

**THE PSYCHOMETRIC PROPERTIES OF THE MENTAL
HEALTH RIGHTS COMPREHENSION TEST**

by

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Abstract

The capacity to comprehend rights under mental health legislation is an untapped area of research that deserves attention. For those committed to hospital under British Columbia's Mental Health Act, youths under 16 years are provided fewer procedural protections than those over 16 years. However, both are told their rights under that Act. Research relating to adolescents' understanding of rights is presented, primarily from the juvenile justice context. Generally, by middle adolescence, most youths understand their rights to counsel and silence as well as adults. In general, most adolescents do not appreciate the full consequences of waiving their rights, and hence do not perform up to the legal standard under criminal law. The development of a new research program is suggested by the application of rights comprehension research to the mental health arena. The primary focus of the present project is the development of a new tool for tapping comprehension of rights under the Mental Health Act: The Mental Health Rights Comprehension Test (MHRCT). The MHRCT was administered to 120 healthy adolescents and its psychometric properties and structure were investigated. While the MHRCT shows modest structural reliability and convergent validity, it demonstrates excellent interrater and test-retest reliability. Evidence for the measure's construct validity and unidimensionality were examined with factor analysis. Exploratory factor analysis did not result in a rejection of the null hypothesis of unidimensionality. Therefore, confirmatory factor analysis (CFA) was performed in an effort to determine what model of unidimensionality best fit the data. A fit assessment determined that the MHRCT fits the parallel model of unidimensionality, indicating it is a homogenous measure of rights comprehension. This project was an important first step in a research

program that aims to quantify rights comprehension in a population whose rights have been the focus of debate and shifting policy.

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The psychometric properties and structure of the Mental Health Rights
Comprehension Test

Introduction

Mental health consumers' conception and utilization of their rights in Canada's mental health system combines myriad psychological, medical, and legal issues. This is especially so for adolescents. Those under the age of 16 who suffer from mental illness face a double hurdle in regard to their legal and social status. In Canada, young people and those who are mentally ill each fall under statutes and legislation with deep roots in the philosophy of *parens patriae*, or "father of the country." *Parens patriae* has its origins in English law that allowed state intervention for its citizens under a number of circumstances, usually for those dependent on others for basic care, such as children and the elderly. For instance, in the English feudal era, if parents could not raise children properly, the economic value of the child to the feudal landowner was threatened. Laws were created allowing the state to assume guardianship, and make provisions for a person's care if the family was unable to do so. *Parens patriae* philosophy provides the impetus for the government to act in their wards' "best interest" under the assumption those under care lack the capacity to decide this for themselves (Melton, 1983). Today, this philosophy is imbedded in legislation dealing with persons who may require guardianship, such as those that need protection from caregivers, or protection from themselves (Grisso, 1981; Melton, 1983; Melton, Lyons, & Spaulding, 1998). While all persons suffering from serious mental illness are subject to legislation with *parens patriae* philosophical roots, young adolescent patients are under additional paternalistic policies on account of their age. These paternalistic policies, as discussed below, allow for the

parents of those under 16 to decide their children's mental health treatment, regardless of the wishes of the child¹.

The United Nations Convention on the Rights of the Child was adopted in Canada in 1992. This includes a set of principles, although not binding, that are meant to guide law and policy relating to children. The Convention holds no power of law; a law that is interpreted as contrary to one or more U.N. principles may still be passed (although it may be politically embarrassing on an international level) (Bala, Hornick, McCall, & Clarke, 1994). One of the principles from the U.N. convention is that as children age, they deserve to have an increasingly central role in life decisions affecting them. There are many facets in Canadian law where children are expected to be more involved with their own decisions as they mature. For example, family law allows children's views and wishes to be taken into account regarding their custody post-divorce, when appropriate (Family Relations Act, 1996). Case law has provided family court judges with some guidelines as to when the child's view is "appropriate," that appears to be based, in part, on the age of the child. The B.C. Court of Appeal has stated that when a child reaches "near adult years" (which, in the case at hand, was age 14) he or she is capable of determining his or her own future (*Alexander v. Alexander*, 1988). However, a judge is able to render a decision that overrides the wishes of the young person if it is felt to be in the child's best interest.

¹ Adolescents (those under 19 in B.C.) may accept or reject treatment if they qualify as "mature minors" under the Infant's Act (where adolescents must demonstrate they understand nature and consequences of receiving and not receiving treatment). If an adolescent is brought in to hospital with a suspected mental illness, it seems less likely he or she would qualify for mature minor status. Unfortunately, no statistics or reports are available for how many youth under 16 who are in hospital under the Mental Health Act and request mature minor status.

Age standards in Canada reflect a trend that as children get older, they gain more autonomy regarding adult-like decisions. For example, a child may consent to sexual activity at 14 (*Criminal Code of Canada (Code)*, s. 150(1)), quit school at 16 (*School Act*, 1996, s. 3 (1)(b)), join the armed forces at 18, and purchase alcoholic beverages at 19 (*Liquor Control and Licensing Act*, 1996, s. 34) in British Columbia. While some of these standards may not make much sense developmentally (for example, the long-term consequences of quitting school are probably more serious than purchasing alcohol), they nevertheless reflect social and legal trends that allow adolescents increased self-determination as they get older.

The current project was developed in response to legal psychological issues regarding patients' capacity under mental health law to determine their own hospitalization and treatment, and the capacity of adolescents to understand their protections under that legislation. These issues raise a plethora of empirical questions regarding the appropriateness of legal protections under B.C.'s Mental Health Act. This project focuses on the legal rights provided to patients who are committed to hospital for treatment under ss. 34 and 34.1 of the MHA. The first step in this research program is to develop a psychometrically valid and reliable tool that taps comprehension of the rights provided under that Act.

This dissertation will begin with a review of the legal status of people with mental illness. Next, in an attempt to establish how Canadian law balances competing philosophies of *parens patriae* and self-determination, I will review statutes and laws that grant or deny adolescent rights and protections. This review will primarily focus on statutes and laws that deal with British Columbian adolescents' legal rights: The Youth Criminal Justice Act (YCJA) and the B.C. Mental Health Act (MHA). Once the legal

rights of adolescents with mental illness are detailed, I will review research that deals with comprehension of rights and capacity to waive those rights. To presage the conclusion from this review, the MHA is arguably a paternalistic statute for all British Columbians with mental illness, but it is especially paternalistic toward those under 16 years old. And while there are due process protections in the MHA, the review reveals almost no research on how patients with mental illness understand and utilize these rights in the mental health context. The first step in examining these issues is to develop a tool to measure comprehension of rights under the Mental Health Act. Therefore, the purpose of this dissertation is to develop that measure, and to explore the psychometric properties and structure of the instrument.

Mental Health Law and Policy – Historical Background

A brief history of Canada's mental health legislation provides insight into how the treatment of people with mental illness has changed over time. Legislation for handling mental illness has its roots in English law. In England in the 1700's, segregation, restraint and physical maltreatment were the primary societal response to those who were mentally ill. Gradually, under the movement known as moral treatment (Pinel, 1806), physical maltreatment and confinement were replaced with more humane principles of treatment. The moral treatment movement was due, in part, to a shift in medical thinking regarding mental illness (Warson, 1941; Bockoven, 1970). For example, by the 19th century, physicians considered mental illness as a medical problem, and attributed behavioural abnormalities to a disease of the brain (Warson, 1941).

While segregation was still the primary response to mental illness in the 19th and 20th centuries, the proponents of moral treatment advocated for improved treatment conditions. American schoolteacher Dorothea Dix began advocating for humane

treatment of the mentally ill in her country, and established 30 mental institutions by the time of her death in 1887 (Hunter & Macalpine, 1963). In British Columbia, the province established a number of large hospitals for treating the mentally ill. For example, The Public Hospital for the Insane opened in New Westminster in 1878 (Menzies, 2001). In B.C. at this time, the provincial response to mental illness reflected an “asylum ideology;” the goal was to treat the sick so they may become valuable members of society (Menzies, 2001, p. 128).

Social Darwinism, eugenics and assimilation of First Nations into colonial society were concomitant social ideologies. In the early and mid 20th century, the treatment of mentally ill reflected these colonialist and paternalistic values inherent in this historical context, and patients were subjected to procedures that are today viewed with repugnance. For example, in 1933, B.C. passed the Sexual Sterilization Act, which allowed for the involuntary sterilization of those diagnosed mentally ill or mentally retarded (Park & Radford, 1998). The sterilization of mentally ill and mentally retarded individuals had already begun in Alberta after that province passed its own Sexual Sterilization Act in 1928. Alberta’s Act came in the wake of a US Supreme Court ruling, *Buck v. Bell* (1927), which upheld a statute instituting compulsory sterilization of the mentally retarded “for the protection and health of the state.” In his ruling (as cited in Park and Radford, 1998), Justice Holmes wrote:

We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of

waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. (p. 318)

While the asylum ideology was certainly an improvement over physical maltreatment of the past, people with mental illness could still lose their liberty without procedural protections, and remain institutionalized for many years. For example, if a person was deemed unfit to re-integrate with society, physicians had great power to detain at will (Menzies, 2001).

Mental health reform continued through the 20th century in the United States and Canada. In the United States, Clifford Beers published his autobiography, which chronicled the Yale-educated businessman's physical and mental abuse in a mental institution (National Mental Health Association, 2006). Beers founded the Connecticut Society of Mental Hygiene in 1908, which set out to improve the public's attitudes towards mental illness and the mentally ill, improve services for the mentally ill, and work for the prevention of mental illness (NMHA, 2006). Thus, the community mental health movement was born. In Canada, The National Committee for Mental Hygiene (The Committee) set out to replace large asylums with smaller hospitals for the voluntary treatment of mental disorders (Bockoven, 1970; Felix, 1957). The Committee was also responsible for some key changes in mental health policy: They advocated for social workers, psychologists and psychiatric nurses to help care for and treat the mentally ill (Menzies, 2001).

By the 1950s and '60s, the Committee was re-named the Canadian Mental Health Association, and reforms were gaining slow ground. Nevertheless, the development of a

national, socialized health insurance system provided extra ammunition to close provincial hospitals in favour of separate mental health units in general hospitals (Bachrach, Goering, & Wasylenki, 1994). In 1957, The (Federal) Hospital Insurance and Diagnostic Services Act cut operating costs to provincial mental hospitals to encourage the development of general hospital psychiatric units. These units opened and issued services, but the demand for use left the large psychiatric hospitals open across the country.

In the late 1950s, a number of social and professional movements provided additional support for the transfer of mental health services from large hospitals to community-based care. For example, institutional neurosis was described by Barton in 1959 as an illness in its own right, and led to loss of interest, lack of initiative, and apathy in patients in long-term institutional care (Kelly & McKenna, 2004). The deinstitutionalization movement in the 1960s and 1970s was prompted by the awareness of the problems associated with long-term institutionalization, and sought to find ways to reintegrate patients into the community. Psychotropic medication such as chlorpromazine was developed in 1950 and used clinically in the treatment of psychosis after 1955 (Lopez-Munoz, Alamo, Cuenca, Shen & Rubio, 2005), allowing more patients to stabilize and re-integrate into the community. Together, these social, political, and medical factors helped to move mental health treatment out of hospitals and into the community (Gordon, 1993).

British Columbia's Mental Health Consultation Report in 1987 provided the terms of reference for the Riverview Replacement Project, which was the provincial plan to transfer patients at Riverview Hospital to community-based tertiary care facilities. Riverview Hospital is a large psychiatric facility serving Greater Vancouver, and held

4631 patients in 1951. The Consultation Report redistributed funds from the large hospital to community support programs, and Riverview was downscaled to 1032 beds by the early 1990s (Bachrach et al., 1994, Hayes, 1992) and to 479 beds by October, 2005. Despite these changes, Riverview is still providing psychiatric treatment services that should be based in the community, according to the Consultation Report. Some have argued that Riverview is maintaining these services because much of the redistributed funds has gone toward increased labour costs of running smaller programs (Hayes, 1992).

Involuntary Commitment and Treatment

Each province and territory is responsible for creating and administering a statute for handling mental health services [s. 92(7) Constitution Act, 1867]. These statutes outline, *inter alia*, voluntary and involuntary admission and treatment guidelines, and the rights of hospitalized patients to contest their admission and, where applicable, to refuse treatment. In some jurisdictions, historically and presently, involuntary patients' need for treatment overrides personal autonomy. That is, reflecting *parens patriae* philosophy, involuntarily committed patients are assumed to be ignorant of their own best interests, and the state can order treatment against patients' wishes. At the heart of this issue are assumptions regarding the competency of mentally ill patients to make different kinds of decisions for themselves. Many provincial mental health statutes, including B.C. and Newfoundland, assume that if a person lacks the capacity to decide his or her voluntary or involuntary status in hospital, he or she concomitantly lacks the capacity to decide treatment.

While conceptually different, the right to refuse hospitalization and the right to refuse treatment are not legally distinct in many Canadian mental health statutes. In fact, a person with a mental disorder who meets the criteria under s. 22(3)(a)(i) and (ii), but

refuses treatment, denies his or her disorder, or both, may be subject to involuntary hospitalization and treatment in B.C. (MHA, 1996). Under B.C.'s MHA, a person can only be admitted as an involuntary patient if he or she cannot be suitably admitted as a voluntary patient (s. 22(3)(a)(iii)). This criterion allows for the admitting physicians to determine a person's willingness to submit to treatment; if not, he or she may be involuntarily admitted and treated (Ministry of Health, 1999, 2005). These details reflect the treatment and care model in the B.C. MHA; if a person does not need treatment, the state does not have the legal authority to detain them under the Act. As a consequence, the capacity to refuse hospitalization and the capacity to refuse treatment are not considered separately by the admitting physician.

Some provinces have separated the right to refuse hospitalization and the right to refuse treatment, and recognize that these decisions may require different abilities. Manitoba's *Mental Health Act* (1998) is an example of this distinction. Section 7 of the *Canadian Charter of Rights and Freedoms* (1982) entitles the right to liberty and the right not to be deprived of that liberty except in accordance with the principles of fundamental justice. In support of this principle, the Manitoba Court of Appeal found sections of the province's MHA dealing with involuntary commitment unconstitutional because it did not allow involuntary patients to refuse treatment (*Thwaites v. Health Sciences Centre*, 1988). Today, Manitoba's MHA separates the issue of capacity to consent to treatment and the capacity to consent to hospitalization (Gray, Shone, & Liddle, 2000). As a result of *Thwaites*, the right to refuse treatment is now based on competency to do so, in that province. It is therefore possible for somebody to be found incompetent to consent to hospitalization, yet competent to refuse treatment (Gray et al., 2000). Separating these consent procedures allows for the situation when a person may require hospitalization to

reduce the danger they pose to themselves or another person, but may be competent to direct his or her own treatment.

Ontario's mental health legislation has also separated the consent procedures regarding hospitalization and treatment decisions. The Ontario MHA has strict provisions for involuntary treatment, whereby an involuntarily hospitalized person is assumed to be competent to consent to treatment, unless he or she is determined to be incompetent under the Health Care Consent Act (1996). In the absence of the patient's consent, treatment can only commence once the physician completes the competency determination. A person is considered incompetent if he or she fails to understand and appreciate the information relevant to the treatment decision and the consequences of accepting or refusing that treatment. If he or she is found incompetent, that patient can challenge the decision by applying to the Ontario Consent and Capacity Board for a review.

In *Fleming v. Reid* (1991), the Ontario Court of Appeal ruled on the constitutionality of a section in the Province's *Mental Health Act* (1990) that allowed a review board to override a patient's treatment refusal, even if that refusal was made before admission when the patient was competent. The Court ruled that to disregard the wishes of a competent person violated s. 7 of the Charter. In *Fleming*, they noted that right to refuse unwanted medical treatment is fundamental to a person's dignity and autonomy, and this right is equally important in the context of treatment for mental illness.

Prior to 2003, Ontario physicians were required to provide detailed information about how they came to a decision about competency. This requirement changed slightly in 2003 with *Starson v. Swayze*. In *Starson*, the Supreme Court of Canada upheld the lower court's decision to overturn the Board's order to treat the respondent against his

will. Mr. Starson was a gifted physicist who suffered from bipolar disorder, and was found Not Criminally Responsible on account of a Mental Disorder (NCRMD) on a charge of uttering death threats. While *Starson* did not change the Ontario statute, the Court lowered the standard by which the Board may determine capacity. Due to *Starson*, the Board now determines capacity on the basis of a “balance of probabilities.”

Previously, the Board was required to provide detailed information about each element of the capacity determination (i.e., if the person understands the information relevant to making a decision, and whether the patient appreciates the reasonably foreseeable consequences of the treatment decision or the lack of one). The elements of the standards of incapacity did not change as a result of the ruling. However, since physicians are no longer required to provide detailed proof of incapacity of each element of the standards, it may make findings of incapacity more difficult to overturn on appeal to the Consent and Capacity Board (Brookes, O’Reilly, & Grey, 2003).

The enactment of the *Charter* and the case law that followed created the “new legalism” in mental health statutes, which emphasizes the due process rights owed to anyone potentially deprived of their liberty (Tutty, 1990). Manitoba and Ontario mental health acts illustrate an appreciation for the autonomy of involuntary patients who are competent to consent to treatment, representing a shift away from the paternalistic “best interest” focus of previous Acts in those provinces (Grazer & Matas, 1994). These changes represent greater recognition of self-determination in a population that historically faced stringent *parens patriae* protections. The paternalistic protections in older statutes were based on an assumption that mental illness and competency were mutually exclusive; an assumption that has received little empirical support (see Appelbaum & Grisso, 1995; Grisso & Appelbaum, 1995; Grisso, Appelbaum, Mulvey &

Fletcher, 1995; Winick, 1997). The trend toward greater self-determination for those with mental illness reflects greater understanding of and appreciation for the capacities of those with mental disorders.

British Columbia's Mental Health Act

While self-determination rights have improved, the treatment of involuntary patients in British Columbia is still strongly imbedded in paternalism. Once involuntarily committed, patients are assumed incompetent to refuse treatment, and can be administered treatment by order of the director of a facility. The criteria for involuntary commitment vary across jurisdictions, and the remainder of this paper will focus on the British Columbian statute.

In November, 1999, amendments to B.C.'s MHA came into effect through Bill 22 (Ministry of Health, 1999). The Bill opportuned policy makers to strike a new balance between conflicting philosophical issues imbedded in mental health legislation. These issues include procedural safeguards for the mentally ill, accessibility to treatment, public protection from potentially dangerous patients, and *parens patriae* philosophy. Overall, the amended MHA emphasizes public safety and protection, strengthens paternalistic policies aimed at protecting mentally ill persons from personal injury or self-harm, and enforcing treatment measures. For example, prior to the 1999 amendment, a citizen could appeal to a Provincial Court judge to order an examination of a person with a (suspected) mental disorder who was "dangerous and at large" (s. 28(3)). Today, this section provides criteria that are identical to a physician's criteria for completing a medical certificate under s. 22(3)(a)(ii) and (c). The criteria in this latter section do not include dangerousness, but focuses on the need for treatment and supervision or the prevention of deterioration of the disorder, among other criteria that reflect *parens patriae* philosophy.

Before reviewing the commitment procedures for involuntary patients, it is important to examine the guidelines for voluntary psychiatric treatment. Under s. 20 of the Act, British Columbians 16 years and older may admit themselves to a hospital for voluntary psychiatric treatment. A physician and the director of a facility must concede that the admission is valid. Once in the hospital, the voluntary patient can discharge himself or herself at any time. If that patient wishes to leave, a director can transfer the patient to involuntary status if it is felt the patient may qualify (s. 20(7); Ministry of Health, 2005).

Involuntary admission to a mental health facility may be handled through three routes; examination by a physician, police intervention, or a judicial warrant. Two physicians must each complete one medical certificate; one is required to detain a person in the hospital for 48 hours, and the second is required for examination and treatment beyond the 48-hour mark. There are emergency provisions in the Act, under s. 28, that allow for police or a judge to hospitalize a person if it is felt to be necessary. Once the patient is hospitalized, a physician must follow the usual procedures for medical certificates to detain a person longer than 48 hours. The certificates are granted if the person meets the committal criteria. Under s. 22, the four criteria for committal in B.C. are (1) the physicians determine the person is suffering from a mental disorder; (2) treatment is required through a designated facility; (3) the person requires care, supervision and control in order to prevent substantial physical or mental deterioration or for the protection of the person or the protection of others; and (4) the person cannot be suitably admitted as a voluntary patient (MHA, 1996). The third criterion allows for two separate reasons for supervision and care; to prevent substantial deterioration of the condition, or to protect persons from harming themselves or another person. B.C.'s statute

allows for committal and ordered treatment for those who meet the four criteria. If a person meets the criteria for involuntary commitment, treatment authorized by the director of the facility is deemed to be given with the consent of the patient (s. 31(1)). Therefore, a person can be involuntarily committed to hospital through one of the three routes if they meet the first three criteria, and, under the fourth criterion, he or she is unwilling or unable to voluntarily admit himself or herself to hospital (s. 22(3)(c)(iii)).

MHA and Youth Under 16 Years

Persons 16 years and older may volunteer for psychiatric treatment in a designated facility, or they may face involuntary committal if they meet the criteria outlined in s. 22 of the MHA. However, the right of those under 16 to volunteer for treatment is non-existent. Under s. 20(1)(a)(ii), youths under 16 may be admitted by their parents or guardians as “voluntary” patients if the director of the facility and the admitting physician agrees. If a person 16 years and older volunteers for treatment, there is a concomitant right to consent or refuse that treatment. However, a person under 16 years and admitted “voluntarily” is not given the right to consent to or refuse treatment. While these youth are in hospital as “voluntary” patients, the young people themselves have not volunteered themselves for hospitalization and treatment. Most important, these youths are detained in the same manner as involuntary patients, but they are not given the more rigid due process applied to the involuntary commitment process for those age 16 years and older. An involuntary patient must have 2 medical certificates within 48 hours. A youth under 16 admitted under s. 20(1)(a)(ii) does not need 2 medical certificates; he or she can be admitted at the request of his or her parent if the director is satisfied that the youth has been examined by one physician and has been deemed to have a mental disorder.

Sections 34 and 34.1 provide instructions for notifying patients admitted under ss. 22 and 20(1)(a)(ii) of their rights as patients under the MHA. These rights will be discussed in greater detail below. However there are small but important differences in the notices. Ss. 34(2)(c) and 34.1(2)(c) (for those ages 16 and older, and those under age 16) require that the director inform patients of their right to a second medical opinion under s. 31. However, in Form 14 (Notification to patients under 16, admitted by parent or guardian, of rights under the MHA) the right to a second medical opinion is not included in the list of rights. Inexplicably, s. 31 does not include provisions for those patients admitted under s.20(1)(a)(ii), even though s. 34.1(2)(c) requires that they be informed of their right under that section. This is clearly an inconsistency within the legislation, and has an important impact on the due process rights of those admitted under s. 20(1)(a)(ii). In effect, youth under 16 years *may have* the right to a second medical opinion, but they are *not informed* of this right.

Together, the process of admitting young people under s. 20(1)(a)(ii) with only one medical certificate, and the inconsistency in the legislation between ss. 34.1(2)(c) and 31, and Form 14, youths under 16 years are committed with fewer due process protections than involuntary patients 16 years and older.

In 1992, Canada adopted the principles of the United Nations Convention on the Rights of the Child. While these principles do not hold the power of law, they are meant to help guide policy on Canadian children and youths (Bala et al., 1994; Prilleltensky, 1994). An important principle espoused by the convention is that children's physical and mental immaturity requires special safeguards, including appropriate legal protection. In Canada's juvenile justice system, adolescents are guaranteed special entitlements through the Youth Criminal Justice Act (YCJA, 2003), due to their dependent status and assumed

vulnerability to coercion. While all Canadians have the right to retain and instruct counsel under s. 10(b) of the *Charter*, the YCJA allows for legal aid or counsel to be granted to a youth who is unable to retain his or her own counsel (s. 25(4)(b)). This provision is detailed in law because as dependent persons, youths are not expected to have the resources to pay for counsel. Further, it is assumed that youths are especially vulnerable to coercion by authorities. Thus, under s. 56 of the YCJA, police are required to tell a young suspect his or her rights in language appropriate to his or her age and understanding. Also, a waiver of the right to counsel or to silence must be in writing (Bala et al., 1994). Therefore, in recognition of youths' dependent status and vulnerability, the YCJA provides youths with more extensive due process rights than the Criminal Code grants adults.

Due process rights are enshrined in the youth justice system because the YCJA emphasizes that youths should be responsible and accountable for their criminal behaviour. Responsibility and accountability are actualized through punitive measures such as incarceration. As we have seen, mental health policy is historically based on strong *parens patriae* roots, and the state is assumed to be acting in the best interests of its citizens. As a result, until recently, due process rights have not been an important focus of mental health statutes. Nevertheless, B.C.'s MHA provides some rights to those admitted involuntarily and those under 16 years who are admitted as "voluntary" patients.

Patients admitted under s. 22 (involuntary patients, including youths 16 years and older) and s. 20(1)(a)(ii) (youths under 16 years) must be told of their rights on admission, as specified under s. 34 and s. 34.1, respectively. These patients are to be informed of the reasons for admission, the hospital's name and location, the right to contact, retain and instruct a lawyer, the right to have the validity of the detention

determined by the court, right to regular reviews by a physician, the right to apply for a review panel hearing under s. 25(1), and the right to apply to court for a discharge under s. 33(2). Only those admitted under s. 22 are told they have a right to a second medical opinion, despite s. 34.1(2)(c) granting that right for those admitted under s. 20(1)(a)(ii).

While the process of admitting youths under s. 20(1)(a)(ii) involves less stringent due process than those admitted under s. 22, the rights detailed in ss. 34 and 34.1 are meant to provide some protections for youths once they are hospitalized. If the rights are to act as a safeguard against improper admission to a hospital, youths or their advocates must understand them properly. While large psychiatric facilities such as Riverview Hospital (which house only adult patients) have patient advocacy services available, there is no systemic advocacy for youths when they are first admitted to hospital. As such, the MHA assumes young people are capable of understanding and utilizing their rights on their own.

Thesis

The rights detailed in ss. 34 and 34.1 of the Mental Health Act provide no protections for youths if they do not understand these rights or waive them without full appreciation of the consequences of doing so. Virtually no research has explored youths' understanding of rights in the mental health arena. As such, there exists no reliable measure to tap understanding of rights in this context. The purpose of the present project is to develop a new tool with which to measure comprehension of rights and to examine its psychometric and structural properties using a healthy adolescent sample. Research in the area of youths' understanding of rights in the criminal arena provides a knowledge base that will guide the development of the new tool.

Understanding Rights: Juvenile Justice

How well do children and adolescents understand their rights in the juvenile justice context? In the late 1960s, Ferguson and Douglas (1970) conducted the first study of juvenile rights waiver. The California Supreme Court had recommended that police officers state *Miranda* warnings to juvenile suspects in language appropriate to their age. Ferguson and Douglas' (1970) study was an investigation of whether a simplified version of *Miranda* rights led to better understanding of those rights in an adjudicated and non-adjudicated sample of adolescent boys. In the era before more stringent research ethics standards, the investigators led participants to believe they were being investigated for involvement in a crime. Participants were read the standard or the simplified *Miranda* warnings, asked if they would like to waive their rights (verbally), and were then tested on their comprehension of their rights. Results showed that only 5% of the entire sample understood their rights. No differences emerged in participants' understanding of the two versions of rights; in fact, the simplified version was understood less than the formal one, and adjudicated youths understood the formal version better than the non-adjudicated youths. Although many youths did not understand their rights, 96% of the entire sample waived their right to silence (Ferguson & Douglas, 1970). Of the 4 participants who did refuse to talk, 3 were read the formal version of the rights.

Grisso (1981) conducted the most comprehensive study to date on young offenders' conception of *Miranda* rights and their capacity to waive those rights. Four hundred and thirty-one detained youth (ages 10 to 16 years) and 260 adults (206 of whom were offenders, the rest were non-offenders) were administered Grisso's newly developed *Miranda* rights measure and intelligence measures (Wechsler, 1955, 1974). The adult sample was used as a standard by which to compare the performance of the youth.

Results showed that IQ scores were highly related to understanding rights. Age was a less reliable predictor of comprehension, but still accounted for some variance in understanding rights. For example, 75% of those under 12 years, and 50% of those between 13 and 15 years, did not adequately understand any of their rights. Roughly 66% of adults adequately understood their right to counsel before and during interrogation, while about 30% of juveniles ages 10 to 16 understood this right. Grisso (1981) concluded that youth under the age of 15 years, as a group, did not adequately understand their rights to silence and counsel. By mid-adolescence, IQ played an important role in predicting comprehension of rights. Those youths 15 and 16 years old who had higher IQ (over 90) had adequate comprehension of their rights, compared to adults. Grisso's (1981) study was an important first step in quantifying comprehension of rights in youths, and spawned new research programs in the United States and Canada.

Other researchers have focused on age-related differences in comprehension of rights. A group of University of Toronto researchers explored this area using Canadian legal standards for comprehension of rights. These researchers tested comprehension of rights in a series of cross-sectional studies examining age-related changes in comprehension of right to counsel and silence, and reasoning in plea decisions (Abramovitch, Higgins-Biss, & Biss, 1993; Abramovitch, Peterson-Badali, & Rohan, 1995; Peterson-Badali, & Abramovitch, 1992, 1993; Peterson-Badali, Abramovitch, & Duda, 1997; Peterson-Badali, Abramovitch, Koegl, & Ruck, 1999; Ruck, Abramovitch, & Keating, 1998). These researchers focused on the rights to silence and counsel out of a concern that young people are more likely to confess to a crime, and the rights to counsel and silence are particularly critical for protecting a person against self-incrimination.

These researchers outlined some important components in understanding the right to counsel. Understanding the role of defense counsel is to appreciate counsels' role as an advocate for the accused in an adversarial system, that information provided to them by the accused is confidential, that the accused instructs them for their defense, and they provide advice and support in their defense (Peterson-Badali et al., 1999). Understanding this right is directly applicable to the mental health arena because ss. 34 and 34.1 of the Mental Health Act explicitly inform those admitted under ss. 20(1)(a)(ii) and 22 that they have the right to contact, retain, and instruct a lawyer.

The majority of these studies have children and youths (who were either non-adjudicated or at-risk) read a series of vignettes where a person is suspected of a crime and meets with a lawyer. The subjects are then asked a series of questions relating to rights and the criminal justice system. In general, children as young as 10 are *capable* of a reasonably accurate understanding of the role of the defense lawyer, and understanding improves with age (Peterson-Badali, & Abramovitch, 1992; Abramovitch et al., 1995; Peterson-Badali et al., 1997). Older adolescents grasp the role of the defense lawyer better than children and young adolescents. While 80-83% of tenth and thirteenth graders understood the right to counsel, only 30-35% of sixth and eighth graders understood this right (Abramovitch et al., 1995). Similarly, 80-90% of youths over 16 could correctly paraphrase their rights to counsel and silence, and 33% of youths under 16 could do the same. Thus, there are important age-related differences in understanding rights.

While many young people have a broad understanding of the right to counsel, these researchers soon discovered that with probing, a number of serious misconceptions emerged in comprehension of the finer points of this right. To illustrate, while 81% of children ages 7-12 described a defense lawyer as an advocate, the majority did not

understand the confidentiality clause. Eighty-four percent of young children believed the defense lawyer could tell the client's parents what they were told, and 72% believed the lawyer could report client information to the police. Developmental trends emerged between ages 7 to 9, and 10 to 12 years; 92% of the younger children and 43% of the older children thought the defense lawyer could tell the judge what they knew about their client's involvement in a crime (Peterson-Badali et al., 1997). Of further concern is that in another study, most students could not paraphrase the "retain and instruct" aspect of the right to counsel, although this ability improved with age (Abramovitch et al., 1993). In this study, 55% of twelfth graders could paraphrase the duty of arresting officer to inform of the right to counsel, while only 23% of sixth graders adequately paraphrased this duty. Therefore, while children and adolescents display some general understanding of the right to counsel, there are considerable misconceptions regarding the details of that right.

In Grisso's (1981) sample, although many youths understood that they should ask for an attorney, few actually did. In one study, Grisso and Pomicter (1977) drew a random sample of all felony referrals to a juvenile court over 3 years. The subjects ranged in age from 6 to 17, and the average age was 14.5 years old. The authors measured whether *Miranda* rights were read to the youth, whether the youth waived his or her rights or refused to do so, and whether a police interrogation occurred (thus the right to silence was waived). In this study, over 90% of youths (all of whom were being investigated for a crime) waived their right to silence. Because this was an archival study, it was not possible to measure actual comprehension of rights, so it is not known if the youths actually understood their rights or if they thought silence would make them appear guilty.

A Canadian study demonstrated a large gap between understanding rights and exercising them; in a young offender sample, 60% recalled being told by police that they could have a lawyer, but 75% of these youth did not exercise this right (Peterson-Badali, et al., 1999). Of greater concern, 64% of those who did not exercise their right to counsel wished they had after the fact. Grisso (1981) speculates that youths in trouble with the law are often too in deference to authority to properly exercise their rights when they are in a stressful situation such as an interrogation. Other researchers believe that youths do not exercise their rights when they feel they are morally guilty, and fail to appreciate the distinction between legal and factual guilt (Ferguson & Douglas, 1970).

In a recent development in the United States, a group of researchers are revising Grisso's (1981) original measure to reflect legislative changes in *Miranda* warnings (Condie, Goldstein & Grisso, in preparation; Goldstein, Oberlander-Condie, Kalbeitzer, Osman & Geier, 2003). Tentatively titled the *Miranda Rights Comprehension Instruments – II*, this new measure simplifies the wordings of the rights, and updated norms are in progress. As a part of the ongoing norm development, the new measure was administered to 57 boys in a post-adjudication facility (Goldstein et al., 2003). Consistent with Grisso's (1981) results, age and IQ independently predicted comprehension of *Miranda* rights in the new sample.

The Canadian youth justice system is reasonably sensitive to youths' vulnerability to coercion and lack of legal sophistication. Section 146 of the YCJA provides developmentally sensitive guidelines for arresting officers to collect statements from youths. In order to be admissible in a trial against the youths, a statement must be voluntary, and the officer must explain, "in language appropriate to his age and understanding," that the youth is under no obligation to give a statement, that the

information may be used against him, that he has the right to consult counsel and a parent, that counsel must be present unless the youth desires otherwise, and the youth must be given a reasonable opportunity to consult with counsel or a parent. Case law has upheld the developmental sensitivity of this safeguard; in *R. v. J.(J.T.)* (1990), the Supreme Court of Canada conceded that even youths who are streetwise and apparently experienced in the legal system deserve to have these safeguards upheld, because “certainly they do not appreciate the nature of their rights to the same extent as would most adults” (767).

While Canada’s criminal justice legislation is sensitive to developmental differences in understanding rights, it does not specify how to communicate those rights to youths, nor does it guarantee that arresting officers are capable of discerning what language is appropriate for the youths’ age and understanding. And given Ferguson and Douglas’ (1970) study, which demonstrated that simplifying the wording of *Miranda* rights did not improve young people’s comprehension, one wonders if these developmentally sensitive safeguards are meeting their goals.

The safeguards under the YCJA (and in its previous incarnation, the Young Offenders Act, 1984) were initiated in response to the increased emphasis on youth accountability and responsibility for criminal actions. These justice principles (accountability and responsibility for crime) led to more stringent due process protections for those facing possible incarceration. Given what we know about youths’ understanding of their rights in a criminal context, it is reasonable to assume that youths in the mental health arena do not appreciate their rights on admission to hospital.

Understanding Rights in the Mental Health Arena

Scant research has directly studied understanding rights in the mental health arena. Lidz, Gross, Meisel, and Roth (1980) conducted an exploratory study with 15 American

youths admitted to hospital by their parents or the state as “voluntary” patients (similar to s. 20(1)(a)(ii) in B.C.’s MHA). Although none of the patients felt the hospitalization was appropriate, few of the patients made an effort to resist the placement and expressed fairly positive attitudes about the intentions of their treatment. The 15 patients were divided into three groups; less than a third were committed by their parents, a little more than a third were committed through the juvenile court, and 3 patients were independent of family and state (it was not reported how these latter youth were admitted to hospital). Those admitted by their family consented to the admission, preferring to defer the decision to their parents, even if they did not agree with the reasons for hospitalization. The court-committed youths assumed that objecting to the hospitalization was a waste of time, since a review hearing would go before the same judge that ordered the hospitalization (a fear that, according to the authors, was valid). These youths did not believe that anyone was looking out for them. Two youths objected to the hospitalization, and both were from the group that was previously living independently from family and state. One of those who objected withdrew her objection when she felt the ward was a nice place.

While Lidz et al. (1980) did not examine capacity to waive rights, all the subjects appear to be reasoning at a pre-conventional level; they deferred decisions to those in authority, even though they did not think they should be hospitalized. It is noteworthy that while the level of reasoning was the same for youths who were committed by their parents and those committed by the state, the reasons behind their inaction were different. The youths committed by their parents had faith that their family knew what was best for them. Those committed by the state felt that asserting their rights would not help them because they were powerless at the hands of the system that brought them into hospital.

More recently, Cooper (2004) examined comprehension of *Miranda* rights in an adult psychiatric sample. Both Grisso's (1998) original tool and the new version (Condie, Goldstein & Grisso, in prep; Goldstein, Oberlander-Condie, & Kalbeitzler, 2005) were administered to 75 psychiatric inpatients (not under criminal adjudication) to explore whether changes in wording improved comprehension, and to provide normative data for comprehension of criminal rights in psychiatric patients. Results showed that comprehension of rights in this population was impaired, compared to adjudicated and non-adjudicated adults (Galloway-Cooper, 2004, Cooper & Zapf, 2004). The simplified version of *Miranda* rights did not improve understanding in this population (Cooper, 2004), which is consistent with previous research that found no improvement in understanding *Miranda* rights when they were simplified (Ferguson & Douglas, 1970).

Research by Grisso and colleagues (1977, 1981, 1998), Abramovitch and colleagues (1993, 1995), Peterson-Badali and colleagues (1992, 1993, 1997, 1999) provide a solid background of literature regarding children and adolescents' understanding and appreciation of rights. This research shows that, generally, the ages of 15 and 16 are critical periods below which children show inadequate understanding of rights, and above which children show adequate understanding (i.e., they meet the standard for a valid waiver in American and Canadian case law). Recent research in this area with adult psychiatric patients shows that the ability to understand rights is compromised in this population relative to a non-psychiatric population (Cooper, 2004; Cooper & Zapf, 2004; Galloway-Cooper, 2004; Goldstein et al., 2005). These results help to emphasize the importance of starting a research program in comprehension of rights under mental health legislation. The importance of this program is two-fold; if evidence suggests adult psychiatric patients show poor understanding of their *Miranda*

rights, it is important to determine how well psychiatric patients understand the rights that are most relevant to patients' circumstances. Second, under B.C.'s MHA, those under age 16 are provided fewer rights on account of their age. As a result, it is necessary to quantify how well young people understand rights under mental health legislation.

Development of a Measure

The first step in this research program is to develop an instrument that taps understanding of mental health rights. For aid in content and structure of the new measure, I looked to Grisso's (1998) *Instruments for Assessing Understanding and Appreciating Miranda Rights* (hereinafter, *Miranda Instruments*), and Ogloff and Olley's (1992) Test of Charter Comprehension (ToCC). These tests tap the understanding of legal rights under United States and Canadian jurisdictions, respectively. At the time of this writing (and during the present measure's development), the new version of Grisso's comprehension tools is under development and unavailable. From the available tests, the Mental Health Rights Comprehension Test (MHRCT) was developed. Grisso's (1998) instrument provides for the basic structure and administration of the MHRCT. The MHRCT is administered by interview, and the participant's responses are audiotaped and transcribed for coding purposes.

The psychometric properties and structure of the MHRCT will be examined using a healthy adolescent sample. The healthy population was used in response to concerns by hospital administration regarding the appropriateness of using an unvalidated measure on a clinical population.

*Method**Participants*

The participants were 120 healthy adolescents. Youths ages 13 to 18 were recruited from youth drop-in centers, youth summer camps, and through the Catholic school system. The response rate was low; 36% of youth who were invited to participate consented to the procedures. The response rate varied tremendously across testing sites. The students at one high school were particularly forgetful about returning parental consent forms, and only 26% of those invited to participate took part. The response rate at the summer camps was much better, at 85%. The summer camp testing occurred toward the end of the recruitment period, and these subjects were offered a \$5 honourarium for participating. This small remuneration improved the response rate considerably, and the limitations of these recruitment procedures are considered below. All participants who agreed to the procedures completed their testing sessions; no one withdrew consent after the form was signed. Apart from the 120 participants included in the results and discussion, 24 participants were taken through the full procedures, but were omitted from the analyses. These participants were omitted because they were administered an earlier version of the MHRCT, which was not comparable to the final version presented below.

As described below, I performed factor analyses on the data. MacCallum, Widaman, Zhang, and Hong (1999) provide guidelines for determining the appropriate sample size for factor analysis. Very generally, as sample size increases, standard error in the loadings will decrease, thus variability in factor loadings across samples will decrease. There are many different recommendations in the literature regarding what sample size is large enough to stabilize the factors across samples (and to closely represent the true population structure). Gorsuch (1983) recommends a minimum sample size of 100, while

other authors suggest that a minimum number of participants per variable (Brown & Cudeck, 1993) is a more precise way to determine minimum sample size.

Recommendations for the participant/variable ratio vary from 3 to 20 participants per variable (Mundfrom, Shaw, & Ke, 2005). However, MacCallum and colleagues (1999) argue that sample size and participant/variable ratio are not the sole determinants of quality analyses. Overdetermination, the degree to which each factor is represented by a sufficient number of items, will also influence the quality of the analysis. Highly overdetermined factors are those that have high loadings of sufficient number of items. MacCallum and colleagues (1999) suggest that a factor that is loaded with 3 to 4 items shows good overdetermination. When factors are highly overdetermined, sample size is less important.

The appropriate sample size for factor analysis is also dependent on the communality of the variables (the proportion of variance of a variable that is accounted for by the common factors). Again, as communalities of the variables increase, the influence of the sample size on the stability of the analyses decreases (MacCallum et al., 1999). Additional empirical support for this notion is provided by Hogarty and colleagues (2005), who found that no minimum N , or participant/variable ratio, consistently achieved good factor recovery across various conditions. Good recovery was consistently found when there were fewer factors and strong overdetermination of factors.

Guided by the discussion above, as well as practical considerations, 120 participants were recruited and included in the analyses. This is considered to be a reasonably large enough sample size to complete the factor analyses. There is no theoretical backdrop on which to predict the number of factors that will emerge in the

analyses. Therefore, communalities and overdetermination will not be quantifiable until after the exploratory analyses are completed.

Materials

The Mental Health Rights Comprehension Test

The MHRCT was developed as a part of the current project to measure understanding of the rights that are read on admission to a mental health facility. These rights are based, in part, on those guaranteed in the *Charter*, such as the right to retain and instruct counsel. Other rights, such as informing the patient of the hospital's name and location and the right to a second medical opinion, are specific to the circumstances of involuntary commitment. The MHRCT is based on similar measures of rights comprehension: Grisso's (1998) *Instruments for Assessing Understanding and Appreciation of Miranda Rights*, and Ogloff and Olley's (1992) ToCC. Tests of agreement between independent scorers in Grisso's original sample of adjudicated juveniles (1981) were high; inter-rater reliability was reported as Pearson r coefficients between .92 and .98 for two components of the test. Alpha coefficients for the Comprehension of *Miranda* Rights instrument (CMR) and the Comprehension of Vocabulary instrument (CMV) were .56 and .68, respectively. Subsequent use of Grisso's measure yielded high agreement between raters for the vocabulary test ($r = .92$) (Wall & Furlong, 1985), and over 90% agreement between raters on all three components (Fulero & Everington, 1995; Everington & Fulero, 1999). Ogloff and Olley's (1992) measure demonstrated encouraging interrater reliability: Intraclass correlation reliability coefficients ranged from .75 to .83 for each part, and .89 for overall scores (Olley, 1993).

As noted in the introduction, the rights under the MHA provided to youths under 16 years and those 16 years and older vary somewhat. These two versions of rights

overlap considerably, with the primary difference being that youth under 16 are not told of their right to a second medical opinion. Two rights (reasons for hospitalization and the right to renewal of involuntary patient status) are presented to the younger patients with slightly different wording, but the essential meanings are the same. For example, when told of their right to know the reasons for hospitalization, youth under 16 are told they are in hospital because their parents requested their admission, and a doctor believes they have a mental disorder. Patients ages 16 years and older are told the same thing, but without the reference to the parents' request. Personal communication with Grisso (March 12-16, 2005) indicates that when the essential meanings are the same, all ages can be tested on a single version of rights. One version of the rights will indicate how well they comprehend mental health rights, even if in practice they may be told a different version on account of their age. Empirical support for this contention comes from Cooper (2004), who compared comprehension of rights in psychiatric patients using two versions of the *Miranda* instruments. The simplified wording in the updated instruments did not change comprehension of rights, which is consistent with previous research (Ferguson & Douglas, 1970).

Grisso's (1998) instrument for measuring understanding and appreciation of *Miranda* warnings provides for the basic structure and administration of the MHRCT. The test consists of three subscales, which are administered in a one-on-one interview, audiotaped, and transcribed for scoring purposes.

The first subscale, Comprehension, presents the individual with eight sentences, one on each of eight cards, which are the rights read to a person on admission to a facility. The sentence is read aloud, and the individual is asked to explain what the sentence means, in his or her own words. The second subscale, True-False, presents the same

sentences as those presented in the first subscale; and each sentence is presented with 3 additional sentences. The individual is asked to determine if the 3 additional sentences are the same as or different than the original sentence. The third subscale, Vocabulary, is a vocabulary test of 10 key words from the list of rights. Each word is read aloud and used in a sentence. The individual is then asked to explain what the word means, using his or her own words. See Appendix A for the MHRCT.

The Comprehension and Vocabulary subscales are scored on a three point system; 2 points are awarded for answers that accurately reflect the meaning of the right or the word, 1 point is awarded for an answer that reflects partial understanding, and 0 is given when the answer reflects no understanding. The maximum scores possible for these subscales are 16 and 20, respectively. For the True-False subscale, the participant is given one point for each correct response, for a maximum of three points for each of the eight rights and a maximum score of 24. To develop scoring guidelines, I broke down each right into 2 or 3 core elements, and full points were given if the participant was able to comprehend most or all of these elements. Partial understanding was assumed when a participant was able to comprehend one element. Inadequate understanding was assumed when the participant did not comprehend any of the elements for each right. See Appendix B for the scoring manual.

Wechsler Abbreviated Scale of Intelligence

The review of literature detailing comprehension of rights in the criminal arena shows that intelligence is an important predictor of understanding rights. Estimates of participants' cognitive abilities should be positively linearly related to a measure designed to tap comprehension of rights. The Wechsler Abbreviated Scale of Intelligence (WASI, Wechsler, 1999) was administered to a portion of the participants to examine the

MHRCT's convergent validity. The WASI was developed based on key subscales of the full form intelligence scales as published by Wechsler (1991, 1997) for children and adults. The WASI has been validated for use with children and adults from age 6 to 89 years (Wechsler, 1999). The scale consists of 4 subscales; the vocabulary and the similarities subscales yield a verbal I.Q. (VIQ) score, and the block design and matrix reasoning subscales are used to yield a performance I.Q. (PIQ) score. All four subscales yield an estimate of the full scale I.Q. (FSIQ) of general mental ability. Reliability, as reported in the manual, is $r = .96$ for children and $r = .98$ for adults. Concurrent validity of the WASI was demonstrated on a sample of Canadian children, which yielded a pattern of relationships that were very similar to those reported in the WASI manual: Specifically, a high correlation emerged between the verbal subscales and the performance subscales (Saklofske, Caravan, & Schwartz, 2000). Other investigations have supported the use of the WASI as a valid screening measure for intellectual ability in psychiatric inpatients (Hays, Reas & Shaw, 2002). It should be noted that unlike the WAIS-III and the WISC-III (Wechsler, 1997, 1991), Canadian norms are not available for the WASI. Therefore, the scores reported below are based on U.S. norms.

Demographic Questionnaire

The demographic questionnaire is a brief form that records gender, age, psychiatric history, past and present medication use, education level, ethnic identity, and parent's occupation. See Appendix C for the Demographic Questionnaire.

Procedures

The project received ethical approval from the Simon Fraser University Research Ethics Board. The participants were recruited through three avenues: Youth drop-in centers, youth summer camps, and the Vancouver Catholic School system. Approval to

recruit healthy adolescent participants was granted by the Archdiocese of Greater Vancouver, as well as the school administration in two high schools run by the Archdiocese. Approval to recruit and test participants was also granted by the directors of youth drop-in centers and summer camps located in Vancouver, Richmond, and Burnaby.

To recruit adolescent participants, I spoke to large groups of youths at the schools, drop-in centers, and summer camps. I told the youths I was conducting a study about how well young people understood their rights under the law. Some of the participants from the drop-in centres and high schools were entered into a lottery for two free movie tickets. The youths at the summer camps were offered a \$5 honorarium for their participation. These incentives provided a small, non-coercive encouragement to participate in the study. They were given a letter and consent form to take home to their parents. The adolescent participants who returned the parental consent form were taken through a one-on-one interview.

All participants were taken through consent procedures, where they were informed of the voluntary nature of the study, that they could stop at any time, and did not have to answer a question if they chose not to. They were informed of the confidential nature of the interview, i.e., that information they provided would not be shared with anyone. Participants were told that participation could have no impact on their grades at school or their status at the camp or drop-in centre.

For those who agreed to participate, the MHRCT, the WASI, and the demographic questionnaire were administered. Before administration of the MHRCT, the researcher gave a brief overview of mental health problems and hospitalization under the Mental Health Act. The purpose of this introduction was to orient participants to the situation

where someone would be read mental health rights. The brief overview is presented in the instructions of the MHRCT (see Appendix A). The interview was recorded by pen and paper and audiotape. The audiotape was transcribed to a computer file for scoring purposes.

After the interview the participants were thanked for their participation and the investigator answered any additional questions the participants raised. Thirty-three participants were re-tested on the MHRCT 4 to 6 weeks later in order to evaluate test-retest reliability of the original measure.

Scoring

Two upper-level undergraduate students who were majoring in psychology served as independent raters on the MHRCT. Six transcribed interviews were randomly selected from the entire sample and used to train the raters on the scoring system. The raters scored the transcripts independently and then met to discuss discrepant item scores. Once the raters demonstrated reasonable independent agreement on the items, both raters scored every transcript independently.

Results

Participants

One hundred and twenty youths participated in the study and were used to explore the psychometric properties and factor structure of the MHRCT. Of these participants, 57 were administered the WASI in addition to the MHRCT, and these results were used for the convergent validity analysis. Of the total number of participants, 33 were re-tested on the MHRCT 4 to 6 weeks after the first administration, and these results were used for the test-retest reliability analyses. Independent samples *t*-tests did not reveal significant differences on MHRCT scores between those who were and were not administered the

WASI ($t(118) = 1.13, p = NS$), or between those participants who were and were not re-administered the MHRCT ($t(118) = 1.21, p = NS$). Therefore, the participants included in the convergent validity and the test-retest reliability analyses did not differ from the larger sample on their performance on the MHRCT.

The typical participant was 16 years and 6 months of age, and was in grade 11 at the time of testing. Over half ($N = 68, 56.7\%$) of the sample identified with Western European ancestry, less than a third ($N = 34, 28.1\%$) identified as Chinese or Filipino, and the remaining participants ($N = 16, 13\%$) represented a diverse number of cultural backgrounds, such as First Nations, South Asian and South American. These numbers closely mirror the cultural and ethnic landscape of Greater Vancouver, according to the 2001 census (City of Vancouver, 2003). The participants' socioeconomic status was derived from Blishen and colleagues (1987) scaling for Canadian income, based on the 1981 national census. The scale provides a number between 0 and 100, with 0 representing no income and 100 representing high-income professions such as specialized doctors and judges. Most (77%) of the sample lived with two parents whose averaged income provided mid-level earnings for the home. The average SES for this sample was 49.83, indicating a middle-income household. Roughly two-thirds of the sample (63.3%) were girls.

Grisso's (1998) measure of rights comprehension is not considered a single scale, but three separate tools with which to determine how well a person understands rights at the time of administration. The three tools may be presented as a complete package, or one or two of the measures may be used to guide clinical judgment in a particular case. The MHRCT should be considered a research tool at present, and the properties of each subscale of the MHRCT and its total score are reported below, where appropriate.

Reporting the MHRCT in this manner allows for direct comparison of the MHRCT with other rights comprehension measures. Also, analyzing each subscale separately and together allows for a more flexible exploratory factor analyses of the MHRCT and its subscales.

Table 1 provides an overview of the sample in terms of its distribution by gender, testing site, and those between ages 13 and 15 years old, and ages 16 and 18 years old. As will be discussed in greater detail below, there were no significant differences between gender groups, age groups, or testing sites by MHRCT total scores.

Table 1

Description of sample

	Age Group		Significant Differences
	Ages 13-15	Ages 16-18	
Gender (%)			
Male	41.93%	35.23%	$x^2 = .44$
Female	58.06%	64.77%	
Ethnicity (%)			
Caucasian	64.5%	53.4%	$x^2 = 2.75$
Hispanic	-	1.10%	
Black	-	-	
Aboriginal	-	1.10%	
Asian	32.3%	27.3%	
Other	3.2%	13.6%	
SES	51.67 (SD = 13.28)	49.18 (SD = 11.41)	$t = .95$
Testing Site			
High School	12.90%	73.86%	$x^2 = 34.97^{***}$
Summer Camp	87.09%	26.13%	
MHRCT Total Score	45.13 (SD = 5.32)	45.25 (SD = 4.61)	$t = .19$

Note: The chi-square value for the ethnicity variable was computed across age groups by removing the Hispanic and Aboriginal participants from the older age group (each group had one participant).

*** $p < .001$

Interrater Reliability

Interrater reliability was obtained by having two research assistants independently score all 120 participants, using the scoring system I developed (see Appendix B).

Interrater reliability was assessed using intraclass correlation coefficients (ICC). ICC expresses reliability as the ratio of true score variance to total variance. When true score variance predominates over error variance, ICC will be close to 1. When error variance

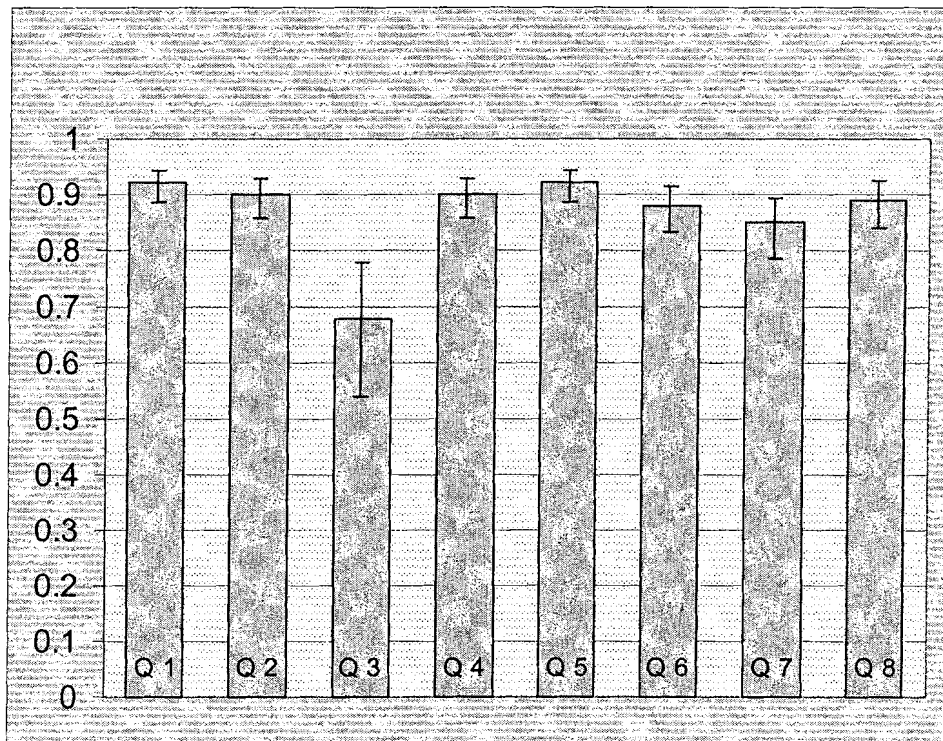
predominates over true score variance, ICC will be close to 0 (Wastell & Barker, 1988).

A two-way random effects model was used, as the targets and the raters are considered random samples from the population. Both raters scored every participant, so the average measure is reported. The True-False subscale is scored using objective criteria and was not subject to interrater reliability analyses.

As illustrated in figures 1 and 2, ICCs for the individual items on the Comprehension subscale ranged from .68 to .92, and rater agreement for the Vocabulary subscale ranged from .73 to .92. Figure 3 shows the ICCs for the Comprehension and Vocabulary subscale total scores.

Figure 1

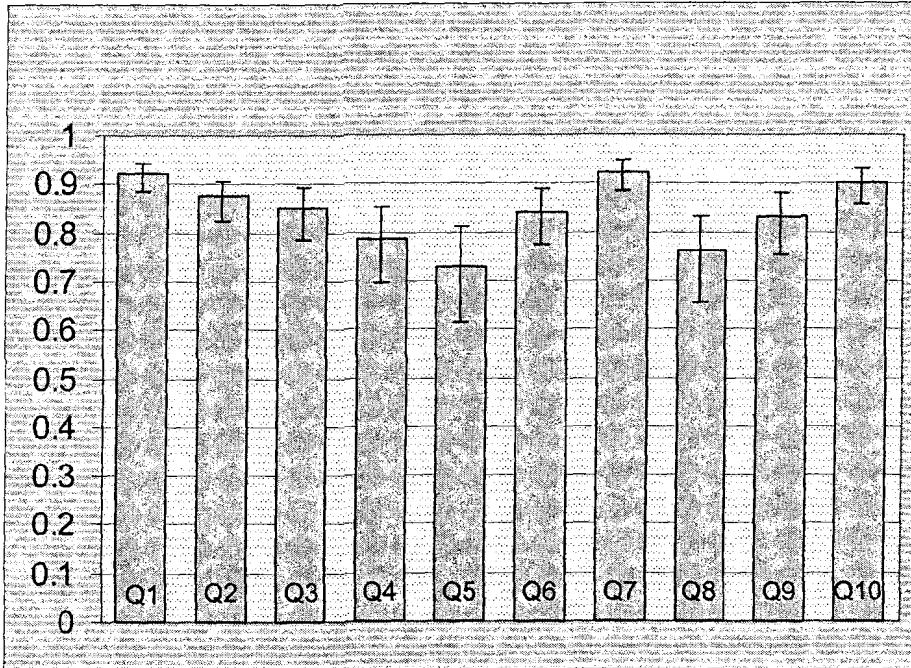
Comprehension subscale ICCs with 95% confidence intervals for each item.



N = 120. Q1 through Q8 represent each item on the subscale.

Figure 2

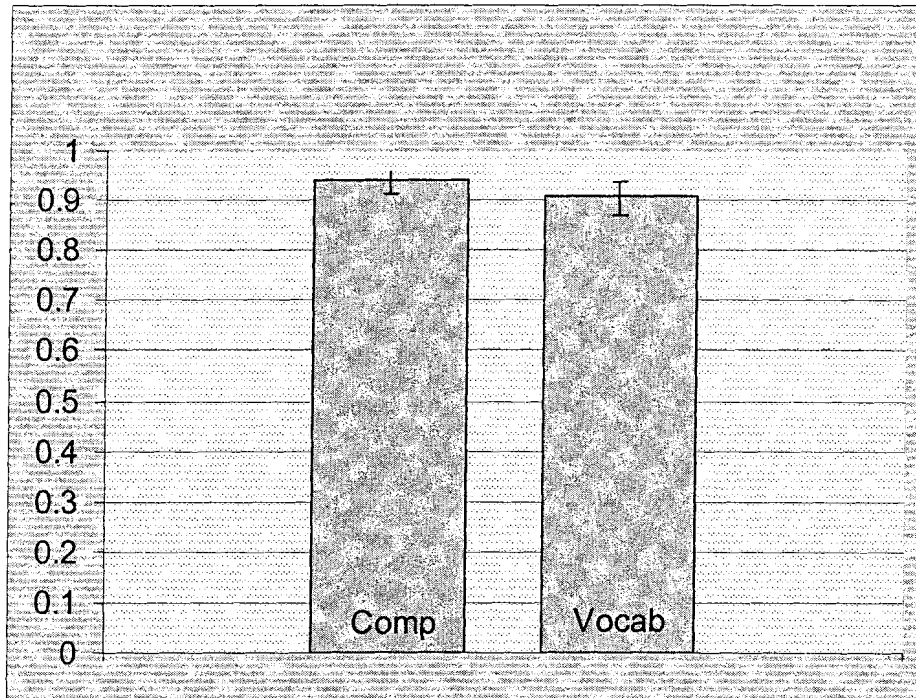
Vocabulary subscale: ICCs with 95% confidence intervals for each item.



N = 120, Q1 through Q10 represent each item on the subscale.

Figure 3

Comprehension and Vocabulary subscales: ICCs with 95% confidence intervals for total score.



$N = 120$, Comp = Comprehension subscale; Vocab = Vocabulary subscale

To interpret the practical value of ICCs, Bedard and colleagues (2000) suggests an ICC of .70 and higher indicates good reliability for research (as opposed to clinical) instruments. Cicchetti (1994) provides the following guidelines for interpreting the clinical significance of ICCs: .75 – 1.00 is considered excellent reliability, .60 - .74 is good, .40 - .59 is fair, and below .40 indicates poor agreement. Overall, these results indicate that the subscale total scores and the individual items of each subscale of the MHRCT show good and excellent interrater reliability.

Test Retest Reliability

The extent to which the MHRCT produces stable scores over time was examined with ICCs. Thirty-three participants were re-administered the MHRCT 4 to 6 weeks after

the first administration. The MHRCT total score produced an ICC of .93 between administrations. For the subscale total scores, ICCs were .83, .88 and .74 for the Comprehension, True-False and Vocabulary subscales, respectively. Descriptives and correlations for all items and the total scores are presented in tables 1 through 3:

Table 2

Comprehension subscale: Descriptives and ICCs across administrations

	Mean		Range		SD		ICC
	Time	Time	Time	Time	Time	Time	
	1	2	1	2	1	2	
Comprehension Total	10.55	12.39	2-15	6-16	3.38	2.58	.83**
Name & Location	1.39	1.52	0-2	0-2	.66	.62	
Reasons/hospital	1.24	1.58	0-2	0-2	.71	.66	
Contact Lawyer	1.7	1.94	0-2	1-2	.53	.24	
Habeas Corpus	1.21	1.52	0-2	0-2	.82	.67	
Certificate Renewal	1.3	1.76	0-2	0-2	.73	.50	
Review Panel	1.3	1.52	0-2	0-2	.81	.67	
Second Opinion	1.45	1.55	0-2	0-2	.67	.67	
Apply to Court	1.78	1.89	1-2	0-2	.43	.47	

Note: $N = 33$, maximum range for the items is 0-2; for the total score is 0-16.

* $p < .05$

** $p < .01$

Table 3

True-False subscale: Descriptives and ICCs across administrations

	Mean		Range		SD		ICC
	Time	Time	Time	Time	Time	Time	
	1	2	1	2	1	2	
True-False Total	20.24	20.36	14-24	15-24	2.29	2.49	.89**
Name & Location	2.79	2.82	1-3	1-3	.55	.47	
Reasons/hospital	2.67	2.64	1-3	1-3	.54	.55	
Contact Lawyer	2.61	2.67	0-3	1-3	.75	.54	
Habeas Corpus	2.91	2.94	1-3	2-3	.38	.24	
Certificate Renewal	2.88	2.73	2-3	1-3	.33	.52	
Review Panel	2.45	2.58	1-3	1-3	.67	.56	
Second Opinion	2.52	2.61	1-3	1-3	.71	.61	
Apply to Court	2.56	2.50	1-3	1-3	.71	.71	

Note: $N = 33$, maximum range for the items is 0-3, for the total score is 0-24.

* $p < .05$

** $p < .01$

Table 4

Vocabulary subscale: Descriptives and ICCs across administrations

	Mean		Range		SD		ICC
	Time	Time	Time	Time	Time	Time	
	1	2	1	2	1	2	
Vocabulary Total	11.28	11.82	5-16	5-17	2.83	2.78	.74**
Designated facility	1.42	1.09	0-2	0-2	.75	.81	
Mental Disorder	1.15	1.33	0-2	0-2	.67	.54	
Lawyer	1.30	1.24	0-2	1-2	.53	.44	
Habeas Corpus	0.61	0.55	0-2	0-2	.70	.71	
Lawful	1.45	1.70	0-2	0-2	.79	.53	
Right	1.18	1.24	0-2	0-2	.53	.61	
Review Panel	0.67	1.12	0-2	0-2	.65	.65	
Discharge	1.44	1.36	0-2	0-2	.56	.60	
Court	1.24	1.21	0-2	0-2	.66	.60	
Appeal	0.81	.94	0-2	0-2	.81	.79	

Note: $N = 33$, maximum range for the items is 0-2; for the total score is 0-20.

* $p < .05$

** $p < .01$

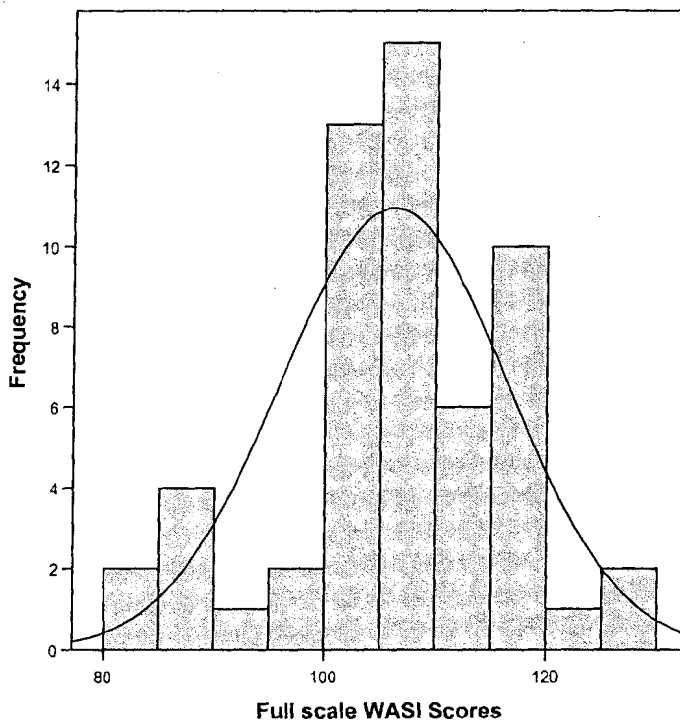
Participants scored higher on all three subscales and most of the individual items during the second administration of the test, which was likely due to learning. The second administration occurred, on average, 35 days after the first. According to the guidelines provided by Cicchetti (1994), the Comprehension and True-False subscales show excellent test-retest reliability, and the Vocabulary subscale shows good test-retest reliability.

Convergent Validity

Past research demonstrates that comprehension of rights is related to intelligence. Therefore, estimates of participants' cognitive abilities should be positively and linearly related to a measure designed to tap comprehension of rights. Fifty-seven participants were administered the Weschler Abbreviated Scale of Intelligence in addition to the standard protocol². The distribution of the WASI scores is presented in figure 4 and the descriptives and Pearson *r* correlations are presented in table 4:

Figure 4

Distribution of full scale WASI scores



² While 57 participants were administered the WASI, full scale IQ was estimated on 53 participants. Due to time constraints during the testing interview, four participants completed the verbal or performance subscales only. Also, the WASI allows one to estimate full scale IQ based on completion of one verbal (vocabulary) and one performance (matrix reasoning) subscale, but one cannot estimate verbal or performance IQ from this shortened protocol. Thus, estimates of verbal and performance IQ were only possible for 41 and 40 participants, respectively.

Table 5

Descriptives and Pearson's *r* for WASI with MHRCT

	VIQ (<i>N</i> = 41)	PIQ (<i>N</i> = 40)	FSIQ (<i>N</i> = 53)
Mean IQ	107	103	105
MHRCT Total	.56**	.32*	.50**
Comprehension	.45**	.34*	.39**
True-False	.32*	.08	.29*
Vocabulary	.46**	.27	.38**

Note: VIQ – Verbal IQ; PIQ – Performance IQ; FSIQ – Full Scale IQ

* $p < .05$

** $p < .01$

The MHRCT total score and the Comprehension subscale were positively related to the VIQ, PIQ and FSIQ estimates. Estimates of VIQ and FSIQ were positively related to the total score and each part of the MHRCT. The only non-significant associations appeared between the estimate of PIQ and the True-False and Vocabulary subscales. Overall, the MHRCT shows the strongest positive relationship with verbal IQ scores, and the weakest positive relationship with performance scores. These results provide preliminary evidence that the MHRCT demonstrates convergent validity.

Distribution Considerations

A review of the skew and kurtosis of the items indicates that a number of the variables (items) are skewed ($< |1.0|$, the majority of these were negatively skewed) and that a number of variables are asymmetrical (kurtosis $< |1.0|$). Therefore, logarithmic transformations were performed on the data to normalize the sample. The resulting data are still skewed and asymmetrical (albeit to a lesser degree), so the factor analyses will be interpreted with caution.

Exploratory Factor Analysis

The central notion of common factor models is that there are factors that account for what is common among variables, as well as what is unique to each of the variables (Krane & Slaney, 2005). These hypothetical factors are said to account for the linear relationships among the observed variables. Exploratory and confirmatory factor analyses can provide evidence of a measure's construct validity, and these analyses were run on the MHRCT to test its validity.

Since there was no a priori theory or research that could guide assumptions about the structure of the measure, these analyses began with exploratory factor analysis (EFA) to identify the most plausible model that fits the data. Confirmatory factor analysis (CFA) confirms the analysis by allowing the user to specify the number of factors in the model, as well as the pattern of zero and non-zero loadings on each factor (Fabrigar, Wegener, MacCallum, & Strahan, 1999).

Maximum Likelihood (ML) estimation was used to conduct these analyses on the MHRCT, which assumes a normal distribution of variables. Even though the data at hand were skewed and asymmetrical, this estimation technique is reasonably robust under violations of normality (MacCoy, 2004), but non-normality still puts one at greater risk for type 1 errors (Powell & Shafer, 2001). The factor analyses will be interpreted with these issues in mind.

Cudeck (2000) describes the "rotation problem," in which interpretation of factor solutions can be problematic because for any given correlation matrix, there is an infinite number of sets of matrices that describe the data equally well. The common factor model rests on the assumption that it is possible to find an interpretable set of factor solutions, based on the estimated parameter matrices. The interpretable solution is estimated

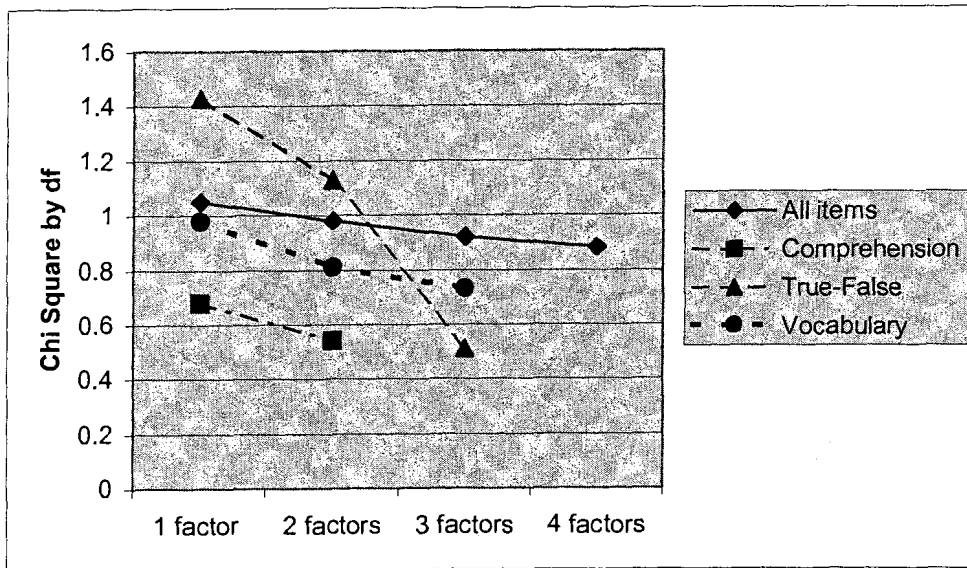
through rotation. Rotating the factors produced a factor solution with the simplest pattern of effects on the variables. Varimax rotation was used to find the current pattern of effects. The analyses were re-run using oblique rotation, in the event that non-orthogonality of the factors may alter the results. The results using oblique and varimax rotation were identical, so, by convention, varimax is reported below.

In sum, an exploration of the latent constructs of the MHRCT was performed using maximum likelihood extraction and varimax rotation. The analysis was run on each part of the measure separately, and on all the items together, to determine what form of the MHRCT creates the best solution.

Figure 5 presents a comparison across exploratory models, examining the model fit for each subscale and all items together. Each subscale and all items were forced into a single factor, then 2 factors, et cetera. Dividing each chi-square statistic by its corresponding degree of freedom derived the y-axis in figure 5. This procedure provides comparable scores across the models for each subscale and all items together.

Figure 5

Comparison of factor models for each subscale and all items combined



A test of the 1 factor model for each subscale and all items together produced chi-square values that did not allow a rejection of the null that the variables are unidimensional. The Bartlett's test of sphericity tests the independence of the sample correlation matrix, or that all of the item-item correlations are zero. If they approximate zero, then the test will be significant. The test of significance for the one factor model and Bartlett's test of sphericity are presented in table 5.

Table 6

Tests of significance for the one-factor model: Each subscale and all items together

	χ^2	df	<i>p</i>	Bartlett's χ^2	Bartlett's df	Bartlett's <i>p</i>
All Items	315.26	299	.25	454.15	325	.000
Comprehension	13.62	20	.85	83.76	28	.000
True-False	28.65	20	.95	42.52	21	.004
Vocabulary	34.46	35	.49	67.35	45	.002

Note: N = 120

Although Grisso (1998) conceives of his instruments as three separate tools with which to measure comprehension of rights, the EFA results do not lead to a rejection of the null hypothesis of unidimensionality when the items in all three subscales are combined. The variance accounted for by the single factor (all items combined) is fairly low (12.6%). However, the two (13.8%), three (17.4%) or four (21.1%) factor solutions did not lead to a dramatic jump in the variance accounted for in each model. In other words, the MHRCT contains sizable variance unaccounted for, regardless of its structural model.

The literature reviewed above demonstrated that there is an IQ-dependent developmental trend across adolescence in their comprehension of rights. If this trend represents a qualitative change across time, it may affect the variance and structure of a measure that taps comprehension of rights. While the present sample is not comprehensive enough to test structure across certain age groups, it is possible to factor analyze the MHRCT in the older portion of the sample (those ages 16 years and older) alone. An EFA run on participants ages 16 to 18 ($N = 89$) suggested the same unidimensional structure as when the analyses included the younger participants (χ^2

(299) = 285.65, $p = .70$). Future studies will include more younger adolescents so comparisons can be made across age.

Overall, these results lead to a hypothesis of unidimensionality of the MHRCT as a whole, which was tested via confirmatory factor analysis using LISREL 8.72 statistical software (Jöreskog & Sörbom, 1996). Prior to running the EFA, the data were randomly split in half, and the EFA was run on the first half, and the CFA was run on the second half. While ideally, the CFA should be performed on an independent sample, for the present analyses, splitting the data randomly allows one to calibrate a model on one part of the data, and confirm the model on another. This procedure reduces the likelihood of a type II error in the CFA.

Confirmatory Factor Analysis

Confirmatory factor analysis (CFA) allows for restrictions to be placed in terms of the number of factors in a solution and the number of factors on which a variable is permitted to load (Gorsuch, 2003). LISREL computed the correlation matrix, **R**, and estimated the matrix of factor loadings and a diagonal matrix of residual variances. The program then tested how close the data are aligned with the population matrices (Bernstein & Nunnally, 1994; Jöreskog & Sörbom, 1996). Chi square analyses tested the null hypothesis that the items are unidimensional, and a series of increasingly stringent models of unidimensionality were examined to determine which model best describes the data. These models are (1) congeneric, which assumes unequal loadings and residual variances (2) tau-equivalent, which assumes equal loadings and unequal residual variances, and (3) parallel, which assumes equal loadings and residual variances, (Jöreskog & Sörbom, 1996). If the parallel model best describes the data, then one can claim that all items are equally precise indicators of the construct. The other 2 models

describe unidimensionality of the items, but allow for variance in regards to how well each item measures the construct.

Table 6 presents fit indices and the chi-square test statistic for congeneric, tau-equivalent and parallel models. The analyses were run on both the correlation and covariance matrices, with similar results. The analyses with the correlation matrix are reported here.

Table 7

Comparison of three models of unidimensionality.

Model	χ^2	<i>df</i>	<i>p</i>	RMSEA (<i>p</i> close fit test)	RMSEA CI
Congeneric	344.71	299	.04	.026 (.99)	.0 - .045
Tau-Equivalent	391.48	324	.01	.037 (.91)	.01 - .052
Parallel	395.69	324	.04	.027 (.99)	.0 - .044

Note: *N* = 120; RMSEA – Root Mean Square Error of Approximation; CI – 95% confidence interval.

A number of fit indices were used to assess the fit of each model. The chi-square test statistic provides useful information on small samples (*N* = 100 to 200), but becomes less useful as sample size increases, because large sample sizes will always lead to rejection of the null. For the present sample, the chi-square test provides a statistical test of the null hypothesis of three models of unidimensionality.

The root mean square error of approximation (RMSEA) provides an estimation of the discrepancy between the model and the data (Fabrigar, et al., 1999; MacCallum & Hong, 1997), or discrepancy per degrees of freedom. It is calculated by $\chi^2/((n-1)df) - df/((n-1)df) \times .5$. An RMSEA that is less than or equal to .05 indicates good model fit (Browne & Cudeck, 1993), although Hu and Bentler (1999) suggest that RMSEA that is

less than or equal to .06 indicates good model fit. The p close fit test tests the null hypothesis that RMSEA is no greater than .05. A p of less than .05 would lead to a rejection of the null hypothesis that the RMSEA is greater than .05.

Setting p at .01, the test of the congeneric model did not lead to a rejection of the null that the items are unidimensional and have unequal loadings and unequal residual variances. The χ^2 for the congeneric model indicated that the estimated correlation matrix did not deviate significantly from the population matrix, $\chi^2(299) = 344.71, p > .01$. The RMSEA and the p close fit test indicated good model fit as well (RMSEA = .026, $p = .99$). The upper parameter of the RMSEA confidence interval fell within the boundary of adequate fit (RMSEA > .05). Taking the χ^2 and all the indices together, it is reasonable to retain a single factor null hypothesis, and that the MHRCT fits the least restrictive model of unidimensionality. This indicates that the items may all measure the same construct, even though some items may tap the unitary construct better than others. A test of more restrictive models will determine the homogeneity of the items' loadings and residuals.

A test of the tau-equivalent and parallel models yielded similar results. The χ^2 and the RMSEA for these more restrictive models indicated that the data do not significantly differ from each model. First, the tau-equivalent model adequately fit the data, in that the χ^2 could not lead to rejection of the null ($\chi^2(324) = 391.48, p > .01$), and the RMSEA and p close fit test indicated adequate fit (RMSEA = .037, $p = .91$). The upper parameter of the RMSEA confidence interval fell within the boundary of adequate fit (RMSEA > .05). The retention of the tau-equivalent model means that the items are all loading reasonably equally, but the model allows for unequal errors.

Given the adequacy of the tau-equivalent model, the fit of the parallel model was examined. The parallel model describes the most restrictive model, and does not allow

for unequal residual variances among the items. The data appeared to fit the parallel model adequately, as well. The χ^2 of the parallel model could not lead to a rejection of the null ($\chi^2(324) = 395.69, p > .01.$), and the RMSEA and p close fit test indicated adequate fit (RMSEA = .027, $p = .99$). Similar to the less restrictive models, the upper parameter of the RMSEA confidence interval fell within the boundary of adequate fit (RMSEA > .05). The adequate fit of the data to the parallel model lends support to the supposition that each item in the MHRCT measures the construct equally well, as this restrictive model assumes equal loadings and equal residual variances of the items.

Reliability

Given the evidence of the MHRCT parallel unidimensional structure, the reliability coefficient of the measure was given by the following formula:

$$k * f^2 / k * f^2 + u^2$$

where k is the number of items, f is the estimate of the factor loading, and μ^2 is the estimate of the unique variance (McDonald, 1985). This formula is sensitive to the assumptions under the parallel measurement model, and is thus the most appropriate indicator of the MHRCT's reliability. Applying the data to the formula,

$$\begin{aligned} & 26 * .27^2 / 26 * .27^2 + .92^2 \\ & = 1.895 / 2.752 \\ & = .69 \end{aligned}$$

Therefore, the parallel model reliability coefficient for the MHRCT is .69.

Item-item and item-subscale correlations, correlations between subscales, and subscale score to MHRCT total score correlations provide estimates of the extent to which the items and the subscales could be related to a common theoretical construct.

Table 7 provides the correlation matrix for all 26 items of the MHRCT, and includes the item-subscale total correlations, as well.

V1	-.01	.04	-.05	.12	-.01	-.03	-.06	-.06	.08	.22	.05	.11	-.13	.03	.08	-.06	1									
V2	-.01	-.08	-.05	.08	.03	.13	-.08	.13	.13	.02	.03	.09	.01	.01	.07	.05	-.03	1								
V3	-.10	.07	.04	.08	.10	.05	.15	.03	.25	.14	.04	.07	.01	-.04	.12	.01	.11	-.12	1							
V4	-.04	.05	-.11	.16	.15	-.07	.13	.08	.14	.03	.06	.01	.17	.02	.03	.07	.10	-.13	.20	1						
V5	.14	-.07	-.05	.03	.08	.01	.10	.02	.13	.18	.01	.20	-.03	-.04	.04	.03	.03	.02	-.01	-.10	1					
V6	.33	-.09	.29	.19	.17	.13	.10	.17	-.03	.06	.17	.31	.21	.01	.05	.12	.04	.20	.00	-.09	.19	1				
V7	.10	.09	.01	.01	.23	.11	.11	-.03	.13	-.05	.07	-.04	.03	-.08	.02	-.07	-.06	.03	-.13	-.04	.10	.16	1			
V8	.04	.05	-.01	.17	.16	.11	.04	.11	.24	-.10	.23	.11	.10	.02	.10	.01	.19	.23	.04	-.02	.06	.18	.16	1		
V9	.17	-.05	.08	.09	.16	.14	.07	.01	.14	-.02	.03	.01	.09	-.13	.05	.16	.15	.17	.00	.07	.12	.16	.18	.10	1	
V10	.02	.04	.06	.04	.19	.17	.21	.11	.19	.10	.20	-.02	.19	.04	.09	-.01	.01	-.05	.15	-.05	.09	.12	.17	.13	.15	1
<i>C r</i>	.54	.38	.44	.57	.52	.62	.47	.55	.40	.48	.51	.48	.41	.37	.44	.38										
<i>T r</i>																										
<i>V r</i>																										

Note: C1 - C8 = Comprehension items 1 through 8; T1 - T8 = True-False items 1 through 8; V1 - V10 = Vocabulary items 1 through 10. *C r*, *T r*, and *V r* = Item to subscale total correlations for Comprehension, True-False and Vocabulary subscales, respectively.

As demonstrated in table 7, item-item correlations for the Comprehension subscale ranged from $-.03$ to $.33$. Correlations between items on the True-False subscale range from $-.10$ to $.31$, and for the Vocabulary subscale, $-.13$ to $.20$. Item-subscale correlation coefficients were used to examine the relationships between each item and its subscale total score. Item-subscale correlations are presented in the last three rows of table 7, and ranged from $.38$ to $.62$ (Comprehension), from $.37$ to $.51$ (True-False), and from $.18$ to $.52$ (Vocabulary). While not presented in table 7, the subscale total scores correlated moderately with each other; r ranged from $.23$ to $.36$. In addition, each subscale total score correlated significantly with the total MHRCT score, with Pearson $r = .74$ (Comprehension), $r = .66$ (True-False), and $r = .80$ (Vocabulary).

Discussion

The purpose of this study was to develop a new measure that taps comprehension of rights under the Mental Health Act (MHA), and examine its psychometric properties and structure. A valid and reliable tool is the first step in a research program that seeks to quantify rights comprehension in a population whose social and legal status remains the subject of legislative debate and shifting policy. Specifically, the research program was developed out of the concern that patient rights under mental health legislation will not protect patients if they do not understand those rights. If rights are meant to be a legally protective mechanism against improper hospitalization, they need to be understood by those they are designed to protect.

The literature reviewed at the beginning of this paper demonstrated that adults with mental illness (Cooper, 2004; Cooper & Zapf, 2004; Goldstein et al., 2005), and some adolescents (Abramovitch et al., 1993, 1997; Grisso et al, 1977, 1981, 1998; Olley,

1993, 2000; Peterson-Badali et al., 1992, 1993, 1997, 1999) have compromised ability to understand and appreciate their rights under the law. In this developing research program, particular interest is warranted to patients under the age of 16 years, because they are given fewer procedural rights under the MHA than those aged 16 years and older. Given these important issues for adolescents treated under the MHA, the present study aimed to develop an appropriate research tool for measuring comprehension of rights.

Unfortunately, I was not able to access youth who were hospitalized under the MHA. Therefore, the present sample consists of healthy adolescents, and these data do not provide estimates of the measure's properties from the target clinical population. However, this study allowed me to develop an appropriate protocol, to create a reliable scoring method, and to assess the psychometric properties and latent constructs of the MHRCT. Portions of these data were requested by hospital administration before they would allow this type of research to go forward at their facilities. Further, there has been a call for more rigorous validation of rights comprehension measures (see Rogers, Jordan & Harrison, 2004), and the present study responds to that appeal.

Overall, the MHRCT demonstrates excellent interrater reliability; ICCs ranged from .68 to .92 for the items, and .91 and .94 for the Comprehension and Vocabulary subscales totals. Question 3 in the Comprehension subscale (the right to contact a lawyer) had the lowest ICC of .68. This result was surprising, given the scoring criteria were taken directly from Grisso's (1998) measure. In the early stages of this project, pilot testing and scoring by raters produced similarly low agreement, and raters consulted on this item extensively. Regardless, the item demonstrates good reliability between raters.

In general, the interrater reliability of the MHRCT is consistent with Grisso's (1998) and Olley's (1993, 2000) reports of reliability between raters. Grisso (1981, 1998) reported Pearson's r coefficients ranged from .80 to .94 for independent raters, and Olley (1993, 2000) reported intraclass coefficients ranging from .75 to .83 for each part, and .89 for overall scores. One may argue that ICCs are a better indication of interrater reliability, because it observes agreement between raters, whereas Pearson r represents the extent to which there is a linear relationship between ratings. These results lend strong support to the contention that independent raters will produce similar scores on the MHRCT.

The test-retest reliability of the MHRCT is also very promising, given some learning was expected between the two administrations. ICCs between administrations are .83, .88 and .74 for the three subscales, respectively. These results are consistent with the test-retest reliability of the CMR (corresponding to the Comprehension subscale of the MHRCT), which was $r = .80$ (Grisso, 1981, 1998). Mesiarik, Goldstein, and Thomson (2002) reported that the test-retest reliability of the MRCI-II (Goldstein et. al, in prep) are $r = .61$, $r = .75$ and $r = .77$ for the three measures that correspond to the three subscales of the MHRCT. Comprehension of rights is not considered to be a stable ability over time, as it varies with age (Goldstein et al., 2003, 2005; Grisso, 1981, 1998, 2004; Olley, 1993, 2000). Like its ancestral instruments, the MHRCT is designed to be a measure of how well a person understands their rights at the time it is administered, and is not considered to be predictive of how well a person will perform in a month's time (or "postdictive" of how well a person understood their rights prior to administration). Thus, a degree of change across time is expected in a measure designed to tap comprehension of rights. Overall, the MHRCT demonstrates high stability across administrations.

Intelligence and comprehension of rights are both related to cognitive capacity, so measures designed to tap these abilities should be related to one another. The convergent validity of the MHRCT is demonstrated by the observed relationship between it and the WASI, a measure that estimates intelligence (Wechsler, 1999). Estimates of VIQ and FSIQ are significantly and positively related to the total score and each part of the MHRCT, and PIQ is significantly and positively related to the total score and the Comprehension subscale. The MHRCT total score and three subscales show the strongest positive relationship with VIQ scores, and a weaker positive relationship with PIQ scores. Compared to the other subscales, there is a weaker positive relationship between the True-False subscale of the MHRCT and the WASI scales.

These results are logical, given that the Comprehension and Vocabulary subscales require skills related to verbal expression and vocabulary. All three MHRCT subscales show the strongest positive relationship to estimates of VIQ and FSIQ, and a weaker relationship between the scales and PIQ. This result indicates that while rights comprehension is related to both verbal and performance components of IQ, comprehension of rights is more strongly related to verbal abilities.

The True-False subscale was developed specifically for young people who have less sophisticated verbal expression. It provides the opportunity to show that they understand the fundamental meaning of a right, even if they are not able to describe it verbally (Goldstein et al, 2003, 2005; Grisso, 1981, 1998). It is therefore not surprising that there was a weaker positive relationship between the True-False subscale and all estimates of IQ. In particular, the relationship between PIQ and the True-False test was very low ($r = .08$). This latter result indicates that while the True-False subscale is less

strongly related to all estimates of IQ, the subscale taps skills that are nearly unrelated to spatial reasoning abilities.

The relationship between the MHRCT and intelligence scores is consistent with previous research, which shows association between estimates of IQ and performance on rights comprehension measures (Clare & Gudjonsson, 1995; Everington and Fulero, 1999; Fulero & Everington, 1995; Goldstein et al., 2003; Grisso, 1981, 1998; Gudjonsson, Clare, & Cross, 1992; Ogloff & Olley, 1992; Olley, 1993, 2000). Consistent with the results presented above, Everington and Fulero (1999) found a significant relationship between FSIQ and Grisso's Comprehension and Vocabulary *Miranda* subscales, and no significant relationship between FSIQ and Grisso's True-False subscale. These authors did not report VIQ and PIQ scores. Overall, based on the established relationship between other measures of rights comprehension and estimates of IQ, the relationship between the MHRCT and the WASI provides evidence of the MHRCT's convergent validity.

No previous study has explored the structure of a rights comprehension measure, although the literature is rich with exploratory and confirmatory factor analyses of measures of capacity for criminal adjudication (see Zapf, Skeem & Golding, 2005, for a review). Exploratory factor analysis of the items shows promise that combining the three subscales may produce a unidimensional scale. The established rights comprehension measures (Grisso, 1998; Ogloff & Olley, 1992) were conceptualized as a series of separate scales with which to tap understanding of legal rights.

The confirmatory factor analysis provides evidence that the MHRCT, in its entirety, is a homogenous measure of rights comprehension. The retention of the parallel

model of unidimensionality indicates that each item measures the construct with equal loadings and equal errors. The 26 items of the MHRCT appear to tap a single construct, and so the MHRCT demonstrates its structural reliability with all three subscales combined. Until replication and confirmation of the present analyses are completed on an independent sample, the MHRCT should be presented as a complete scale, rather than administering one or two of the subscales (as Grisso, 1998, suggests is possible with the *Miranda* instruments). Presently, the complete scale provides the most comprehensive and structurally validated indication of comprehension of rights under the MHA.

The internal consistency of the MHRCT is moderate; the reliability coefficient was .69. This indicates that the variance of the MHRCT includes a certain proportion of systematic or measurement error. The mean inter-item correlation is low, at .11. The correlations between the items, subscales and total scores are moderate; item-subscale correlations range from .18 to .62, subscale to total score correlations range from .66 to .80, and correlations between the subscales range from .23 to .36. An item-total correlation of .30 is considered a minimum standard for an item to meaningfully contribute to the total score of the subscale (Nunnally & Burnstein, 1994). Other than 2 items in the Vocabulary subscale (definitions of “lawyer” and “habeas corpus”), all of the items appear to contribute to the total score for each subscale. The modest relationships between the subscales indicate that the three subscales may be related to the same construct.

The measures on which the MHRCT was modeled were not subject to this level of validation; some of the above results do not lend themselves to direct comparison with Grisso’s (1998) or Ogloff and Olley’s (1992) measures. For the results that are

comparable with past measures, the MHRCT performs similarly to the other instruments' item consistency and inter-item correlations. The MHRCT produces a similar pattern of a moderately low reliability coefficient, and moderately high correlations for items to subscales, and subscales to total scores. In combination, these results show that the MHRCT demonstrates similar structural reliability to that of Grisso's (1998) and Ogloff and Olley's (1992) measure.

Like these past measures, the MHRCT items are drawn directly from the relevant legislation, and use the exact wording as the rights themselves. The rights under the current MHA are based on the *Charter* and previous legislation, are selected and drafted by government bureaucrats, who undoubtedly gave little consideration for the internal consistency of these items. Thus, by attempting to maximize the measure's face and content validity, the MHRCT loses some structural reliability.

The parallel model reliability coefficient suggests that the MHRCT may include a sizable amount of measurement error. Also, the inter-item correlations are quite small. Under less sophisticated analyses, these might be taken as indicators of the measure's multidimensionality. However, confirmatory factor analysis should be regarded as a more precise measure of the MHRCT's structure. In combination, these results suggest that although the items are not highly related to one another, they can conceivably tap a single construct. This study suggests that rights comprehension is a unitary construct that is tapped by a series of variables (as represented by items in the MHRCT) in a reasonably independent fashion. That is, while the items function reasonably independently of one another, they are separately but equally contributing to the construct.

Limitations

According to the official standards of test validation and documentation, a test and its manual must specify test construction, its reliability, errors of measurement, scale development, norms, validity and validity generalization (AERA/APA/NCME, 1999). While no single study could possibly satisfy all these standards, the doctrine may serve as a measuring stick for the present study's limitations. This study has documented and provided evidence of the MHRCT's test construction, reliability, error of measurement, scale development, and validity.

The clearest limitation in this study is that the healthy adolescent sample does not represent the population of persons who would typically be facing hospitalization for a mental disorder. Thus, at present, the validity generalizability of the MHRCT is very limited. However, the present adolescent sample will serve an important purpose in future studies under this research program. As mentioned in the introduction, there exists no legal standard for a valid rights waiver under the MHA. In the criminal context, the waiving of any procedural safeguard must meet the legal standard in order to be valid. The legal standard is enshrined in case law. In *Korponay v. Attorney General of Canada* (1982), the Supreme Court of Canada declared that waiving of any right must be done with full knowledge of the right the safeguard was provided to protect. Also, a waiver is only valid if the person understands the effect of the waiver on that person's rights. Similarly, in *Clarkson v. The Queen* (1986), the Court decided a waiver is only valid if the person demonstrates a true appreciation of the consequences of waiving that right. No case law has provided a legal standard to assess the capacity to waive rights in the civil context.

Since there is no legal standard under mental health law with which to evaluate patients' comprehension, the healthy adolescents' scores will serve as a comparison for assessing how well hospitalized adolescents understand their rights, compared to their healthy peers. Given that comprehension of rights follows a developmental course (as demonstrated in the literature), it is important that a comparison group is of a similar age. It is expected that the presence of mental illness will reduce a person's capacity to understand rights and hospitalized youth will score lower on the items and total scores.

During the first year of data collection, participants were recruited from Catholic high schools almost exclusively, and volunteered without remuneration (although a small portion of these students were entered into a lottery for 2 free movie tickets). As well, I interviewed all participants in the high schools and youth drop-in centers. Then, in an effort to recruit more subjects in a shorter period of time, youths participating in summer camps were invited to participate for a \$5 honourarium. Also, two research assistants were trained to interview participants at the summer camps. Therefore, the testing environment was quite different for half of the participants. The differences in testing environments include the interviewer, the motivation of the participant, and the physical environment itself. For example, at the high schools, testing took place in a standard administration office; at the theatre-sports summer camps, testing took place in a cramped backstage sitting room. Post-hoc comparisons did not find any significant differences across testing environment for participants' age, gender, SES, cultural background, or whether the participant lived with one or two parents. However, the motivation to participate was clearly different across sites; summer camp youths had greater incentive than did those at the high schools. While this is only an anecdotal

observation, the high school participants appeared to be high achieving and interested in research. Youth in the summer camps appeared to volunteer for the remuneration alone. Unfortunately, comparisons by IQ and testing environment are not possible, because the WASI was cut from the protocol for the summer camp testing sessions. The \$5 honourarium and multiple interviewers dramatically improved the *N* and the response rate, but these likely heterogenized the sample in ways that were not measured. Overall, differences in testing environment may have created systematic (and construct-irrelevant) error variance. This may have contributed to the moderately low reliability of the MHRCT.

Practical considerations did not allow for extensive pilot testing of different items for two of the three subscales, thus the content validity of these two subscales is problematic. Each item on the first subscale, Comprehension, represents each right from the legislation. As such, the items in this subscale include every possible target from the population of items, so the content of the Comprehension subscale is valid. However, pilot testing a number of different items for the True-False and Vocabulary subscales would have improved the content validity of these two subscales. Many of the 3 sentences in each item on the True-False subscale were too easy for the participants to answer. For example, the range of scores in the True-False items shows that participants scored between 1 and 3 on every single item. On items 3 and 6 (the right to contact a lawyer and the right to a review panel), only one participant scored less than 2 out of a possible 3 points. While participants scored across the full range of scores in the Vocabulary subscale, very few participants scored 0 when asked to define “discharge,” “lawful,” and “lawyer.” Conversely, very few participants received full points for their

definition of “habeas corpus.” When developing the Vocabulary subscale, I selected the 10 most difficult words from the mental health rights. While it is reasonably easy to discard items with ceiling effects from the Vocabulary subscale post-hoc, it is not possible to discard an entire item from the True-False subscale, because each item represents each right under the MHA. Instead, pilot testing different sentences in each item of the True-False subscale would have increased the range of scores, the variability of the subscale, and increased its validity.

Norm development is an essential part of test construction. The present study does not contribute norms for the clinical population, and provides limited norms for a healthy youth population. The adolescents in this study were kept as homogeneous as possible to aid in the exploration of the latent structure of the test. Future studies will cross validate the instrument on a more heterogeneous healthy sample, and develop norms for the clinical population as well. At present, the MHRCT should only be used as a research tool and not a clinical assessment tool. In the future (once norms are more fully developed), the instrument may provide information for clinical use, so a clinician may make a judgment as to how well a hospitalized young person understands his or her rights, compared to other hospitalized or non-hospitalized youth.

Canadian norms were developed for both the WISC-III and the WAIS-III (Wechsler, 1991, 1997), when it was discovered that Canadians score significantly higher than children and adults in the U.S on these intelligence measures (Saklofske, Gorsuch, Weiss, Zhu & Patterson, 2005; Wechsler, 1996). The WASI consists of adapted subtests of the WISC-III and the WAIS-III, so it is reasonable to assume that Canadians score higher than Americans on the WASI, as well. Unfortunately, Canadian norms are not

available for the WASI. The present study does not seek to interpret the clinical meaning of WASI scores in this sample. However, these scores likely represent an overestimation of IQ scores, which demands consideration when comparing to norm-corrected samples in the future.

The data violated normality assumptions of the maximum likelihood estimation technique in the factor analyses. This issue demands caution in the interpretation of the structure of the MHRCT. In general, non-normality reduces the robustness of results across samples, although Monte Carlo simulations show that violations of normality do not appear to increase the bias of the standard errors of the loadings (Lei & Lomax, 2005). Also, when factors are overdetermined, violations of normality have less of an impact on the quality of the analysis (DiStefano, 2002). MacCallum and colleagues (1999) suggested that a factor with 3 or 4 variables in it shows good overdetermination. Given 26 variables were loaded successfully on to a single factor, the factor is clearly overdetermined. Nevertheless, until the present results are replicated with an independent sample, caution is warranted regarding claims about the MHRCT's structure. The factor analysis results presented above suggest it is a homogeneous measure, but the non-normal distribution of the data, and the possible measurement error as indicated by the reliability coefficient, challenge the strength of that conclusion.

Despite these limitations, the present study provided acceptable psychometric properties of the MHRCT as a research instrument, which provides impetus for continuing this research program in new directions. There are a wide variety of ways in which to determine if a test is a reliable and valid one, and some types of evidence should be considered more important in some cases, and less important in others

(AERA/APA/NCME, 1999). Critical to the MHRCT is that it may be a homogenous measure that taps a unified construct, the content reflects the actual rights from mental health legislation, that high scores are indicative of better comprehension of rights, that independent raters produce reliable scores, that it is reasonably stable across administrations, and that variability in intelligence will be related to variability in the MHRCT.

Next Steps

Policy makers do not seek to capture a unitary construct when they develop a series of rights to ensure due process for a vulnerable population, and forensic psychologists do not define a construct (such as comprehensible rights) for policy makers to follow. The results of the present study demonstrated a surprising meld between the needs of policy makers to develop legally valid legislation, and the needs of forensic psychology to generate psychometrically valid and reliable instruments.

Since the MHRCT was developed based on legislated rights, adding or removing items to capture a construct would have invalidated the content of the test. Fortunately, the results of the factor analysis indicate that the 26 items of the MHRCT may fit a unidimensional structure. Regardless, there were aspects of the reliability analysis that could be improved, thus increasing the robustness of the measure. Specifically, the reliability coefficient (.69) indicates that the MHRCT may have a certain amount of measurement error.

The True-False and Vocabulary subscales likely include items that were too easy for participants to answer. It may be appropriate to remove some of the easier Vocabulary items from future versions of the MHRCT to reduce ceiling effects. Also,

the validity of the measure may be improved if future studies pilot test a series of new sentences for some of the items in the True-False subscale. These sentences should be constructed to allow for greater discrimination between participants in terms of their ability to understand rights. So while it would not be appropriate to add additional items to any of the subscales, the reliability coefficient may be improved by removal of some of the Vocabulary items, and replacing some of the sentences that make up the True-False items.

Grisso (1981) developed his instruments in order to measure how well young people understand and appreciate their *Miranda* rights. At the time, the *Miranda* instruments were used for research purposes only, as no one had attempted to quantify comprehension of legal rights before that time. In the years after the publication of Grisso's (1981) *Juveniles' waiver of rights: Legal and psychological competence*, legal psychologists were called on by the courts in the United States to make clinical judgments about how well a defendant understood his or her *Miranda* rights. In the absence of any other available method of measuring this concept, psychologists used Grisso's (1981) research measure. Grisso responded to the demand by publishing the measure as a series of clinical forensic assessment tools in 1998. The instruments were intended to guide clinical judgment as to whether a defendant demonstrated understanding and appreciation of his or her *Miranda* rights at the time of testing. The instruments were intended to be one piece of information for the clinician to determine whether a waiver was valid, given the "totality of circumstances" (which should include the defendant's capacities and state of mind, police conduct, presence of parents or counsel, among others) (Grisso, 2004, p. 720). Thus, comprehension of rights measures

are designed to provide the clinician with information to guide judgment of comprehension of rights, given the circumstances in which those rights were waived. As an aid to that judgment, Grisso's (1998) measure provides norms with which to compare a person's performance. At this developmental stage of the MHRCT, there are no norms with which to compare a person's score. As such, it would be inappropriate to use the MHRCT to make clinical judgments regarding how well a person comprehends his or her rights under the MHA. However, given the promising psychometric properties of the MHRCT demonstrated in this study, it is appropriate to continue its use for research purposes.

A critical next step in this research program is to quantify comprehension of rights under the MHA in a clinical sample. That way, the measure's psychometric properties and structure can be further developed, and its results can be compared to the healthy sample provided by the present study. Most important, having those data could be used to inform mental health policy regarding the appropriateness of some of the procedural safeguards legislated under the MHA.

In April 2005, one year after data collection began for the present study, the B.C. Ministry of Health published a new *Guide to the Mental Health Act*. As a part of that guide, the forms that are used to inform patients of their rights under the MHA were substantially changed. While the essential meaning of each right is identical to the older version, the wording is simplified and the patient is only told essential components of the right. For example, regarding the right to habeas corpus (see sentence number 4 in the Comprehension subscale), patients are now told "You have the right to apply to the court to ask a judge if your medical certificates are in order." The simplification reduced the

reading level of the rights from a grade 9 to a grade 8 level. These changes have made the notices of rights under ss. 34 and 34.1 (for patients ages 16 years and older, and those under 16 years, respectively) more similar in their word content, but the right to a second medical opinion is still left out of the notice for those under 16 years. If patients wishes to know more about each right, they are provided a separate form, which provides the more detailed, older version of the right. The appropriateness of this change is an important empirical question, and would be an interesting next step in this research program. Comparisons can be made between the old and new wording to see if simplifying the rights improves comprehension, or if removing some of the legal details makes the rights more difficult to understand. As is typical of many legislative changes, the forms were changed and implemented in the absence of evidence that these changes will improve comprehension.

Policy

This research program is in early stages of development, and a discussion of its application to policy is intended to reflect how a more developed program could inform policy. The present study is an important first step in the program, and provides a crucial measurement tool that taps comprehension of rights under the MHA.

Case law has applied the *Charter* to mental health legislation in regard to capacity to consent and has enshrined due process protections for those facing commitment. Sections 34 and 34.1 of the MHA explicitly state patients' s. 10 *Charter* right to contact, retain and instruct counsel. Case law has defined a clear legal standard of capacity to waive rights, but this has yet to be applied to the civil context. If a research program

demonstrates the capacities of psychiatric patients to waive their rights in the civil arena, it may provide impetus for a patient to legally challenge admission procedures.

This research program may also provide support for creating developmentally sensitive procedures for communicating rights to youths. Given that there are developmental trends in adjudicated and non-adjudicated adolescents' comprehension of rights, this research program seeks to determine if similar developmental trends appear in patients hospitalized with a mental disorder. If so, developmentally sensitive hospital procedures could include a way to ascertain patients' understanding of their rights, and could determine whether a waiver meets certain standards³. If this research program finds that young people in hospital routinely waive rights without understanding them, more rigid due process is necessary to ensure that involuntary hospitalization is valid in a particular case. As a part of this change, an advocacy system could be integrated into the commitment procedure that would ensure due process and that youth's developmental needs are being met. Developmentally sensitive procedures and systemic advocacy are likely important for all young patients in the mental health arena. However, these changes are especially important for those youths under 16 who are admitted to hospital with fewer procedural protections than those 16 and older.

Conclusion

This study represents an important first step in a developing research program on comprehension of rights under the MHA. The present study provides evidence that the MHRCT demonstrates acceptable psychometric properties and has a reliable

³As discussed in earlier sections of this paper, there is no explicit legal standard for waiving rights in the mental health arena. Therefore, barring constitutional challenges, legislative changes, or both, individual facilities would have to develop their own standard of care for when patients waive their rights. Ideally, of course, those standards of care would be evidence-based.

unidimensional structure. This study provides a springboard for tapping comprehension of rights in a population whose rights have been the subject of debate across history and political landscapes. In keeping with its historical *parens patriae* philosophical roots, B.C.'s MHA remains a paternalistic statute, which assumes that those involuntarily hospitalized for a mental disorder lack the capacity to consent to treatment. Compared to other Canadian jurisdictions (e.g., Manitoba and Ontario), patients in B.C. are subject to mental health legislation that provides fewer procedural protections against improper hospitalization and treatment. The rights that are provided under B.C.'s MHA are one avenue of protection provided to involuntary patients and to patients under age 16 who are hospitalized "voluntarily" by their parents. Given the precarious social and legal status of people with mental illness (and especially young adolescents with mental health problems), this research program will provide critical information as to whether the procedural protections under the MHA are serving those in need.

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Appendix A

The Mental Health Rights Comprehension Test

Establish with the examinee if they know anything about mental health issues. Ask:
“Have you heard about mental health problems?” and,
“Have you heard about problems such as schizophrenia or depression?”

Whether the examinee has heard about these disorders or not, explain:

“These are disorders of the mind that seriously impair a person’s thinking and social functioning. It’s pretty normal to be a little depressed once in a while. But when these problems get very serious, a person can be put into hospital against their will, and can be forced to take treatment. Since they lose their liberty, they are given certain rights. These rights are the focus of the exercise.”

Comprehension

Practice questions:

I will show you some cards with some sentences on them. When I show you one, I will read the sentence to you. Then I want you to tell me what it says, in your own words. Try to tell me what it says, but in different words from those that appear in the sentence you see. Do you understand what I want you to do?

The first card is just for practice so you can get used to what I want you to do. Here is the card. It says, “I have volunteered to be in this study.” Now tell me in your own words what is said in that sentence.

If the examinee uses the same words to describe the meaning of the sentence, re-iterate that he or she is to use different words than what appear on the card.

Continue with the cards:

- 1. Right to be informed of the name and location of the designated facility. You have been admitted to Riverview Hospital, which is a facility designated under the *Mental Health Act*, located in Coquitlam, B.C.**
-
-
-

Inquiry:

1. If the examinee misses the idea that they need to interpret the right (for example, they answer “I’m being put into the hospital.”), re-iterate “And what does it mean to have the right to be informed of the name and location of the designated facility?”

2. **Right to know the reasons for your involuntary hospitalization.**

You were involuntarily admitted to the hospital because a doctor signed a medical certificate under the Mental Health Act stating that you should be here for treatment.

Tell the examinee “I will tell you a little more about the right. You don’t need to know word for word what I say, but try to get the gist of it.” Continue:

The doctor signed the medical certificate because the doctor is of the opinion that:

- a) You are a person with a mental disorder that seriously impairs your ability to react appropriately to your environment or to associate with other people; and
 - b) You require treatment in or through a hospital; and
 - c) You should be in hospital to prevent your substantial mental or physical deterioration or to protect yourself or other people; and
 - d) You cannot be suitably admitted as a voluntary patient.
-
-
-

Inquiry:

If they leave out the reasons for hospitalization, query “and why are you in hospital?”

3. **Right to get advice from a lawyer.**

You have the right to contact a lawyer without delay and at any time. You may contact any lawyer you wish.

Inquiry:

- 1. If they leave out the time frame, ask “does the right tell you anything about when you can have a lawyer?”
- 2. If the identity of who can be consulted is left out (i.e., “I can talk to someone”), ask “Who can you talk to?”

4. **Right to make *habeas corpus* application to court.**

You have the right to apply to the court to have the legal validity of your hospitalization determined by *habeas corpus*. This means you can ask the court to look at the documents authorizing your detention in hospital to determine whether it is lawful. If you wish to do this, you will need to contact a lawyer.

Inquiry:

1. If the answer does not identify who is asked to look at the documents (“You can ask people to look at how you were admitted to hospital,”) query “What do you mean by ‘somebody’ or ‘people?’”
2. If no time frame is given, query “and when can you do this?”

5. Right concerning renewal of involuntary patient status.

If a second medical certificate is completed within 48 hours after your admission, you will have to stay in hospital for one month unless you are discharged earlier. Prior to the end of the month, a physician must examine you to determine whether you continue to meet the requirements as an involuntary patient. If you do not meet these requirements, you must be discharged. If you do meet the requirements, your certificate can be renewed, which then provides the authority to keep you as an involuntary patient for a further one-month period. Subsequent renewal periods are for three months, and for six-month periods thereafter. Each time a renewal certificate is written, you have the right to request a hearing by a review panel.

Inquiry:

1. If no time frame is given, query, “and when does this happen?”
2. If the participant mentions that “they” have to examine him or her, query, “who examines you?”

6. Right to review panel hearing.

If you think, or a person on your behalf thinks, that you are ready to leave hospital but your doctor does not agree, you have the right to request by a review panel. A review panel is made up of three people. You have the right to appoint one of these three people. This person cannot be yourself or a member of your family. If you do not appoint a person to serve on the panel, the director may appoint that person. The review panel will hold a hearing within 14 days from the time your application is received. At the hearing, they will listen to information about your disorder and decide whether or not they think you should stay in hospital or on leave as an involuntary patient.

Inquiry:

1. If response does not include an initial disagreement between the patient (or somebody on the patient’s behalf) and the doctor, OR if the response does not include the idea that the patient initiates the review panel hearing, query, “Under what circumstances would a review panel occur?” or “when does this happen?”

2. If no mention (or vague mention) is given as to who is on the panel (i.e., “they meet and decide if I can leave the hospital,”) query, “Who meets and decides this?” or “whom do you mean by ‘they?’”

7. Right to request a second medical opinion about your treatment.

You, or a person on your behalf, may request a second medical opinion on the appropriateness of your treatment. This may be done once during the first period of admission and once during each renewal period. You have the right to ask to be examined by a physician of your choice, or you can ask the director to select a physician to examine you and to provide a second medical opinion to the director. There may be a cost to you depending on the distance the physician has to travel. On receipt of the second medical opinion, the director must consider whether the treatment is appropriate. The director may then authorize changes to the treatment.

Inquiry:

1. If no time frame is provided, query, “and when can you do this?”
2. If they are vague about who is examining them, ask “who examines you?”
3. If no indication of what happens after the examination (the director decides on changes), then query, “what happens after that (the examination)?”

8. Right to appeal to the court.

If you think you are ready to leave the hospital but the doctor does not agree, you can take your case to the Supreme Court of British Columbia. The judge will then decide whether or not you should stay in the hospital. This could take longer than a review panel hearing and may cost you money.

Inquiry:

1. If the examinee does not indicate how the case is brought to court, query, “and when would this happen?”
2. If no indication of what happens once the case is in front of the judge (the judge decides if he or she should stay in the hospital) then query, “what happens after that (the time in court)?”

True-False

“We’re going to go through these rights again, but do a different exercise. This time, I’ll show you a target sentence, like this:”

Show the practice target sentence:

“I have volunteered to be in this study. Then I’ll put down another sentence like this:”

Place the first practice sentence below the target sentence:

“I have agreed to take this test and nobody forced me to do it. I want you to tell me if the second sentence means the same thing or something different than the target sentence.”

If the examinee gets it wrong, correct him or her. Once he or she understands, present the second example and say:

“Here is the next card; I have to take this test whether I want to or not. Is that the same as the target sentence or something different?”

The first example statement should be identified as meaning the same thing as the initial sentence, the second example statement should be identified as meaning something different. If the examinee makes an error on either of these examples, the correct responses should be indicated and explained to the examinee before continuing with the remaining sentences.

It is important that the participant understands that they should grasp whether the sentences are the same or different, not “correct” or “incorrect”.

Continue with the rest of the cards:

1. You have been admitted to Riverview Hospital, a facility designated under the *Mental Health Act*, located in Coquitlam, B.C.

- a. You have been admitted to a relaxation centre in Victoria.
- b. You have been admitted to a hospital on the lower mainland that helps people with psychiatric problems.
- c. You have been admitted to a Coquitlam hospital for people with mental disorders.

2. You were involuntarily admitted to the hospital because a doctor signed a medical certificate under the *Mental Health Act* stating that you should be here for treatment.

- a. You are in hospital because you have a mental disorder and need treatment.
- b. You are in hospital because you have broken the law.
- c. You are in hospital because you need medical care for a physical problem.

3. You have the right to contact a lawyer without delay and at any time.

- a. You can talk to a social worker before anything happens.
- b. A lawyer will come and see you after you’ve been in the hospital for a while.
- c. You can have a lawyer now if you ask for one.

4. You have the right to ask the court to look at documents authorizing your hospitalization to determine if it is lawful.

- a. You can ask a court of law to see if somebody made a legal mistake putting you in the hospital.
- b. If you request it, a court of law will look at how you were admitted to hospital, and decide if legal errors were made in that process.
- c. A court of law will let you leave the hospital if you give money to the court.

5. Prior to the end of the first month in hospital, a physician must examine you to determine whether you continue to meet the requirements as an involuntary patient.

- a. Within the next month, a doctor will examine me to see if I need to stay in the hospital or be released.
- b. A nurse will tell me when it's time to leave the hospital.
- c. The doctors will keep me in hospital whether I am sick or not.

6. You have the right to request a hearing by a review panel to determine whether you should be discharged.

- a. The review panel at the hospital will let you leave anytime you want.
- b. You can ask the review panel to let you leave the hospital.
- c. If you request it, a review panel will meet and decide if you can leave the hospital.

7. You, or a person on your behalf, may request a second medical opinion on the appropriateness of your treatment.

- a. You can ask the doctor and the nurse to decide what your treatment should be.
- b. You can have a second doctor examine you and decide if your treatment is appropriate.
- c. One doctor must examine you twice before deciding your treatment.

8. If you think you are ready to leave the hospital and the doctor does not agree, you can have a lawyer take your case to the Supreme Court of British Columbia. The judge will then decide whether or not you should stay in the hospital.

- a. You can ask a lawyer to ask a judge in a court of law to decide if the doctors were wrong in admitting you to a hospital.
- b. If you feel you shouldn't be in the hospital, you can ask a lawyer to ask a judge in a court of law to let you leave.
- c. You can ask the doctor to let you leave the hospital.

Vocabulary

Now we're going to do some vocabulary. I am going to give you some cards that have some words on them. As I give you a card, I will read the word and use it in a sentence. Then I would like you to define the word; tell me in your own way what the word means.

The examiner then performs the procedure just described for the first word, and asks:

What does 'designated facility' mean?

General inquiries:

1. Ask "Anything else?" after examinee's response for every word.
2. If the examinee interprets the sentence at any point in the exercise (for example, says "he's been put into a facility for treatment," for the first sentence) explain again that you want them to define the word itself. For example, say "And what is a designated facility?" Make this general inquiry *one time only* for the entire exercise.

The words and corresponding sentences are as follows:

1. **Designated facility** He was admitted to a **designated facility** for treatment.

2. **Mental disorder** His **mental disorder** caused him to be depressed.

3. **Lawyer** The judge asked the **lawyer** a question.

4. **Habeas corpus** The defendant asked the judge, through **habeas corpus**, to determine if his arrest followed the proper procedures.

5. **Lawful** It is **lawful** to pay your taxes.

6. **Right** You have the **right** to vote.

7. **Review panel** The **review panel** met to decide if he was well.

8. **Discharge** After her **discharge** from the hospital, she could go home.

9. **Court** The judge is in charge of the **court**.

10. **Appeal** After the man was convicted of the crime, he sent an **appeal** to a higher court.

Appendix B

MHRCT Scoring Manual

Comprehension

Items for Comprehension will be scored according to the following criteria:

- 2 points: An adequate comprehension of the right.
- 1 point: A partial comprehension of the right.
- 0 points: A lack of understanding of the right.

1. Right to be informed of the name and location of the designated facility. You have been admitted to Riverview Hospital, which is a facility designated under the *Mental Health Act*, located in Coquitlam, B.C.

General: The idea that the person has the right to be told what hospital they are in and where that hospital is located.

Elements:

1. Told the name of the hospital they are in,
 2. where it's located.
- *Note that it is not necessary to say specific name of hospital or the city. However, specifying the name and location on the card counts for credit.*

2 points

Must contain both elements to receive full points.

Examples: "I have the right to be told where I am, the hospital and its name." "I should be told what hospital I am in, and where it is." "I should be told I'm in Riverview Hospital in Coquitlam."

1 point

Contains at least one of the elements.

Examples: "I should be told where I'm going." "I have to be told the name of the hospital."

0 points

Contains none of the elements.

Examples: "I was put into a hospital."

2. Right to know the reasons for your involuntary hospitalization.

General: *The idea that the person has to be told that they have been put into hospital for treatment for a mental disorder.*

Elements:

1. Told why they are in hospital,
2. they have a mental disorder, and
3. they require treatment.

2 points

Must contain two out of the three elements to receive full points:

Examples: “I should be told why I was put into hospital, and because I have a mental problem and need help.” “I need to be told what I’m doing here in the hospital, because my brain is not functioning properly and I need treatment.”

1 point

Contains at least one of the elements.

Examples: “It means I need to go into the hospital for treatment.” “I’m in the hospital because I have a problem with my brain.”

0 points

Contains none of the elements.

Examples: “They put me in the hospital because I hate my mom.” “The doctor wants me in the hospital.”

3. Right to get advice from a lawyer.

General: The idea that one has the right to consult a lawyer, either right away or any time in the future.

Elements:

1. Can talk to a lawyer, and
2. can do this at any time.

2 points

Must contain two elements for full points

Examples: “I can talk to a lawyer about my being in the hospital/my situation any time I want.” “I can ask for a lawyer now or later.”

1 point

Contains at least one of the elements.

Examples: “I can talk to a lawyer about being in the hospital.”

OR, the type of person you can contact is left unclear: “I can talk to someone any time I want about why I’m in hospital.”

0 points

Contains neither of the elements.

Examples: “I can talk to someone about being in hospital.” “I can talk to the doctor about my situation.”

4. Right to make *habeas corpus* application to court.

General: The idea that a person can ask a court of law (court or judge is acceptable) to determine if the process by which a person was admitted to hospital was lawful.

Elements:

1. That the process takes place in a court,
2. that the court determines the legal validity of the hospitalization (*this is not to do with whether the patient is mentally healthy or not*).

2 points

Must contain two elements for full points

Examples: “I can ask a court to look at the papers that led to my being hospitalized and see if the forms were all done the way they were supposed to.” “When the court looks over all the papers dealing with my being in hospital, and the judge decides if the doctors made mistakes along the way.”

1 point

Contains at least one of the elements.

Examples: “The doctor will look at the process of how I was admitted to hospital to see if somebody made a mistake putting me in the hospital.” “A judge in a court of law looks at documents to see if I’m well enough to leave the hospital.” (*This last example deals with the situation where examinee mistakenly believes the court determines the mental health of the patient.*)

0 points

Contains neither of the elements.

Examples: “When you ask those who want to keep you in hospital to let you out.” “A Latin phrase.”

5. Right concerning renewal of involuntary patient status.

General: The idea that the person will have to stay in hospital for one month, and will need to be examined by a doctor before it is determined if the person should stay in hospital or be discharged.

- Note that it’s okay for examinee to discuss other examinations they may have in hospital, but must say that they have to be examined after one month. Also, the participant does not have to remember the subsequent renewal periods of 3 and 6 months, nor do they need to remember that they have the right to a review panel hearing in each renewal period, in order to receive full points.

Elements:

1. An examination by a doctor,
2. the person can only be held in hospital if he or she continues to meet the requirements of an involuntary patient (i.e., is not well enough to leave the hospital), and
3. must be examined after one month in hospital (only the first month of hospitalization necessary for credit, see note above.)

2 points:

Must contain two out of the three elements to receive full points.

Examples: “I have to stay in the hospital for one month, then I have to be examined by a doctor to see if I’m well enough to leave.” “I have to be here for one month, after that I might have to stay in the hospital for longer.”

1 point:

Contains at least one of the elements.

Examples: “I have to stay in the hospital until the doctor tells me I can go.” “A doctor has to examine me after a month.”

0 points:

Contains none of the elements.

Examples: “I have to stay in the hospital now.” “They can put me in the hospital any time they want.”

6. Right to review panel hearing.

General: The idea that the person can request a hearing by a review panel if the doctor does not discharge him or her. The three people (one of which the patient can appoint) will meet and listen to information about the disorder and decide if the patient should stay in hospital or leave.

Elements:

1. Disagreement between the doctor and patient/patient advocate,
 2. the patient (or advocate) requests (“ask for” “gets” “can have”) the review panel, and
 3. the decision to stay or leave hospital is provided by panel.
- *Note that the panel does not examine or determine the mental health of the participant, just whether they should or should not be in hospital. If the examinee mentions diagnosis or examination, do not give credit.*
 - *A Review Panel only happens if the patient initiates it. In order to get credit for the second element, the examinee must indicate that the Review Panel comes about due to his or her agency. Give credit for the less explicit examples in parentheses above.*

2 points

Must contain two out of the three elements to receive full points.

Examples: “If the doctor says I have to stay in the hospital, I can ask a review panel to decide if I’m well enough to leave.” “A group of three people will meet and see if I can leave the hospital, if the doctor says I can’t leave.”

1 point

Contains one of the elements.

Examples: “If I want to get out of the hospital, I can get a review panel, which is made up of three people. They will meet and see if I’m healthy.” “The review panel will meet to decide if I’m well enough to leave the hospital.”

0 points

Contains none of the elements.

Examples: “The review panel meets to decide if your brain is working properly again.”

- *Note that no points should be awarded if the response indicates that some other body is making the decision for the review panel. This includes a judge, jury, the doctor or director. However, a response such as “If you request it, the review panel meets. The panel is sort of like a jury, with three people who meet and decide if you’re well enough to leave the hospital” is acceptable as a 2-point response because the word ‘jury’ is qualified.*

7. Right to request a second medical opinion about your treatment.

General: The idea that the patient can ask for another doctor to examine him or her and give his or her opinion on the appropriateness of the treatment. The director then decides if changes to the treatment are appropriate.

- *Note that while the law is explicit about the director authorizing changes to treatment, in practice the person in charge of the patient’s care makes the changes.*
- *Note that ‘treatment’ deals with diagnosis or medication, but it is also unnecessary to define in order to receive full points.*

Elements:

1. A second doctor’s examination (or opinion), and
2. the director (or an appropriate authority such as a physician) can authorize changes to the treatment (due to that 2nd medical opinion).
 - *Note that the second medical opinion does not refer to whether the patient can stay in the hospital, but whether the treatment is appropriate.*

2 points

Must contain both elements for full points.

Examples: “I can ask for another doctor to come and examine me and give his opinion about my treatment. They (the director, the doctor) can then decide if my treatment should be changed.”

1 point

Contains one of the elements.

Examples: “A doctor of my choice can come and examine me and see if the treatment is right. Then the doctor can change my treatment.” “A different doctor can come and examine me to see if I can leave the hospital.”

- *Note that this second example deals with situation where examinee mistakenly believes the second opinion might lead to release from hospital).*

0 points

Contains none of the elements.

Examples: “A different doctor can come and examine me to see if I’m healthy enough to leave the hospital.”

8. Right to appeal to the court.

General: The idea that the person can take their case to court if the doctor wants to keep him or her in hospital. The judge will then decide if he/she will stay in hospital or not.

Elements:

1. Disagreement between the person (and/or advocate) and the doctor,
2. can take the case to court, and
3. the judge will decide whether or not the person will stay in hospital.

2 points

Must contain two out of the three elements to receive full points.

Examples: “If the doctor won’t let me go, I can take my case to court. Then the judge decides if I can leave the hospital.”

1 point

Contains one of the elements.

“A judge can decide if I’m well enough to go home from the hospital.” “If the doctor says I’m supposed to stay in the hospital, then I can take it to court.”

0 points

Contains none of the elements.

Examples: “I can sue the doctor in court.” “A judge can decide if I should have new treatment.”

True-False

Scoring: Participants receive one point for each correct response, for a maximum of 24 points.

Answer Key

- | | |
|-------------------------|-------------------------|
| 1. a. D
b. S
c. S | 5. a. S
b. D
c. D |
| 2. a. S
b. D
c. D | 6. a. D
b. S
c. S |
| 3. a. D
b. D
c. S | 7. a. D
b. S
c. D |
| 4. a. S
b. S
c. D | 8. a. S
b. S
c. D |

Vocabulary

Items for the Vocabulary subscale will be scored according to the following criteria:

- 2 points: An explanation similar to the given definition.
- 1 point: A partial definition or accurate synonym
- 0 points: Responses indicating a lack of understanding; an incorrect definition, or an incorrect synonym.

1. Designated facility

General: A hospital, mental health facility, psychiatric unit or observation unit.

Scoring:

2 points

Contains one or more elements.

Examples: “A mental health facility.” “A hospital.”

1 point

Identifies a health-related setting, but does not specify a unit or hospital setting.

Examples: “A place you go when you’re sick.” “Where the doctors help you get better.”

0 points

Contains none of the elements.

Examples: “A designated place.” “Where the hospital is.”

2. Mental disorder

General: The idea that it is a disturbance of the mind that requires treatment and seriously impairs the person’s ability to react appropriately to the person’s environment, or to associate with others.

Elements:

1. A disturbance of the mind,
2. requires treatment.
3. Any example that deals with problems typical of mental disorders, within the environment or between people.

Scoring

2 points:

Must contain 2 or more elements for full points.

Examples: “A disease of your mind, where you can’t live by yourself.” “A disorder that effects your thinking, where you can’t go to work or you get into fights with people.”

1 point:

Contains at least one of the elements.

Examples: “A problem with your brain.” “You think others are out to get you when they’re not.”

0 points

Contains none of the elements.

Examples: “What happens if you get too stressed out.”

3. Lawyer

General: Member of the legal profession, those who give advice about legal matters and/or representing clients in court.

Elements:

1. **Someone who is empowered to act for (and in the interest of) another person in legal proceedings.** *Examples:* “The lawyer is someone who’s on your side.” “Someone who defends you/stands for your rights.” “He fights for you in court.” “Someone in your favour.” “Helps you get out of trouble.”
2. **Someone especially trained in law and legal processes.** *Examples:* “Someone who knows everything about the courts.” “He knows all about the law.” “He knows what your rights are.” “Someone who can interpret laws, knows what they mean.”
3. **An accurate synonym.** *Examples:* attorney, defence counsel, counsellor, legal counsel, advisor, barrister, solicitor.

Scoring:

2 points

Any response satisfying at least 2 of the three elements listed previously.

1 point

A response including only one of the three elements listed previously.

0 point

A response including none of the preceding three elements.

4. Habeas Corpus

General: A legal process by which a court investigates and determines the lawfulness of a person’s detention.

Elements:

1. That the process takes place in a court, or that a judge or lawyer is involved,
2. that the court looks at documents to determine the legal validity of the hospitalization

- *Note that Habeas Corpus does not involve a test or a consideration of the patient's mental health. Take a point away only if reference to mental health is explicit.*

2 points

Must contain two elements for full points

Examples: "The court looks at the papers leading to the hospitalization, and see if the forms were all done the way they were supposed to." "When the court looks over all the papers dealing with my being in hospital, and the judge decides if the doctors made mistakes along the way." "A judge would look at the hospital papers to make sure I'm supposed to be in the hospital."

1 point

Contains at least one of the elements.

Examples: "The doctor looks at the process of admission to hospital to see if somebody made a mistake along the way." "A judge in a court of law looks at documents to see if I'm well enough to leave the hospital." (*This last example deals with the situation where examinee mistakenly believes the court determines the mental health of the patient.*)

0 points

Contains none of the elements.

Examples: "When you ask those who want to keep you in hospital to let you out." "A Latin phrase."

5. Lawful

General: Conforming with, permitted by, or recognized by law.

Scoring

2 points

A response that includes one or more of the elements in the general definition, or an accurate synonym.

Examples: "Acting within the law." "Not against the law." *Note that this last example allows for responses that are a double negative.*

1 point

A response that indicates this term is related to doing things a certain way, but without reference to law or code.

Examples: "The right way to do things." "Behaving yourself."

0 points

A response that indicates a lack of understanding, or inaccurate synonym.

Examples: "What the police do." "Against the law."

6. Right

General: That which a person has a just claim; a power, privilege, etc. that belongs to a person by law, nature or tradition.

Scoring

2 points

An action or condition which is allowed to a person by law or Charter or member of citizenship, as well as the notion that this privilege is protected, or not able to be denied arbitrarily by others.

Examples: “By law, if you qualify, you can do it if you want.” “You can legally do it even if someone else doesn’t like it.” “You can do it because you were born here.” “You are entitled to it by the Charter.”

1 point

The idea of being allowed to do something or the notion of protection of one’s privilege to lay claim to that allowance, but without reference to law, Charter or member of citizenship.

Examples: “You can do it.” “You’re allowed to do that.” “You can if you want to.” “You can do it without asking.” “It’s your decision.” “It’s your privilege.” “It means you can do something no matter what.”

0 points

No recognition of allowance or privilege.

Examples: “Your right hand.” “Right, left.” “Like you should vote, it’s important to do that.” “Means something is the right thing to do.”

7. Review panel

General: A group of three people, including a chair, a doctor, and a person appointed by a patient, who meet and discuss the appropriateness of the detention of the patient.

Elements:

1. A group of people who
2. Meet and decide if the patient is well enough to leave.

Note: the group of people in the RP does not include members of a court, such as a lawyer or a judge. A response that includes those people would not get credit for the first element.

Note: If the response includes reference to the RP administering tests to determine the mental status of the patient, give no credit to element 2.

Scoring

2 points

Must contain both elements to receive full points.

Examples: “The review panel is a group of people who decide if I’m well enough to

leave.” “They are kind of like a jury, but it’s people who look at your case and tell you if you can leave the hospital.”

1 point

Contains one of the elements.

Examples: “The review panel is where the judge decides if you’re well enough to leave the hospital.” “It’s a group of three people, one of whom I’m allowed to appoint.”

0 points

Contains none of the elements.

Examples: “The review panel meets and tests your brain to see if it’s working properly again.”

8. Discharge

General: To be let go, released, especially from a duty, commitment, or a period of confinement.

Elements:

1. To be let go, released (or any reasonable synonym)
2. from duty, commitment, period of confinement (or any reasonable synonym).

Scoring

2 points

Must contain both elements to receive full points.

Examples: “To be released from hospital.” “When the doctor tells you that you can leave the hospital and go home.” “When you’re allowed to leave.”

1 point

A response that indicates this term is related to a person being released, but without reference from where the person is being released.

Examples: “To be let go.” “When you leave the hospital.”

0 points

A response that indicates a lack of understanding.

Examples: “When the doctor tells you what to do.” “When something leaks out of a wound.”

9. Court

General: An assembly of a judge and other persons acting as a tribunal in civil and criminal cases.

Elements:

1. assembly (group) of a judge and/or other legal professionals (a jury or lawyer are also acceptable)
2. where criminal or civil cases are heard or decided.

Scoring

2 points

Must contain both elements to receive full points.

Examples: “The place where a lawyer takes your case in front of a judge, argues your case, and the judge decides if you can be released from hospital.” “The place where a judge or jury decides if you’re guilty or not.”

1 point

Contains one of the elements.

Examples: “Where you take your case to be decided.” “Where the judge does his job.” “Where you go to see if you can get out of hospital.”

0 points

Contains none of the elements.

Examples: “The place you go when you get into trouble.” “Where you play tennis.”

10. Appeal

General: A new hearing in a different court. A resort to a higher authority or greater power, as for sanction, corroboration, or a decision. The transfer of a case from a lower to a higher court.

Elements:

1. A new hearing by a different court,
2. the transfer of a case from a lower to a higher court, or a resort to a higher authority.

Scoring

2 points

A response that includes one or more of the elements in the general definition, or an accurate synonym.

Examples: “To ask a higher court to look at your case, maybe after the review panel says you can’t leave the hospital.” “To ask another court to re-consider the decision made by a lower court.”

1 point

A response that indicates understanding that an appeal is a legal process, but without reference to the transfer of decision making to a higher authority.

Examples: “Ask another court to look at your case.” “A different judge makes the decision to let you out of the hospital.”

0 points

A response that indicates a lack of understanding, or inaccurate synonym.

Examples: “When somebody is attractive.” “The review panel looks at your case again.”

Appendix C

Demographic Questionnaire

Date _____

Subject _____

Background

DOB: _____ (yy-mm-dd) Gender: M F

What is your cultural/ethnic background?

Anglo/Western European Asiatic First Nations

African Eastern European Hispanic Other _____

Marital status: Married Separated Divorced Single

Children: Yes No

Highest level of education:

Highest grade in elementary/high school

Number of years in college or university

University degree (specify) _____

Post-graduate/professional degree (specify) _____

Do you work full time Part time

What is your main occupation? _____

The following 4 questions are for young subjects who are still living in the familial home.

I live with (check only one):

Two parents (biological, step or adopted)

One parent (biological, step or adopted)

Other family member(s) (e.g., grandparents)

Guardian(s)

Do you live with your mom? If so, what is her main occupation? _____

Do you live with your dad? If so, what is his main occupation? _____

If you live with another family member or a guardian, what is his or her main occupation? _____

Health History

Have you ever been put into hospital for psychiatric (mental health) care?

Yes No

If **YES**, how many times?

Date admitted (yy-mm-dd)	Hospital (name and location)	Illness	Date released (yy-mm-dd)

Have you ever taken medication for a mental health problem?

Yes No

If **no**, STOP here.

If **yes**, please list medications and for how long you took them:

Name of medication	Date started	Length of treatment (in months)

Where did you get the medication?

My doctor (general practitioner)

A psychiatrist (private practice)

A psychiatrist at a mental health clinic

A psychiatrist at a hospital