Competency to Consent to Voluntary Psychiatric Hospitalization: A Theoretical Approach

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The proliferation of legal initiatives and judicial decisions concerning the rights of psychiatric patients has led to an increasing formalization of the relationship between the mental hospital and the psychiatrist on the one hand and the psychiatric patient on the other. Though a large number of these efforts have been made on behalf of the involuntarily committed patient, there appears to be considerable support for an extension of the legal model for hospitalization to the voluntary patient, as well. Foremost among the suggestions for the further protection of the rights of voluntary patients is the legal concept that voluntary admission be construed as a contractual arrangement. This legal status requires that the patient be competent and capable of giving an informed consent in order to establish the validity of the contract.[1,2] A corollary of that view is that the patient thus admitted then has the right to refuse proposed treatments and must give informed consent to those he accepts.

Previous investigations[3,4] have cast substantial doubt on the proposition that more than a small percentage of current voluntary admissions represent truly informed decisions, but no formal instrument has been devised for determining the competency of those mentally ill persons seeking voluntary admissions to consent to that act. This paper will survey the history and current alternative views of the ability of psychiatric patients to consent to their own hospitalization, and will then propose a model of competency that can be used in empirical tests of these hypotheses.

Although the first statute in the United States which allowed an individual to voluntarily enter a psychiatric hospital was enacted in Massachusetts in 1881, by 1949 only 10% of patients were voluntarily admitted.[5] Only in 1972, following widespread revision of commitment laws to encourage voluntary (as opposed to involuntary) status, were the majority of admissions accomplished in a voluntary manner.[6] The reluctance of many jurisdictions to encourage voluntary admissions stemmed from the increased administrative burden of such patients who

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This work was supported in part by a grant from the Foundations Fund for Research in Psychiatry.

could leave the hospital at will. This led many states to require that even willing patients be involuntarily committed.[7] In the second half of this century, psychiatric hospitals began to acknowledge that the element of cooperation said to be implicit in a voluntary application was to be desired and encouraged;[5] however, it took changes in commitment laws, some requiring that all patients be offered voluntary status, to turn the tide.[4]

Characteristics of voluntary admission statutes include provisions for patients to request care and to request discharge, and for hospitals to be able to detain patients for a prescribed period after the discharge request is filed, in order to evaluate the need for, and perhaps to institute, involuntary commitment proceedings. Some states have provisions for "informal" admissions, which require institutions to discharge patients immediately upon their request. Other states permit a "non-protesting admission" status, under which the absence of objection is taken as agreement to voluntary hospitalization.[5]

The Question of Competency

Early statutes authorizing voluntary admissions required that the patient be "mentally competent to make his application and to understand what he is doing on the sound theory that unless the patient is aware of what he is consenting to, the consent to detention is not voluntary."[8] The 1952 Draft Act Governing Hospitalization of the Mentally Ill, published by the National Institute of Mental Health, omitted the explicit requirement for a competent consent.[5] By 1971, only five states still required that the applicant be competent, and one, New York, explicitly stated that the legal capacity to contract not be a condition of admission. No state has dealt with the issue of a patient who becomes incompetent following admission. The rationale for the abandonment of the competency standard was that to require such status would deprive a large part of the mentally ill population of the benefits of voluntary admission.[5] Indeed, one court cast doubt on whether any voluntary patient was capable of consenting to a valid contract on admission.[8]

Recent impetus for a reconsideration of these assumptions has come from theorists who contend that voluntary status is actually less desirable for the patient than involuntary commitment. The rights to automatic judicial review, legal assistance, and periodic reassessment, which have lately been secured for civilly committed patients in many jurisdictions, are not available to voluntary patients. In one jurist's words, the new statutes, which mandate that all patients be offered voluntary status, "make it the duty of a public official to induce a mentally ill person to accept a status which thereby reduces the unknowing, bewildered mentally ill and incapacitated person to the disadvantaged position of waiving the protection of court surveillance and protection against the possibility of unjustified hospitalization which may continue indefinitely."[9] This line of reasoning is supported by a study which showed that the

majority of voluntary patients hospitalized at one state facility were either not informed or were misinformed about their rights at the time of admission and/or were in some way coerced into a voluntary status.[10] Thus, the argument goes, not only are voluntary patients subject to the same deprivations of liberty as their involuntary peers (*i.e.*, regulations governing hospital routine and possible involuntary detention should they request discharge), and to verbal threats of such, but they are also deprived of a *quid pro quo* — automatic judicial review — for the surrender of their rights.

While some legal activists were demanding that an informed consent be required of all voluntary patients as a means of correcting this situation,[1] and as part of a general thrust towards applying the contractual model to all aspects of psychiatric treatment (*i.e.*, consent to and refusal of medications), several reports in the psychiatric literature suggested that the situation would not be so easily ameliorated. An Ohio study[3] showed that one to ten days after admission, 24 of a sample of 40 patients did not remember signing the voluntary admission forms and only one patient could recall even part of its contents. Although that in itself could be taken as an indication of poor information procedures at the time of admission, the form was then read to 39 of the patients and 13 of them could not repeat even one provision. Similar results were obtained with the release of information authorization and the notification of legal rights form.

Two Massachusetts researchers, Olin and Olin, interviewed one hundred patients within one week of admission and found that only eight percent could completely recall the details of the voluntary hospitalization procedure as explained on the admission form.[4] There was some increase in understanding among patients who were interviewed at five days into their stay and again five days later, perhaps suggesting that cognitive disorganization is greater at the time of admission. A set of anecdotal reports by Owens[11] documented that there is a class of voluntary patients who are incapable, by reason of their psychosis, of giving an informed consent, regardless of the efforts made to inform them at the time of their admission.

Thus, two lines of reasoning have been generated simultaneously. One side, coming from a fine legal tradition of respect for constitutional rights, argues that a competent informed consent ought to be obtained from all voluntary patients; the other examines the clinical condition of the patients in question and tentatively suggests that it is unlikely that many of them will be able to meet that requirement. The resulting conceptual difficulty is exemplified by the "Suggested Statute on Procedures for Voluntary Treatment" drawn up by the Mental Health Law Project, a patient-advocacy group.[12] While requiring an informed consent for voluntary admission, the proposed statute grants a presumption of capacity to do so to any applicant 18 years of age or older. This legal myth at least approximates the actual situation now existing in most

mental hospitals, where competency is presumed as long as the patient is willing to sign the admission form.[13]

The Nature of Competency to Consent to Voluntary Admission

The legal concept of competency varies with the situation in question. One is competent to draft a will as long as "insane delusions" do not impair one's perception of the potential heirs. In order to be competent to testify in court, one must be able to correctly perceive an act, recollect it, and communicate the information. Competency to contract involves an understanding of the nature of the transaction and the absence of psychotic compulsion. One who is competent to stand trial must understand the nature and object of court proceedings and be able to cooperate with his lawyer in his own defense. It is generally recognized that incompetence to perform one of these acts does not necessarily imply incompetence in any other sphere.[14]

Despite the arguments noted above, no systematic attempt has been made to define the components of competency in the case of mental patients seeking voluntary admission. Focusing on patients' ability to retain information as one component of competency, Olin and Olin[3] noted that they were in general not well-informed about the conditions of their voluntary admission. Owens[11] spoke of the need for patients to have a "minimum of intact cognitive functions . . . including perception, comprehension, reality-testing and a sense of reality of the self and the world." He also noted that loosening of associations and intense ambivalence can interfere with a competent decision. Perr argued that the patient should be able to comprehend that he is ill, that treatment is required or recommended, and that he is being asked to assent to admission.[15]

What follows is an attempt to characterize the components of competency to consent to voluntary admission in such a manner as to permit their operationalization in a clinical setting.

The Elements of Competency

Two broad principles guided the development of these criteria: 1) that a competent decision must be based on rational motivations; and 2) that the patient must show a real capacity to engage in the decision-making process, including the evaluation of potential risks, benefits, and consequences. Roth *et al.*,[13] in categorizing the possible approaches to determining competency, noted five differing tests: 1) ability to evidence a choice, 2) ability to produce a reasonable choice, 3) ability to reach a choice based on rational reasons, 4) ability to understand the decision-making process, and 5) actual understanding of the whole process. Our criteria stress the third and fifth tests, though elements of the others are incorporated as well. Although they note the difficulty in distinguishing between rational and irrational reasons and in ascribing causation to

them, that is precisely what we seek to do. This is particularly important since, based on past studies, many of the patients to whom this applies have severe cognitive impairments at the time of admission.

In the outline that follows, each element of competency is indicated first, followed in parentheses by a sample question which might be asked in a clinical situation to assess that element.

I. Does the patient appreciate the nature of his condition?

A) Does he recognize that he has a mental illness? (Question: "Do you think that you have psychiatric problems?") A rational decision to enter a psychiatric hospital should be based in the belief that one is ill, although the patient may have a different way from the doctor's of expressing that fact (*e.g.,* "I think there's something wrong with my brain"). A patient who denies the psychological nature of his illnesss, attributing his difficulties solely to external forces ("They've poisoned the drinking water"), has no logical basis for seeking admission to a facility whose aim is to treat individuals with psychiatric illness. Although the function of the hospital as "asylum" from the hostile world is an historic and a continuing element of its task, that in itself should not be the grounds on which entry to a facility is sought, lest the psychiatric hospital, abandoning its true function, find itself the refuge for uncounted thousands who would wish to retreat from the rigors of life outside its walls.

B) Does he think that he requires treatment? (Question: "Do you think that you need some kind of treatment for your problems?") Disagreement between the patient and the hospital staff as to the existence of a condition which requires treatment can lead the patient to an early rejection of the hospital's attempts at aid and to his subsequent departure against medical advice. One has the impression that many struggles between patients and staff over medication, participation in milieu activities, and other parts of a treatment program originate in the failure to make explicit the hospital's assumption that the patient is entering in order to be treated, or in the patient's failure to clarify differing expectations. A patient who is unable, at the time of admission, to acknowledge the need for treatment is not acting rationally in entering the hospital. Note that the patient's maintaining a need for treatment does not necessarily imply that the patient and the hospital agree on the nature of that regimen. The patient may have little idea of available modes of intervention. There may, in addition, be legitimate differences of opinion over the use of various modalities, *i.e.,* electroconvulsive therapy vs. tricyclic antidepressants in severe depression. But the patient should not believe that he will be receiving a form of treatment that the hospital cannot provide (*e.g.,* macrobiotic diet or transcendental meditation).

C) Does he know of a reasonable alternative to hospitalization? (Question: "Do you think that you need to be in the hospital to get that treatment?") The issue of alternatives to hospitalization is not as critical

a determinant of competency: hospitalization may be the treatment of choice or simply desirable, even if other alternatives exist. But the patient should be able to realistically assess the availability and relative desirability of the various alternatives (*e.g.*, "I know I won't be able to take my medication regularly if it isn't given to me in the hospital.") and conclude in favor of hospitalization.

II. Does the patient understand the nature of hospitalization?

A) Does he understand the role of his doctor? (Question: "What will your doctor do for you while you are in the hospital?") This criterion, and the two that follow, meet Roth *et al.'s*[13] "actual understanding" test. A patient who is willing to sign himself into a hospital without a clear idea of what will then transpire is not competently protecting his interests. The necessary information may come from previous experience, general knowledge, advice of acquaintances, or failing those, questions directed to the admitting physician. One would expect the patient to recognize that his doctor will oversee his treatment, employing pharmacologic and/or psychotherapeutic means, as appropriate. The incoming patient should not believe that his doctor is actually a member of a conspiracy designed to silence him or that he is arraigned against him in some other adversary posture.

B) Does he understand the role of medication, if indicated? (Question: "What will the medication do for you while you are in the hospital?") The near-ubiquitous use of medication in the treatment of inpatients makes this an important element of concern. Medication, if it is to be employed, ought to be viewed as having a potentially salutary influence, not as a subtle, but pernicious, means of poisoning the patient.

C) Does he understand the nature of an inpatient setting? (Question: "Are there particular activities that go on in the hospital that will be of benefit to you, that aren't available to an outpatient?") Although a patient's knowledge of the nature of an inpatient service will undoubtedly vary with the extent of his previous contact with psychiatry, he should have some sense of the nature of the place where he will live (*e.g.*, closed or open ward, availability of activities, milieu programs, etc.).

III. Is the patient able to comprehend the basis for the doctor's recommendations concerning admission? (Question: "Why do you think the doctor recommended that you come into the hospital?")

This is a paradigmatic question that tests both the patient's ability to understand the recommendations for admission and the more general functioning of his cognitive processes. Here one is seeking to distinguish between rational and delusional perception (*e.g.*, "The doctor thought I was sick and needed help," versus "This is just part of the punishment for what I've done to my family"). As distinct from I A and B, it is not the patient's beliefs concerning his condition that are being asked about, but his understanding of the explanation offered by the admitting doctor. The

response to this item bears implications for the patient's ability to comprehend the basis of later recommendations dealing with his treatment in the hospital.

IV. Is the patient able to make a decision to cooperate with his doctor's recommendations? (Question: "Do you think that you will go along with your doctor's suggestions for treatment here in the hospital?")

Two distinct functions are being tested here. In order to benefit from treatment, the patient must be able to make a decision to form a treatment alliance concerning his hospitalization. Owens[11] noted that intense ambivalence can cripple a competent decision-making process. In addition, a patient who is unable to affirmatively cooperate with his physician is not going to achieve substantial benefit from hospitalization. This does not necessarily mean acceding to all of his physician's recommendations, as long as the patient has a rational reason for an alternative. Patients who sign in voluntarily and then refuse treatment present enormously complex therapeutic issues for themselves and for the hospital staff. A patient who is anticipating such an outcome at the time of admission is not making a rational choice to seek treatment. An analogy to the client about to stand trial is instructive: just as such an individual must be able to cooperate with his attorney in order to be deemed competent to enter the judicial arena, so a patient about to enter a hospital should be expected to collaborate with his doctor concerning his treatment.

It is frequently felt that the breakdown of a therapeutic alliance itself might be valid grounds for hospitalization. In this case, although cooperation with the current therapist is temporarily impossible, the voluntary patient should be expected to be able to work with other members of the hospital staff to reconstruct the lost therapist-patient alliance.

V. Can the patient act affirmatively to protect himself in the hospital environment? (Question: "If you were having what you thought were unpleasant side-effects from the medication, what would you do?")

Again, as in the analogy to a defendant about to stand trial, one would expect that a person about to enter what can be a dangerous environment should have the ability to react in such a way as to defend himself. The competent answer might be, "I would tell my doctor," the delusional answer, "It would be a sign that God is punishing me." The response, "I'd stop taking them" could be followed up to determine if the side-effects would be taken as delusional evidence of a plot against the patient or if cooperation with the doctor in their amelioration would be possible.

VI. Is the patient aware of his rights as a voluntary patient as outlined to him in the information he received on admission (*i.e.*, can he attend to, assimilate, and recall this material)?

A) Is he aware of his right to file a request for discharge? (Question: "What procedure would you have to follow if you decided to leave the hospital and your doctor didn't think that you were ready to go?"

B) Is he aware of his right to refuse medication? (Question: "Do you have to take your medication if you don't want to?")

C) Is he aware of his right to legal representation? (Question: "Do you have access to a lawyer if you need one?")

D) Is he aware of the existence of a civil rights advisor in the hospital? (Question: "Does the hospital have someone to whom you can talk about your legal rights as a patient?")

The specific criteria in this section may need to be modified to accord with local situations. Beyond just measuring understanding of one's rights, we are concerned here with a number of vital cognitive functions, including attention, comprehension, and recall. Obviously if no procedure exists for informing the patient of his rights, either in a written or in an oral form, this question is meaningless; the concept of a voluntary admission competently agreed to is also without meaning in that case. The work of Olin and Olin,[4] noted above, and of Palmer and Wohl,[3] has demonstrated that in a variety of settings retention of this material is poor. One would expect of the competent patient that he understand the basic legal protections which he is afforded in the hospital, particularly since entry to a hospital involves the temporary forfeiture of a number of important personal freedoms.

VII. Is the patient aware of adverse consequences that might result from admission?

A) Is he aware of any potential disadvantages? (Question: "Are there any disadvantages to your being hospitalized?")

B) Is he aware of the possibility of involuntary detention even after he requests discharge? (Question: "Can the hospital keep you here against your will if you want to leave and your doctor doesn't think that you're ready to go?")

Although it is hoped that the benefits of admission outweigh the potential disadvantages in every individual case, one would like to see the patient demonstrate a true awareness of such possible liabilities as: loss of job, inability to care for family members, social stigma, suspension of welfare payments. In some cases there may truly be no obvious disadvantages and in that case the patient could fairly acknowledge that. One might also expect to provoke delusional responses such as: "They will torture me here."

The possibility of prolonged detention following a request for discharge is so serious a civil liberties issue as to lead some to suggest that because of it no truly "voluntary" admission exists.[1,16] No patient can be considered to have made a competent decision unless he is able to take this into serious account.

Discussion

The foregoing appear to be the essential elements in the determination of competency to consent to voluntary hospitalization. To be sure, merely to outline these elements does not indicate what weight should be given to each of them, since some are clearly of greater importance than others, or how many of the criteria a patient must meet to achieve that state that we would label "competent." The advantage, however, of an independent enumeration of the elements of competency, rather than a determination based on a more global assessment of the patient's status, is that it permits the operational definition to be varied experimentally. Thus, one can assess the standing of a large number of patients with regard to the elements of competency, and explore the effect of varying the stringency of the definition on the percentage of incompetents that results. The authors are currently conducting such a study.

If a large proportion of voluntary patients are not competent at the time of admission, as other studies have suggested, a change in the system itself would seem to be in order. State legislatures would be obliged to do away with the legal fiction that all voluntary patients are indeed competent, and instead, either adopt a different standard of agreement to admission (perhaps mere "assent"), or provide elaborate and costly judicial or parajudicial procedures for all patients.[12]

Many civil liberties lawyers would undoubtedly favor the latter alternative. Recognizing that in a condition of impaired autonomy the patient is surrendering his decision-making authority to a proxy, they would argue that the patient's rights are most likely to be protected if that proxy is the court. At the very least, the patient's agent should be an impartial decision-maker not involved in the patient's treatment, perhaps an appointed "patient advocate."

Although theoretically pleasing, this approach runs into substantial practical difficulties. To delay admissions until a judicial hearing could be held is impossible in emergency situations. Requiring all patients to undergo a hearing to confirm their voluntary status at some fixed time after admission would mandate tens of thousands of hearings yearly, overwhelming the courts or requiring the establishment of an entirely new parajudicial apparatus. The Supreme Court recently noted the practical obstacles to such a procedure[16] as far as admission of children is concerned, citing not only the court time involved, but also the drain on expensive and limited mental health manpower resources which would otherwise be used in the treatment of patients.

Similarly, substituting the judgment of a professional advocate or otherwise "impartial" third-party is problematic. One must question whether a non-involved arbitrator is more capable of making a decision as to the reasonable nature of the patient's entering into a psychiatric hospital than the psychiatrist, who has presumably offered a recommendation to that effect based on his examination of the patient. If the patient is forced to surrender autonomy, to whom is he better off yielding

it — his doctor, or an impartial third party who will not have to live with the consequences?

Most psychiatrists would probably prefer an explicit acceptance of a less strict standard of patient competency and the avoidance of third party review. The recognition of the negotiations between admitting psychiatrist and troubled patient as different from those that occur in more formal contractual settings would ease some of the pressure to view the doctor-patient relationship as an adversary contest, while encouraging the development of a therapeutic alliance based on trust. A standard of mere "assent" might meet this need: requiring that the patient affirmatively concur with the recommendation for admission, without inquiring into the nature of the thought processes involved.

Just as a stricter standard would undoubtedly complicate the admission process, perhaps to an unreasonable degree, so might a less demanding standard result in some instances of unjustified admission of incompetent patients. A variety of compromise approaches are available, including a screening for competency and a review of only those cases in which the patient's status is questionable. In any event, such decisions ought to be based on empirical data, the collection of which it is hoped will be facilitated by this analysis.

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