable turn of events by any of the affected parties. The rise of the patients' rights movement gives clear indication that people with mental illness prefer treatment that is not coerced and that values individual autonomy in treatment decision-making, while mental health professionals have long considered involuntary commitment procedures to be resource consuming, countertherapeutic, and of value only as a last resort. Also, after nearly three decades of research indicating that civil commitment hearings often provide little if anything in the way of meaningful due process protections for respondents,[21,22] few would argue that significant legal benefits would result from compelling even more clients to enter through the involuntary commitment process. Thus, the present data pose a dilemma for the field of forensic psychiatry: the failure of a substantial number of patients to demonstrate adequate capacity on a weak measure such as the MUD-VH raises the question of whether a meaningful standard of capacity that most patients would pass can be found.

Alternative Approaches to Assessing Capacity to Consent to Voluntary Hospitalization In trying to resolve this dilemma, at least two courses of action are open, and both would be informed by further research on patients' capacity to consent. One course of action would be to lower the threshold for demonstrating sufficient capacity. This could be accomplished either (1) by relaxing the criteria such that something less than perfect MUD-VH performance was acceptable, or (2) by using an even less demanding test of understanding. A model recently offered by the American Psychiatric Association (APA) Task Force on Voluntary Hospitalization[5] proposes that an assenting patient is appropriate for voluntary admission if he/she demonstrates understanding of only two items of information: ". . . that he/she is being admitted to a psychiatric hospital or ward for treatment, and . . . understands release from the hospital may not be automatic . . ." (p 300).[5] Perhaps reducing the comprehension demands from four (MUD-VH) to only two (APA) elements would appreciably increase the number of patients demonstrating sufficient capacity. Although the APA Task Force asserted that its model is "lenient but meaningful" (p 301),[5] it remains an open question whether the face validity concerns of consumer advocates or the demands of the due process clause would be satisfied by such a test.[¶] Ultimately how high or low the barrier to voluntary admission can be and still be clinically and/or constitutionally meaningful is a policy question; empirical research can inform the debate by illustrating some of the practical implications, such as the numbers of prospective patient "passing" or "failing" a given test.

An alternative approach would not involve further relaxing of the criteria, but rather would explore alternative ways of measuring what patients understand about disclosures such as the MUD-VH. Our data regarding performance on the ConRX measure suggest that structuring the response solicitation task differently

[¶] Dr. Hoge left open the question ". . . whether the due process clause would preclude a weak version of informed consent" (p 449, note 31).[6]

may enable patients to more capably demonstrate their comprehension of disclosed information. Recall that a much higher percentage of patients attained a perfect score on ConRX (74.2%) than on the MUD-VH (45%) despite the fact that the ConRX was lengthier, more complex, and contained information that was arguably less familiar to the patients. However, the response solicitation format of the ConRX was a *recognition* task, demanding only that patients identify correct information from alternatives in multiple choice format. The MUD-VH, however, utilized a *recall* format, which places greater demands on patients to retain, remember, and mentally organize their responses for verbal presentation. Our hypothesis is that the differing response formats may explain much of the difference in performance on these measures. The recall format may be quite challenging to persons in an acute phase of psychiatric disturbance, where expansive thinking, flight of ideas, personalized associations to the disclosed materials, or other symptoms may substantially interfere with the mental organization and verbal expression of complex material. In contrast, a recognition format alleviates the need for significant recall and mental organization of the disclosed material. During multiple-choice testing, the important elements of the disclosed material are represented visually to patients, and the structure, which limits response options, may effectively preclude erroneous responses, the production of which is affected by current symptoms.

Support for this hypothesis can be found in general research on human memory and learning,[23] in the theoretical underpinnings of other contemporary tests of the competence-related abilities of persons with mental disorder,[24] and in the general literature on test development.[25] Further, recent empirical studies of the competence-related abilities of persons with mental illness to understand information relevant to treatment decisionmaking[20, 26] or capacity to proceed to adjudication on criminal charges[27] have demonstrated that substantially higher indicia of understanding are obtained using *recognition* as opposed to *recall* formats for response solicitation. Together, these studies suggest that people with mental illness may know more than they are able to show when challenged with a test of capacity that relies on recall. Future studies should use objective, recognition format tasks to optimally assess patients' ability to understand disclosed information.

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