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GUARDIANSHIP AND SEVERELY CHRONICALLY MENTALLY ILL ADULTS: A MEASURE OF ADVANTAGES AND DISADVANTAGEOUS IN A PAIR-MATCHED RECORDS REVIEW

James H. Hoerchler, M.A.

A Culminating Project Presented to the Faculty of the Graduate School of Lindenwood University in Partial Fulfillment of the Requirements for the Degree of Master of Business Administration

2005

ABSTRACT

This thesis examined adults with chronic severe mental illness and the use of legal guardianship executed to protect them from harming themselves or others, while attempting to improve their overall quality of life.

The earliest manifestation of mental health law appeared in the Roman Empire. The Romans established the legal use of surrogates to handle the property and commercial affairs of disabled citizens. By the sixteenth century England had developed standards of supervision by which a guardian might supervise a disabled person. The first guardianship recorded in America was decided under English law in 1637 in Jamestown, Virginia (Goldstein, Alan and Irving Weiner 306).

For much of history persons with mental illness were treated in residential institutions. In recent years the residential populations in long-term mental hospitals and institutions has been reduced. Nationally, the patients who used to receive care in long-term institutions now live in community residences and receive their care from outpatient psychiatrists and general hospitals. When patients are admitted to inpatient wards, treatment plans are focused on acute symptom stabilization and discharge to receive follow-up and care on an outpatient basis (Mechanic 790). This system requires the participation of the patient and has predicated changes in practice, treatment and the law.

The purpose of this research was to investigate the possibility that persons with chronic severe mental illness would experience improved activities of daily living, quality of life, length of occupancy in placements, increased socialization, stabile income and higher rates of treatment and medication compliance. They report fewer hospitalizations, less alcohol and illegal drug use and abuse and fewer criminal legal difficulties.

Thirty-one subjects who had legal guardians were pair-matched to 105 non-guardianship subjects. Ninety-four data points were collected on each subject. Chi Square analysis was conducted in two formulas, traditional and McNemar's formula for small group pair-matched subjects.

Results of the analysis produced considerable evidence to suggest that the hypothesis be accepted and to conclude, within the sample pool, that persons with chronic severe mental illness with resulting poor insight and judgment benefit substantially on all measures from the oversight of a legal guardian.

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COMMITTEE IN CHARGE OF CANDIDACY:

Associate Professor Daniel W. Kemper
Chairperson and Advisor

DEDICATION

This is dedicated to my wonderful wife, Tarren Fritz Hoerchler, in most grateful appreciation of her valuable help and unwavering support.

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Preface

The psychiatric service at Barnes-Jewish Hospital will treat in excess of 2500 patients in 2004 (Barnes-Jewish Hospital Psychiatric Service Confidential Financial Report, 2004). A small number of these mentally ill patients, even when functioning at their best, will demonstrate judgment and insight so poor that they require assistance in making care decisions. These individuals have mental illnesses diagnosed as chronic and severe. Left to their own devices they stop taking medicines, cease to attend to their hygiene, eat irregularly, and seek inappropriate shelter (Guze, 1997).

These patients are in need of psychiatric treatment but ironically often actively avoid it. As their mental condition deteriorates concerned friends or family members, mental health coordinators, or police officers frequently bring them to a hospital emergency room for evaluation and treatment. If during the evaluation they refuse treatment and do not present a serious likelihood of physical harm to themselves or others, they will be treated, to the extent they allow, and released. Those convinced of their need for treatment are admitted, or more likely readmitted, to the psychiatric ward where the process of treatment planning and discharge planning begins with a review of previously failed plans. Patients who are in danger of harming themselves or others can be held involuntarily for short-term treatment and evaluation (Guze, 1997).

Missourians who are over the age of 17 possess the right to make all of life's choices presented to them. This is true unless an individual continually makes decisions that jeopardize their well-being and the court intervenes. Only the court has the power and authority to compel an individual into involuntary treatment through either an inpatient or outpatient commitment proceeding. Concerned individuals, such as doctors, social workers, lawyers, friends, or family members must present evidence that demonstrates the patient is in danger of harming herself or others.

When a patient has a long history of mental instability and behavior that endangers herself or others, those concerned can again turn to the court for legal assistance in providing some measure of control. After the proper paperwork has been filed a judge will conduct a full evidentiary hearing meant to determine the patient's competence. If the judge finds the patient to be incompetent she can appoint a legal guardian. That is, a competent individual who is adjudicated the responsibility of care and custody of the incompetent (Missouri Revised Statutes, 1999).

This project means to examine the lives, health, and functioning of 31 psychiatric patients who have legal guardians through comparison of 31 non-guardian contemporaries. Answers to two basic questions are sought. Does guardianship positively impact the stabilization of patients who possess severe chronic mental illness? Secondly, is there a measurable difference in the quality of life between patients with guardians and their non-guardian counterparts?

Chapter I

INTRODUCTION

Liberty and Justice for All: A Historical Perspective

The United States of America was founded in the late 1700's. Our forefathers fled their oppressive society to create a place where they could develop a government that would be run by and for common people. A government that would honor individual's rights and freedom. After toiling to develop a constitution, which embodied those ideals, James Madison continued writing amendments to the Constitution of the United States. Today we refer to these first ten amendments as the Bill of Rights (Grolier, 1993).

Madison and his colleagues wanted to develop and protect citizens' civil liberties. To do this they amended the constitution to insure individual rights. The most sacred of these rights were the freedom of religion, speech, the press, assembly, and petition. Additionally, they assured the security of our homes and papers against unwarranted actions by the government. Finally the authors added protections to criminal procedures which, although not absolute, included the right to a speedy trial, to a federal grand jury, to reasonable bail, to confront one's

accusers, and not to be placed in jeopardy twice for the same crime (Grolier, 1993).

With the emphasis on protection, one is led to the conclusion that the forefathers wanted to protect every citizen's rights. This was during a period in which many of the founding fathers owned human beings. It was common practice to purchase people for the purpose of enslaving them as laborers. Slavery was the original target of the civil rights movement. Idealistically, the framers forwarded the concept of equality; a concept that would not be so easily accepted or endorsed. In fact, it became the central issue of the nation's greatest internal conflict, the civil war (Grolier, 1993).

After nearly ninety years of national strife and blood shed, President Abraham Lincoln stated in his Gettysburg address, "Fourscore and seven years ago our fathers brought forth on this continent a new nation, conceived in liberty and dedicated to the proposition that all men are created equal" (Grolier, 1993). Equality remains an issue with which Americans continue to struggle to define, maintain and protect.

Unfortunately, physicians now have scientific evidence that proves all people are not created equally. Today, in utero genetic testing can reveal disease or its absence. Through these tests doctors can measure an individual's strengths and weaknesses. Society's challenge, however, continues. That is, to ensure the pledge of equal rights for every man, woman and child.

Mental Illness and Guardianship

It is against this backdrop that this investigation examines adults with chronic severe mental illness and the use of legal guardianship executed to protect mentally ill individuals from harming themselves or others, while attempting to improve their overall quality of life. Guardianship is currently the only legal process that is designed to permanently set aside a person's civil rights. Imprisoning a criminal limits their freedom, but even prisoners have civil rights. In most states of this country, if a judge rules that a person is incapacitated, or legally incompetent, she can appoint a legal guardian for that incapacitated person. This guardian becomes entrusted with the legal care and custody of the incapacitated person known as the ward (Missouri Revised Statutes, Section 475).

In Missouri the process of acquiring guardianship and conservatorship (a conservator "is a person or corporation appointed by a court to have the care and custody of the estate of a minor or a disabled person" (Missouri Revised Statutes, Section 475.010 (3)) requires full evidentiary hearings. By statute guardianship and conservatorship are two separate legal proceedings requiring separate hearings. Often both are needed for the effective management a person's welfare and well-being. This is especially true with mentally ill adults.

One then can construe the following from the Missouri guardianship laws. If a psychiatrist informs a guardian that the ward requires placement in a treatment facility the guardian is obliged to act upon this information. Guardians who are

also conservator of the patient's estate encounter fewer problems in making these decisions. The court and several state agencies monitor the conservator's performance. Complications arise when the patient has a guardian but retains the right to manage their own financial matters. In this scenario the guardian can arrange a needed placement and the patient, the ward, can refuse to pay for it. This effectively limits the guardian's ability to care for the patient and fulfill his legal responsibility (Missouri Revised Statutes, Section 475).

In St. Louis guardianship and conservatorship petitions can be filed at the same time and heard consecutively by the court. The respondent, the potential ward, is provided with an attorney if they are without financial means and cannot afford private counsel. These matters are heard and ruled upon in the probate court, usually by a judge or the judge's commissioner. Additionally, the respondent has the right to request a trial by jury. The right to a full evidentiary hearing and/or a jury trail are two of the legal safeguards in place to prevent the illegal or unnecessary revocation of a person's civil rights through guardianship (Missouri Revised Statutes, Section 475).

At first glance coming to the decision to petition the court for guardianship might appear simple. That is, if one is a minor child and, for whatever reason, finds themselves without parents or caretakers the court can appoint a guardian to look after and care for them. Similarly, if an adult as defined in the Missouri Revised Statutes,

> is one who is unable by reason of any physical or mental condition to receive and evaluate information or to communicate decisions to such an extent that he lacks capacity to meet essential requirements for food, clothing, shelter, safety or other care such that serious physical injury, illness, or disease is likely to occur (RSMO 475.010.(8))

then the court should appoint a guardian. In real life one frequently finds that these decisions present with a noticeable lack of clarity and frequently offer a great deal of ambiguity, especially when attempting to determine the capacity of an adult who is mental ill.

Understanding Mental Illness

Understanding mental illness is a complicated task because the world is an exceedingly complex place. On a daily basis people are bombarded with data and information in quantities that can be overwhelming. People are forced to simplify this information into understandable usable concepts. This process helps prevent being constantly dismayed. Unfortunately, all too often, "the process" becomes a fertile breeding ground for misunderstanding and misconception.

Many people have used the term "crazy" in the description of someone or their behavior. For example, "He is crazy to risk his marriage by having an affair." Or, "She is crazy to quit that great job to become a model." Language helps people define their world. The act of engaging in relationships, interacting with others, sets us up to be students of reality, personality and human nature.

Through this education individual's develop their layman's understanding of human behavior. Individuals decide what is rational and what isn't. They decide who's crazy and who isn't, according to their experiences, values, beliefs, and limited knowledge (Elgin, 20 – 21).

The media helps people refine their language and their worldview. For a long time the media's portrayal of schizophrenia lent layman to believe that it was some form of split personality. One personality could be loving and reasonable, while the other might be totally irrational and shockingly violent. The Bantam Medical Dictionary defines the prefix of schizophrenia, schizo as, "denoting a split or division" (398). Of course, schizophrenia is not a split personality; it is a schism from reality. Schizophrenia is a neurobiological brain disorder that profoundly alters the architecture and function of the afflicted brain. Affected are one's thoughts, emotions, movements, behavior, senses, and the ability to sort and interpret incoming sensations and to develop appropriate responses. It changes a person's perception of self and their reality (Torrey, Out of The Shadows 1 - 30).

To fully understand something, the investigator must be able to identify the thing's individual components while understanding their function, relation and purpose towards the action of the whole. This idea is true of mental illness. Currently, mental illness cannot be diagnosed through the use of a simple medical test. Medical practitioners routinely use x-rays, endoscopes, magnetic resonance imaging (MRI), positron emission tomography (PET) scans and blood tests to diagnose physical illnesses. These technologies can only occasionally confirm the

observational diagnosis of mental illness by a qualified mental health practitioner (Torrey, Schizophrenia and Manic -Depressive Disorder 99 - 103).

Diagnosing mental illness involves an elaborate process. The process to determine a diagnosis for an individual with a new onset of mental illness should include the following elements. Information should be collected concerning the patient's history. This information should be gathered from both the patient and reliable family members. Has the patient experienced hallucinations, headaches, or a recent head injury? Does she have a family history of mental illness? If so, have those individuals received and responded to treatment? A competent psychometrician should administer neuropsychological tests. The patient should receive thorough neurological and physical examinations that would include basic laboratory work, blood count, blood chemical screens, and urinalysis. Finally, the physician could order a MRI, CAT, or PET brain scan. Even with all of this information the diagnostician will observe the patient's response to treatment to confirm the proper diagnosis (Torrey, Schizophrenia and Manic -Depressive Disorder 99 - 103).

Receiving the proper diagnosis offers the patient the opportunity of getting proper treatment. But what of choice, remember the United States constitution affords citizens the freedom of choice. What if the patient does not want treatment? What if the patient does not believe he is mentally ill? This is a common feature of mental illness. The patient refuses to believe the diagnosis and subsequently refuses treatment; because he believes his delusions, hallucinations, or twisted perception of reality that his brain produces. After

being told his diagnosis and having been given treatment recommendations the patient responds, "I'm fine! You are the crazy one if you think I'm going to believe this conspiracy and take that poison you call medicine" (Guze, 15 – 25).

Herein lies the problem with which mental health practitioners wrestle. The patient is ill. The illness is impairing the patient's cognition, perception, emotions, reasoning and behavior. After a thorough assessment and evaluation the doctor believes that not only does the patient have a severe mental illness, he presents a serious likelihood of danger to himself or others. The practitioner has a treatment, which she believes will enable her patient to function more normally thereby alleviating the danger. The patient says, "No thank you".

So where is the line? What if our hypothetical doctor says, "Well, it's his right to choose." Essentially, she does nothing and hopes for the best. When should the mental health practitioner utilize the legal system? Should the psychiatrist petition the court for a short-term involuntary treatment order? Maybe she should contact one of the patient's family members or friends and inform them that he must have treatment, or she could recommend that they file for guardianship and force the patient into treatment?

This option produces an obvious violation of the patient's right to confidentiality that will almost undoubtedly be viewed by the patient as a betrayal, causing him to never engage treatment with this doctor. Breaching patient confidentiality adds to the practitioner's legal liability. By contacting anyone in the patient's world without his consent, the doctor opens the door to the substantial risk of being sued for that breach. There are times that the doctor is

compelled to warn outsiders, this is not one of them. What is the good doctor to do? She thinks the patient is ill. He thinks she and the rest of the world are in on some scheme to get him. It is a perfect stalemate.

Unfortunately, this lack of this physical evidence allows the patient and laymen to insert their own beliefs. If the patient harbors the misconception that mental illness is only a feature of ones personality and therefore is something that with determination, discipline and willpower can be controlled or cured, they will not pursue an appropriate corrective course.

So which mental illnesses are capable of rendering individual's literally and legally incompetent? Surprisingly, there are a number of neurobiological illnesses which when manifested in moderate to severe forms can impair a person to a level of incapacity. Senile onset Dementia, and Alzheimer's Disease are two conditions which commonly effect the elderly. Huntington's Disease, Down's Syndrome, Epilepsy, and Autism can impair children and adults. Always yielding degrees of impairment are Schizophrenia, Schizoaffective Disorder, Bipolar Affective Disorder, Mental Retardation, Organic Mental Disorder, and Major Depressive Disorder. Impairment due to these illnesses impact insight and judgment and is often either a circumstance of luck (that is, the nature of severity of the individual's illness) or, it is a matter of illness/symptom mismanagement.

Board Certified Licensed Psychiatrists formulated the diagnoses of mental disorder for this study. The chronically mentally ill patients of the study met DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) criteria for severe forms of Schizophrenia (Table 1), Schizoaffective Disorder

(Table 2), Bipolar Affective Disorder (Table 3), Mental Retardation (Table 4), Organic Mental Disorder (Table 5), and Major Depressive Disorder (Table 6).

Table 1

Diagnostic Criteria for Schizophrenia

A. *Characteristic symptoms:* Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):
(1) Delusions
(2) Hallucinations
(3) Disorganized speech (e.g., frequent derailment or incoherence)
(4) Grossly disorganized or catatonic behavior
(5) Negative symptoms (i.e., affective flattening, alogia, or avolition)

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. *Social/occupational dysfunction:* For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescent, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. *Duration:* Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. *Schizoaffective and Mood Disorder exclusion:* Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, manic, or Mixed Episodes have occurred

concurrently with the active-phase symptom; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. *Substance/general medical condition exclusion:* The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.
F. *Relationship to a Pervasive Developmental Disorder:* If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

Source: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (1994).

Table 2

Diagnostic Criteria for Schizoaffective Disorder

A. An uninterrupted period of illness during which, at some time, there is either a Major Depressive Episode, a Manic Episode, or a Mixed Episode concurrent with symptoms that meet Criterion A for Schizophrenia.

Note: The major Depressive Episode must include Criterion A1: depressed mood.

B. During the same period of illness, there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms.
C. Symptoms that meet criteria for a mood episode are present for a substantial portion of the total duration of the active and residual periods of the illness.
D. The disturbance is not due to the direct physiological effects of a substance (e/g/, a drug of abuse, a medication) or a general medical condition.

Source: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (1994).

Table 3

Diagnostic Criteria for Bipolar Affective Disorder

A. Presence (or history) of one or more Major Depressive Episodes.
B. Presence (or history) of at least one Hypomanic Episode.
C. There has never been a Manic Episode or a Mixed Episode.
D. The mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
E. The symptoms cause clinically significant distress or impairment in social, occupational, of other important areas of functioning.

Source: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (1994).

Table 4

Diagnostic Criteria for Mental Retardation

A. Significantly sub average intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly sub average intellectual functioning).
B. Concurrent deficits or impairments in present adaptive functioning (i.e., the person's effectiveness in meeting the standards expected for his or her cultural group) in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, work, leisure, health, and safety.
C. The onset is before age 18 years.

Code based on degree of severity reflecting level of intellectual impairment:

317	Mild Mental Retardation:	IQ level 50-55 to approximately 70
318.0	Moderate Mental Retardation:	IQ level 35-40 to 50-55
318.1	Severe Mental Retardation:	IQ level 20-25 to 35-40
318.2	Profound Mental Retardation:	IQ level below 20 or 25
319	Mental Retardation, Severity Unspecified: when there is strong presumption of Mental Retardation but the person's intelligence is untestable by standard tests.	

Source: <u>Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition</u> (1994).

The diagnosis of Organic Mental Disorder was established for DSM III, during a time, which the etiology of certain mental disorders was unknown. It encompasses a group of illnesses for which either the cause is unknown, or is caused by the patient ingesting a known substance. Not much has changed toward the understanding of etiology, even with the advancements of medical science technology. The etiology is still unclear. However, the diagnosis is no longer listed in the DSM IV (Yutzy, 2000). Functionally, these disorders can be grouped into three categories. First, there are the brain disorders related to aging. These include Dementias Arising in the Senium and Presenium (Primary Degenerative Dementia of the Alzheimer Type and Multi-infarct Dementia).

Diagnosis then was a matter of observing, cataloging, and attempting to confirm a patient's functional limitations through neuropsychological testing. Remember, MRI, PET, and CAT scans were not available for these diagnostic purposes in 1980. Interestingly, today with these technologies doctors are quite able to determine the area and extent of brain damage or dysfunction. However, physicians are still uncertain as to the issue of etiology (Yutzy, 2000).

The second group encompasses the various Psychoactive Substance-Induced Organic Mental Disorders. Included in this category are; Intoxication, Withdrawal, Delirium, Delusional Disorder, Mood Disorder, and Other Syndromes. Finally, there are those disorders whose etiology or pathophysiologic

process is due to a physical disorder or condition, or is unknown. Listed with these disorders are conditions ranging from viral infection to brain tumor.

A sad but interesting example of a patient initially diagnosed with Organic Mental Disorder is the case of John North. The information for this case example was gleaned from interviews with the patient, (who's name and identifying data has been changed to protect his true identity) the patient's wife, mother, psychiatrist, neurologist, social worker, and attorney (North, 1999). John was a 46-year-old self-employed businessman with no previous history of mental illness. As a teenager he graduated high school and after a few semesters of college joined the United States Armed Services and fought in Vietnam. He married a Vietnamese woman who was pregnant with his child. They divorced shortly after he returned to the United States. During his tour of duty he developed business interest in the area of antique sales. John married for the second time at the age of forty. One evening he and his second wife were attending a party. Mr. North was on a balcony with other guests. As he leaned back against the railing it gave way and he fell twenty feet to the concrete below, landing on the back of his cranium. The result for Mr. North was a closed-head injury (North, 1999).

When his wife reached him, Mr. North was unconscious. He had a few minor scalp lacerations and a sizeable lump on the back of his head but did not regain consciousness. Mr. North was rushed to the hospital. He remained hospitalized in a coma for a week. He was diagnosed with closed-head trauma. CAT scans revealed bruising to both the posterior and anterior portions of his brain. His prognosis was hopeful. When Mr. North awoke from his coma he

experienced mild language impairments and mild to moderate motor skill problems. Initially, he did not recognize his wife. After 9 months of speech therapy, physical therapy, and occupational therapy he appeared to be recovering well (North, 1999).

One afternoon he arrived at the Neuro Rehabilitation Clinic for his regularly scheduled appointment with a duffel bag. When asked about the contents of the bag he told the therapist that he had $14,000.00 in cash for an antique deal he was about to close. The therapist asked him if it worried him to carry such a large sum of money. He said, "No" and reached into the bag and took out a small caliber handgun. Frightened at this development she asked John to put the gun away. To her surprise he became agitated. John began to accuse her of conspiring with his wife to ruin his business. The more she pled, the angrier he became. Coworkers overheard John yelling and the therapist pleading and called hospital security. After lengthy negotiations John gave the pistol to the security officers. They secured John and transported him to the inpatient psychiatric unit (North, 1999).

The psychiatric treatment team reviewed the patient's medical records, interviewed the patient, his wife, and his mother in an attempt to ascertain Mr. North's condition. Mr. North insisted that he was fine. He had no memory of the party or the fall. He could recall little of his recovery. Mostly he wanted to talk about his business and his fear that his wife was undermining him and ruining his business. He was perplexed as to why she would do this, and could not offer reason, motive, or evidence to support these accusations (North, 1999).

John's mother did not like his second wife and was extremely verbal about this. Like her son, she could offer only vague suspicions without any proof of wrongdoing. Mrs. North blamed John's wife for the accident and was upset that she did not have enough money to travel from Tennessee to be by his side in the hospital and at his home for his recovery. Mother North held her son in high esteem and touted his grand accomplishments. His wife provided the best information concerning the patient's premorbid and post fall functioning (North, 1999).

Mrs. North told the team that she and her husband ran a small antique business. The antique market had been poor for the last couple of years. The accident was the final blow. Unfortunately, Mr. North had canceled their health insurance prior to the accident without Mrs. North's knowledge. The accident rendered them incapable of running the business and their medical bills were mounting. Mrs. North said her husband's recovery was slow and untoward. She stated that his mood was labile, his memory was poor, he appeared to have extreme difficulty concentrating, he exhibited great difficulty conversing on topic, he was grandiose, and was subject to bouts of rage. The patient was no longer able to attend to many of his activities of daily living (North, 1999).

Additionally, he had little appetite and was losing weight. He experienced great difficulty sleeping, seemed preoccupied with ideas that "someone was out to get him," and on several occasions accused his wife of sleeping with other men. During two of these confrontations Mr. North threatened to kill his wife and became enraged to the point of hitting her. These were dramatic changes to the

patient's functioning. Prior to the accident Mrs. North described her husband as a mild mannered intellectual type who loved art and reading. Two weeks prior to the Neuro clinic incident Mrs. North moved out of the couple's home of 5 years because she was afraid her husband would harm her (North, 1999).

On the advice of their personal injury attorney, Mrs. North sought and became guardian ad litem for her husband. Ultimately Mr. North was diagnosed with the DSM IV equivalent of a DSM III organic mental disorder. He was diagnosed with bipolar affective disorder--mixed, secondary to closed head trauma injury. Through the course of several legal proceedings a legal guardian and conservator was appointed. Mr. North's anger, mistrust and disdain for his wife worsened. Two years after the accident, with great regret and after all other options were tried and failed Mrs. North divorced Mr. North (North, 1999).

As can be see from a review of the criteria listed below in Table 5 Mr. North meets criteria 2, 3, and 4.

Table 5

Diagnostic Criteria for Organic Mental Disorder

1. Delirium and Dementia, in which cognitive impairment is relatively global;
2. Amnesic Syndrome and Organic Hallucinosis,* in which relatively selective areas of cognition are impaired;
3. Organic Delusional Syndrome* and Organic Affective Syndrome,* which have features resembling Schizophrenic or Affective Disorders;
4. Organic Personality Syndrome,* in which the personality is affected;

5. Intoxication and Withdrawal, in which the disorder is associated with ingestion or reduction in use of a substance and does not meet the criteria for any of the previous syndromes (Strictly speaking, these two Organic Brain Syndromes are etiologically rather than descriptively defined.);
6. Atypical or Mixed Organic Brain Syndrome, which constitutes a residual category for any other Organic Brain Syndrome not classifiable as one of the previous syndromes.
   (This manual does not divide the Organic Brain Syndromes into psychotic and nonpsychotic or acute and chronic [irreversible] forms, as have other classifications. Whereas these distinctions were made on the basis of severity, mode of onset, and presumptions concerning prognosis, the present classifications is based on clinical syndromes alone. Delirium may, however, be said to be roughly equivalent to the DSM-I concept of acute brain syndrome, and Dementia, to that of chronic brain syndrome.)

Source: Diagnostic and Statistical Manual of Mental Disorders, Third Edition (1980).

Table 6

Diagnostic Criteria for Major Depressive Disorder

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

   Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

   (1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.
   (2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
   (3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

(4) Insomnia or hypersomnia nearly every day
(5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness of being slowed down)
(6) Fatigue or loss of energy nearly every day
(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

A. The symptoms do not meet criteria for a Mixed Episode (see p. 335).
B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
C. The symptoms are not due to the direct physiological effect of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
D. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairments, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Source: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (1994).

Through research and clinical practice it was determined that individuals with the above listed 6 diagnoses often suffer levels of cognitive impairment significant such that they became incapacitated. When left to their own devices those incapacitated individuals lose the ability to find food and clothing, medical care and medications, and exhibit an inability to maintain adequate living environments. One anonymous patient wrote this poem about her mental capacity.

My mind is a November wood
Black and bare and cold
In which leafless skeletons
Rattle dismally.
I have covered its desolation
With a white snow blanket,
Praying that someday
Spring might return to it again
(Anonymous, 1995).

Patients, their family members, health care providers and their concerned fellows of the legal community continually seek solutions to the problems that arise from these losses of capacity. Those close to incapacitated mentally ill adults often find it difficult to helplessly watch as the patient deteriorates to the point of destruction. Fortunately, science provides new information concerning neurology and neurofunctioning almost on a daily basis. Following these better understandings are better treatments and medications. Unfortunately, all too often these interventions fall woefully short of providing the sanity these patients require. The illness robs them of rational thought replacing reality with some twisted version of truth. Reality shifts like sand in a desert storm leading to paranoia and withdrawal. Frightened, they hide within themselves from the world questioning everything they see, hear, know and feel.

Given the level of medical technology and the understanding of brain functioning in the 18th century, it is difficult to imagine that the country's

forefathers could have foreseen the legal and medical dilemmas the citizens now face. In our century we are being forced to choose between individual rights and the protection of the individual and the community.

Who would believe that a quiet shy schizophrenic college professor, Theodore "Ted" Kaczynski, could be the infamous Unabomber? Some people harbored concerns for 42-year-old Russell Eugene Weston, Jr. The United States Secret Service maintained an open file on Weston because of his ongoing threats to kill the President (Lehrer, 1998). After a 13 year poorly fought battle with schizophrenia, he entered the United States Capitol building east entrance and on, July 24, 1998, gunned down two armed policemen (Lehrer, 1998). Who could have imagined that 32 year-old Kendra Webdale would die instantly at the hands of Andrew Goldstein when he pushed her in front of a speeding subway train on that cold January afternoon in 1998 (Chamberlain, 1 - 3). Later it would be reported that Goldstein, a medication non-compliant schizophrenic with 13 years of treatment, had "fallen between the (healthcare) cracks" (Collins, 1998).

There are many people who could have predicted these violent outcomes. They just could not predict them with any degree of certainty. Forensic psychiatrist Susan Boyer quotes Ennis and Litwack's 1974 study which states psychiatrist are no better than social workers, correction officers or high school teachers at predicting dangerousness. In her 1999 Psychiatric Grand Rounds presentation she also reviewed Resnick's 1997 study findings that psychiatrist over-predict violence by a false positive rate of 40% to 95% (Boyer, 2 - 5). These questions of prediction and certainty, of individual rights versus the safety of one

or others, are central to this research. Can a legal process help the severely chronically mentally ill? Can guardianship provide the necessary control of an individual? Is it fair to impose guardianship on a ward knowing that the very process eliminates the wards civil rights?

This research will investigate individuals who have chronic severe mental illness with persistent symptoms, which reduces their insight and judgment to a degree that they are prevented from receiving and interpreting information in a functional way. So dramatic are the cognitive changes in these patients that they frequently exhibit the inability to make appropriate decisions concerning their activities of daily living which affects, not only their quality of life, but their health and welfare. Because of this reduced capacity, these individuals often are at risk of endangering their lives and/or the lives of others. Hopefully, research results will help mental health care providers when faced with the decision of curtailing a patient's personal freedom to ensure the safety of the patient and the community in which he lives.

Let us begin this investigation from an anonymous patient's point of view.

There is a madness in thoughts
That can never be spoken.
They clamor inside like madmen
Screaming behind cold steel bars;
Though you bind them with
manacles, chain them down with great force,
Still they are shrieking; they scream
"Let us out!" "Let us out!"
And you fear that some day the
cell sentinels,

Will be waylaid by those howling
maniacs,
And they will rush forth and
betray you,
Betray you to all whom you love
(Anonymous, 1995).

Chapter II

LITERATURE REVIEW

Guardianship: Is it a Legal Intervention or an Intrusion into Personal Liberties To Manage People Who Cannot Manage Themselves

The earliest manifestation of mental health law appears in the Roman Empire. They established the legal use of surrogates to handle the property and commercial affairs of disabled citizens. By the sixteenth century England had developed standards of supervision by which a guardian might supervise a disabled person. The first guardianship recorded in America was decided under English law in 1637 in Jamestown, Virginia (Goldstein, Alan and Irving Weiner 306).

Robert Martensen reports in a 1995 JAMA (The Journal of the American Medical Association) article "Our oldest medical specialty, psychiatry (then called "alienism"), took official form in 1844 when 13 physicians who directed asylums for the "insane" formed the Association of Medical Superintendents of American Institutions for the Insane (AMSAII), the forerunner of the American Psychiatric Association" (923). The group proposed a new approach to the treatment of the insane that they called the "moral" approach. The treatment methodology was based on the work of Doctor William Tuke's retreat model.

The model removed afflicted individuals from their homes and families to house and treat them in institutions. The approach was initially supported publicly and privately because the providers deemphasized the use of drugs and physical restraints. Providers boasted "cure" rates ranging from 70% to 90% (923). An early group of neurologists from both the United States and Europe including Edward Spitzka, MD, J. Crichton Browne, MD, Emil Kraepelin, MD, and Alois Alzheimer, MD disagreed. They viewed "insanity" as a disease of the brain and nerves. As such, treatment would require medical pharmacological intervention. Neurologists, and JAMA editorialist, Edward Spitzka wrote "in 1874 that institutional psychiatrists were experts at everything except the diagnosis, pathology, and treatment of insanity" (924).

The reality is that the patients were not cured they were boarded. Boarding of these individuals became an expensive proposition and a social political issue (923-924). Similar models were investigated by Doctor DE Riggs. He inspected programs in Europe, Gheel, Belgium, and Scotland. He especially liked the Scottish program that featured farm-like board-and-care practices. However, he doubted the system could work in America. Martensen noted, "that Riggs thought America had the political will and character to establish a decentralized and well-administered system that treated chronically mentally ill patients with dignity and respect" (924). Martensen concluded, "If Riggs walked the streets of our major cities today, he would discover, alas that time has proven him right (924).

Michael Jarvis, MD reported in his Washington University Grand Rounds lecture that the Washington University Psychiatry staff developed and forwarded the "medical" model of psychiatry in the 1950's (2004). It was one of the many changes since the 1800's. David Mechanic, PhD reported in an article in the Archives of General Psychiatry,

> In recent years the continuing reduction of residential populations in long-term mental hospitals, hospital closures and mergers, managed care, and an increasingly competitive marketplace have transformed the psychiatric inpatient sector. Resident populations in public psychiatric hospitals fell to less than 80,000 in the 1990s. In contrast, the number of specialized psychiatric units in general hospitals increased from 664 to 1516 between 1970 and 1992 and the number of private mental hospitals more than tripled, with inpatient admissions quadrupling. Most Americans are now in behavioral health care programs and most persons with severe mental illness (SMI) reside in the community commonly with Medicaid coverage. Medicaid managed care enrollment has been growing rapidly, increasing from less than 10% in 1991 to 48% in 1997. The consequences of these changes are poorly understood (1998).

What is understood is that across the county there is a decrease in the number of public mental hospitals, and long-term institutions, and the dollars available for care are shrinking. St. Louis Post Dispatch columnists, Joe Scott, authored an article on May 5, 2005 concerning Missouri's Medicaid changes. He reported,

> Governor Matt Blunt signed a bill April 26 that would cut $250 million from the state's Medicaid program, require lower incomes for eligibility and provide for eligibility verification. Missouri would save $93 million in expenditures from the general revenue. But it would lose about $157 million in revenue from federal funds. Nearly 100,000 people statewide would lose Medicaid coverage by 2007 (St. Louis Post Dispatch 2005).

Nationally, the patients who used to receive care in those long-term institutions now live in community residences and receive their care from general hospitals. When patients are admitted to inpatient wards, treatment plans are focused on acute symptom stabilization and discharge (Mechanic 790). Changes in practice and treatment have predicated changes in the law.

The twentieth century in America has produced the most change to the mental health and guardianship laws with the majority of those changes being concentrated through the last thirty years of the century (Frost, Lynda and Richard J. Bonnie 2001). Frost and Bonnie reviewed the precipitating factors that led to these changes in the preface of the text they edited, <u>The Evolution of Mental Health Law</u>.

> Three decades ago, mental health law did not exist as an identifiable field of specialized research or practice. Psychiatric hospitals and facilities for people with mental retardation carried on their activities without much guidance or limitation by the law, and the interest of people with mental disabilities had relatively skimpy legal protection. In the late 1960s and 1970s however, innovative attorneys brought and won novel cases on behalf of people with mental disabilities. In the beginning, this litigation was understood as an effort to reign in the unchecked power of mental health professionals over institutionalized patients and residents. State

> legislatures drafted detailed mental health codes, and state departments of mental health found it necessary to craft policy according to emerging legal principles and requirements enunciated by courts and legislatures. More recently, a body of legal protections for people with mental disabilities outside institutions has begun to emerge (xiii).

Seeds of this revolution were planted in the 1950s by the parents of mentally retarded children. These brave people overcame their guilt and shame and fought for the rights of their mentally retarded children in a social-political environment that was openly hostile toward them. Attorney Robert Burt believed the clearest example of this hostility was found in the now famous 1927 U.S. Supreme Court decision, Buck v. Bell, written by Oliver Wendell Holmes.

> 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 … 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 … Three generations of imbeciles are enough (16).

The decision legalized the sterilization of disabled individuals. From where did these parents draw their strength to fight the Supreme Court? They drew from Black Americans who were no longer willing to be unseen, unheard and unrecognized. Black Americans took their fight to the streets and to the legal

system and did not stop fighting until they had gained legitimate legal status and standing (15-28).

Robert Burt was involved in the legal health care revolution through his 1972 representation of Louis Smith. Mr. Smith was charged but not convicted of rape and murder when he was a teenager. As an alternative to prosecution his parents asked to have him civilly committed. The state of Michigan did so for eighteen years. Of all the individuals in the state of Michigan who were convicted of first degree murder during that time the longest sentence served was sixteen years (12). This case highlighted the nation-wide practice of the confinement of individuals considered to mentally abnormal under the guise of medical treatment and beneficent paternalism. Smith was labeled a criminal sexual psychopath. As such, he was untreatable. Absent treatment the courts decided he no longer met the treatment criteria for civil commitment and released him (14-16).

These pivotal cases paved the way for the mental health clinicians, legal professionals and society to develop legal options to protect persons with mental retardation and mental illness. Additionally, laws and procedures were developed that protected the citizenry from incapacitated individuals and incapacitated individuals from themselves. A focus on preserving personal rights was central to the process.

To these ends five options are currently available and supported by Missouri law. Do nothing, that is, evaluate the patient under a practice of equal citizenship and allow that person to make their own decisions (Schopp 39). The second option would be to employ the Emergency Medical statute for use in

providing life-saving medical treatment without the consent of the patient. Two physicians have this authority only after they have evaluated the patient and determined that he is physically or mentally incapacitated and in need of "emergent life-saving" treatment. Their evaluations and treatment decisions must be documented in the patient's medical record prior to the provision of care (Missouri Revised Statute, 475.125).

If a person is determined to be incapacitated by reason of mental defect or disease and they present a likelihood of physical harm to themselves or others they can be civilly committed (Schopp 39). Civil commitment is the third option. According to St. Louis City Circuit Attorney, Timothy Finnegan, to meet the first criteria of civil commitment the patient must exhibit signs and symptoms of a diagnosed mental disorder. It is not enough that a person have a previous history of mental illness. To be civilly committed the individual must be in an active episode of their mental illness. Harm, to self or others, is the second criteria. States differ in their definition of harm (2005).

Missouri has two definitions and sets of standards of harm. The first standard of harm pertains to a person who is physically located in the community. To meet the harm criteria allowing forcible apprehension and detention from the community the individual must exhibit "imminent" dangerousness (2005). Commissioner Kenneth Feretti of the St. Louis City Probate Court defines imminent as "a gun, a knife, or a noose in their hand with the ability and intent to use it" (2003). The second, and less stringent, definition and standard of harm is employed when a person with active mental illness is anywhere on the property of

a hospital or mental health facility. In these situations the harm criterion changes to a "serious likelihood" of physical harm. Feretti defines serious likelihood as harm potential "based upon their behavior over the last 30 days, and to within a degree of medical certainty, that this individual could physically hurt themselves or others if left untreated" (2003). As stated and defined the purpose of civil commitment is protection (Schopp 39-43).

Option four is that of the Advanced Directive. Advanced Directives (also referred to as a Living Will) are documents drawn up by an individual prior to their loss of capacity. Within this document the person names a successor to their decision making authority and expresses their health care wishes. Often included are directives concerning emergent treatment within set parameters and guidelines pertaining to the cessation of treatment. When Advanced Directives are provided to a treating physician she is obliged by law to place a copy of this document in the patient's chart and will usually write an accompanying order in the patient's medical record pertaining to this subject. The medical community commonly referred to this as a "DNR" (Do Not Resuscitate) order because it directs the treatment team as to when to stop life-saving measures (Missouri Attorney General's Office, 2005, Communicating About the End of Life section 2004).

Advanced Directives were forced to the front of the social stage in the 1990's by a Missouri case. Nancy Cruzan was an 18 year-old who sustained severe injuries in a car accident. So severe were her injuries that she laid in a hospital in a persistent vegetative state. After all hope of recovery was lost by her parents they requested to terminate her artificial nutrition and hydration. The

Cruzan's reasoned that they had the right to make this decision under federal law and further stated that they knew that their daughter would not want to continue her life in this state. The hospital refused to honor the Cruzan's request without a court order. Eventually the Supreme Court would decide the case (Legal Information Institute. Online. 2005).

Another development to the Advanced Directive concept is a specialized document called a Psychiatric Advanced Directive (PAD). This document is meant to direct psychiatric care in the event of psychiatric incapacitation. The state of Missouri has yet to legally acknowledge these documents, but 20 other states have legally accepted them (Duke University Program on Psychiatric Advanced Directives. Online. Overview of Psychiatric Advanced Directives in the United States. 2005).

The National Alliance for the Mentally Ill (NAMI) is a client centered organization and therefore a strong supporter of the PAD movement. They suggested that persons with mental illness develop a PAD to preserve their wishes and autonomy through their named surrogate decision maker instead of leaving those decisions to health care providers or the court (NAMI. Online. "Psychiatric Advanced Directives: An Overview." 24 April. 2005).

According to Barnes-Jewish Christian corporate attorney, Jennifer Hardester,

> There are two problems with Advanced Directives. They are revocable on the word; Meaning that an individual can revoke the agreement just by saying so. The second issue is that the Missouri Statutes are silent on the issue of POAs [Power of Attorneys] authorizing psychiatric inpatient hospitalization (2004).

Legal guardianship is the fifth process available to address capacity issues. It is the most extreme measure and is used when a person is incapacitated by physical or mental illness to the degree that they can no longer take in information for the use of finding the basic elements of food, clothing and shelter and the maintenance of their well being (O'Donohue, William and Levensky, Eric R. 216-227).

Standards of Care: Respect Their Choice or Set it Aside

Care providers are faced with the "do nothing" dilemma regularly. This dilemma occurs when a patient presents for an appointment or a hospital admission. The treatment provider assesses the patient's symptoms and develops a diagnosis. Based upon this diagnosis the provider recommends treatment courses, possible plans and interventions. The care provider believes the patient will choose the treatment most likely to resolve the symptoms and its underlying disease. The dilemma occurs when the patient who is seemingly competent, refuses rational treatment. Bernard Lo highlights this process in the case of Mrs. C. The patient is

a 78 year-old widow with mild dementia, is admitted for congestive heart failure and angina pectoris that has progressed despite maximal medical therapy (2). In the past 3 years, she has suffered two myocardial infarctions. Her physician recommends coronary angiography and, if possible, angioplasty (82).

Mrs. C refuses treatment and her cognitive condition declines while she is hospitalized. The physician consults the patient's closest living relative, her nephew. His normal involvement with his aunt is minimal. He pays a person to shop, clean and cook for her. The nephew is reluctant to intervene so the treatment team persists in questioning the patient about the treatment until she consents. The morning of the procedure Mrs. C changes her mind and refuses the treatment. Faced with this refusal the physician called for a psychiatric consult. Mrs. C declined to complete the psychiatric evaluation stating, "I'm not crazy" but the psychiatrist collected enough information to determine that the patient was obviously impaired. Presented with this information and a request to consent on her behalf the nephew again declined (82). Lo points out "Her refusal did not seem so unreasonable to some physicians and nurses [because of her age and her concern that she might not survive the procedure]. Furthermore, some nurses asked why her consent to angiography was not questioned, only her refusal" (82).

This question strikes at the heart of the issue. People are likely to disagree on the issues of seriousness, risks versus benefit, treatment choices and treatment

refusals, but most of all, they will debate the meaning of capacity (83). Incapacitated is defined by the state of Missouri in the Revised Statutes, Chapter 475, the Probate Code—Guardianship, Section 475.010, Definitions.

> [An] "Incapacitated person", one who is unable by reason of any physical or mental condition to receive and evaluate information or to communicate decisions to such an extent that he lacks capacity to meet essential requirements for food, clothing, shelter, safety or other care such that serious physical injury, illness, or disease is likely to occur. The term "incapacitated person" as used in this chapter includes the term "partially incapacitated person" unless otherwise specified or apparent from the context (9).

Unfortunately, the criteria listed in the definition are subjective. By this definition should Mrs. C be declared incapacitated due to the dementia, the failed psychiatric mental status exam, and her perceived lack of ability to receive and evaluate information? The doctor could reason, "She just doesn't understand that this procedure will improve the quality and longevity of her life." Her nephew pays someone to meet her essential requirement for food. Does this make him a nice person, or does it prove that she can no longer meet her essential requirement for food. Does she understand that the angiograph will relieve her chest pain? Lo states the treatment team was unable to make these determinations. He asserted that it is normal for people to ponder decisions, but excessive vacillation back-and-forth is a demonstration of the inability to make a decision (85).

Some view this issue from the prospective of the rationality of the decision. In this case the matter becomes how rationality is defined. In a psychiatric setting "rational" could imply that one is free of delusions (fixed false beliefs) and hallucinations (hearing things that others do not hear, or seeing things that others do not see). Another measure of rationality in the psychiatric setting is the observance or purposeful goal directed behavior that is appropriate and consistent. The simplest test of rationality might be, "what a reasonable person might choose in the situation" (86).

What constitutes a reasonable decision? Bernard Lo offers another case to ponder. Seventy-two year-old Robert Quackenbush withdrew his consent to have his gangrenous legs removed. He was evaluated by two psychiatrists. Both testified at his probate court hearing for the purpose of determining his legal competence. While testifying the first psychiatrist stated that Mr. Quackenbush had organic brain syndrome accompanied by disorientation to place and people, visual hallucinations, and psychosis. He conceded that the psychosis may be due to the gangrene infection. The second psychiatrist testified that the patient had poor train of thought, but no hallucinations. He stated that the patient knew that his legs were gangrenous and that Mr. Quackenbush understood the severity of his condition. The judge interacted with the patient and found his interaction similar to that of other 72 year-olds in his situation. Mr. Quackenbush did not want his legs amputated. He hoped for a miracle but realized that there was not much chance of that. The court ruled in favor of Mr. Quackenbush's decision. The

judge found that even though the patient had an abnormal mental status he was competent to make his own medical decisions (85-86).

Emergent Medical Treatment

In 1986 the Federal Government through the Health Care and Finance Administration (HCFA) passed the Emergency Medical Treatment & Labor Act (EMTALA). The agency has changed its name to CMS (Centers for Medicare & Medicaid Services). CMS summarizes EMTALA thusly.

> In 1986, Congress enacted EMTALA to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented (CMS 2005).

EMTALA specifically addresses the treatment of psychiatric patients. Persons who present to a hospital with psychiatric symptoms must be stabilized prior to discharge or release. If the hospital does not provide psychiatric care, the patient must be "stable for transfer". When is a person who is severely depressed and

has just committed a serious suicide attempt, stable? How is stability measured in the case of a person who has severe schizophrenia with chronic command auditory hallucinations to commit murder? Neither EMTALA nor CMS provides a definition or guideline for the term stable. The Missouri Statutes do not address the issue.

In accordance with the EMTALA, Missouri has responded with the development of its own emergency medical statutes. These three laws set out the legal framework for treating individuals who lack the capacity to consent. Chapter 431 outlines who may consent and when they may consent.

Table 7

Consent to Surgical or Medical Treatment, Who May Give, When.

431.061. 1. In addition to such other persons as may be so authorized and empowered, any one of the following persons if otherwise competent to contract, is authorized and empowered to consent, either orally or otherwise, to any surgical, medical, or other treatment or procedures not prohibited by law:
(1) Any adult eighteen years of age or older for himself;
(2) Any parent for his minor child in his legal custody;
(3) Any minor who has been lawfully married and any minor parent or legal custodian of a child for himself, his child and any child in his legal custody;
(4) Any minor for himself in case of:
(a) Pregnancy, but excluding abortions;
(b) Venereal disease;
(c) Drug or substance abuse including those referred to in chapter 195, RSMo;
(5) Any adult standing in loco parentis, whether serving formally or not, for his minor charge in case of emergency as defined in section 431.063;

(6) Any guardian of the person for his ward;
(7) During the absence of a parent so authorized and empowered, any adult for his minor brother or sister;
(8) During the absence of a parent so authorized and empowered, any grandparent for his minor grandchild;
(9) "Absence" as used in (7) and (8) above shall mean absent at a time when further delay occasioned by an attempt to obtain a consent may jeopardize the life, health or limb of the person affected, or may result in disfigurement or impairment of faculties.
2. For purposes of consent to hospitalization or medical, surgical or other treatment or procedures, a "minor" shall be defined as any person under eighteen years of age and an "adult" shall be defined as any person eighteen years of age or older.
3. The provisions of sections 431.061 and 431.063 shall be liberally construed, and all relationships set forth in subsection 1 of this section shall include the adoptive and step-relationship as well as the natural relationship and the relationship by the half blood as well as by the whole blood.
4. A consent by one person so authorized and empowered shall be sufficient notwithstanding that there are other persons so authorized and empowered or that such other persons shall refuse or decline to consent or shall protest against the proposed surgical, medical or other treatment or procedures.
5. Any person acting in good faith and not having been put on notice to the contrary shall be justified in relying on the representations of any person purporting to give such consent, including, but not limited to, his identity, his age, his marital status, and his relationship to any other person for whom the consent is purportedly given (Missouri Revised Statute. 461.061).

Note that the statute does not address the (medical or psychiatric) reason for the lack of capacity. It would appear that the Missouri legislators want to ensure compliance with EMTALA and are giving treatment providers legal options for doing so. Evidence of this notion is found in Section 9 subsection 3 stating "431.061 and 431.063 shall be liberally construed."

Statute 431.063 drills down farther and instructs medical professionals to treat even when consent cannot be obtained. The caveat to this is the definition of emergency.

Table 8

Implied Consent, When Valid--Lack of Consent, When Excused--Emergency Defined.

431.063. In addition to any other instances in which a lack of consent is excused or in which a consent is implied at law, a consent to surgical or medical treatment or procedures shall be implied where an emergency exists if there has been no protest or refusal of consent by a person authorized and empowered to consent, or, if so, there has been a subsequent change in the condition of the person affected that is material and morbid, and there is no one immediately available who is authorized, empowered, willing and capacitated to consent. For the purposes hereof, an "emergency" is defined as a situation wherein, in competent medical judgment, the proposed surgical or medical treatment or procedures are immediately or imminently necessary and any delay occasioned by an attempt to obtain a consent would reasonably jeopardize the life, health or limb of the person affected, or would reasonably result in disfigurement or impairment of faculties (Missouri Revised Statute. 461.063).

Again this statute is silent on the matter that might require a surrogate to consent to medical care or surgery. However, the statute does clearly define emergency.

The final statute concerning emergent medical treatment does not directly address the issue of capacity. It clarifies when emergent procedures may be performed on individuals who have been adjudicated incompetent. People who

have been adjudicated incompetent are called wards because they are legally a ward of the state. The probate court and judge names an appropriate guardian. The guardian takes a sworn oath to make decisions that are appropriate for the ward's care and wellbeing (Feretti 2003).

Table 9

Medical and Surgical Procedures--Consent--Emergency.

475.123. 1. No medical or surgical procedure shall be performed on any ward unless consent is obtained from the guardian of his person except as provided in subsections 2 and 3 hereof.
2. If the life of the ward is threatened and there is not time to obtain consent, a medical or surgical procedure may be performed without consent after the medical necessity for the procedure has been documented in the medical record of the ward.
3. If the life of a person is threatened and his consent to a necessary medical or surgical procedure cannot be obtained, a court, on petition filed pursuant to section 475.060, after hearing, may authorize consent on behalf of such person.
4. Any hearing conducted pursuant to subsection 3 of this section, involving a life threatening medical emergency, may be conducted within or without the county at the medical facility where the person has been admitted with such notice and in such form as is practicable considering the time limitations imposed due to the condition of person. The fact of attempted oral notice to persons interested in the welfare of the person shall be made a part of the record of the hearing (Missouri Revised Statute. 475.123).

Also missing in this statute is the mention of psychiatric treatment. All three of the statutes reference medical treatment and surgical procedures. It is

clear then that the State of Missouri wishes to treat psychiatric issues and their treatment separately (RSMO 457.010 (17) 2004).

Involuntary Detention and Treatment

St. Louis attorney, Kenneth Bean specializes in health care law. Mr. Bean addressed the topic of Involuntary Detention and Treatment in materials that he authored for a 1995 presentation.

> Missouri has a statute which allows detention of a patient for 96 hours upon court order or the request of the local mental health coordinator followed by more formal hearings if the patient is still a threat to him/herself or to others. RSMo. 632.300 et seq. However, I believe that the statute is permissive; there is no statutory duty for a physician, nurse, or mental health professional to detain or seek the detention of a suicidal or homicidal patient (D3 1998).

On January 15, 2004 the Missouri Department of Mental Health, in conjunction with, The Missouri Hospital Association provided a conference for members on the topic of EMTALA and Psychiatric Patients. Richard Gowdy,

PhD facilitated the conference. He started the day stating, "Compared to the rest of the country, Missouri has one of the most comprehensive sets of involuntary laws, we hope to help you understand them better with the material presented and discussion here today". The laws to which Dr. Gowdy referred are housed in Chapter 630 Department of Mental Health, Chapter 631 Alcohol and Drug Abuse, and Chapter 632 Comprehensive Psychiatric Services.

These statutes provided the outline for the legal treatment of persons with mental retardation, alcohol and substance issues and mental illness. Chapter 632 clearly defined the treatment of person with mental illness. This chapter addressed; who may be treated, who may treat them, where and when they can be treated, and the length of treatment. Additionally, legal issues pertaining to the paperwork that must be filed, filing timelines and the regulations regarding court proceedings are detailed within (Chapter 632 2004).

Section 632.105 states that a private or public facility shall accept a patient if the program provides the appropriate service and has space available. Adults, adolescents and children should ideally be admitted to their own programs. The statute only delineates between 18 and older and 18 or younger. The statute details which illnesses can be treated, "If a person is diagnosed as having a mental disorder, other than mental retardation or developmental disability without another accompanying mental disorder, and is determined to be in need of inpatient treatment, the person may be admitted" (2). Finally 632.105 addresses the patient's admission status,

A person who is admitted under this section is a voluntary patient and shall have the right to consent to evaluation, care, treatment and rehabilitation and shall not be medicated without his prior voluntary and informed consent; except that medication may be given in emergency situations" (3).

Section 632.120 is similar to 632.105 except that this statute outlines the treatment of patients who have been adjudicated incompetent. Again the patient must have an approved mental disorder. This statute refers to the definitions of Chapter 630 to define the allowed and disallowed disorders.

> (22) "Mental disorder", any organic, mental or emotional impairment which has substantial adverse effects on a person's cognitive, volitional or emotional function and which constitutes a substantial impairment in a person's ability to participate in activities of normal living;
>
> (23) "Mental illness", a state of impaired mental processes, which impairment results in a distortion of a person's capacity to recognize reality due to hallucinations, delusions, faulty perceptions or alterations of mood, and interferes with an individual's ability to reason, understand or exercise conscious control over his actions. The term "mental illness" does not include the following conditions unless they are accompanied by a mental illness as otherwise defined in this subdivision:
> (a) Mental retardation, developmental disability or narcolepsy;
> (b) Simple intoxication caused by substances such as alcohol or drugs;
> (c) Dependence upon or addiction to any substances such as alcohol or drugs;
> (d) Any other disorders such as senility, which are not of an actively psychotic nature;
> (24) "Mental retardation", significantly subaverage general intellectual functioning which:

(a) Originates before age eighteen; and
(b) Is associated with a significant impairment in adaptive behavior;

Note the use of the term "senility" in (23(d)) is meant to include all forms of dementia and Alzheimer's disease. This means that a person who is senile, but does not have a concomitant mental illness, may not be admitted to an in-patient psychiatric facility.

Chapter 632.305 states that a person who meets both criteria, being mentally ill, and dangerous to themselves or others, may be held for up to 96-hours. Weekends and holidays are not included in the counting because the court is closed on those on those days (Bean D4). Additional statutes allow for extensions of the original 96-hours. They provide for 21-Days, 90-Days and 1-Year but must be sought in succession. Each of these time periods run consecutively through weekends and holidays. During any of the above three time periods a patient can be released on a Conditional Release (Bean D4 – D5).

The Conditional Release is essentially a contract among the patient, their doctor and the administrator of the facility. The contract states that the patient will take her medications, will keep her follow up appointments, will participate in outpatient treatment, and will reside where all three have agreed. It is in effect for a year from the day it is initiated. If the patient violates any of the terms of the agreement her Conditional Release will be revoked and she will be returned to the facility to serve out the remaining days of her confinement. Involuntary

Commitment is an effective tool in stabilizing persons with acute exacerbations of illness or persons who are experiencing an episode with unremitting symptoms. It is not meant to be a long-term solution (Bean D4 – D5). Those who become impaired and cannot manage their own affairs effectively, to the degree that they can no longer make appropriate decisions and thereby become ineffective at obtaining food, clothing and shelter will require a legal guardian.

Guardianship

If asked, most attorneys would describe guardianship as a legal process aimed at providing decision-making oversight of elderly incapacitated adults. When pressed for more information they would no doubt explain that it is also a process used to provide minor children with pseudo-parents when theirs are incapable, unavailable or deceased. Using guardianship as a mechanism to assist in stabilizing persons with chronic severe mental illness is an unfamiliar legal concept. Mark Swearingen is an attorney with Greensfelder, Hemker & Gale, P.C. In his position he serves as attorney for plaintiffs who are seeking guardianship. It is his job to gather the proper information that will enable him to complete and file the petition with the proper probate court. During his four-year tenure at Greensfelder he had only sought guardianships for elderly respondents. When approached about filing a petition seeking a public administrator to be

appointed guardian of a mentally ill person Mark said, "I don't think it can be done. You know he [the patient] is talking and is living in a house. That means he is competent" (Swearingen, 2002).

Healthcare providers often mirror this belief. Doctors, nurses and social workers, frequently use the terms "capacity" and "competent" interchangeably. Author Bernard Lo addressed this issue in his 1995 book, Resolving Ethical Dilemmas – A Guide For Clinicians. He states,

> This book uses the term competent to refer to patients who have the capacity to make informed decisions about medical interventions. Strictly speaking, all adults are considered competent to make such decisions unless a court has declared them incompetent. In everyday practice, however, physicians usually make *de facto* determinations that patients lack decision-making capacity and arrange for surrogates to make decisions, without involving the court (3-6). This clinical approach has been defended because routine judicial intervention imposes unacceptable delays and generally involves only superficial hearings (Lo 83).

Clinicians and officers of the court must possess conceptual understandings of, and the differences between, incompetence and poor decision making. Patients must be allowed the same power as non-patients to make decisions that might be regarded as foolish, imprudent or harmful (Lo 83).

Strauss and Lederman state that conceptually there are two ways to view guardianship.

> It is a well intended and benign process designed to afford protections to people in need of them by assigning the power to exercise the rights of an incapacitated person, who is not in a position to do so in his or her own best interest, to someone who can do so on his or her behalf. According to this view, the guardianship process should be flexible and easy to use so that it is readily available to people in need of its help.
> It is, in effect the taking away of an individual's rights and freedoms, a deprivation of constitutional magnitude under any circumstances and not necessarily in the best interests of an incapacitated person, who is not always able to protest. In this view, only the strictest application of due process standards will safeguard against potential abuse and conflicts of interest (162).

The author's continue stating that both views are correct. Protection must be weighed against an individual's rights and freedom (162).

If both views are in deed correct then this will increase the difficulty of determining who needs a guardian. In the Handbook of Forensic Psychology: Resource for Mental Health and Legal Professionals, Craig Yury addressed this issue, reviewd the literature and made assessment suggestions. The clinician must become familiar with the patient's ability to care for themselves. She needs to assess the patient's physical and mental health paying close attention to any physiological changes. Similarly the physician must evaluate for changes in the patient's intellectual functioning. To develop an understanding of the patient's intellectual function the doctor must assess any memory changes. Memory includes the concepts of short-term or working memory. Working memory is a spontaneous store-and-retrieve process. Long-term or semantic memory is the ability to recall words, their meanings, and the ability to use them correctly in

speech. Finally, the physician must attempt to determine a cause for physical, functional or conditional changes and develop a prognosis pertaining to the patient's ability to resume their normal functioning (217-221).

Yury sums this process up nicely,

> There is a consensus in the literature regarding specific cognitive abilities that should be assessed as part of any competency evaluation. These include (1) orientation, (2) recent and remote memory, (3) intellectual capacity (i.e., reasoning and the ability to understand abstract ideas), (4) attention, and (5) judgment (Kapp 1996). Mathematical abilities should be assessed when an individual's ability to manage his or her finances is questioned (222).

Recall the State of Missouri's definition of incompetent, a person who by reason of mental or physical defect cannot receive or evaluate information to the degree that it impairs their ability to care for them self (RSMO 475.010. (8)). The law addresses the concepts of Yury's assertions. These concepts can be applied to patient's who suffer from chronic severe mental illness.

Once a diagnosis of mental illness is established the clinician then must determine the degree of impairment along with the probable course and duration of the impairment. To do this the physician must test the patient's abilities to reason and make decisions. Physicians do this through the course of their mental status examination. One tool used in such an examination it the Mini Mental

Status Exam. This short instrument helps the physician determine the cognitive functioning of individuals with Organic Brain Syndromes.

Table 10

Mini-Mental Status Exam

Score	Interpretation
0-22	Suggestive of an organic syndrome
Over 22	--

The doctor asks patient "What is the year? What is the Season? …date, …day, and …month?"

0 out of 5 (0 point[s])
1 out of 5 (1 point[s])
2 out of 5 (2 point[s])
3 out of 5 (3 point[s])
4 out of 5 (4 point[s])
5 out of 5 (5 point[s])

The doctor asks the patient "Where are we? What state, county, town, hospital, and floor?

0 out of 5 (0 point[s])
1 out of 5 (1 point[s])
2 out of 5 (2 point[s])
3 out of 5 (3 point[s])
4 out of 5 (4 point[s])
5 out of 5 (5 point[s])

The doctor tells the patient "I'd like to test your memory. Please say these words: boat, cucumber, and wire."

Cannot do it at all (0 point[s])
Gets 1 right (1 point[s])
Gets 2 right (2 point[s])
Gets 3 right (3 point[s])
Gets 4 right (4 point[s])
Gets 5 right (5 point[s])

The doctor tells the patient "begin with 100 and count backwards by 7s."
Answer = (93, 86, 79, 72, 65)

Cannot do it at all (0 point[s])
Gets 1 right (1 point[s])
Gets 2 right (2 point[s])
Gets 3 right (3 point[s])
Gets 4 right (4 point[s])
Gets 5 right (5 point[s])

The doctor asks "Can you name the 3 objects I named before?"

Gets 0 out of 3 (0 point[s])
Gets 1 out of 3 (1 point[s])
Gets 2 out of 3 (2 point[s])
Gets 3 out of 3 (3 point[s])

The doctor asks the patient to names certain items. The doctor will point to a pencil and then a watch.

Gets neither one right (0 point[s])
Gets 1 out of 2 (1 point[s])
Gets them both right (2 point[s])

The doctor tells the patient to repeat the following: "No ifs, ands, or buts."

Does none of the 3 things (0 point[s])
Does 1 of the 3 things (1 point[s])
Does 2 of the 3 things (2 point[s])
Does 3 of the 3 things (3 point[s])

The doctor asks the patient to "Take a paper in his right hand, fold it in half, and put it on the floor."

Does none of the 3 things (0 point[s])
Does 1 of the 3 things (1 point[s])
Does 2 of the 3 things (2 point[s])
Does 3 of the 3 things (3 point[s])

The doctor tells the patient to read and obey the following and writes "CLOSE YOUR EYES."

Patient does not close eyes (0 point[s])
Patient closes eyes (1 point[s])

The doctor tells the patient to "Write a sentence."

Patient does not write a sentence (0 point[s])
Patient writes a sentence (1 point[s])

The doctor draws interlocking pentagons and has the patient copy it.

Patient does not copy the design properly (0 point[s])
Patient copies the design properly (1 point[s])

Source: Rosen et al, ed, Emergency Medicine: Concepts and Clinical Practice. 3rd ed. St. Louis, MO: Mosby. 1998: 1771-1772

The assessment information drives the physician's treatment and care recommendations. If the physician determines that the patient lacks capacity he must decide the degree of impairment. Missouri, like many other states allows for degrees of guardianship, temporary limited and full guardianship. "The role of guardian over a ward's personal affairs is usually spelled out in the court order appointing him or her in a general statement giving the guardian broad powers over care, custody, and control of the ward (Strauss, 164). Alternatively, if the physician determines that the patient only needs assistance with finances or certain daily tasks she may recommend a limited guardian. "A limited guardianship is a grant of powers of a lesser magnitude that the common broad authority over a ward's person or property… Courts have the inherent power to fashion orders without specific statutory authority (Strauss, 165). Once the assessment is complete and the decision is made as to the level of guardianship needed, a candidate for the appointment can be suggested.

Often a family member will accept the role. For those who are the sole remaining family members there are attorneys who will provide the service for a fee. Those who cannot afford to hire a guardian can be appointed a public administrator. Each city or county has a public administrator (PA). It is the PA's

role to act as guardian for poor or needy people. It is up to the court to determine the level of guardianship (Strauss 166-170).

<u>The Case of Ms. W</u>

Ms. W is a 46 year-old African American female who was brought to a free standing psychiatric facility for an involuntary admission secondary to psychosis. Upon examination the physician noted the patient to have an abdominal mass. She was transferred to a medical center that could provide both psychiatric and physical care. Ms. W was five-foot one-inch tall and normally weighed 105 pounds. At the time of examination the patient weighed 155 pounds. The patient was assessed and treated by psychiatrists, general practitioners and surgeons. Ms. W was agitated and claimed that she did not need medical attention. Doctor's noted that the patient had the appearance of being eight months pregnant. When questioned about her appearance, the patient gave various responses. They ranged from "I'm pregnant," to "I really ate a lot for lunch."

The psychiatrist assessed the patient and provided psychiatric treatment. Table 11 provides a facsimile of the doctor's history and physical report which includes information from the Mini Mental Status Examination.

Table 11

History and Physical Report: Patient: Ms. W

DIAGNOSES:
AXIS I:
Schizophrenia, paranoid type, chronic, with acute exacerbation.
AXIS II:
None.
AXIS III:
Uterine mass with compromise of abdominal blood supply.
Microcytic anemia.
AXIS IV:
Chronic mental illness.
Potential eviction from apartment.
AXIS V:
Global assessment of functioning 32.
SOURCE OF INFORMATION:
Sources of information include the patient who appears unreliable, medical record, and other, Dr. Will, OB/Gyn.

CHIEF COMPLAINT:
Transfer from a free standing psychiatric facility to coordinate care with OB/Gyn for necessary surgery with postoperative care.
IDENTIFYING INFORMATION:
This is the third hospitalization for this transferred patient from a free standing psychiatric facility, who is a 46-year-old African-American female with a history of chronic schizophrenia, paranoid type, who was admitted to the in-patient psychiatric unit under the care of Dr. Jones as an involuntary patient.
HISTORY OF PRESENT ILLNESS:
The patient has a longstanding history of schizophrenia that appears to have onset at age 30. The patient states she had a good childhood until she met the "pastor" at age 30, when he started visiting her at night and "playing with her toes." Previous records report that she lived independently and worked until the age of 34. Records report that she had one previous admission in 1997 at a free standing psychiatric facility, and has been receiving outpatient follow-up at a clinic. She has also possibly had one admission at this hospital, although no records of a psychiatric admission are found in the electronic record. On 08/04/2004, the patient states that her case coordinator visited for the third time and called the police to take her to the free standing psychiatric facility. She did not

understand or know the reason. The free standing psychiatric facility intake assessment from 08/04/2004 states that the patient was court ordered into the free standing psychiatric facility, and at the emergency department presentation, she was severely psychotic with symptoms of paranoia, increased agitation, decreased self-care, decreased appetite, tangential conversation, disorganization. At this time, she was found to have an abdominal mass which was equivalent to the size of an eight month pregnancy.

The patient was transferred to this hospital's Emergency Department where she was given Haloperidol 5 mg p.o. and lorazepam 2 mg p.o. and underwent abdominal CT with contrast and pelvic CT with contrast which showed a very large myomatous uterus with calcifications and recruitment of collateral vessels. A gynecology consultation was requested. However, the patient was uncooperative and would not consent to the vaginal examination, keeping her legs clenched closed. An outpatient follow up was ordered, and the patient was seen at the OB/Gyn clinic on 08/13/2004 and 08/27/2004 after treatment for acute psychosis. From 08/04/2004 to discharge from the State Mental Hospital, the patient was treated with Risperdal 4 mg at bedtime (as determined by State Mental Hospital records) and Zyprexa. On 08/13/2004, the patient allowed a Pap smear to be performed. See 08/13/2004 pathology report. It was determined that the patient would return to the clinic for a D&C, colposcopy, and LEEP procedure on 08/27/2004, at which time she denied the procedure. It was decided that a request for 90 day involuntary detainment at BJC Hospital would be filed with the courts in order to do what was required to obtain a court ordered guardian to act on behalf of the patient to ensure she received the care she needed for her gynecological issue which could become life-threatening. Dr. Jones agreed to admit the patient if the 90 day hold was granted. The court granted the 90 day hold today, so the patient was transferred here to the in-patient psychiatric unit from the free standing psychiatric facility.

PAST MEDICAL/SURGICAL HISTORY:

1. Uterine mass.
2. Microcytic anemia.
3. Polypectomy and endometrial biopsy 08/13/2004.

ALLERGIES/SENSITIVITIES:

The patient has no known drug allergies.

MEDICATIONS:

1. Risperdal 4 mg p.o. at bedtime.
2. Ferrous sulfate 325 mg p.o. every day.

FAMILY HISTORY:

She has a brother whom she reported to have depression. Records show that she has three siblings and her mother with schizophrenia. No known history of alcoholism, suicide, bipolar disorder, dementia, or drug use in the family.

SOCIAL HISTORY:
The patient states that she grew up in a major metropolitan area. Records show that she completed the twelfth grade and lived independently and worked until the age of 34. The patient states that she had been married for a month, but could not give details and could not give when. Occupational history - the patient states that she was a cashier at a restaurant and also cooked hamburgers. Living situation - she currently lives independently, but is at risk of being evicted from her apartment. She does not smoke. She stopped drinking at 27 years of age, and she no longer drinks alcohol. She has marijuana use that she said she did at the age of 17 years.

REVIEW OF SYSTEMS:
Was remarkable for the patient reporting having tiny headaches, sore throat occasionally vomiting, and constipation.

ASSETS:
Include access to medical health services, SSI, and a supportive family.

PHYSICAL EXAMINATION:
HEENT: Head atraumatic. White sclerae, no bruits. Moist membranes.
NECK: No thyroid enlargement. No lymph node enlargement.
CARDIOPULMONARY EXAMINATION: Unremarkable. ABDOMEN: Remarkable for very enlarged abdomen equivalent to eight months pregnancy. Unable to assess whether hepatosplenomegaly is present. Normal bowel sounds in some regions.
EXTREMITIES: She has some scar.
NEUROLOGIC EXAMINATION: Was significant for right iliopsoas muscle 3 out of 5 strength, with all other muscles being 5 out of 5. Unable to assess the palate rising symmetrically because patient was unwilling to open her mouth completely. Physical examination was also significant for bilateral toenails that were excessively long.

LABORATORY TESTS:
Please see surgical pathology report 08/13/2004, pelvic CT 08/04/2004, abdominal CT 08/04/2004, and laboratories from the emergency room 08/04/2004.

MENTAL STATUS EXAMINATION:
GENERAL APPEARANCE AND BEHAVIOR: The patient is well-nourished, well-developed, fairly groomed, with some facial hair, wearing sunglasses. She has bare feet because her toe nails prohibit the wearing of shoes. She is wearing a hospital gown. The patient has body odor, poor hygiene. She is polite and cooperative for the most part and has some psychomotor agitation.
SPEECH: Her speech has normal latency, normal rate, normal rhythm, normal volume. She has an increased amount and use of neologisms.
THOUGHT CONTENT: Denies suicidal ideation. The patient denies homicidal ideation. The patient reports auditory hallucinations that are

prominent, severe delusions. The patient reacted to auditory hallucinations throughout the interview.
FLOW OF THOUGHT: Tangential, derailment. Perseverates about toes and toenails. Poverty of content.
MOOD: Patient states "I'm doing okay. I don't need to be here."
AFFECT: Is normal with limited range. She can be evoked to laugh. Affect is stable, slightly apprehensive and requires much reassurance.
INSIGHT AND JUDGMENT: Patient's insight is poor. She is unable to comprehend or explain her mental illness, schizophrenia. She has no comprehension of her gynecological problems. Patient's judgment is poor. She is unwilling to undergo a procedure to remove mass that is damaging internal organs.
SENSORIUM AND INTELLECT: The patient was alert and oriented to person, place, and time. She was able to spell "world" forwards and backwards; however, was unable to perform serial 7's. Memory - she had three out of three at zero and five minutes. Language was good, although she could not construct a sentence and was instead only able to draw squiggly lines which she reported stated something. She was unable to abstract reasoning with proverbs, but she was able to provide similarity of an apple and an orange, although could not give similarity of a shelf and desk. She was unable to construct a clock or to draw intersecting pentagon.
IMPRESSION AND PLAN:
The patient is a 47-year-old African-American female with a history of schizophrenia, paranoid type, chronic, with large abdominal mass that is contiguous with the uterus, causing ventral herniation of left hepatic lobe and loops of bowel and mass effect on the inferior vena cava. The patient requires a court ordered guardian to authorize OB/Gyn intervention and follow up. Will coordinate psychiatric care and OB/Gyn followup. Will maintain medications written per the free standing psychiatric facility discharge orders until further evaluation.

Source: Adapted from the Medical Report of Doctor Jones. St. Louis, MO. 2004.

Ms. W received medical care and was examined in these institutions for most of her life. The tumor was detected by clinic physicians five years earlier. It was described as a 3 centimeter mass located in her uterus. For five years doctors provided Ms. W with diagnostic information and treatment options and honored her decisions. She continually chose to do nothing. Although Ms. W had family

members who were available to assist in decision making she never developed an Advanced Directive. Because of this, the family was legally unable to assist, intervene or assert their authority over hers (Medical Records of Ms. W 2004).

The patient was held involuntarily only after the psychiatrist in the free standing psychiatric facility performed a routine physical examination. During this examination he felt several loops of intestine and a portion of the patient's liver protruding through a hole in her abdominal wall. Her organs had been displaced by the growing tumor and it had completely filled her abdomen. With no place to go several loops of bowel and part of her liver were forced through the abdominal wall and were only contained by her epidermis. This process trapped and strangled the organs. Doctor Jones explained these findings to the patient and their seriousness. The symptoms of her mental illness were severe to the degree that they grossly impaired her insight, judgment and her ability to comprehend the severity of her condition (Medical Records of Ms. W 2004).

Doctor Jones filed a 96-Hour Involuntary Detention and Treatment petition with the court. He subsequently filed a petition for a 21-Day Involuntary Detention and Treatment order with hopes of stabilizing the patient's psychiatric condition. Once stabilized, the patient would be better able to comprehend the information and would hopefully agree to additional tests and treatment. By day 17 of the 21-Day involuntary detention the patient's psychiatric symptoms showed no signs of relenting. The psychiatrist contacted colleagues at the medical center to discuss the patient, and to develop a plan of care. Doctor Jones filed a 90-Day Involuntary Detention and Treatment petition with the probate court. The order

was granted and the patient was transferred to the medical center and the care of psychiatrist Dr. Smith (Medical Records of Ms. W 2004).

Ms. W continued to receive psychiatric treatment without symptom reduction. Her medical condition was classified as serious but stable. This determination ruled out the use of the emergency medical statute to provide the needed tests and probable surgery. Remember, only life threatening conditions can be treated under the emergent medical statute. Eventually, her liver would become septic or she would develop a life threatening bowel obstruction, but for now she was stable and reporting no pain or discomfort. The treatment team met with the patient's family members. They reviewed the patient's mental and physical conditions. The family agreed to participate in the process (Medical Records of Ms. W 2004).

After consultation with the medical center's administrator, risk management department personnel and attorneys, Doctor Smith requested that the medical center file a petition for a 30-Day temporary guardianship petition. An emergency hearing was convened at the probate court within 3 days of the filing. The psychiatrist testified concerning Ms. W's mental illness and her inability to comprehend her current mental and physical conditions. An obstetrician provided testimony regarding the additional tests needed to properly diagnose the patient's mass. Finally, a surgeon testified to the possible treatment plans and outcomes. He stated that there were several possible diagnoses concerning the tumor. It could be a common fibroid mass. If so, surgical removal would be the desired intervention. Without knowing the full extent of the tumor and its involvement

with organs, blood vessels and arteries he offered a guarded prognosis for this plan. The patient could die from complication that might arise during surgery. If the tumor was cancerous the type of cancer would dictate the treatment. A slow growing cancer would require removal of the tumor and treatments of chemotherapy and possible radiation therapy. If the tumor was determined to be a fast growing cancer the patient would be provided palliative care. The surgeon concluded his testimony with the statement "The strangulated bowel and liver are ticking time bombs. If left untreated they will kill the patient" (Medical Records of Ms. W 2004).

The probate court judge declared the patient incompetent based on the clear and convincing evidence. She granted the medical center's temporary guardianship petition and named the patient's sister, guardian. The guardian met with the treatment team and authorized the needed tests. The test results revealed that the tumor was a non-cancerous fibroid type. Surgery was performed and the 60 pound tumor was successfully removed. Three days after surgery the patient was returned to the in-patient psychiatric unit where the patient's mental illness was aggressively treated without success. Forty-five days later the patient returned to the probate court. The family sought and received a permanent guardianship order (Medical Records of Ms. W 2004).

The case of Ms. W highlights the legal options available to patient's, their families and medical professionals. It shows the progressive use of the options that may not be practical in all cases. Finally, the family chose to exercise their

option to seek permanent full guardianship to provide their loved one with the care and oversight that she could not provide herself.

Richard Lamb and Linda Weinberger authored a 1992 American Journal of Psychiatry article titled "Conservatorship for Gravely Disabled Psychiatric Patients: A Four-Year Follow-Up Study". The term "conservator" is frequently and incorrectly, used interchangeable with the term "guardian". The state of California defines the term conservator in its probate code.

Table 12

California Codes, Probate Code, Section 3000-3012

3000. Unless the provision or context otherwise requires, the definitions contained in this article govern the construction of this part.
3002. "Community property" means community real property and community personal property, including, but not limited to, a community property business that is or was under the primary management and control of one of the spouses.
3004. "Conservator" means conservator of the estate, or limited conservator of the estate to the extent that the powers and duties of the limited conservator are specifically and expressly provided by the order appointing the limited conservator, and includes the guardian of the estate of a married minor.
3006. "Conservatorship estate" includes the guardianship estate of a married minor.
3008. "Conservatorship proceeding" means conservatorship of the estate proceeding and includes a guardianship of the estate proceeding of a married minor.
3012. (a) Unless the spouse lacks legal capacity under the applicable standard prescribed in subdivision (b), a spouse has legal capacity to:
(1) Manage and control community property, including legal capacity to dispose of community property.
(2) Join in or consent to a transaction involving community property.
(b) A spouse lacks legal capacity to:

(1) Manage and control, including legal capacity to dispose of, community property if the spouse is substantially unable to manage or control the community property.
(2) Join in or consent to a transaction involving community property if the spouse does not have legal capacity for the particular transaction measured by principles of law otherwise applicable to the particular transaction.
(3) Do any act, or engage in any activity, described in paragraph (1) or (2) if the spouse has a conservator.
(c) Nothing in this section shall be construed to deny a spouse, whether or not lacking legal capacity, any of the following:
(1) The right to control an allowance provided under Section 2421.
(2) The right to control wages or salary to the extent provided in Section 2601.
(3) The right to make a will.
(4) The right to enter into transactions to the extent reasonable to provide the necessities of life to the spouse, the other spouse, and the minor children of the spouses.

Source: California Probate Codes, Section 3000-3012. Internet. Online. 2005

A conservator is similar to a guardian but has fewer powers and is more restricted in their actions. The majority of a conservator's powers revolve around the capacity to manage the conserve's finances and estate.

Lamb and Weinberger examined the outcomes of 60 psychiatric patients over the course of four years. Of the group of patients 58 percent of the patients received a conservator. The length of time for conservator oversight ranged from three months to one year. The patients that Lamb and Weinberger studied had chronic severe mental illness. Many had concomitant substance issues and almost half of the individuals were homeless. Sixty-five percent of the patients received Social Security Disability. Almost all, 95 percent, had been treated in an in-patient psychiatric facility. Only 67 percent had received out-patient psychiatric

treatment. Interestingly, 50 percent of these patients had been involved with the legal system due to their violent acts against another people. Lamb and Weinberger concluded after the four years,

> We believe that for a considerable number of chronically and severely mentally ill individuals, conservatorship would play an important role in their clinical management and treatment by helping to eliminate their chaotic life styles, their cycles of admissions and discharges from hospitals and jails, and/or their living on the streets, particularly when family support is absent (909).

Chapter III

RESEARCH METHODOLOGY

Subjects

Data were collected on a total of 136 subjects. Prior to the study 31 subjects had been adjudicated incompetent and were appointed guardians by the court. The remaining 105 subjects made up a non-guardianship pool from which 31 subjects would be pair-matched to the guardianship subjects for purposes of comparison and statistical analysis. Demographic data were collected as well as data concerning mental illness, substance abuse, living situation, contacts with the legal system, sources of financial support, social supports and their involvement, the number of hospitalizations, and medication compliance. Table 13 lists the raw data totals for both groups.

Table 13

Raw Data for Al Subjects Separated by Group

	Guardian Subjects		Control Subjects	
CATEGORIES	TOTAL	#, PERCENT, or AVERAGE	TOTAL	#, PERCENT, or AVERAGE
# of Subjects	31		105	# of Subjects
Age	41.0	Average	42.85	Average

	Guardian Subjects		Control Subjects	
CATEGORIES	TOTAL	#, PERCENT, or AVERAGE	TOTAL	#, PERCENT, or AVERAGE
Age of Onset	20.1	Average	23.07	Average
Age at Diagnosis	22.3	Average	25.55	Average
GUARDIANSHIP				
Own	0	0.00%	105	100.00%
Family Member	20	35.48%	0	
Public Administrator	11	64.52%	0	
Pt Age at Guardianship	33.5	Average	0	Average
EDUCATION				
Grade School	6.7	93.55%	7.97	98.10%
High school	2.3	57.66%	3.71	93.33%
College	.74	18.55%	2.1	42.86%
Grad School	.10	4.84%	1.6	4.76%
RACE				
Caucasian	22	70.97%	58	55.24%
African American	9	29.03%	47	44.76%
Hispanic	0	0.00%	0	0.00%
Asian	0	0.00%	0	0.00%
GENDER				
Male	16	51.61%	59	56.19%
Female	15	48.39%	38	36.19%
MATRTIAL STATUS				
Never been Married	23	74.19%	51	48.57%
Married	5	16.13%	13	12.38%
Separated	0	0.00%	12	11.43%
Divorced	3	9.68%	23	21.90%
Annulled	2	6.45%	0	0.00%
Widow	1	3.23%	6	5.71%
Children	15 by 5	16.12%	113 by 59	56.19%
No Children	26	83.88%	46	43.84%
PRIMARY DIAGNOSIS				
Schizophrenia	14	45.16%	39	37.14%
Schizoaffective	2	6.45%	27	25.71%
Bipolar Disorder	10	32.26%	37	35.24%
Mental Retardation	1	3.2%	1	.95%
Organic Mental	2	6.45%	1	.95%
Major Depression	2	6.45%	1	.95%

	Guardian Subjects		Control Subjects	
CATEGORIES	TOTAL	#, PERCENT, or AVERAGE	TOTAL	#, PERCENT, or AVERAGE
SUBSTANCE ABUSE				
Ethanol	8	25.81%	34	32.38%
Street Drugs	6	19.35%	34	32.38%
Prescription Drugs	2	6.45%	4	3.81%
LIVING SITUATION				
How Long	7.46	24.07%	4.18	3.98%
With Family	5	16.13%	29.00	27.62%
Own Home	3	9.68%	22	20.95%
Family Member's Home	4	12.90%	14	13.33%
Own Apartment	4	12.90%	37	35.24%
Alone	5	16.13%	31	29.52%
With Other	1	3.23%	7	6.67%
Hotel	0	0.00%	1	0.95%
Boarding Home	19	61.29%	18	17.14%
Mission	0	0.00%	2	1.90%
On the Street	1	3.23%	1	0.95%
None	0	0.00%	1	0.95%
Unknown	0	0.00%	1	0.95%
LEGAL DIFFICULTIES				
Number of Arrest	2	6.45%	16	15.24%
Civil/criminal Charges	2	6.45%	18	17.14%
SOURCES OF FINANCIAL SUPPORT				
Employment	9	29.03%	50	47.62%
Currently	2	6.45%	11	10.48%
Sporadically	7	22.58%	29	27.62%
Prior to Illness	1	3.23%	10	9.52%
Spouse	2	6.45%	5	4.76%
Family	5	16.13%	14	13.33%
SSI	4	12.90%	18	17.14%
SSD	21	67.74%	75	71.43%
Food Stamps	1	3.23%	5	4.76%
Worker's Comp	0		0	
AFDC	1	3.23%	3	2.86%
Savings	1	3.23%	3	2.86%
Investments	1	3.23%	2	1.90%
Pension	2	6.45%	10	9.52%
No Known Financial Support	2	6.45%	2	1.90%

	Guardian Subjects		Control Subjects	
CATEGORIES	TOTAL	#, PERCENT, or AVERAGE	TOTAL	#, PERCENT, or AVERAGE
SOCIAL SUPPORTS				
Family	9	29.03%	27	25.71%
Mother	18	58.06%	27	25.71%
Father	7	22.58%	17	16.19%
Siblings	7	22.58%	22	20.95%
Grandparents	2	6.45%	1	0.95%
Extended Family	1	3.23%	9	8.57%
Friends	1	3.23%	25	23.81%
Others	8	25.81%	13	12.38%
LEVEL OF INVOLVEMENT				
In Person	22	70.97%	43	40.95%
By Phone	14	45.16%	9	8.57%
Daily	16	51.61%	61	58.10%
Weekly	14	45.16%	27	25.71%
Monthly	6	19.35%	2	1.90%
Quarterly	1	3.23%	1	0.95%
Semiannually	0	0.00%	0	0.00%
Holidays Only	0	0.00%	0	0.00%
Annually	0	0.00%	0	0.00%
SOCIAL AGENCIES				
DFS	4	12.90%	3	2.86%
DMH	6	19.35%	0	0.00%
St Louis Mental Health	3	9.68%	6	5.71%
Regional Center	7	22.58%	1	0.95%
Independence Center	3	9.68%	12	11.43%
Church	1	3.23%	15	14.29%
Salvation Army	0	0.00%	0	0.00%
Other	10	32.26%	26	24.76%
HOSPITALIZATIONS PRE GUARDIANSHIP				
Malcolm Bliss	11	35.48%	39	37.14%
Barnes/Jewish	58	187.10%	145	138.10%
Metro	42	135.48%	15	14.29%
Outside Metro	56	180.65%	5	4.76%
VA	0	0.00%	0	0.00%

CATEGORIES	Guardian Subjects TOTAL	Guardian Subjects #, PERCENT, or AVERAGE	Control Subjects TOTAL	Control Subjects #, PERCENT, or AVERAGE
HOSPITALIZATIONS POST GUARDIANSHIP				
Malcolm Bliss	35	112.90%	0	0.00%
Barnes/Jewish	92	296.77%	0	0.00%
Metro	26	83.87%	0	0.00%
Outside Metro	25	80.65%	0	0.00%
VA	0	0.00%	0	0.00%
HISTORY OF OUTPATIENT TREATMENT				
Yes	28	90.32%	104	99.05%
No	2	6.45%	1	0.95%
Pre Guardianship	24	77.42%	104	99.05%
Post Guardianship	27	87.10%	0	0.00%
MEDICATION COMPLIANCE PRE GUARDIANSHIP				
Yes	7	22.58%	37	35.24%
No	20	64.52%	65	61.90%
Deconate Meds	11	35.48%	41	39.05%
MEDICATION COMPLIANCE POST GUARDIANSHIP				
Yes	12	38.71%	0	0.00%
No	19	61.29%	0	0.00%
Deconate Meds	22	70.97%	0	0.00%

Source: Data collected from medical records reviews, 1998 – 2005.

The 136 subjects ranged in age from 19 to 79 years old. Their average age was 42. Age at the time of mental illness onset was 20 for the guardian group versus 23 for the non-guardians. Demographically the subjects were quite similar. The similarity continues when comparing their educational backgrounds. Ninety-three percent of the guardianship subjects completed an average of 7th

grade, while 98% of their non-guardian counterparts completed eight grades of grade school. There were differences between the two groups.

The non-guardianship subjects were almost evenly split on marital status while 74% of the guardianship subjects never married. Of the married non-guardianship subjects 12% were married at the time of the study, 11.43% were separated, and 22% were divorced. All of the subjects had a primary diagnosis of severe chronic mental illness that was deemed debilitating. Again the two groups were fairly similar concerning their use or abuse of alcohol, street drugs and prescription drugs. They did, however, vary greatly in terms of their living situations.

The guardianship group averaged almost eight years per placement while the non-guardians averaged half that. Sixty-five percent of the guardianship subjects lived in supportive housing placements like boarding homes, residential care centers or nursing homes. Only 17% of the non-guardianship subjects lived in supportive settings. Thirty percent of the non-guardianship subjects lived alone while half that, 15%, of the guardianship subjects lived alone. Another difference was in the number of contacts each group had with law enforcement. Six-and -a-half percent of guardianship subjects had either been arrested or convicted of a crime. The non-guardianship group more than doubled that number. The financial support information, although very detailed, was not difficult to interpret.

Nearly 70% of both groups received Social Security Disability (SSD) income or Supplemental Security Income (SSI). A greater number of non-

guardianship subjects received SSI because a greater number of them worked at some time in their life. Another area of major difference is the amount and frequency of social support each group received. The guardianship subjects had more primary relationships with their first-degree relatives while their counterparts had relationships with extended family and friends. This difference is further marked by the type of involvement. Seventy percent of the guardianship subject's contact was in person and 52% of it was on a daily basis. Continuing the trend of increased support the guardianship group received more support from agencies like the Division of Family Services (DFS), the Department of Mental Health (DMH), and the other helping agencies. Information regarding the number of hospitalizations was also collected.

Data concerning the number of hospitalizations before and after guardianship was collected. Before guardianship each group averaged 1.93 hospitalizations per subject. After the appointment of the guardian, hospitalizations of guardianship subjects increased to an average of 2.23 per subject. Ninety-nine percent of the non-guardianship subjects had participated in out-patient treatment compared to 90% of the guardianship subjects. Only 77% of the guardianship subjects had engaged in out-patient treatment prior to the appointment of their guardian. This finding was also influenced by the subjects living arrangements. Those who reside in facilities (residential care centers and nursing homes) received government mandated treatment in those facilities. Recall that the guardianship subjects more often lived in those facilities. The structure of payments to those facilities and government insurance payments

(Medicare and Medicaid) mandated one paid treatment program per day. So in reality the guardianship subjects received more treatment and medication management than their non-guardianship counterparts.

Medication compliance and their delivery mechanism were the final areas of comparison. Prior to the appointment of a guardian only 22.58% of the guardianship subjects were compliant with their prescribed medication regimes. Thirty-five percent of their non-guardianship counterparts were compliant. Slightly more, 39.05% versus 35.48%, of non-guardianship subjects received deconate medication than their pre-guardianship counterparts. Deconate medication is a long-acting, three to four week, intramuscular injectable form of an antipsychotic medication. It greatly simplifies the medication regimen by eliminating daily oral medication administration. After the appointment of a guardian the guardianship group increased in compliance by 16.13% and doubled, 70.97%, in the number of subjects who received deconate medication.

Instrument

The instrument for this study was a paper and pencil collection tool designed by the researcher. Data was entered by hand on the 81/2 X 11 inch single-sided form. The tool contained both fill-in blanks and boxes to check. Once complete the information was entered into a Microsoft Excel spreadsheet. Subjects were coded as either a G for guardianship, or a C for control. A number

was added to this code and it became the unique identifier for each subject's data set. Table 14 is a representation of the paper tool.

Table 14

Data Collection Tool

Name__________ Code___ DOB_____ Age____ Date_______
SSN________ Age at onset of illness______ Age of first diagnosis_____

Guardianship
☐ Own ☐ Family member
☐ Public Administrator
Date of Guardianship_______
Pt Age at Guardianship______

Education
☐ Grade school ☐ r. High
☐ High school 1 2 3 4 ☐ G.E.D.
☐ College 1 2 3 4
☐ Graduate____ ☐ MS/A ☐ Ph.D.

Race
☐ White ☐ Black ☐ Hispanic ☐Asian

Gender
☐ Male ☐ Female

Marital Status
☐ Never Been Married ☐ Married____ ☐ Separated____ ☐ Divorced___
☐ Annulled____ ☐ Widowed____ ☐ Children____ ☐ No Children

Primary Diagnosis
☐ Schizophrenia ☐ Schizoaffective ☐ Bipolar Disorder ☐ Retardation
☐ Organic Mental/Dementia ☐ Major Depressive Disorder

Substance Abuse ☐ Ethanol ☐ Street drugs ☐ Prescription Drugs

Living Situation at the time of last hospitalization. Length of time in months in this living arrangement_________
☐ With Family ☐ Own Home ☐ Family Member's Home ☐ Own Apt
☐ Alone ☐ With Other ☐ Hotel ☐ Boarding Home ☐ Mission
☐ On the Street ☐ None ☐ Unknown

Legal Difficulties # of Arrest _____ # of Civil/Criminal Charges______

Sources Financial Support
☐ Employment ☐ Currently ☐ Sporadically ☐ Prior to illness onset
☐ Spouce ☐ Family ☐ SSI ☐ SSD ☐ Food Stamps ☐ Worker's Comp
☐ Aid to Dependent Families with Dependent Children ☐ Savings
☐ Investments ☐ Pension ☐ No Known Source of Financial Support

Social Supports
☐ Family ☐ Mother ☐ Father ☐ Sibling(s) ☐ Grandparents
☐ Extended Family Members ☐ Friends ☐ Other
Level of Involvement ☐ In Person ☐ By Phone ☐ Daily ☐ Weekly
☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Holidays only ☐ Annually

Social Agencies ☐ DFS ☐ DMH ☐ St. Louis Mental Health
☐ Regional Center ☐ Independence Center ☐ Church ☐ Salvation Army
☐ Other____

History of Psychiatric Hospitalizations Pre Guardianship
☐ Public (Malcolm Bliss) # of Admissions ____________
☐ Barnes/Jewish # of Admissions ____________
☐ Metro # of Admissions ____________
☐ Outside Metro # of Admissions ____________
☐ VA ____________

History of Psychiatric Hospitalizations Post Guardianship
☐ Public (Malcolm Bliss) # of Admissions ____________
☐ Barnes/Jewish # of Admissions ____________
☐ Metro # of Admissions ____________
☐ Outside Metro # of Admissions ____________
☐ VA ____________

History of Outpatient Treatment
☐ Yes ☐ No
☐ Pre Guardianship
☐ Post Guardianship

Medication Compliance Pre Guardianship
☐ Yes ☐ No
☐ Deconate Medication

Medication Compliance Post Guardianship
☐ Yes ☐ No
☐ Deconate Medication

Source: Author developed data collection tool 1998.

Procedure

Data was collected from patient records at a private hospital on the psychiatric service during the regular course of business by a licensed clinical social worker and practicum students. The principle investigator would be randomly assigned patients who had diagnoses of severe chronic mental illness, with or without a guardian, and would either collect the data or assign the task to a student. The data collector read the patient's medical record and completed the tool based upon the information therein. Once collected the principle investigator

would verify the information collected by reviewing the chart and the collected information. After verification the data would be entered into a Microsoft Excel spreadsheet by a student. Each entered data set was verified for accuracy by the principle investigator. No special codes were used with the exception of the use of an identifier code that replaced the patient's identity (their name, date of birth and social security number). The code was, G1 for the first patient who had a guardian, G2 for the second patient who had a guardian and so on to G31. Similarly, the code for the control subjects, the non-guardianship subjects, was C1 for the first patient that did not have a guardian, C2 for the second patient that did not have a guardian, and so on through C105.

The principle investigator maintained a list of subjects from whom data had already been collected to eliminate the possibility of collecting data from the same subject more that once. Data collection continued until the goal of collecting information on at least 30 guardianship and three times as many non-guardianship subjects was met. The ratio of non-guardianship subjects was pre determined to ensure the ability to pair-match guardian subject with non-guardian subjects.

<u>Data Analysis</u>

This study was a pair-matched two-group design that compared 62 subjects. The criteria for matching subjects was determined prior to the collection of data. Each criterion also included a definition of what constituted a match.

Both the criterion and its accompanying definition are listed in the order of priority below.

1. Gender. Must be an exact match.
2. Age. Plus-or-minus six months.
3. Race. Must be an exact match
4. Diagnosis. The category is first divided into two groups, diagnoses of primary thought disorder (Schizophrenia and Schizoaffective Disorder), and diagnoses of primary affective disorder (Bipolar Disorder and Major Depressive Disorder). In three cases the first diagnosis written in the patient's chart was Mental Retardation, Organic Mental Disorder or Dementia. All three of these individuals were guardianship subjects. Each of these three subjects had been diagnosed with two primary diagnoses. The subject diagnosed with Mental Retardation also carried a diagnosis of Schizoaffective Disorder. Of the two subjects diagnosed with Organic Mental Disorder one received a second diagnosis of Bipolar Affective Disorder and the other had a diagnosis of Schizoaffective Disorder. Two subjects were diagnosed with Major Depressive Disorder; both were also diagnosed with Bipolar Disorder.
5. Age of first diagnosis. Plus-or-minus six months.
6. Each subject must be used only once.

The remainder of the data points were not included in the list of criteria as they were the items that would be studied. Study items were determined to be the possible variables that would provide insight into the helpfulness or hindrances of guardianship. The selection criteria were programmed into Microsoft Access and

the software selected the matching pairs. Once selected, the data for both groups were totaled on another spreadsheet where the statistical analysis was conducted. Two statistical tests were selected and calculated. The traditional chi square test and the McNemar's chi square test.

These tests were selected because they are non-parametric tests of statistical significance for bivariate tabular analysis. The tests can determine whether two different samples are different enough in some characteristic or aspect of their behavior. The difference can be generalized from the samples that the populations from which the samples were drawn were also different in the behavior or characteristic. The chi square is a rough estimate of confidence. It accepts weaker less accurate data as input than parametric tests (like t-tests and analysis of variance) and therefore has less status in the pantheon of statistical tests. Its limitations are also its strengths, because chi square is more 'forgiving' in the data it will accept.

The forgiving nature of the chi square is why the McNemar's chi square formula was also calculated. This formula is also used with dichotomous variables and is more sensitive to smaller sample sizes. Both tests were calculated at the .05 level of significance.

Chapter IV

RESULTS

Descriptive Statistics

Data were collected on 136 subjects who belonged to one of two groups; guardianship subjects, or control subjects. All had diagnoses of chronic severe mental illness. They ranged in age from 19 to 79 years old with an average age of 41. The average age of mental illness onset was 21 years old for the guardian group and 21 for the non-guardian group. Table 13 located in Chapter III provides the raw data totals for all subjects. Listed below in Table 15 are the data for the thirty-one pair-matched subjects. Descriptive information of the subjects was developed using gender, age, race and diagnosis. These item were used to pair-match the subjects in this order.

Gender was the first matching criteria. Subjects were matched one-to-one for gender. The gender of the guardianship group is nearly evenly split at 16 males and 15 females and therefore set the requirement for the control group. Viewed in terms of percentages the group composition was 51.61 percent male and 48.39 percent female.

The age criteria were applied to subject's current age. The selection criteria for pair-matching were plus or minus six months. In terms of age the

groups were quite similar. The racial composition of the subjects was interesting in that there were only two races. The study was designed for multiple races to reflect the population of psychiatric patients the hospital serves. However, only African American and Caucasian patients had guardians. Like gender, race was matched one-to-one. Nine (29.03%) of the guardianship subjects were African American while twenty-two (70.97%) were Caucasian. The final descriptive element used for pair-matching was diagnosis.

Numerous elements are present concerning diagnostic formulation. The psychiatrist assesses the patient to determine treatment and diagnosis. During this assessment the patient reports her symptoms. Her report may be affected by her mental condition. She may have impaired insight, judgment or perception. The patient might be suffering from paranoia and as such might be less truthful or less inclined to share symptomatic information. She might be experiencing delusions or hallucinations. If she is hearing voices, the voices might be telling her to not share information with the doctor. Therefore an important part of the assessment and diagnostic impression is the reliability of the patient and the information they impart.

Equally important is the skill and knowledge of the physician. Doctors have their dynamic part in the process. Physicians vary in assessment skills and diagnostic abilities. Medical training programs are base on a philosophy, psychodynamic, pharmacological or whole person for example. The philosophy provides a framework, a context, from which the physicians' knowledge and skills develop. Also of issue is where and when the patient was diagnosed. The

set of symptoms may not be fully expressed early in a patient's course of illness. These variables make it difficult to compare diagnosis. Sorting out symptoms is particularly difficult. If a patient presents with delusions (fixed false beliefs), visual and auditory hallucinations (seeing and hearing things that others do not see or hear), and mood lability (a mood that fluctuates from manic to depressed), is the diagnosis schizophrenia, schizoaffective disorder, bipolar disorder or depression with psychosis. Time observation and clinical experience will provide the best answer to this question.

Because of these issues patients were pair-matched on diagnoses with similar symptom sets. Other factors included the patient's course of illness. This included age of illness onset and the patient's age at the time of diagnosis. You will note a difference, as reported in Table 15 below, in the number of individuals with schizoaffective disorder and bipolar disorder. As stated, their symptom sets and current diagnostic label were matched.

Table 15

Data for 31 Pair-Matched Subjects Separated by Group

	GUARDIANSHIP		CONTROLS	
CATEGORIES	TOTAL	#, PERCENT, or AVERAGE	TOTAL	#, PERCENT, or AVERAGE
# of Subjects	31.00		31.00	
Age	41.0	Average	41.0	Average
Age of Onset	20.06	Average	21.4	Average
Age at 1st Diag	22.28	Average	21.7	Average
Own	0.0	0.00%	31.0	100.00%
Family Member	20.0	64.52%	0.0	

	GUARDIANSHIP		CONTROLS	
CATEGORIES	TOTAL	#, PERCENT, or AVERAGE	TOTAL	#, PERCENT, or AVERAGE
Public Administrator	11.0	35.48%	0.0	
Pt age at Guardianship	33.5	Average	0.0	Average
EDUCATION				
Grade School	6.7	83.47%	8.0	99.60%
High School	2.3	57.66%	3.6	91.13%
College	0.74	18.55%	1.0	24.60%
Grad School	0.1	4.84%	0.1	6.45%
RACE				
Caucasian	22	70.97%	22.0	70.97%
African American	9	29.03%	9.0	29.03%
GENDER				
Male	16	51.61%	16.0	51.61%
Female	15	48.39%	15.0	48.39%
MARITAL STATUS				
Never Been Married	23	74.19%	15.0	48.39%
Married	5	16.13%	1.0	3.23%
Separated	0	0.00%	3.0	9.68%
Divorced	3	9.68%	9.0	29.03%
Annulled	2	6.45%	0.0	0.00%
Widow	1	3.23%	2.0	6.45%
Children	15	16.13%	37.0	48.39%
No Children	26	83.87%	16.0	51.61%
PRIMARY DIAGNOSIS				
Schizophrenia	14	45.16%	14.0	45.16%
Schizoaffective	2	6.45%	6.0	19.35%
Bipolar Disorder	10	32.26%	6	19.35%
Mental Retardation	1	3.23%	1	3.22%
Organic Mental	2	6.45%	2	6.45%
Major Depression	2	6.45%	2	6.45%
SUBSTANCE ABUSE				
Alcohol	8	25.81%	13.0	41.94%
Street Drugs	6	19.35%	13.0	41.94%
Prescription Drugs	2	6.45%	1.0	3.23%

	GUARDIANSHIP		CONTROLS	
CATEGORIES	TOTAL	#, PERCENT, or AVERAGE	TOTAL	#, PERCENT, or AVERAGE
LIVING SITUATION				
How Long	7.5	24.07%	3.1	10.14%
With Family	5	16.13%	8.0	25.81%
Own Home	3	9.68%	3.0	9.68%
Family Member's Home	4	12.90%	5.0	16.13%
Own Apartment	4	12.90%	14.0	45.16%
Alone	5	16.13%	12.0	38.71%
With Other	1	3.23%	3.0	9.68%
Hotel	0	0.00%	0.0	0.00%
Boarding Home	19	61.29%	3.0	9.68%
Mission	0	0.00%	0.0	0.00%
On The Street	1	3.23%	0.0	0.00%
None	0	0.00%	1.0	3.23%
Unknown	0	0.00%	0.0	0.00%
LEGAL DIFFICULTIES				
Number of Arrest	2	6.45%	9.0	29.03%
Civil/Criminal Charges	2	6.45%	9.0	29.03%
SOURCES OF FINANICAL SUPPORT				
Employment	9	29.03%	18.0	58.06%
Currently	2	6.45%	3.0	9.68%
Sporadically	7	22.58%	12.0	38.71%
Prior To Illness	1	3.23%	4.0	12.90%
Spouse	2	6.45%	0.0	0.00%
Family	5	16.13%	5.0	16.13%
SSI	4	12.90%	6.0	19.35%
SSD	21	67.74%	25.0	80.65%
Food Stamps	1	3.23%	3.0	9.68%
Worker's Compensation	0	0.00%	0.0	0.00%
AFDC	1	3.23%	2.0	6.45%
Savings	1	3.23%	2.0	6.45%
Investments	1	3.23%	1.0	3.23%
Pension	2	6.45%	0.0	0.00%
No Known Financial Support	2	6.45%	0.0	0.00%

	GUARDIANSHIP		CONTROLS	
CATEGORIES	TOTAL	#, PERCENT, or AVERAGE	TOTAL	#, PERCENT, or AVERAGE
SOCIAL SUPPORTS				
Family	9	29.03%	5.0	16.13%
Mother	18	58.06%	9.0	29.03%
Father	7	22.58%	6.0	19.35%
Siblings	7	22.58%	6.0	19.35%
Grandparents	2	6.45%	0.0	0.00%
Extended Family	1	3.23%	4.0	12.90%
Friends	1	3.23%	8.0	25.81%
Others	8	25.81%	4.0	12.90%
LEVEL OF INVOLVEMENT				
In Person	22	70.97%	14.0	45.16%
By Phone	14	45.16%	2.0	6.45%
Daily	16	51.61%	17.0	54.84%
Weekly	14	45.16%	11.0	35.48%
Monthly	6	19.35%	0.0	0.00%
Quarterly	1	3.23%	0.0	0.00%
Semiannually	0	0.00%	0.0	0.00%
Holidays Only	0	0.00%	0.0	0.00%
Annually	0	0.00%	0.0	0.00%
SOCIAL AGENCIES				
DFS	4	12.90%	2.0	6.45%
DMH	6	19.35%	0.0	0.00%
St Louis Mental Health	3	9.68%	2.0	6.45%
Regional Center	7	22.58%	0.0	0.00%
Independence Center	3	9.68%	5.0	16.13%
Church	1	3.23%	3.0	9.68%
Salvation Army	0	0.00%	0.0	0.00%
Other	10	32.26%	7.0	22.58%
HOSPITALIZATION PRE GUARDIANSHIP				
Malcolm Bliss	14	0.00%	40.0	0.00%
Barnes/Jewish	58	0.00%	137.0	0.00%
Metro	42	0.00%	79.0	0.00%
Outside Metro	56	0.00%	4.0	0.00%
VA	0	0.00%	0.0	0.00%

	GUARDIANSHIP		CONTROLS	
CATEGORIES	TOTAL	#, PERCENT, or AVERAGE	TOTAL	#, PERCENT, or AVERAGE
HOSPITALIZATION POST GUARDIANSHIP				
Malcolm Bliss	35	0.00%	0.0	0.00%
Barnes/Jewish	92	0.00%	0.0	0.00%
Metro	26	0.00%	0.0	0.00%
Outside Metro	25	0.00%	0.0	0.00%
VA	0	0.00%	0.0	0.00%
HISTORY OF OUTPATIENT TREATMENT				
Yes	28	90.32%	31.0	100.00%
No	2	6.45%	0.0	0.00%
Pre-guardianship	24	77.42%	31.0	100.00%
Post-guardianship	27	87.10%	0.0	0.00%
MEDICATION COMPLIANCE PRE GUARDIANSHIP				
Yes	7	22.58%	11.0	35.48%
No	20	64.52%	18.0	58.06%
Deconate Meds	11	35.48%	11.0	35.48%
MEDICATION COMPLIANCE POST GUARDIANSHIP				
Yes	12	38.71%	0.0	0.00%
No	19	61.29%	0.0	0.00%
Deconate Meds	22	70.97%	0.0	0.00%

Source: Data collected from medical records reviews, 1998 – 2005.

Inferential Statistics

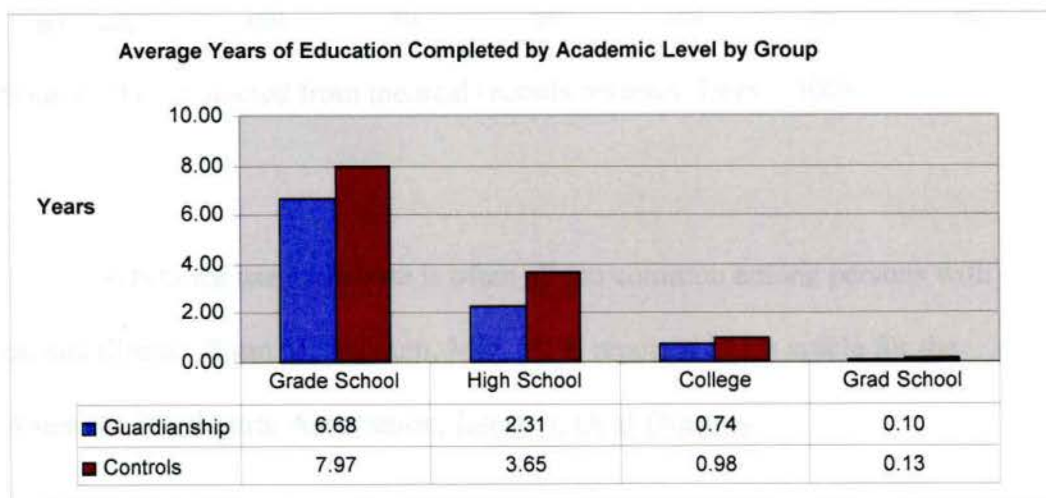
Included in the inferential statistics were all of those indicators that have the potential of providing insight into the statistical differences between the two populations. The indicators were; education, martial status, substance abuse,

living situation, legal issues, sources of financial support, family support, agency support, hospitalizations and medication compliance.

Education was withheld as one of the pair-matching criteria because it held the potential of denoting differences between the two populations. Chart 1 graphically reveals the average number of years completed by each group in each category, Grade School, High School, College and Graduate School.

The control subjects had higher academic achievement across the board. Ninety-nine percent of the control subjects graduated grade school compared to 83.47 percent of the guardianship subjects. More control group subjects attended high school, 91.13 percent, than their counterparts of whom only 57.66 percent attended. Control group subjects outdid their guardianship equal by six percent in the attendance of college. Both groups averaged a little over two years of college.

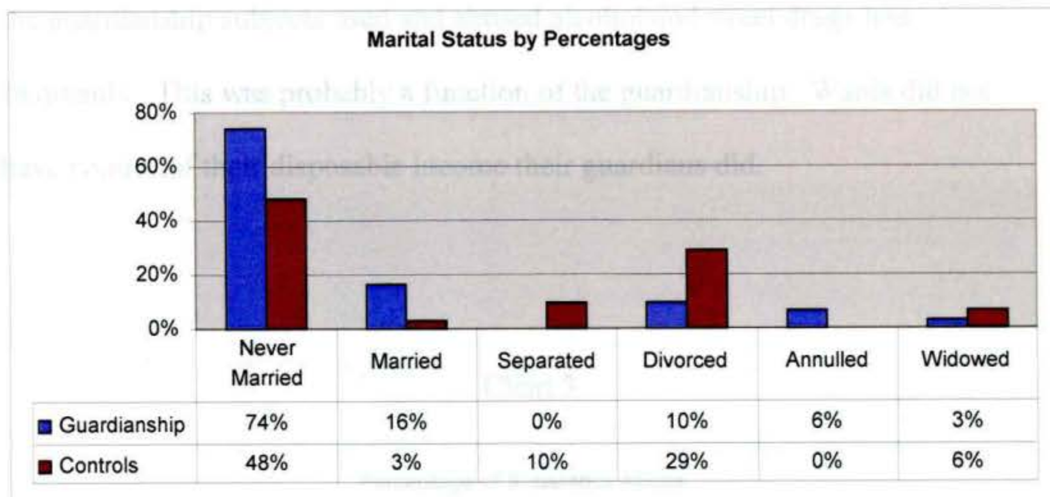
Chart 1



Source: Data collected from medical records reviews, 1998 – 2005.

Marital status was another category that highlighted differences between the groups. Viewing the data in Chart 2 by percentage accentuates the raw data differences. Three-quarters of the guardianship subjects had never married. Only a small percentage of subjects were married at the time of the study. Interestingly, six percent of the guardianship subjects had marriages annulled while their control counterparts have had none.

Chart 2



	Never Married	Married	Separated	Divorced	Annulled	Widowed
Guardianship	74%	16%	0%	10%	6%	3%
Controls	48%	3%	10%	29%	0%	6%

Source: Data collected from medical records reviews, 1998 – 2005

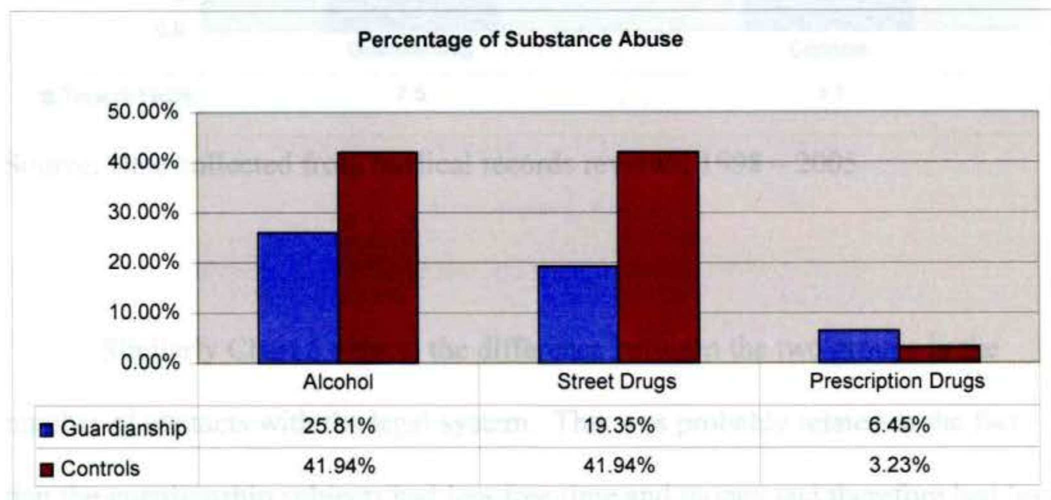
Substance use and abuse is often all too common among persons with mental illness. Ihsan M. Salloum, MD, MPH reported in his article for the American Psychiatric Association, Issues in Dual Diagnosis,

The Epidemiological Catchment Area Survey has found a lifetime rate of 13.5 % for alcohol use disorders among the general population. The rate of

alcohol use disorders increased to 16.5 for major depression, 21% for dysthymic disorder, 24% for obsessive-compulsive disorder, 29% for panic disorder, 34% for individuals with schizophrenia, and the highest rates among the major psychiatric disorders were found for bipolar II (39%) and bipolar I (46%) disorders.[1] The more recent surveys of nationally representative samples, the National Comorbidity Survey[2] and the National Institute on Alcohol Abuse and Alcoholism's National Epidemiologic Survey on Alcohol and Related Conditions (NESARD),[3] the largest survey to date, have reported similar findings for lifetime[2] and 12-month[3] rates (2005).

Data collected in the guardianship study were consistent with Salloum's report. The information presented in Chart 3 demonstrated these similarities. Note that the guardianship subjects used and abused alcohol and street drugs less frequently. This was probably a function of the guardianship. Wards did not have control of their disposable income their guardians did.

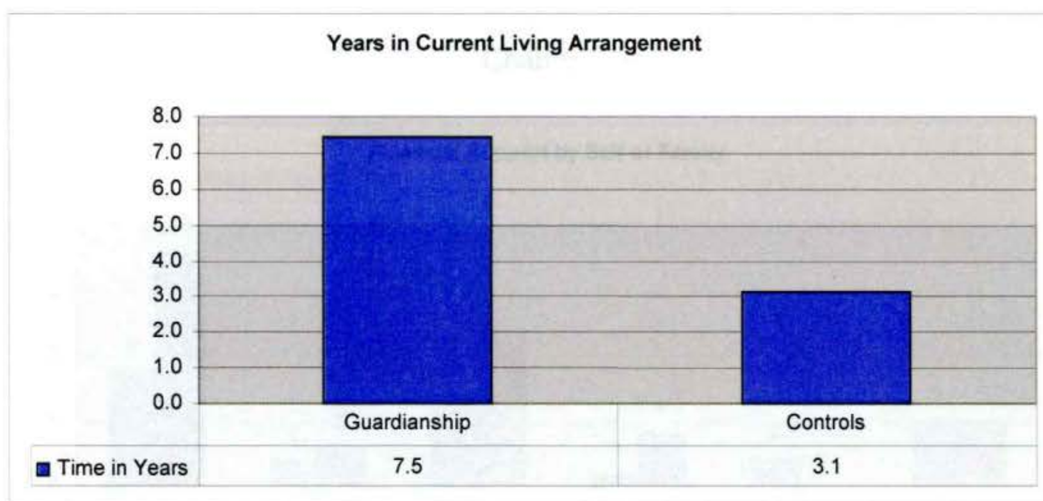
Chart 3



Source: Data collected from medical records reviews, 1998 – 2005

Possibly one of the most interesting findings of the study was the location and duration of subject's residence. Guardianship subjects lived an average of seven-and-a-half years in their placements while the controls lived less than half that time in one place, at just a little over three years. Chart 4 lists the placement choices where subjects lived. The majority of guardianship subjects lived in boarding homes (a group living facility) and the majority of controls lived in their own apartments.

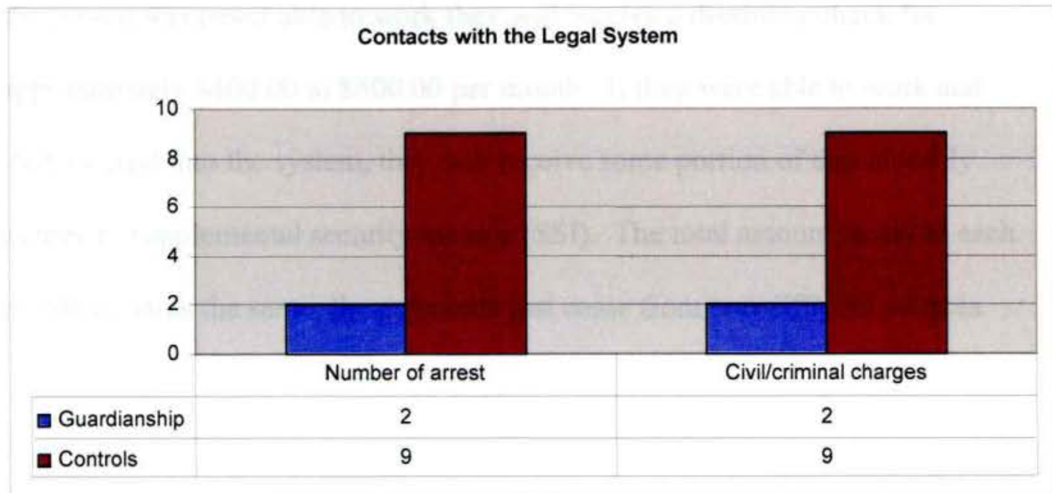
Chart 4



Source: Data collected from medical records reviews, 1998 – 2005

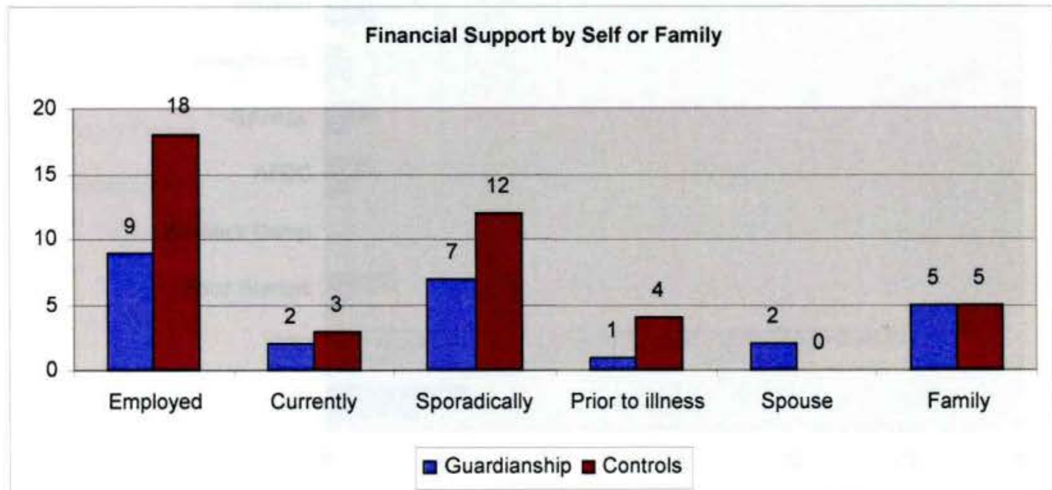
Similarly Chart 5 depicts the difference between the two groups in the number of contacts with the legal system. This was probably related to the fact that the guardianship subjects had less free time and money and therefore had less time and money to expend on illegal activities.

Chart 5



Source: Data collected from medical records reviews, 1998 – 2005

Chart 6

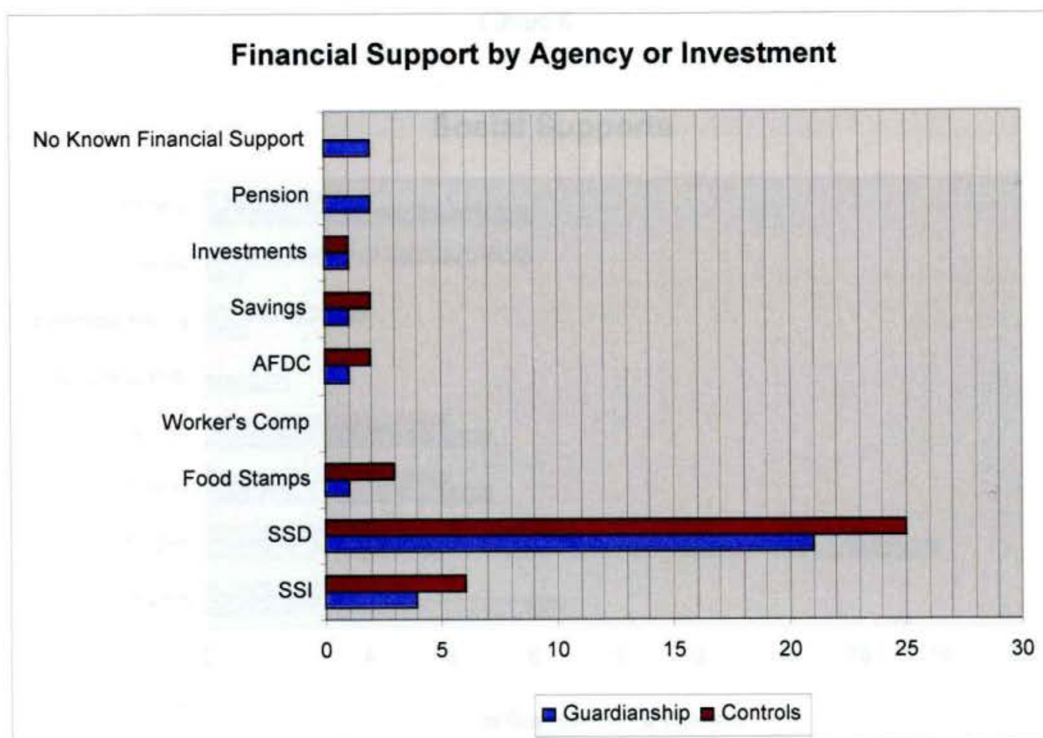


Source: Data collected from medical records reviews, 1998 – 2005

Finances affect every aspect of human lives and the same is true for these subjects. Almost seventy-five percent of the subjects were determined by the federal government to be legally disabled. Those who have been determined to be

disabled by the federal government are paid social security disability (SSD). If the person was never able to work they will receive a disability check for approximately $400.00 to $600.00 per month. If they were able to work and thereby paid into the system, they will receive some portion of that monthly money as supplemental security income (SSI). The total amount received each month remains the same, the payments just come from two different sources.

Chart 7



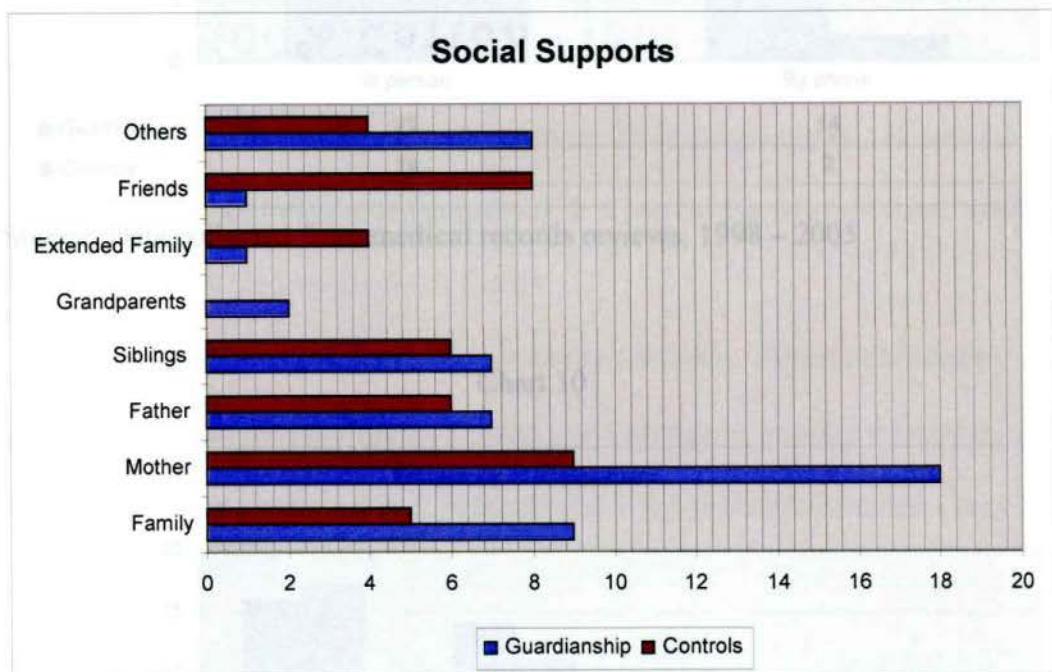
Source: Data collected from medical records reviews, 1998 – 2005

Another source of government income comes from a program that attempts to aid families with dependent children (AFDC) in need. Chart 7, Financial Support by

Agency or Investment, is consistent with previous findings. The control subjects were more likely to have at one time or another been married (Chart 2) and to have had children.

Chart 8 provides a stunning snapshot of the subject's social lives. Patients with guardians had exceedingly more social contacts and more contact with their families. The control subjects only exceeded the guardianship subjects in the area of friends (8 to 1) and extended family (4 to 1).

Chart 8

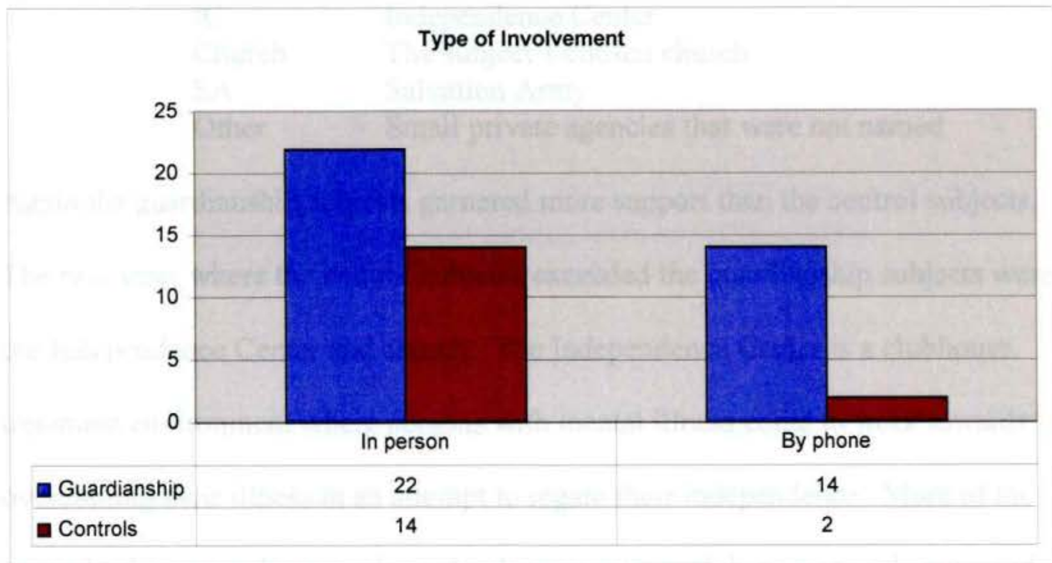


Source: Data collected from medical records reviews, 1998 – 2005

Charts 9 and 10 provide information concerning the type of contact the subjects had and how often they were in contact. The guardianship subjects were

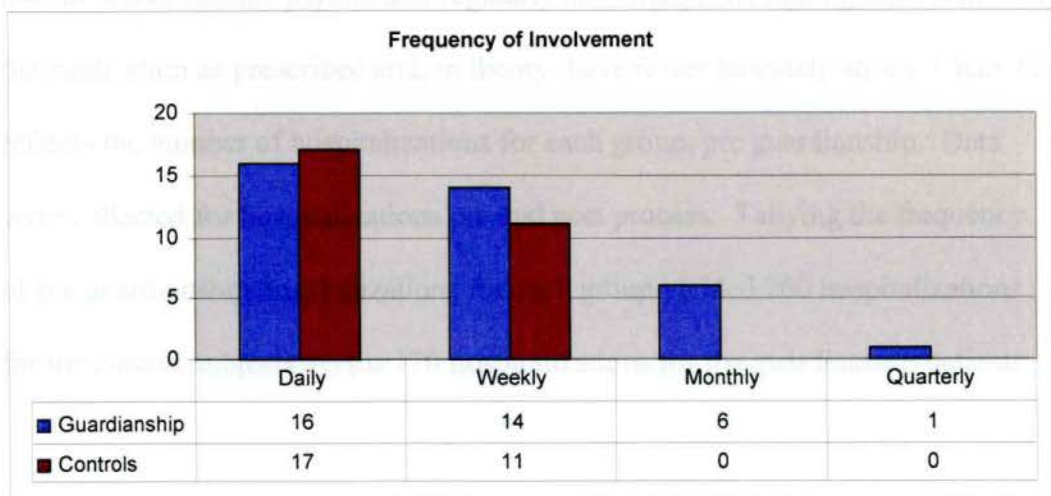
engaged in more one-to-one contact and they had more telephone contacts than the controls.

Chart 9



Source: Data collected from medical records reviews, 1998 – 2005

Chart 10



Source: Data collected from medical records reviews, 1998 – 2005

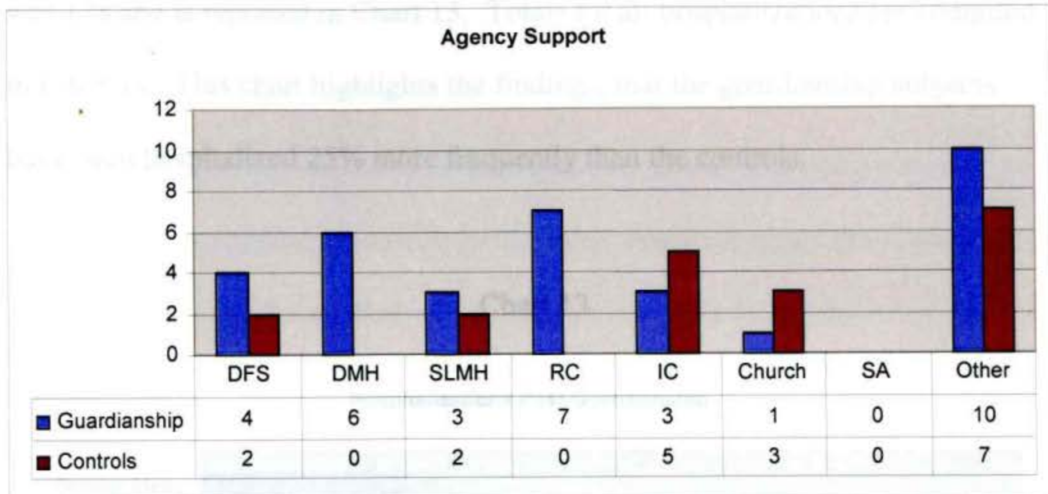
Continuing the theme of contact and support Chart 11 gives information pertaining to the agencies who were involved with the subjects. The agencies were: guardianship. The list of hospitals was complied during the data collection

DFS	Division of Family Services
DMH	Department of Mental Health
SLMH	St. Louis Mental Health
RC	Regional Center
IC	Independence Center
Church	The subject's chosen church
SA	Salvation Army
Other	Small private agencies that were not named

Again the guardianship subjects garnered more support than the control subjects. The two areas where the control subjects exceeded the guardianship subjects were the Independence Center and church. The Independence Center is a clubhouse treatment environment where persons with mental illness come to work towards overcoming their illness in an attempt to regain their independence. More of the control subjects are living independently so it is logical that more of them would be involved with the Independence Center.

The last five charts focus on measures of stability. When stabilized a patient should see the psychiatrist regularly and engage in ongoing treatment, take the medication as prescribed and, in theory, have fewer hospitalizations. Chart 12 reflects the number of hospitalizations for each group, pre guardianship. Data were collected for hospitalizations pre and post process. Tallying the frequency of pre guardianship hospitalizations for each group yielded 260 hospitalizations for the control subjects versus 170 hospitalizations for the guardianship patients.

Chart 11

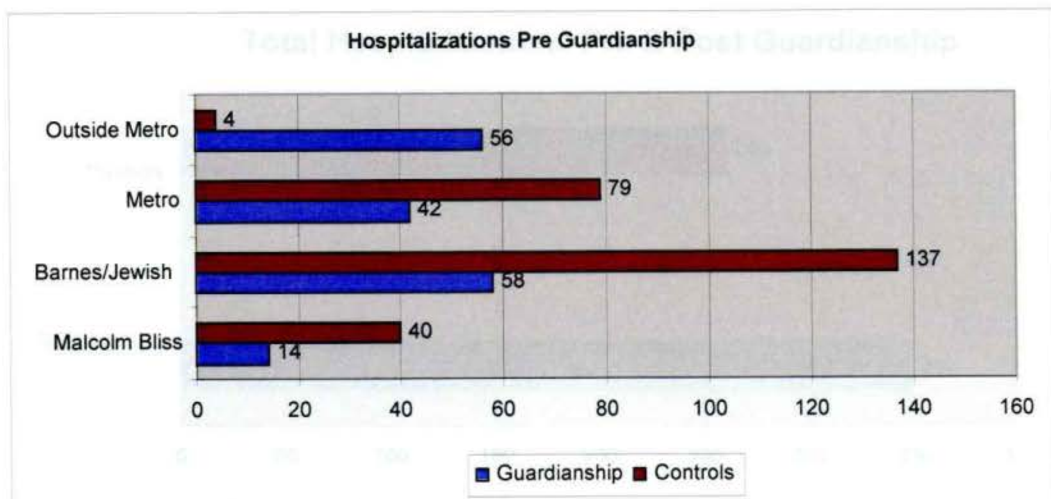


	DFS	DMH	SLMH	RC	IC	Church	SA	Other
Guardianship	4	6	3	7	3	1	0	10
Controls	2	0	2	0	5	3	0	7

Source: Data collected from medical records reviews, 1998 – 2005

The control subjects had 35% more hospitalizations than guardian subjects. That was 90 more hospital admissions which was and average of 2.9 admissions per control subject.

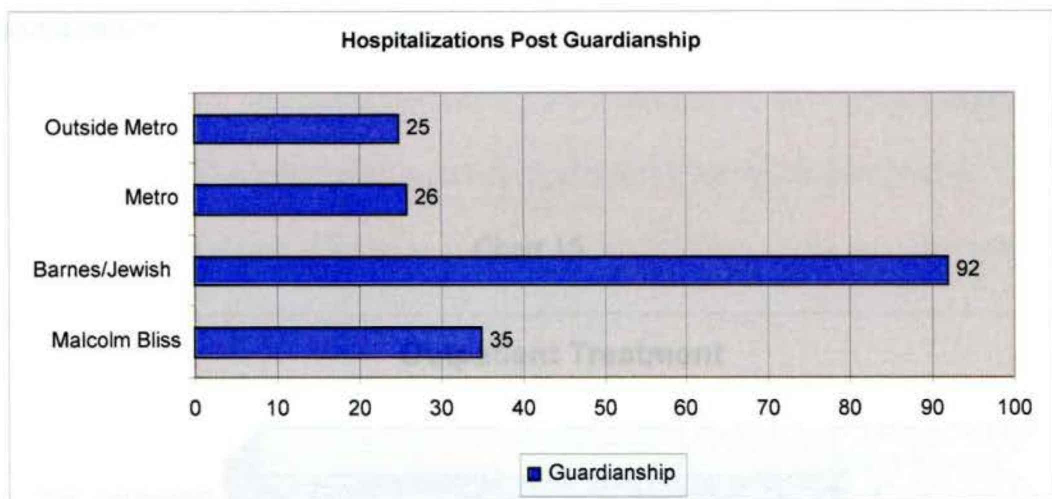
Chart 12



Source: Data collected from medical records reviews, 1998 – 2005

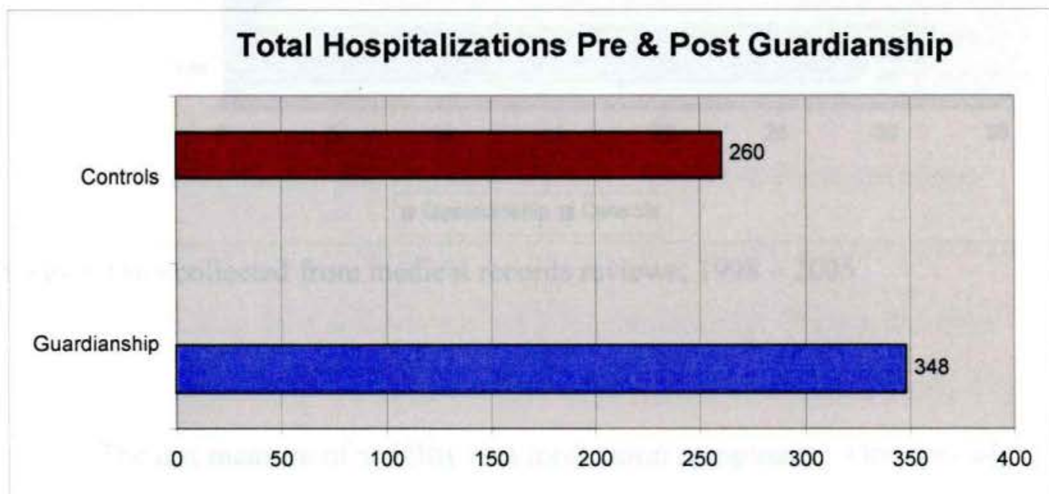
The post guardianship number of hospitalizations for the guardianship subjects was 178 and is reported in Chart 13. Totals for all hospitalizations are compiled in Chart 14. This chart highlights the findings, that the guardianship subjects have been hospitalized 25% more frequently than the controls.

Chart 13



Source: Data collected from medical records reviews, 1998 – 2005

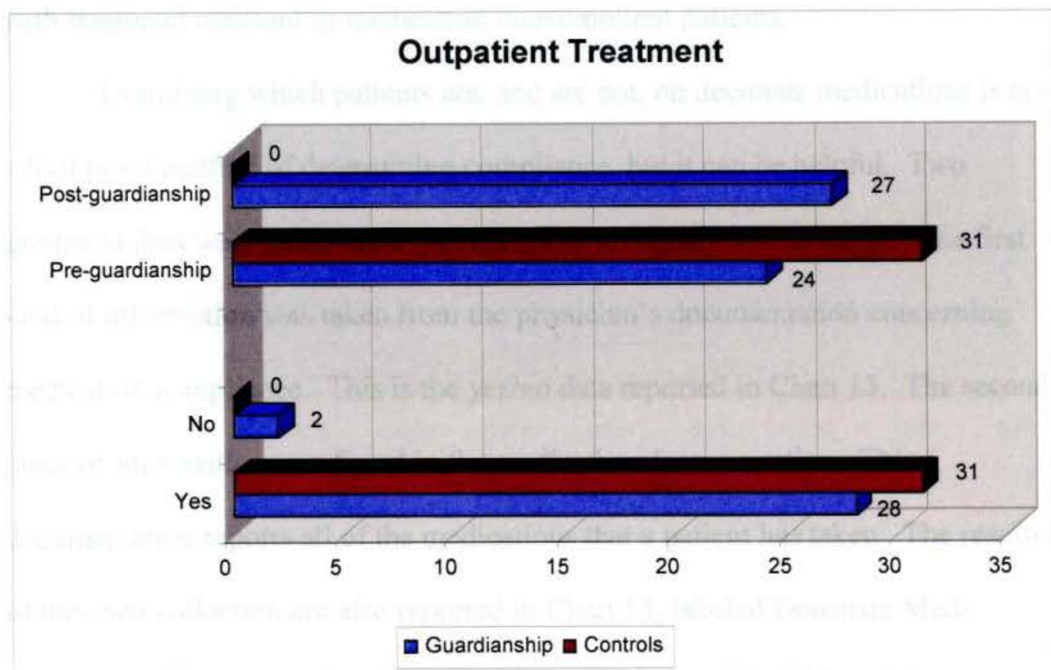
Chart 14



Source: Data collected from medical records reviews, 1998 – 2005

The results of the outpatient treatment data are different from the inpatient data. All thirty-one of the control subjects participated in outpatient treatment while only twenty-eight of the guardianship subjects engaged. Interestingly, the guardianship process boosted compliance, but not to one hundred percent. Twenty-four guardianship subjects participated in outpatient services before they were adjudicated. The number of participants increased to twenty-seven after adjudication.

Chart 15



Source: Data collected from medical records reviews, 1998 – 2005

The last measure of stability was medication compliance. One way of determining which subjects take their medications and which do not is through an

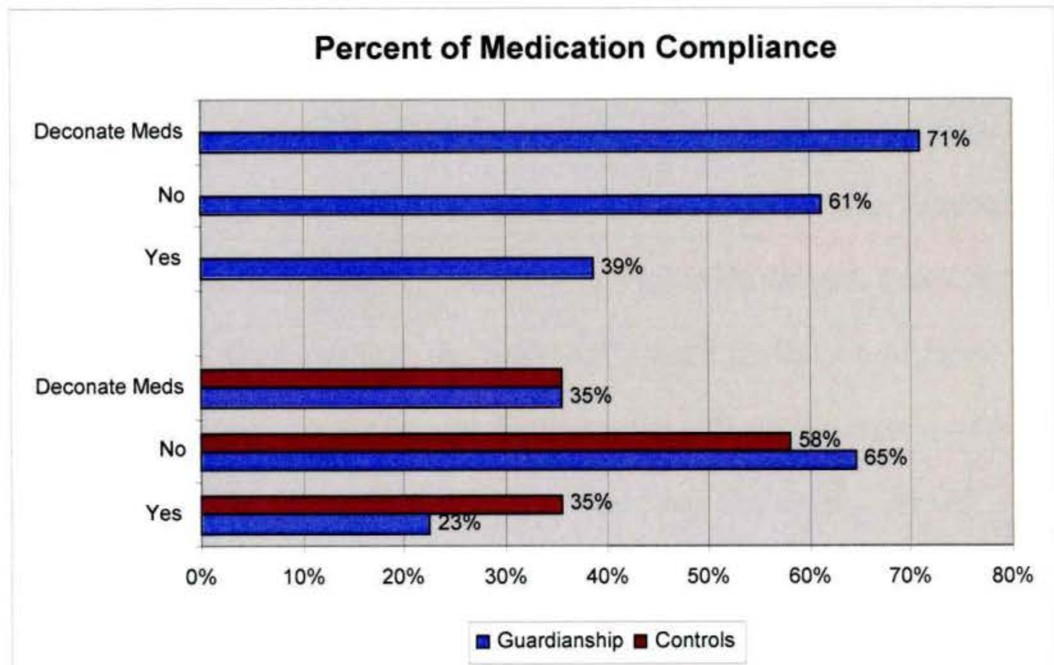
investigation of the kinds of medications subjects are prescribed. Medications come in several forms and formulations. There are medications that are taken orally which are often referred to as "P.O." (Postoperative; by mouth) meds. Included in this category of oral medications are pills, liquids and the fast-dissolving mechanisms. All of the P.O. medications have a relatively short half-life and are therefore are shorter acting. To be effective a patient must take these agents daily or multiple times per day. Another form of medication delivery is through injection. Injectable medications are formulated to have either a short or long half-life. The long acting agents typically last from two to four weeks. These medications are referred to as deconate medications. They are often used with treatment resistant or medication noncompliant patients.

Examining which patients are, and are not, on deconate medications is not a fool proof method of determining compliance, but it can be helpful. Two groups of data were gathered in an attempt to strengthen any findings. The first kind of information was taken from the physician's documentation concerning medication compliance. This is the yes/no data reported in Chart 15. The second piece of information was found in the medication documentation. This documentation reports all of the medications that a patient has taken. The results of this data collection are also reported in Chart 15, labeled Deconate Meds.

The bottom set of stacked data show that the guardianship subjects were less compliant than their counterparts prior to guardianship. During this time period both groups received equal amounts of deconate medications. After guardianship the level of medication compliance improved for the guardianship

subjects. The yes percentage of compliance increased from twenty-three percent to 39% for the guardianship subjects while the no percentage dropped a few points. Most remarkable was the 36% increase in deconate medication administration. Post guardianship 71% of the guardianship subjects received deconate medications as compared to 35% pre guardianship.

Chart 16



Source: Data collected from medical records reviews, 1998 – 2005

In summary the descriptive statistics revealed two groups of 31 subjects who were similar in gender, age, race and diagnosis because of pair-matching on these criteria. The groups were different on many of the remaining items that make up the inferential statistics. The groups appeared to be different in where

they live, how long they live there and how they support themselves financially. Socialization and the use of social agencies were dissimilar for the groups. How much treatment, the kind of treatment, inpatient or outpatient and the method of medication delivery and subjects' compliance with treatment and medications were different from a quantitative perspective.

Chapter V

DISCUSSION

Summary

Analysis of the data was conducted through the use of two formulations of Chi Square statistical test in 2 X 2 contingency tables. The first test was performed using the traditional Chi Square formula, $\chi^2 = \Sigma\ [(f_o - f_e)^2/f_e]$ at the critical value of .05. The second test was performed using McNemar formula for Chi Square as stated by James J. Schlesselman, PhD in his the text, Case-Control Studies: Design, Conduct, Analysis. McNemar's test is similar to the Mantel-Haenszel Chi Square test but is more discriminating with small sample *c* control matched-pairs. The formula is, $E = 2c/(c + 1)$ and was also tested at the .05 critical value (219). Analyses were run on 47 variables. Twenty-one variables were significant with the traditional Chi Square formula, and 37 variables were significant with the McNemar's formula. Fifteen variables were significant for both Chi Square tests.

Table 16 provides a list of the variables and the results. Included are categories for the variable, the traditional Chi Square test and its resulting Pearson's r value. Next are the results of the McNemar's calculation and the

resulting psi odds ratio. The final column of the table displays the critical value, designated "CV". The critical value was determined at 1 degree of freedom.

Table 16

Chi Square results for 31 Pair-Matched Subjects

Variable	Chi Square	phi = r	McNemar's Chi Square	psi = odds ratio	CV .05
Guardianship Own	62.0000	1.00	0.0161	1.00	3.841
Guardianship Family Member	29.5238	0.69	13.0909	0.00	3.841
Guardianship Public Administrator	13.3725	0.46	22.0500	0.00	3.841
Married Never Married	4.3509	0.26	1.5652	1.88	3.841
Married Divorced	3.4313	0.28	4.9655	0.45	3.841
Substance Abuse Alcohol	1.8002	0.17	3.3611	0.57	3.841
Substance Abuse Street Drugs	3.7185	0.24	4.4474	0.52	3.841
Substance Abuse Prescription Drugs	0.3503	0.08	28.0330	0.03	3.841
Total Substance Abuse	13.6858	0.28	25.0096	0.35	3.841
No Children	7.3810	0.35	4.7619	3.20	3.841
Living Situation With Family	0.8760	0.12	10.6176	0.31	3.841
Living Situation Own Home	0.0000	0.00	21.8065	0.11	3.841

Variable	Chi Square	phi = r	McNemar's Chi Square	psi = odds ratio	CV .05
Living Situation Family Member's Home	0.1300	0.05	16.5313	0.19	3.841
Living Situation Own Apartment	7.8283	0.36	4.7805	0.52	3.841
Living Situation Alone	3.9712	0.25	5.9211	0.46	3.841
Living Situation With Other	1.0690	0.13	23.7576	0.10	3.841
Living Situation Boarding Home	18.0364	0.54	6.6667	0.25	3.841
Total Living with Family	0.0825	0.07	53.4433	0.15	3.841
Total Living Alone	0.2200	0.22	9.0419	0.36	3.841
Number of Arrest/Criminal Charges	10.8307	0.30	22.1184	.032	3.841
Financial Support Employment	5.3143	0.29	0.6250	0.82	3.841
Financial Support Supplemental Security Income	0.4769	0.09	14.6667	0.22	3.841
Financial Support Social Security Disability	1.3478	0.15	5.6000	2.50	3.841
Total SSI/SSD	0.9198	0.07	14.5859	0.46	3.841
Social Support Family	1.4762	0.15	12.0000	0.25	3.841
Social Support Mother	5.3143	0.29	1.1364	0.69	3.841
Social Support Father	0.3503	0.08	28.0333	0.03	3.841
Social Support Siblings	0.0973	0.04	12.0333	0.25	3.841
Social Support Extended Family	1.9579	0.18	21.4412	0.13	3.841
Social Support Friends	6.3690	0.32	13.9211	0.27	3.841

Variable	Chi Square	phi = r	McNemar's Chi Square	psi = odds ratio	CV .05
Social Support Other	1.6533	0.16	14.8148	0.17	3.841
Total Family Support	4.3986	0.15	5.0633	0.61	3.841
Level of Involvement In Person	4.2393	0.26	0.6957	1.56	3.841
Level of Involvement By Phone	12.1304	0.44	13.4737	0.12	3.841
Level of Involvement Daily Contact	0.0648	0.03	0.0313	1.13	3.841
Level of Involvement Weekly Contact	0.6032	0.10	1.7500	0.65	3.841
Total Family Contact Daily Weekly Monthly Quarterly	1.9156	0.10	10.0119	0.50	3.841
Involvement with Social Agency Division of Family Services	0.7381	0.11	23.3103	0.07	3.841
Involvement with Social Agency Department of Mental Health	6.6429	0.33	27.0400	0.00	3.841
Involvement with Social Agency St. Louis Mental Health	0.1218	0.06	24.3000	0.07	3.841
Involvement with Social Agency Regional Center	7.8909	0.36	26.0417	0.00	3.841

Variable	Chi Square	phi = r	McNemar's Chi Square	psi = odds ratio	CV .05
Involvement with Social Agency Independence Center	0.5741	0.10	17.4545	0.18	3.841
Total Connected with Agency	5.9370	0.18	21.5513	0.32	3.841
Out Patient Treatment All Subjects	2.1367	0.19	23.7576	15.50	3.841
Out Patient Treatment Pre guardianship	7.8909	0.36	13.9211	4.43	3.841
Out Patient Treatment Medication Compliance	0.9239	0.13	3.2258	0.55	3.841
Deconate Medication	6.6073	0.33	0.0500	1.22	3.841

Source: Data collected from medical records reviews, 1998 – 2005.

Statistical Analysis via Traditional Formula

The analysis of data with the traditional Chi Square formula revealed interesting differences between the two groups of subjects. Statically the guardianship subjects differed from the controls in the areas of guardianship, marital status and children, substance abuse, living situations, financial support, social supports and the level of involvement of those social supports, agency support, and subjects' pre-guardianship participation in outpatient treatment.

The design of the study dictated the initial finding of statistical difference in guardianship status between the two groups. It did not influence the difference

in martial status. Subjects who had legal guardians were more likely to never marry and were three times less likely to have children than their non-guardianship counterparts. These guardianship subjects were also significantly less likely to abuse alcohol street drugs and prescription drugs. The areas of greatest difference manifested in subjects living arrangements, and support systems.

Control subjects were fifty percent more likely to live alone in their own apartments. Guardianship subjects were more likely to live in residential group housing. Control subjects were eighty percent more likely to engage in some level of employment. The traditional Chi Square formula revealed differences between the groups in the area of family support. This test determined that mothers and friends were most likely to provide contact and support to guardianship subjects. When the two groups were compared for all family support the guardianship subjects received sixty percent more support from family members than controls. This trend continued in the comparison of the level of involvement.

The family members of the guardianship subjects were one-and-a-half times more likely to provide contact in person than the family members of controls. Guardianship subjects were also more likely to receive telephone calls from their loved ones. Guardianship subjects more frequently were connected to community support agencies. The traditional Chi Square formula marked statistical differences between the groups for two agencies, The Department of Mental Health, and Saint Louis Mental Health. The tests also determined a

difference in the favor of guardianship subjects concerning all agency support. The final difference highlighted by the traditional Chi Square formula concerns out patient treatment.

Data concerning subject's participation in out patient treatment were collected for the periods of pre and post guardianship. Statistical analysis revealed that control subjects were four-and-a-half times more likely to engage in out patient treatment in the pre-guardianship period than the guardianship subjects. Post guardianship there was no difference between the groups because the guardianship subjects increased their participation rate in out patient treatment. Pre-guardianship, an equal number of subjects between groups received deconate medication. Deconate medication is a long acting injectable formulation used in cases where medication compliance has been an issue. Post guardianship the guardianship subjects were 1.22 times more likely to receive deconate medication.

Statistical Analysis via McNemar's Formula

McNemar's Chi Square formula is designed to determine statistical differences between small group pair-matched subjects. This formula produced the expected statistical difference between the groups pertaining to the issue of guardianship. It did not find a difference between subjects on the issue of getting married. Instead it highlighted a forty-five percent increase in the statistical probability of control subjects getting divorced. Control subjects were more than

three times as likely to have children. McNemar's formula found more difference between the groups pertaining to their substance abuse.

The control groups were fifty percent more likely to abuse all substances, alcohol street drugs and prescription medications. Only three tests were statistically significant, street drugs, prescription medications and total substance abuse. The McNemar's formula determined statistical differences between the groups on all of the tested living situation measures. An important measure of subject stability was determined by the length of time subject's resided in a particular setting. Guardianship subjects averaged seven-and-a-half years while the controls only managed three years.

The reason for this difference can be extrapolated from the rest of the data in this category. The guardianship subjects were twenty-five percent more likely to live in supervised group home (boarding home) settings. Here they were required to maintain a schedule, take their medications, eat a nutritious and regular diet, and they were not allowed to abuse substances. Control subjects were fifteen percent more likely to live with family and fifty percent more likely to live alone in their own apartment than guardianship subjects. Family members were less likely to provide the level of supervision and care that boarding homes did. This was demonstrated in the statistically significant arrest/criminal charges data. Control subjects were thirty percent more likely to have arrests and criminal charges.

McNemar's Chi Square determined statistical differences in the financial status of the populations. The odds ratio predicted that eighty-two percent of

control subjects had engaged in some form of employment. Conversely the guardianship subjects were more likely to be determined disabled and therefore received Social Security Disability. Because of their increased rate of employment the control subjects more frequently received Supplemental Security Income. Combining income from both of these governmental programs yielded a statistically significant finding for the control subjects. This means that the control's received a larger monthly income because they worked at some time during their life. While they worked they paid into the Social Security Income system and this enabled them to collect on these payments.

Again this formula demonstrates its power in determining the statistical difference between the groups pertaining to social supports. Guardianship subjects were twenty-five percent more likely to receive support from their family. A difference between the two formulas was demonstrated concerning support from mother and support from father. The traditional formula found a significant difference in mothers support. The McNemar's formula found the opposite, a significant difference in fathers support. Also significant were siblings support, extended family member's support and other's support for the guardianship subjects. The only area in which the control subjects garnered statistically more support was in the area of support from friends. Statistically the guardianship group was sixty percent more likely than controls to receive support from all family members.

Involvement was more difficult to determine. McNemar's formula found statistical difference in two levels of involvement. Guardianship subjects were

twelve percent more likely to receive telephone calls. Those same subjects were fifty percent more likely than controls to receive family contact on a daily weekly monthly and quarterly basis. Analyzing subject's involvement with social agencies revealed significant results across all variables.

Guardianship subjects were statistically more likely to receive support from the Division of Family Services, the Department of Mental Health, Saint Louis Mental Health, Regional Center and other agencies. The only agency that provided more support to the control subjects was the Independence Center. This is a logical finding. The Independence Center provided service to persons with mental illness who wish to return to independent functioning. This result was supported by the findings concerning placement and finances. Another supportive result was that of out patient treatment.

When compared during the pre-guardianship time period control subjects were fifteen-and-a-half times more likely than guardianship subjects to participate in out patient treatment. Post guardianship the control subjects were still nearly four-and-a-half times more likely to participate in out patient treatment. The McNemar's formula did not detect a statistically significant difference between the groups on the variables of medication compliance and deconate medication use.

Practical and Theoretical Implication

Psychiatric clinicians are frequently asked to evaluate patients for capacity. The process includes taking a history and performing a physical, performing a mental status exam and the administration of tests and measures. Developing a prognosis is a critical outcome derived from the information gathered during the process. The assessment process culminates with a written report that includes a diagnosis, prognosis and options that guide the provision of care. When clinicians determine that patients no longer have the capacity to guide and direct their own care they will often advise care providers concerning the patient's legal status. This can be accomplished in writing or by conversation. If by conversation the discussion often includes issues of ethics, morals, liability, risk management and legal alternatives. Prior to this study no research existed concerning the practicality or the lack of viability pertaining to the use of guardianship to manage incapacitated psychiatric patients. Therefore, the guardianship process was often reserved for the most severe cases or the hopeless cases. This new data provides information that may influence clinicians or family members to use this legal mechanism in an effort to stabilize or protect those who cannot stabilize or protect themselves.

Does Guardianship Help Chronically Severely Mentally Ill Adults

There is no definitive answer to this question. Each case must be evaluated individually because of the gravity of the resulting action. Guardianship strips the ward of all of civil rights and requires another to act completely on their behalf. Guardianship should only be considered when all other options have failed or cannot be employed. When clinicians, lawyers and family members are faced with the decision it is hopeful that the data from this study will provide information that will assist them in the decision-making process.

It is clear that the guardianship subjects in this study experienced a better quality of life than the controls as measured by the preponderance of variables. Arguably these variables and the quality they imply must be weighted against the loss of personal freedom. The freedoms to vote, drive a car, enter into a contract or choose a health care provider. So the exercise comes full circle.

As President Abraham Lincoln stated in his Gettysburg address, "Fourscore and seven years ago our fathers brought forth on this continent a new nation, conceived in liberty and dedicated to the proposition that all men are created equal" (Grolier, 1993). Doctors, lawyers, family members, judges and patients will continue to struggle with the dilemma of freedom versus well being and quality of life as long as inequality caused by the ravages of mental illness exists.

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