

Distinguishing Dementia from Mental Illness and Other Causes of Decline

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I. INTRODUCTION

Whether an individual suffers from dementia, mental illness or another cause of cognitive impairment, these conditions cause symptoms that worry potential clients, family members and caregivers, to the point of leading them to seek the advice of an attorney with experience in this area. Though there may be several legal questions that arise, in the end, all roads lead to capacity or lack thereof. Attorneys must develop the skill set to assess whether a client (or a client's family member or loved one) has capacity in a variety of different situations according to various legal standards, and then advise that client as to how to best proceed to achieve his or her legal goal. The attorney must keep in mind his or her ethical obligations in representing a client with potential or actual diminished capacity. In cases where a client may be unable to make decisions on his or her own behalf due to some type of mental impairment (or where the client is a family member or loved one of a mentally impaired individual), that attorney must then develop a plan that may include executing appropriate legal planning documents or seeking intervention through the court system to protect the best interests of the individual.

Section II will discuss the common clinical syndromes causing clinical dysfunction, with an emphasis on the similarities and differences between them. Section III will explore the issue of capacity and how these various symptoms affect legal representation from the perspective of a privately retained attorney and from the viewpoint of a Mental Hygiene Legal Service attorney. Section IV provides a brief overview of several legal options for clients and/or family members with mental illness, dementia or cognitive decline including advance directives, guardianship, and inpatient hospitalization.

Throughout this article please refer to the following two case studies to guide the discussion.

CASE STUDY #1

Maria, an 81-year-old woman, presents to your law office with her adult daughter, Anna, who encouraged her mother to meet with you. Anna gives you a history of her mother always being a "difficult person to communicate with" but says that they have a good relationship currently. Anna is an only child, is married and has three children. Anna's impression of her mother is that she is "very depressed most of the time." She is concerned that her mother may have early dementia. Anna describes her mother's symptoms as "paranoid, delusional, irritable with a lack of focus and increasingly poor ability to care for herself." She is worried that her mother could request to change her legal documents, such as her Health Care Proxy, Power of Attorney and Will, all of which appoint Anna. Anna is also concerned that due to her mother's increasing paranoia, she could disinherit her and her grandchildren. Anna admits that she had convinced her mother to see a geriatric psychiatrist who diagnosed her with "Rule-out Untreated Geriatric Depression, Severe; Rule-out Typical Dementia, Rule-out Medical Causes."

CASE STUDY #2

Murray, an 85-year-old man, comes to your office seeking legal advice on drafting advance directives and a Will. He is mildly disheveled and there is something "off" about him which you cannot quite figure out early on in your meeting. As your consultation with Murray continues, it becomes increasingly clear that

he cannot complete his thoughts, forgets what he has just asked, cannot recall the information you have just presented to him and spends much of the time looking behind him, staring at the lights above, asks about who else is in the office currently, and suggests the pictures on your wall have a special meaning.

II. DEFINING THE TERMS: DEMENTIA, MENTAL ILLNESS, AND COGNITIVE DECLINE

In adults, particularly in the geriatric population, there are several conditions in the neurologic, psychiatric, and neuropsychiatric spectrum that can interfere with cognitive skills, impede functioning and cause symptoms that concern family members and may require attorney involvement. Among the most common are the dementias, depression/mood disorders and dementia “mimics.” Each of these groups share basic elements with additional symptoms that track to specific disorders.

A. DEMENTIA

Dementia is a grouping of neurological or neuropsychiatric conditions characterized by acquired, progressive, cognitive decline accompanied by loss of function.¹ Overall, all dementias cause cognitive dysfunction, can and, over time, often will, impair judgment, decision-making, affect communication, and impede or prevent independent living. Though the trajectory of illness is universally downward, the rate of progression is individual and the clinical symptoms are condition-specific.

The primary hallmark of dementia is the cognitive decline, usually involving memory and higher executive functioning, such as abstraction, attention, concentration, and planning or follow through. In Alzheimer’s disease, the most common form of dementia, the memory impairment initially affects the most recent and progresses to the most remote. Individuals have the greatest difficulty with new information, its registration (learning), recall, retention (memory) and retrieval. Eventually, long-term memory is affected as well. In frontal-temporal dementia, the memory loss appears variable, almost unpredictable, with changes in personality, loss of social skills and even perceptual distortions such as hallucinations.²

Early in the course of dementia, there may be depression as people struggle with the loss and their fear of the future. Paranoia is not uncommon, as seen in an elderly man who accuses his wife of stealing his glasses after once again forgetting where he placed them. Together with the apathy that occurs mid-course, the affected person becomes less able to negotiate his or her world including relationships and roles.

From the medical expert perspective, the challenge is to determine the client’s diagnosis and clinical status. For example, in early dementia, a person may not be able to handle a complicated computer program but can still manage his or her everyday affairs. In the early and middle stages, the impact on capacity remains situational and needs to be determined on a case-by-case basis. The unpredictable rate of decline as the illness progresses makes it virtually impossible to determine when someone who presents with early signs of dementia will no longer be able to handle his or her own affairs.

It is also important to be aware that older people have multiple medical illnesses that can cause, contribute to, and/or complicate the clinical picture of dementia.³

B. MENTAL ILLNESS

The most common psychiatric conditions for the elderly population are the depressive and anxiety disorders which range from the “blues” to depression with psychotic features and from mild discomfort to full-blown panic attacks. As people age, the number of stressors grows over time with a concomitant loss of close family and friends. Together with any medical issues, there is an increase in risk for new onset or

recurrent depressive disorders, worsening of chronic anxiety, intensification of longstanding family dysfunction, ongoing personality disorders as well as long-term sequelae of chronic psychotic illnesses.

The depressive disorders are a group of psychiatric conditions characterized by mood changes, dysphoria (depressed mood which when severe can morph into despair, hopelessness and helplessness) accompanied by loss of interest in usual activities, abnormal sleep or eating patterns, feelings of low self-worth, and sometimes psychotic symptoms or even suicidal ideation.⁴ In late-onset depression, the loss of attention to dress, weight loss, delusional thinking and suicidal ideation can even mimic terminal illness and may require hospital admission. Decreased motivation and interest, poor concentration, low energy and demoralization can lead to pseudo-dementia, where individuals can appear to be cognitively impaired, even demented.

As with dementia, there are somewhat different symptoms to each subtype of depressive disorder, but overall, they are all marked by very low mood accompanied by other symptoms affecting how people feel about themselves and the world and potentially impacts their ability to function. However, unlike dementia, depressive disorders are most often acute (versus chronic) or episodic and tend to respond to treatment with attenuation, if not full remission, of symptoms. During acute depressive illness there may be impairment of judgment and disordered thinking so that capacity is affected (i.e., a patient who was so depressed she refused to give consent to surgery believing that God had given her a way to die), but once treated the symptoms remit and the person returns to, or close to, his or her pre-depressive baseline.

In addition, there are other conditions such as chronic mental illness, for example, schizophrenia, bipolar disorder or schizoaffective disorder, that may present with a lifelong impairment of judgment and cognitive symptoms accompanied by mood changes that worsen with age.

C. GENERAL COGNITIVE DECLINE OR “DEMENTIA MIMICS”

In addition to dementia and depression there are several other conditions that impact cognitive skills, can impair functioning, and may be part of the client's presentation.

The most common of these is normal aging itself, which affects the way an individual processes information, his or her reaction times and the way he or she stores and retrieves short-term memory. A common manifestation is the “forgetting” of names only to recall them sometime later. People often overestimate the negative impact of these changes. The individual can become depressed or anxious, which if severe enough can impede the learning of new information.

A related condition is known as minimally impaired cognition (MIC), which falls between dementia and normal aging. Individuals suffering from MIC can do everyday things but have impairment of higher executive function affecting the management of their financial portfolios or even simple bank accounts. Even mild forms of MIC are amplified with additional stressors which may be physiological (e.g., lack of sleep), psychological (e.g., grief), or medical (e.g., heart failure). This may mean that in stressful situations, such as during a medical crisis, persons suffering from MIC may not be able to multitask or even fully grasp a complex situation. Hence, planning may be of particular benefit to this subset of the population, some of whom will remain with MIC, while a smaller proportion will progress to dementia of the Alzheimer's type.

In the medical units, a frequently encountered dementia “mimic” is delirium, which is characterized as a temporary global (affecting most components of our brains) brain dysfunction of sudden onset.⁵ The symptoms of delirium can mimic dementia with the loss of attention and focus, confusion, day-night reversal or psychiatric illness with psychotic ideation, agitation, apathy or mood changes. It can have many triggers, and treating the underlying cause is the primary approach. However, the recovery can be prolonged and for those already suffering from dementia, so-called “double delirium,” there is a high risk of worsening residual dysfunction.

Finally, there are medications and medical conditions that can affect any area of cognitive function. For example, many opioid-containing medications can impair focus, cognitive clarity and reaction time, which underlies the caution about driving or using heavy machinery. Severe impairments can occur in this setting but are generally mild to moderate, temporary and reversible, with little or no permanent changes.

In situations where there is uncertainty or even discomfort with the clients' clinical state, and an uncertainty about the correct diagnosis or prognosis and its impact on cognitive function, decision making, and judgment, a medical expert consultation can be very useful.

III. HOW DO THESE DIAGNOSES/SYMPTOMS AFFECT CAPACITY AND/OR LEGAL REPRESENTATION?

A. THE PRIVATELY RETAINED ATTORNEY

"Capacity" is a medical determination that is broadly used to describe a person's ability to act in a legal environment, as well as the level to which he or she is accountable or responsible for his or her actions. The incidence of cases in which capacity is an issue has grown substantially in the past few years because of the aging demographic and the increasing number of cases involving serious mental illness, drug and/or alcohol dependence/abuse, or other related mental health concerns. In civil matters, capacity issues arise as to contracts (e.g., is the party capable of entering into, or suing pursuant to a contract?), executing advance directives, such as a Health Care Proxy, Living Will, or Power of Attorney, in guardianship proceedings under Article 81 of New York's Mental Hygiene Law, and as to a patient's right to consent to and/or refuse medical treatment. As such, different statutes will define capacity as it is applicable to that particular area of law.

Attorneys must make capacity judgments in at least two aspects of representation. First, the attorney must determine whether the potential client even has the capacity to retain an attorney. A retainer agreement falls within the scope of contracts and is governed by contract principles. An individual lacks the mental capacity to retain counsel if he or she lacks sufficient mind and reason for a full and clear understanding of the nature and consequences of making the contract at the time the contract is made.⁶ Then, the attorney must determine whether the potential client has the capacity to "carry out the specific legal transaction(s) under consideration."⁷

Model Rule 1.14 of the ABA Model Rules of Professional Conduct concerns clients with "diminished capacity" and suggests a duty to make informal capacity judgments in certain cases.⁸ Rule 1.14 states:

(a) When a client's capacity to make adequately considered decisions in connection with a representation is diminished, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.

(b) When the lawyer reasonably believes that the client has diminished capacity, is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a guardian ad litem, conservator or guardian.

In determining the extent of the client's diminished capacity, the lawyer should consider and balance such factors as: the client's ability to articulate reasoning leading to a decision, variability of state of mind and ability to appreciate consequences of a decision; the substantive fairness of a decision; the consistency of

a decision with the known long-term commitments and values of the client; and the irreversibility of the decision.⁹ In appropriate circumstances, the lawyer may seek guidance from a diagnostician.

Possible cognitive signs of incapacity may include: short-term memory loss; communication problems; comprehension problems; lack of mental flexibility; calculation problems; and/or disorientation. Possible emotional signs of incapacity may include significant emotional stress; emotional lability and/or emotional inappropriateness. Possible behavioral signs of incapacity may include delusions or beliefs that are unlikely to be true and/or poor hygiene.¹⁰

An attorney may be contacted by either the individual him or herself, a family member, or an otherwise concerned individual. In the first case study, the family member contacts the attorney. As the attorney, what are your prognostic issues and options? One issue is whether Maria has the capacity to revoke her legal documents, and if so, whether an Article 81 guardianship is appropriate to take control of her health care and financial decision-making. Looking at this first case study from the perspective of an attorney representing Maria herself, a potentially incapacitated individual, whose family members are involved as potential guardians, powers of attorney, and/or potential beneficiaries, the attorney is advised to consider the potential conflicts of interest, issues of confidentiality and goals of the representation.

In the second case study, the potentially impaired individual consults with an attorney on his own behalf. As the attorney, you must consider and evaluate your ethical and legal obligations to him. Important questions to consider are whether he may be exhibiting signs of dementia, mental illness, or even side effects of a medical condition, and if so, whether any of these potential ailments affect his capacity to retain and direct counsel. Should the attorney make a referral to a geriatric psychiatrist? Should the attorney consider a voluntary/involuntary psychiatric hospitalization? Or should the attorney draft the documents requested and permit him to execute them, as it seems he can focus some of the time? Either way, the attorney has challenging legal and ethical decisions to make.

B. MENTAL HYGIENE LEGAL SERVICE

Another legal actor to consider is the Mental Hygiene Legal Service (MHLS). MHLS is a legal service organized under Article 47 of the Mental Hygiene Law to provide legal assistance to patients or residents of certain facilities within New York State.¹¹ MHLS derives its statutory authority to represent clients suffering from mental illness and/or diminished capacity as a result of mental illness and/or dementia through Article 47, Mental Hygiene Law Article 81¹² and the seminal case of *Rivers v. Katz*.¹³ In a guardianship matter pursuant to Article 81, the court can appoint MHLS as counsel for the alleged incapacitated person (AIP), whether or not the individual resides in a facility, or as court evaluator.¹⁴ The court is likely to consider the appointment of MHLS where the AIP has minimal or no assets. If the AIP is institutionalized in a mental hygiene facility, then MHLS is entitled to notice of the proceeding, whether or not MHLS is actually appointed.¹⁵

MHLS, through its practice, recognizes that there are varying degrees of capacity and at times capacity can be improved and/or restored. The MHLS attorney must examine what is causing the diminished capacity, what is the extent of the diminished capacity, how the diminished capacity affects the client's ability to understand the options available, the ability to make reasoned decisions based on a risk/benefit analysis, and the ability to manage one's own affairs. The actual structure of the proposed "care plan" for each individual will be guided by the diagnosis and prognosis – for example, if a person has a dual diagnosis of mental illness and substance abuse, which is affecting his or her decision-making, enrollment in a day program that provides drug treatment and also psychiatric medications may allow that individual to live safely in the community. On the other hand, someone with dementia resulting in cognitive decline might need planning that incorporates the prognosis of dementia. That individual may need more help as time continues and the plan can be fashioned based on what we know occurs to someone suffering from that decline.

In the case studies, MHLS would potentially become involved if either Maria or Murray were hospitalized or if a guardianship proceeding was initiated for either individual. If Maria were hospitalized for treatment

of her symptoms such as paranoia, delusions, irritability, and poor self-care, or if Murray were hospitalized for treatment of his bizarre behavior, delusions, possible hallucinations, and lack of focus, as a patient in a mental health facility, they would be entitled to legal counsel through MHLS related to their care and treatment.¹⁶ If Maria's daughter, for example, initiated a guardianship proceeding against her, MHLS could potentially become involved as court-appointed counsel for Maria or as the court evaluator.

In the context of representing a patient in a mental health facility, the role of the MHLS attorney is to first meet with the client and advise him or her of the procedures for admission and retention of patients, and to inform the patient of his or her rights, including the right to have a judicial hearing, to be represented by counsel and to seek an independent medical opinion.¹⁷

In the context of representing an AIP in a guardianship proceeding, the MHLS attorney would play a similar role in meeting with the client and advising him or her about the procedures for the appointment of a guardian, informing the client of his or her rights to have a judicial hearing and to be represented by counsel, among others. The MHLS attorney, just like any other court-appointed attorney for the AIP, would want to determine the client's wishes regarding the appointment of a guardian, his or her living arrangements, and daily life. The attorney would also want to evaluate the client's ability to function in terms of his or her personal needs and ability to manage finances.

In representing the client, whether in a mental hygiene facility or in a guardianship proceeding, the attorney is driven by what would be the least restrictive form of intervention for the client.¹⁸ Any intervention should be tailored to the individual based upon whether that individual suffers from a mental illness, dementia, or another medical condition and his or her prognosis.

IV. SAMPLE LEGAL OPTIONS FOR CLIENTS/FAMILY MEMBERS WITH MENTAL ILLNESS, DEMENTIA OR OTHER COGNITIVE DECLINE

Family members, caregivers and the attorneys involved in the care of a mentally impaired individual must be familiar with the various "legal tools" designed to protect and support that individual. The legal system, working in tandem with the medical and/or mental health care system, can often offer assistance in the form of advanced directives, guardianship, and inpatient hospitalization, among others.

Advance directives are legal documents containing an individual's prior expressed wishes regarding financial affairs or medical treatment that must be executed while the individual has the requisite mental capacity.¹⁹ A *durable* Power of Attorney allows the Principal to appoint an Agent (or Attorney-in-Fact) to make certain financial decisions when the Principal becomes unable to do so.²⁰ Under a Health Care Proxy, the appointed Agent has the power to make certain medical decisions when the Principal becomes unable to do so.²¹ A Living Will can be used to provide medical treatment instructions to a doctor if the patient loses the ability to communicate.²² Advance directives are relatively simple, inexpensive to draft and execute, and can be revoked when the Principal has the capacity to do so.

In the event that an individual has not executed any advance directives, has revoked any advance directives, or no longer has the capacity to execute advance directives, family members and caregivers managing the medical, social and financial issues of their loved one may come up against significant legal roadblocks. Guardianship is a legal proceeding by which a court appoints and oversees a legal decision maker, or "guardian," for another adult, who due to incapacity or other disability, is unable to manage his or her own affairs.²³ The court can appoint a Personal Needs Guardian to make decisions such as consenting to medical care, choosing a place of abode, and determining whether the individual should travel and/or have a driver's license, among others. The court can grant the Guardian the power to

access and disclose medical and confidential records that would otherwise be protected by state and federal privacy laws.²⁴ The court can also appoint a Property Management Guardian to manage the individual's financial affairs, such as paying bills, applying for New York State and/or U.S. government benefits, and handling Medicare or Medicaid applications and claims, among others.

It is important to note that, in a guardianship proceeding, counsel for the AIP, the court evaluator, or a cross-petitioner, for example, can request that the court appoint a medical physician or psychiatrist to perform an independent medical examination.²⁵ If the application for guardianship is based upon a diagnosis of dementia, for example, such a medical exam would confirm the diagnosis and speak to the very issue of capacity and functional limitations. The role of the appointed expert would include performing the evaluation,²⁶ interviewing family members and/or caregivers, reviewing medical records and other documentation, preparing a report for the Court and potentially testifying at the guardianship hearing.

Guardianships are commonly used for the elderly, mentally ill and developmentally disabled individuals, but are often regarded as a last-resort option, since they can be expensive, time consuming, and deprive an adult of significant personal rights.

If the individual requires immediate psychiatric intervention, hospitals offer a safe setting for such treatment including observation, diagnosis, therapy and medication management.²⁷ In New York, Article 9 of the Mental Hygiene Law sets forth the legal requirements for voluntary, involuntary and emergency admission to a hospital, as well as the retention of patients pursuant to a court order.²⁸ However, families and caregivers should not have to wait until the individual decompensates and becomes increasingly symptomatic and impaired before he or she can be evaluated and treated in a hospital. In New York, family and other concerned individuals can make an application to the court for a "Mental Health Warrant," an order for immediate evaluation in an emergency room not to exceed 72 hours.²⁹

These legal tools are designed to assist family members, caregivers and the attorneys involved in the care of a mentally impaired individual while also protecting and supporting that individual.

V. CONCLUSION

Clients, family members, or loved ones come to the lawyer's office with legal queries, but often also bring with them their medical, neurological and psychiatric issues. Lawyers have a need to recognize dementia, depression and other causes of cognitive decline as it can impact the lawyer's work with the clients, drive the legal goals, dictate the plan and its execution and determine any additional components necessary to be decided on a case-by-case basis. In almost all cases involving cognitive dysfunction the most critical legal issues center around capacity.

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ENDNOTES

1. Eitan Z. Kimchi & Constantine G. Lyketsos, *Dementia and Mild Neurocognitive Disorders*, in *The American Psychiatric Publishing Textbook of Geriatric Psychiatry* (177–242) (David C. Steffens et al. eds., 5th ed. 2015).
2. *Id.* at 177–242.
3. For example, poor glucose control in diabetes affects brain function and can exacerbate the lack of focus and distractibility of dementia.
4. Hindi T. Mermelstein & Lynna Lesko, *Depression in patients with cancer*, 1 *Psycho-Oncology* 199, 199–215 (1992).
5. Downing, L., Caprio, T., Lyness, J., *Geriatric psychiatry review: Differential diagnosis and treatment of the 3 D's – delirium, dementia and depression*, *Current Psychiatry Review* 2013 (6) 365–369.
6. See Restatement (Second) of Contracts § 15 (Am. Law. Inst. 1981); 22 N.Y. Jur. 2d Contracts § 26 (2016).
7. Assessment of Older Adults with Diminished Capacity: A Handbook for Lawyers, 13, Am. Bar Ass'n, www.americanbar.org/content/dam/aba/administrative/law_aging/2012_aging_capacity_hbk_ch4.authcheckdam.pdf.
8. Model Rules of Prof'l Conduct R. 1.14 (Am. Bar Ass'n 2006).
9. Model Rules of Prof'l Conduct R. 18 (Am. Bar Ass'n 2006); see Model Rules of Prof'l Conduct R. 1.14 cmt. 6 (Am. Bar Ass'n 2006).
10. Model Rules of Prof'l Conduct R. 14-16 (Am. Bar Ass'n 2006).
11. N.Y. Mental Hyg. Law Article 47 (MHL).
12. MHL Article 81.
13. *Rivers v. Katz*, 67 N.Y.2d 485 (1986).
14. See MHL § 81.09 (McKinney 2011).
15. MHL § 81.07(g) (McKinney 2009).
16. MHL § 47.03 (McKinney 2007).
17. *Id.*
18. See, e.g., MHL § 81.03(d) (McKinney 2004).
19. For the purposes of signing an advanced directive, a person is deemed to have capacity unless proven otherwise. N.Y. Pub. Health Law § 2981(1) (McKinney 2012).
20. Without a *durable* power of attorney, family members or caregivers may have to go to court to get the authority to handle the individual's affairs should he or she lose capacity.
21. As with a guardian, in many states there are certain aspects of a person's care that may never be delegated to an agent such as the involuntary administration of psychiatric medication.
22. These treatments may include resuscitation, artificial nutrition and hydration, and mechanical ventilation, among others.

23. MHL § 81.02(a). In New York, incapacity refers to functional limitations rather than a mental or physical condition. MHL § 81.02(c) (McKinney 1992).
24. This specific power is often crucial when family members and/or caregivers need information about their loved one's medical and/or mental health care.
25. MHL § 81.09(c) (McKinney 2011).
26. Such an evaluation might include but is not limited to, cognitive tests, mental status examinations, MRI/CAT scans, laboratory tests, review of medications, and a review of medical and social history.
27. National Alliance on Mental Illness, <http://www.nami.org/Find-Support>.
28. See MHL §§ 9.13, 9.27, 9.37, 9.39 (McKinney 2016).
29. MHL § 9.43. At any time during the 72-hour period, the patient may, if appropriate, be admitted as a voluntary or involuntary patient. *Id* (McKinney 1989).