weaker. Little orientation to the program was provided for new psychiatric residents and staff members.

Compounding the impact of a lack of commitment by the administration, PES staff members had considerable anxiety about using the three-day beds. They felt insecure in their ability to effect changes in patients in three days, and in particular about how to do so in an inpatient setting that was foreign territory for many of them.

There were frequent confrontations about whether the inpatient service or PES residents were to write orders for brief treatment patients and about who was responsible for all aspects of the patient's medical care. Nonmedical team members felt inadequately informed about the treatment of hospitalized patients and unwelcomed by inpatient staff. To compound problems, during that time period psychiatric residents went from a full-time to a half-time rotation on the psychiatric emergency service, thus lessening their motivation for involvement in the service in general and in the problem-fraught brief hospitalization program in particular.

The inpatient staff had their own problems with the program. They were used to the pace of patients who would be around for weeks, not days, and they had difficulty integrating the three-day patients into their daily schedules and milieu. In addition, inpatient staff were not comfortable working with primary therapists who were not M.D.s. Inpatient nurses, for example, were in the uncomfortable position of having to work with social workers, psychologists, and nurses on the PES staff who could hospitalize patients and act as primary therapists when inpatient nurses could not do so. Competitive feelings and those associated with internal problems on the inpatient unit were often displaced onto the stepchild, the brief hospitalization program. Gradually nearly everyone involved lost interest in the program. The struggle became too much for members of both services. In the end, even the PES director, who had initiated the program, was unable to change cognitive and emotional sets and rebuild the program.

Were we to once again set up an acute inpatient service, we would propose to staff it in one of two ways. We would consider setting up a core staff whose sole responsibility would be to handle the hospitalized brief treatment patients. The brief treatment unit would not be staffed with therapists torn between responsibilities for long-term and short-term patients. Clearly designated permanent staff would be responsible for the short-term patients in the acute unit, and the beds might be located in the psychiatric emergency service itself.

Alternatively we would establish a mini-team of PES staff members who would rotate monthly. For that month only, a team member's main responsibility would be working with the brief treatment inpatients. While any team member could admit a patient to these beds, only a mini-team member would be responsible for carrying out the treatment or observation plan. With this method, the advantage of therapist continuity would be lost; however, having experienced crisis intervention therapists with a clear responsibility for acute care patients would seem to outweigh that loss.

Our program failed because of unanticipated organizational, structural, and human problems that impeded its implementation, but the core ideas behind brief inpatient treatment remain valid. They are to encourage patient autonomy, to discourage the dependence and regression that often accompany longer psychiatric hospitalizations, and to provide an increased time for observation and assessment without necessarily involving an extended hospital stay.

A STUDY OF THE CAPACITY OF SCHIZOPHRENIC PATIENTS TO GIVE INFORMED CONSENT

Lisa Grossman, J.D.
Frank Summers, Ph.D.

■Recent court decisions indicate a trend toward requiring informed consent from psychiatric patients before administering drugs or other forms of treatment. However, many mental health practitioners appear to disagree sharply with the assumption that all legally competent psychiatric patients are capable of giving such consent (1). This study investigated the hypothesis that schizophrenic patients may not fully understand informed consent statements.

The subjects in the study were ten men and ten women patients at a large urban aftercare center; they were diagnosed as schizophrenic according to the Research Diagnostic Criteria (2). Schizophrenic patients were chosen for the study because they are believed to possess a thinking disorder that may affect their capacity to understand the information given them on a consent form.

The age of the subjects ranged from 27 to 63, with an average of 37. None showed evidence of retardation or organicity. All were on a regimen of psychotropic medication that included at least one of the following: fluphenazine, chlorpromazine, imipramine, or thiothixene. The number of previous hospitalizations ranged from one to 17, with an average of 6.5.

Each subject was tested individually for approximately a half hour. All were oriented to person, place, and time. Each was given the comprehension subtest of the Wechsler Adult Intelligence Scale to obtain a standardized measure of verbal comprehension ability. Twelve (or 60 per cent) of the 20 subjects scored below 10, the national average; only eight achieved a score of 10 or better. The mean score was 8.4.

Ms. Grossman is a graduate student in clinical psychology and law at Northwestern University, Chicago campus. Dr. Summers is chief of research and training in the extended ambulatory care program of the Institute of Psychiatry of Northwestern Memorial Hospital and clinical assistant professor in the department of psychiatry and the behavioral sciences at Northwestern University Medical School. Correspondence should be addressed to Dr. Summers at Room 251, 259 East Erie Street, Chicago, Illinois 60611.

The patients were also given an informed consent sheet containing information that was developed according to legal guidelines for an informed consent document (3). So that the patients' previous knowledge of psychotropic medication would not interfere with the purpose of the study, the sheet described a fictitious drug, Lamex.

Each subject was given a copy of the consent sheet to read silently while the evaluator read it aloud. Afterward, the subject was asked a series of questions designed to assess whether he understood the information and if he was capable of deciding whether he wanted treatment. A score of 2 for each item on the consent questionnaire indicated the subject was fully informed; 1, partially informed; and 0, not informed. A total score of 12 to 14 indicated the subject was fully informed; 8 to 11, partially informed; and 0 to 7, not informed.

Scores on the consent questionnaires showed that only three subjects (or 15 per cent) were fully informed, while nine (45 per cent) were partially informed. Eight (40 per cent) were considered not informed. The mean score was 7.75.

Twelve subjects (60 per cent) consented to the medication. Five refused, two said they did not know, and one said both yes and no. However, all three of the fully informed patients consented to the medication. Of the nine who were partially informed, six consented, one refused, and two were indecisive. Of the eight subjects considered not informed, three consented, four refused, and one said both yes and no.

Thus 60 per cent of the sample consented to treatment even though only 15 per cent fully understood what they were consenting to, 25 per cent refused, and 15 per cent were ambivalent.

The clearest finding was that the average subject understood about half the material presented to him. That finding renders questionable the growing belief that severely mentally disordered individuals are able to give informed consent to treatment. Only three subjects were able to do so, and eight of the 20 were not even partially informed. These results suggest that only a small portion of schizophrenics may be able to give fully informed consent as required by law.

The current findings are seriously limited by the lack of a comparison group. One cannot conclude from the present data that schizophrenic patients are less able to provide informed consent than mentally healthy medical patients. However, the low average score on the WAIS suggests that may be so. Furthermore, even if medical patients were found to be no more able to give informed consent than schizophrenics, such a result would not invalidate the finding that there is a serious discrepancy between legal requirements and the capacity of schizophrenic patients. Indeed, it would broaden the result to include some nonmental patients. Without such data, one may draw the conclusion from the present study that most schizophrenics may be unable to fulfill the legal requirement of giving informed consent to treatment. Whether and in what way their ability may differ from, or be similar to, the abilities of the mentally healthy must await further study.

The present investigation indicates that people diagnosed as schizophrenic may have a below-normal capacity to comprehend material. Further, they are not, in general, fully understanding information concerning treatment and therefore are not giving fully informed consent as required by law. The bind is that although the law requires mental patients to give informed consent, it may be that certain types of mental patients, or particular patients at certain times, are too incapacitated to give such consent because they cannot comprehend the information necessary to decide what is in their best interest.

Although more data will be needed to substantiate these findings, it appears that the more informed subjects were more likely to consent to treatment and the less informed subjects were more likely to refuse treatment. One explanation of this phenomenon may be that those uninformed may realize on some level that they are not understanding the information and thus will not consent to what they do not comprehend.

Another explanation, probably more likely, is that the patients considered uninformed randomly choose either the yes or no answer in the absence of any decision-making or judgmental process. The latter reason seems more likely in view of the fact that of the patients not informed, three consented to treatment and four refused. However, of those patients partially informed, six consented to treatment and only one refused. That finding indicates that these patients are exercising a more discriminating decision-making process.

REFERENCES

1) H. Owens, "When Is a Voluntary Commitment Really Voluntary?" *American Journal of Orthopsychiatry*, Vol. 47, January 1977, pp. 104–110.

2) R. Spitzer, J. Endicott, and E. Robins, *Research Diagnostic Criteria (RDC) for a Selected Group of Functional Disorders*, National Institute of Mental Health, Rockville, Maryland, June 15, 1977.

3) R. C. Beloud, "The Growing Importance of Informed Consent," *Lincoln Law Review*, Vol. 8, No. 2, 1973, pp. 115–124.

A COUNSELING SERVICE FOR HOSPITAL STAFF MEMBERS

John Podboy, Ph.D.

■Staff members as well as patients have difficulties adjusting to hospital systems, which by necessity are concerned with the efficient deployment of personnel, the regulation of patient life, and the completion of specific tasks. The hospital's need for functional uniformity has resulted in a system that has been variously described as deprivational, socially sterile, and contributing to certain negative staff behaviors (1). Furthermore, the damaging indexes of human stress such as burnout, al-

Dr. Podboy is a staff psychologist at Sonoma State Hospital, Eldridge, California 95431.