ESCAPING THE LPS REVOLVING DOOR

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I. INTRODUCTION

An LPS conservatorship allows involuntary mental health treatment for individuals who are presently gravely disabled as a result of mental illness or chronic alcoholism.¹ It is designed for individuals that cannot or will not voluntarily accept treatment. Contrary to popular opinion, it is not the only option for involuntary mental health treatment in California. California Probate Code section 2357 provides another option for involuntary mental health treatment, on an outpatient basis, provided state and federal constitutional protections are met. Because probate conservatorships often last for the lifetime of the individual, they can incorporate long-term treatment options unavailable under LPS conservatorships.

This article begins by summarizing the rules governing LPS conservatorships and then discusses the limitations of LPS conservatorships resulting from those rules. It follows with a discussion of the often ignored legal authority in the Probate Code permitting mental health treatment in probate conservatorships, and the circumstances under which the probate court could authorize mental health treatment without the conservatee’s consent.² The article goes on to address the constitutionality of involuntary mental health treatment in probate conservatorships, and then compares Probate Code section 2357 to the involuntary treatment laws in other states. Taking from the successes and failures of assisted outpatient mental health treatment in other states, the authors recommend methods for increasing the effectiveness of mental health treatment in probate conservatorships. The final section discusses the status of current legislation affecting involuntary outpatient mental health treatment in California.

II. LPS CONSERVATORSHIPS

A. LPS Overview

Under the LPS statute, a severely mentally ill patient, who is under an LPS conservatorship, can be involuntarily confined to a mental health facility and/or required to take psychotropic drugs against his or her will. Because of the potential for loss of significant civil liberties, LPS conservatorship proceedings provide protections to the patient similar to criminal proceedings.³ The LPS conservatorship proceeding must be initiated by a public official, often the public guardian, on the recommendation of the professional staff of a treatment facility (i.e., psychiatrist). The individual must be proven to be “gravely disabled” beyond a reasonable doubt.⁴ The patient is entitled to counsel, and generally appointed a public defender.⁵ After a year,⁶ the conservator must re-petition for continuation for another year, and again bear the burden of proving beyond a reasonable doubt that the individual is presently “gravely disabled.” While the LPS statute is effective in protecting the civil liberties of the mentally ill, it often does so at the expense of the individual’s mental health.

B. One-Year Duration under LPS Has Limited Effectiveness

Because of its one-year duration, the LPS conservatorship is limited in its ability to assist patients on a long-term basis. Many LPS conservates lack insight into his or her illness. While under conservatorship, the patient may be required to take medication to treat the symptoms of his or her mental illness. When treatment is effective, however, the patient may interpret the absence of symptoms as further support for his or her delusional belief that he or she was never ill.⁷ Believing there is no need for medication because he or she is symptom-free, the conservatee discontinues medication upon the termination of the LPS conservatorship.

Unfortunately, the LPS system generally fails to provide a mechanism for monitoring and enforcing medication compliance once the individual returns to the community and the LPS conservatorship ends.⁸ The patient who discontinues the antipsychotic medication is almost certain to relapse. The LPS process then starts all over again with another institutionalization, re-introduction of medicine, partial recovery and reduction of symptoms, followed by release from the system after twelve months. Because mental illness frequently starts in late adolescence or early adulthood, it is not uncommon for a mentally ill individual to be in and out of mental health facilities for his or her entire life.⁹

This revolving door effect on LPS conservatees may place the hospital psychiatrist in an ethical bind with a patient, who has a recurrent pattern of non-adherence to medications and resultant re-hospitalizations. This patient may voluntarily agree to take the medications as the LPS conservatorship hearing approaches solely to avoid being conserved (or avoid the conservatorship being renewed for another year) without any new insight into the illness and the need for medication. Fearing that the patient may reconstitute (i.e., “pull it together”) long enough to “win” the hearing, the psychiatrist may be tempted to withhold medications until after the hearing.

C. Requirement of “Present” Grave Disability Often Prevents Reappointment

The drawbacks with the one-year automatic termination in LPS conservatorships are showcased throughout California case law.¹⁰ In Estate of Murphy, an LPS conservatorship was established for Mr. Murphy, who suffered from chronic alcoholism.¹¹ After the first year expired, the public guardian petitioned for reappointment as the LPS conservator which was contested by Mr. Murphy.¹² Although Mr. Murphy was sober at the time of the hearing, the trial court found that once the powers of the LPS conservator stopped, it was reasonably probable that Mr. Murphy would return to alco-
holism and become gravely disabled.\textsuperscript{13} The trial court granted the public guardian’s petition for reappointment.\textsuperscript{14} The court of appeal reversed the trial court’s decision, and held that an individual may only be subject to an LPS conservatorship if he or she is “presently” disabled, and unable to provide for his basic personal needs for food, clothing, or shelter.\textsuperscript{15} The likelihood that Mr. Murphy would almost certainly return to alcoholism within a matter of days, again placing himself in grave disability, was not a consideration.

The LPS requirement that the conservatee be “presently” gravely disabled creates an often insurmountable hurdle for the successful treatment of the patient. If the psychotropic medication is successful in alleviating the conservatee’s symptoms, the conservatee will no longer be gravely disabled by the time the petition for reappointment is up for review. In such case, the petition for reappointment must generally be denied if the conservatee is willing to admit he or she is mentally ill and in need of medication.\textsuperscript{16} The fact that the conservatee is likely to stop treatment and relapse is insufficient alone to allow for reappointment.\textsuperscript{17} However, if the conservatee lacks insight into his illness, thereby denying the need for medication, has a past pattern of failing to take medicine, cannot provide for himself or herself without the medication and will not take the medication without a conservator, then the conservatee may be found presently gravely disabled.\textsuperscript{18}

\section*{III. MENTAL HEALTH TREATMENT UNDER PROBATE CONSERVATORSHIPS}

\subsection*{A. 1990 Legislative Changes Allow Probate Court to Authorize Certain Mental Health Treatment}

In 1990, the Legislature changed Probate Code sections 2356-2357\textsuperscript{19} to give the probate courts the power to order long-term outpatient mental health treatment, something the LPS conservatorship could never do. Unfortunately, many practitioners missed the subtle changes.\textsuperscript{20}

\subsection*{B. Pre-1990 Versions of Sections 2356 and 2357}

Before 1990, both the Probate Code and California case law held that an LPS conservatorship was the sole mechanism for providing involuntary mental health treatment. Section 2356 prohibited probate conservators from authorizing any form of involuntary civil mental health treatment.\textsuperscript{21} It read, in pertinent part, as follows:

No ward or conservatee may be placed in a mental health treatment facility under this division against the will of the ward or conservatee. Involuntary civil mental health \textit{treatment}, for a ward or conservatee may be obtained only pursuant to Chapter 2 (commencing with Section 5150) or Chapter 3 (commencing with Chapter 5350) of Part 1 of Division 5 of the Welfare and Institutions Code.\textsuperscript{22} [emphasis added.]

Prior to 1990, the Probate Code provision authorizing a probate conservator to consent to medical treatment on behalf of a conservatee was expressly limited to \textit{physical} health.\textsuperscript{23} The section made no mention of mental health \textit{treatment}. The pre-1990 case law interpreting sections 2356 and 2357 followed the plain language of the statute, precluding involuntary mental health treatment outside of an LPS conservatorship.\textsuperscript{24} For example, in \textit{Keyheia v. Rushen}, the court found that:

Wards and conservates under the Probate Code are expressly protected from involuntary civil mental health \textit{treatment}. . .This leaves LPS, which appears to provide the sole mechanism for involuntary administration of long-term psychotropic medication.\textsuperscript{25} [emphasis added.]

\section*{C. 1990 Changes to Sections 2356 and 2357 Narrow Restrictions on Mental Health Treatment}

However, the 1990 changes to sections 2356 and 2357 were specifically designed to take away some of the handcuffs on the probate court. Section 2356 subdivision (a) was amended in 1990 to read as follows:

No ward or conservatee may be placed in a mental health treatment facility under this division against the will of the ward or conservatee. Involuntary civil \textit{placement} of a ward or conservatee in a mental health treatment facility may be obtained only pursuant to Chapter 2 (commencing with Section 5150) or Chapter 3 (commencing with Chapter 5350) of Part 1 of Division 5 of the Welfare and Institutions Code.\textsuperscript{26} [emphasis added.]

The restrictive language in pre-1990 section 2356 prohibiting civil mental health \textit{treatment}, except in the case of an LPS conservatorship under the Welfare and Institutions Code, was modified and narrowed to include only involuntary civil \textit{placement}.\textsuperscript{27} The restriction against mental health \textit{treatment} generally in probate conservatorships was eliminated. The LPS conservatorship, however, remained the only forum for involuntary civil placement (i.e., institutionalization).

The California Law Revision Commission explains the reasons for the elimination of the restrictive language as follows:

By providing authority to give necessary medical treatment affecting the \textit{mental} health of the ward or conservatee, the recommended legislation resolves an anomaly in the law that would result where a ward or conservatee needs treatment but does not meet the standards applicable under LPS.\textsuperscript{28} [emphasis added.]

The Legislature did not stop with changing the restrictive language of the former section 2356. The Legislature modified the
enabling language of section 2357 to include mental health treatment. Before the 1990 amendment, under section 2357, the probate court could authorize a conservator to consent to medical treatment over the objection of the conservatee if the court found the following:

(1) The existing or continuing medical condition of the ward or conservatee requires the recommended course of medical treatment;

(2) If untreated, there is a probability that the condition will become life-endangering or result in a serious threat to the physical health of the ward or conservatee. [emphasis added.]

(3) The ward or conservatee is unable to give informed consent to the recommended course of treatment.

The 1990 modification changed section 2357 subdivision (h) by adding the words “or mental health” after the words “physical health,” so the probate court may now authorize the conservator to consent to medical treatment if it finds:

(1) The existing or continuing medical condition of the ward or conservatee requires the recommended course of medical treatment;

(2) If untreated, there is a probability that the condition will become life-endangering or result in a serious threat to the physical or mental health of the ward or conservatee. [emphasis added.]

(3) The ward or conservatee is unable to give informed consent to the recommended course of treatment.

The 1990 changes to the Probate Code gave the probate courts the express power to fashion long-term mental health treatment plans for outpatients. Of course, the discretion is not unlimited. The conservatee is given certain constitutional protections against forced medication.

D. Required Finding: Conservatee Must Lack the Ability to Give Informed Consent to Psychotropic Medications

A probate conservator may not make medical decisions for every conservatee. The appointment of a conservator of the person or estate does not in itself negate the ability of the conservatee to make medical decisions, if the treating physician believes the conservatee has the capacity to do so. If the treating physician does not believe the conservatee has medical decision-making capacity, he or she may seek consent from the probate conservator. However, the conservatee may refuse treatment to which the conservator has consented, unless the court makes a finding that the conservatee lacks the capacity to give informed medical consent. A determination that the conservatee lacks the ability to give informed medical consent may take the form of a general finding, that the conservatee lacks the capacity to give informed consent to all types of medical care or that the conservatee lacks the capacity to give informed consent to a particular procedure or course of treatment.

Under section 813, a person has the capacity to give informed consent to medical treatment or refuse medical treatment if:

(1) The person can respond knowingly and intelligently to queries about his medical treatment;

(2) The person can participate in the treatment decision by means of a rational thought process;

(3) The person can understand all of the following items of minimum basic medical treatment information with respect to the treatment:

(A) The nature and seriousness of the illness, disorder, or defect that the person has;

(B) The nature of the medical treatment that is being recommended by the person’s health care providers;

(C) The benefits and risks of any medical intervention, and consequences of lack of treatment; and

(D) The nature, benefits and risks of any reasonable alternatives.

If an individual suffering from uncontrolled psychosis persists in the delusion that he or she is not mentally ill, and, in turn, will not benefit from psychotropic medication, then the patient will similarly be unable to assess the benefits and risks of taking psychotropic medications and the consequences of failing to control the psychosis. Under the probate standard, this patient lacks the capacity to give, or refuse to give, informed consent to the administration of psychotropic medication.

IV. LPS STANDARD FOR DETERMINING LACK OF CAPACITY TO CONSENT TO MEDICATION IS SUBSTANTIALLY SIMILAR TO THE PROBATE STANDARD

The LPS standard for lack of capacity to give informed consent to psychotropic medications is substantively similar to the probate conservatorship standard. Under LPS statutory, case and regulatory law, the individual lacks the capacity to give informed consent to (or refuse to consent to) the administration of psychotropic medications if:

(a) The individual does not understand his present situation – i.e., that he is mentally ill and needs psychotropic medication to control the symptoms;

(b) The individual does not understand the nature of the
proposed treatment;
(c) The individual does not understand the benefits of treatment;
(d) The individual does not understand the consequences of lack of treatment;
(e) The individual does not understand the potential side effects of such treatment;

or

(f) The individual does not understand the reasonable alternatives to treatment.\(^\text{40}\)

The key factor for LPS purposes appears to be the ability to understand the benefits and risks of the proposed treatment, which necessarily includes an understanding and acceptance that the individual is mentally ill.\(^\text{41}\) The mentally ill conservatee, who denies his or her mental illness, lacks the capacity to informatively refuse the administration of psychotropic medication.\(^\text{42}\)

Both the probate conservatorship and the LPS conservatorship use the "clear and convincing evidence" burden of proof in determining whether the individual lacks the capacity to give informed consent to medical treatment or refuse medical treatment.\(^\text{43}\) The "beyond a reasonable doubt" burden of proof required for the findings needed to establish the LPS conservatorship has been repeatedly determined by case law not to apply to medical determinations.\(^\text{44}\)

V. PROBATE COURT MAY CONSIDER FUTURE NEEDS AND NOT JUST PRESENT DISABILITY

In a probate conservatorship proceeding, the court is not strictly limited to consider only the individual’s present level of impairment. Unlike in LPS proceedings, the probate court may consider whether the proposed conservatee is likely to relapse and need assistance in the immediate future.\(^\text{45}\) In Estate of Hubbard, the appellate court upheld the probate court’s decision to keep Ms. Hubbard, a chronic alcoholic, under conservatorship because of her propensity to drunkenness.\(^\text{46}\)

Under almost identical facts, but in an LPS conservatorship proceeding, the appellate court overturned the LPS court’s decision to keep Mr. Murphy, who was also a chronic alcoholic, under an LPS conservatorship.\(^\text{47}\)

VI. PROBATE BENCH OFFICERS ARE GENERALLY RELUCTANT TO AUTHORIZE MENTAL HEALTH POWERS EXCEPT IN THE CASE OF DEMENTIA

Notwithstanding the changes to sections 2356 and 2357 approximately twenty years ago, many probate courts and probate practitioners continue to operate under the pre-1990 requirements, and decisions like Keyhea v. Rushen.\(^\text{48}\) The misconception is not limited to the bar and bench.\(^\text{49}\) The misconception is found among psychiatrists, professional conservators, and public guardians as well.\(^\text{50}\)

In 1996, the Legislature’s response to the probate courts’ refusal to allow the administration of psychotropic medications for those suffering from dementia, absent an LPS conservatorship, was the enactment of section 2356.5, specifically allowing the probate court to authorize the administration of dementia medication over a conservatee’s objection.\(^\text{51}\) To make certain that the adoption of dementia powers would not be misconstrued as inferring that no other psychotropic medications could be ordered in a probate conservatorship, the Legislature included section 2356.5 subdivision (k), which reads:

Nothing in this section shall affect current law regarding the power of a probate court to fix the residence of a conservatee or to authorize medical treatment for any conservatee who has not been determined to have dementia.\(^\text{52}\)

Some interpret the enactment of section 2356.5 as proof that section 2357 does not permit the court to grant probate conservators the power to authorize administration of psychotropic medication, other than in the dementia context. The argument is based on the premise that, if probate conservators already had the power to authorizer the administration of psychotropic medicine under section 2357, then the enactment of section 2356.5 to allow administration of dementia medication would have been unnecessary. However, this position disregards the most obvious reason for enactment of section 2356.5: the prohibition against involuntary placement (i.e., institutionalization) still contained in revised (post 1989) sections 2356 and 2357. The enactment of new section 2356.5 was essential to allow probate conservators to authorize placement (i.e., institutionalization) of the severely-demented patient in a secured facility to protect the patient—it something probate conservators were strictly prohibited from doing under section 2356. The legislative decision to also include more specific dementia medication powers with new placement powers in section 2356.5 simply gives clearer guidance to practitioners in the dementia arena.

VII. CONSTITUTIONAL PROTECTIONS AGAINST INVOLUNTARY MEDICATIONS

Although section 2357 permits all types of involuntary medical care, other than confinement, the involuntary administration of psychotropic medication brings into play constitutional and common law privacy and due process protection issues.\(^\text{53}\) Each person has a fundamental right to refuse medical treatment. Before being denied that right based on the individual’s lack of capacity, basic due process requirements must be satisfied. This requires a judicial determination of lack of capacity, which necessarily involves the right to counsel and an evidentiary hearing of some form.\(^\text{54}\)

Under section 2357, before the probate court can make a de-
termination that the conservatee lacks the capacity to consent to (or refuse to consent to) the administration of psychotropic medication, a petition must be filed, at least 15 days notice must be given to the conservatee and all interested parties, counsel must be appointed for the conservatee, and the court must generally conduct an evidentiary hearing. Additionally, a medical affidavit must be attached that evidences the following:

1. The nature of the medical condition requiring treatment;

2. The recommended course of medical treatment, which is considered medically appropriate;

3. The threat to the health of the conservatee if authorization to consent is delayed or denied;

4. The probable outcome of the treatment;

5. The medically available alternatives, if any, to the recommended course of treatment;

6. The efforts made to obtain an informed consent from the conservatee; and

7. The names and addresses of interested person and family.55

At the hearing, the court must find that:

1. The existing or continuing medical condition of the conservatee requires the recommended course of medical treatment;

2. If untreated, there is a probability that the condition will become life threatening or result in serious threat to the physical or mental health of the conservatee; and

3. The conservatee is unable to give informed consent to the recommended course of treatment.56

The due process safeguards set forth in section 2357 exceed the protections granted under the LPS statute in that 15 days notice is required in probate before any determination is made. In an involuntary hospitalization under the LPS statute, the petition of the treatment facility for a determination that the individual lacks the capacity to refuse to consent to administration of anti-psychotic medication is heard within 72 hours of filing, allowing little time for preparation of a defense.57

VIII. SECTION 2357-LIKE PROCEDURES AUTHORIZING PSYCHOTROPIC MEDICATIONS IN OTHER STATES

A. Massachusetts

The procedure set forth in section 2357 is substantially similar to the substituted judgment procedure in other states used to authorize “mental health treatment.” Massachusetts authorizes the involuntary administration of psychotropic medication for incompetent persons under guardianship through orders for substituted judgment.59 The petition is brought by the guardian, who is generally a family member. Like California, the hearing on this petition requires notice to the closest relatives and counsel for the individual. The Massachusetts court considers the following relevant factors, when making a substituted judgment for an incompetent individual: (1) the patient’s expressed preferences, (2) the patient’s religious convictions and the relation of those convictions to refusal of treatment, (3) the impact on the patient’s family, (4) the probability of adverse side effects, and (5) the prognosis with and without treatment.60 Unlike California, which focuses primarily on the “best interests” of the individual, the Massachusetts substituted judgment process also considers what the individual would choose, if he or she were competent. When the court grants the power to administer psychotropic drugs over the objections of the patient, the court must also set a termination date for this particular power.51

B. Colorado

Colorado law permits the involuntary administration of psychotropic medication in its general guardianship proceedings if clear and convincing evidence is produced at an evidentiary hearing showing that: “(1) the patient is incompetent to effectively participate in the treatment decision; (2) treatment by antipsychotic medication is necessary to prevent a significant and likely long-term deterioration in the patient’s mental condition or to prevent the likelihood of the patient causing serious harm to himself or others in the institution; (3) that a less intrusive treatment alternative is not available; and (4) that the patient’s need for treatment by antipsychotic medication is sufficiently compelling to override any bona fide and legitimate interest of the patient in refusing treatment.”62

C. Minnesota

Likewise, Minnesota allows for the administration of psychotropic medication in both general conservatorship proceedings and civil commitment proceedings.63 As an additional patient safeguard, Minnesota requires that the general conservator provide the court with information on the specific follow-up procedure to be used to monitor the side effects from the medication. Additionally, in Minnesota, the power to administer psychotropic medicines terminates automatically after a year unless renewed.

D. New York

New York law provides the same basic due process protections.64 There, the state bears the burden of demonstrating by clear and convincing evidence at an evidentiary hearing that the patient lacks capacity to make a treatment decision, and the proposed treatment is “narrowly tailored to give substantive effect to the patient’s liberty interest, taking into consideration all relevant circumstances, including the patient’s best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments.”65
IX. WAYS TO INCREASE EFFECTIVENESS OF OUTPATIENT TREATMENT

A. Statistics Evidence Individuals Benefit from Outpatient Services

Involuntary mental health treatment, with the right kind of support services, can significantly decrease re-hospitalizations. New York enacted Kendra’s Law in 1999 after the death of Kendra Webdale, a young woman pushed in front of a New York City subway train by an individual suffering from untreated schizophrenia. Kendra’s Law provides a procedure for obtaining court orders for certain individuals requiring that they receive involuntary assisted outpatient treatment (“AOT”). The 2005 study by the New York State Office of Mental Health showed that AOT of not less than six months reduced re-hospitalizations by 77%.68

A 1999 study by Duke University researchers found that assisted outpatient treatment of at least six months with the same level of services as found in intensive inpatient treatment, but performed on an outpatient basis (at least three outpatient visits per month with a median of 7.5 visits per month) reduced hospital admission by 57%, compared with individuals without court-ordered treatment.69 For individuals with schizophrenia and other psychotic disorders, long-term assisted outpatient treatment reduced hospital admissions by 72%. However, patients showed no improvement when the AOT was for less than six months, nor did they show any improvement without frequent, consistent mental health services.70

B. Types of Outpatient Services

Administration of psychotropic medicine is only part of the solution. New York’s assisted outpatient treatment requires mandatory case management and assertive team community services, and may include medication, periodic urinalysis to determine compliance with prescribed medications, individual or group therapy, day or partial day programming activities, educational and vocational training or activities, alcohol or substance abuse treatment, and supervision of living arrangements. Each individual has their own treatment plan, which is created by their physician and submitted to the court for approval.71

C. Recommendations for California Practitioners

To increase the chances for effectiveness and reduce the possibilities for abuse, practitioners advocating for psychotropic medication powers should also argue for case management requirements and a detailed physician-prepared treatment plan. The treatment plan should lay out the frequency and nature of other mental health services. The order should further require that the probate conservator actively monitor the conservatee’s adherence to all treatments and require that the conservator arrange for periodic review of medication dosages by the treating psychiatrist. The probate investigator’s annual report should be augmented to include an assessment as to whether the conservatee has been adhering to the treatment plan and whether the plan appears successful. A status report from the conservator and hearing should occur annually, with an updated physician-prepared treatment plan to ensure that the medication dosage is still appropriate.

X. CURRENT LEGISLATIVE EFFORTS TO IMPROVE THE LPS SYSTEM

Several legislative efforts have been initiated in recent years to reform the LPS laws to specifically include outpatient treatment for periods beyond one year, where there is no power of confinement. These proposed solutions have included:

(a) Assembly Bill No. 1800, which attempted to revise involuntary treatment law to provide intervention for those with a history of mental illness. The bill sought to give individuals better access to timely treatment, by providing more effective and humane treatment and commitment laws. Notably, this bill aimed to expand the existing law’s definition of “gravely disabled” from indicating a condition in which a person, as a result of a mental disorder, is unable to provide for his or her needs for food, clothing or shelter, to mean a person who meets these criteria or who presents, as a result of a mental disorder, an acute risk of physical or psychiatric harm to the person in the absence of treatment. This bill was introduced by Representative Helen Thomson, which passed the State Assembly 53 to 16 in 2000 but never made it out of the State Senate.

(b) Laura’s Law, which permits counties to provide court-ordered outpatient treatment services for people with serious mental illnesses when a court finds that a person’s recent history of hospitalizations or violent behavior, coupled with noncompliance with voluntary treatment, indicate the person is likely to become dangerous or gravely disabled without the court-ordered outpatient treatment. Laura’s Law was modeled after New York’s Kendra’s Law. Regrettably, there is no current funding to implement the program. A recent but failed attempt by Senator Leland Yee to pass legislation, which would encourage funding for Laura’s Law, is dead in committee.

XI. CONCLUSION

Given the current recession and budget deficits, it is unlikely that the State or counties will be providing funding for involuntary outpatient mental health treatment. Such treatment plans will need to be funded with family or conservatee funds on a case-by-case basis. In situations where private money is available to provide this extra level of outpatient care, these authors believe the probate bench should consider using section 2357 to order adherence to physician-designed outpatient mental health treatment plans. Even in the absence of a structured outpatient program of the sort envisioned by Laura’s Law, several desirable outcomes would likely ensue.

First, there is a subgroup of individuals with chronic psychotic illness who are adherent to their medication regimen and do quite
well for long periods of time, but are prone to occasional periods of drug refusal. These periods often lead to relapse and re-hospitalization. Simply knowing that the conservator has the authority to compel the administration of prescribed medications is enough to assure continued adherence for the vast majority of such individuals. Second, for those individuals with chronic severe mental illness who are periodically unable or unwilling to consent to needed physical health care, it could avoid the costs of two conservatorships: LPS conservatorship, for mental health care, and probate conservatorship, for physical health care.

Where warranted, the probate bench should also consider giving conservators of the estate the power to grant or withhold non-essential benefits to conservatees, depending on the conservatee’s adherence to the treatment plan. The court would always have the further persuasive power of holding the defiant conservatee in civil contempt for refusing to comply with court-ordered treatment, until the individual complies. At a minimum, a period of short incarceration could keep the conservatee safe and under the watchful eye of law enforcement long enough for them to determine whether initiation of a 72-hour hold in a psychiatric facility is needed to protect the individual from further harm.

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ENDNOTES

1. An LPS conservatorship is available for individuals that are presently gravely disabled. An individual is "gravely disabled" if the individual, as a result of a mental disorder or impairment by chronic alcoholism, is presently unable to provide for his or her basic personal needs for food, clothing and shelter. (Welf. & Inst. Code, § 5008, subd. (h)). An individual is not presently gravely disabled if he or she can survive safely with the assistance of a third party, who has indicated a willingness to help. (Conservatorship of Neal (1987) 190 Cal. App.3d 685, 687; Conservatorship of Early (1983) 35 Cal.3d 244, 250). (In Los Angeles County, the current policy of the public guardian is generally to not seek an LPS conservatorship for an individual whose primary psychiatric diagnosis is alcohol or other substance abuse or dependency.)

2. Contrary to the opinion of these two authors, Los Angeles County Counsel’s Office, a substantial contributor to this article, takes the position that involuntary mental health treatment cannot be authorized under the Probate Code and that such authorization must come through the Welfare & Institutions Code. County counsel cites Welf. & Inst. Code, §§ 5345 – 5349.5 (i.e., Laurn’s Law) as the sole means for obtaining court-ordered outpatient mental health treatment apart from an LPS conservatorship. The authors see Laura’s Law as one tool, but not the exclusive means, by which involuntary outpatient mental health treatment can be implemented.

3. The conservatee is entitled to a court or jury trial on the issue of whether he or she is gravely disabled, which extends to proceedings for readmission of conservatorships. (Welf. & Inst. Code, § 5350, subd. (d)). Although civil in nature, proof beyond a reasonable doubt of the conservatee’s grave mental disability is required, a similar standard to certain criminal proceedings. (Conservatorship of Early (1983) 35 Cal.3d 244, 248).


5. The public defender may decline to represent a mentally-ill patient, who is determined to have the means to hire private counsel. In such case, the Court will appoint a private counsel to represent the proposed conservatee.

6. The periods of possible confinement under the LPS system are graduated. The initial period involves a 72-hour hold for involuntary treatment and evaluation without court intervention, for individuals who as a result of mental disorder are found to be a danger to themselves, a danger to others, or gravely disabled. (Welf. & Inst. Code, § 5150). If, after the 72-hour period of observation the patient is determined to still be dangerous to self or others or gravely disabled, the psychiatrist at the facility may certify the patient for an additional 14 days of involuntary intensive treatment and detention. (Welf. & Inst. Code, § 5250). A second 14-day certification is available only for those dangerous to themselves, and a 180-day post-certification is available for those thought to be dangerous to others. (Welf. & Inst. Code, §§ 5260, 5300). At the beginning of each post-72-hour period of involuntary hospitalization, the patient has the right to counsel and a hearing to determine if there is probable cause to be detained. (Welf. & Inst. Code, §§ 5254, 5254.1). Hearings are typically held in the hospital, and if probable cause is found to exist, the certification is upheld. (Welf. & Inst. Code, § 5256.6). In the case of the gravely disabled, without filing an LPS conservatorship, the patient may be held for an additional 30-day period for intensive treatment after the initial 14-day period. (Welf. & Inst. Code, § 5270.15). After the final hold, the patient must be released unless the hospital has filed for an LPS conservatorship, and the court has issued a 2E number (a temporary conservatorship), in which case the patient can be held in the hospital until the permanent conservatorship hearing. This can add weeks to the period of involuntary hospitalization.

7. For example, in Conservatorship of Amanda B., upon being released from a hospital setting at the expiration of her LPS conservatorship, the patient failed to take her medications or obtain treatment for her mental illness. (Conservatorship of Amanda B. (2007) 149 Cal.App.4th 342, 343). The patient did not believe she had a mental disorder, and her history demonstrated that when she was not under a conservatorship she did not take her medications or seek appropriate medical care. (Id.). The court renewed the LPS conservatorship, and further held that it is the duty of the court, not the conservator, to designate the "least restrictive alternative placement" appropriate for a conservatee, pursuant to Welf. & Inst. Code, § 5358, subd. (c)(1). (Id.).

8. Because the LPS rules require that the conservatee be placed in the least restrictive setting, a conservatee is often removed from civil commitment and placed in a licensed board and care facility (or even returned home) during the one-year conservatorship. Welf. & Inst. Code, §5348 permits the conservator to require the conservatee to take prescribed psychotropic medicine, even if the conservatee is living in the community, provided the conservatee has been determined to lack the capacity to give informed consent to administration of psychotropic medicines.


10. E.g., Conservatorship of Benvenuto (1986) 150 Cal.App.3d 1030 (holding that the conservatee was not still "gravely disabled" on the basis that he would stop taking his medication upon release, and relapse to "grave disability" again), Estate of Murphy (1982) 134 Cal.App.3d 15.

11. Estate of Murphy, at p. 17.

12. Ibid.

13. Ibid.

14. Ibid.

15. Id. at 18.


18. Conservatorship of Guerrero (1999) 69 Cal.App.4th 442, 444 (The court held that jury instruction No. 6, instructing the trier of fact to consider evidence of patient’s past failure to take mental health medication when prescribed,
and patient's lack of insight into mental condition, was not an improper jury instruction).

19. Except where otherwise indicated, all statutory references are to California Probate Code.

20. The LPS system is an anomaly to most probate practitioners, with the substantive provisions set forth in the Welfare & Institutions Code and not the Probate Code. (Welf. & Inst. Code, § 5000, et seq.). In Los Angeles County, LPS-related hearings are conducted in the mental health court, which is entirely separate from the probate court. (Welf. & Inst. Code, § 5256, 1). The proceeding is quasi-criminal in nature, using the "beyond a reasonable doubt" burden of proof (for most things) as opposed to clear and convincing evidence, which is required in probate court. (Conservatorship of Early (1983) 35 Cal.3d 244). The proposed LPS conservatee is represented by a public defender and not PVP counsel. (Welf. & Inst. Code, § 5256, 1). The proceeding must be initiated by the Public Guardian's Office represented by county counsel. The initial filing cannot be done by the conservatee's family. Once the conservatee has stabilized, the LPS conservator is under a duty to consent to the release of the patient from involuntary confinement and then return him or her to a less restrictive living situation. (Welf. & Inst. Code, § 5350). Given the over-load on the mental health system, patients are typically released at the earliest possible date. (Welf. & Inst. Code, § 5270, 10).


22. Ibid.


25. Id. at 540.


27. Ibid.


29. Prob. Code, § 2357. Probate Code section 1881 permits the conservator to make medical decisions for the conservatee who lacks the capacity to give informed consent to any form or medical treatment. This would apply to the individual suffering from severe dementia or other pathology that renders the patient beyond reason in every respect. The schizophrenic patient, by contrast, may be able to make informed choices on many medical decisions, other than the administration of psychotropic medicine.

30. Former Prob. Code, § 2357, subd. (h), before 1990 amendment.


32. Probate conservatorship continues until the conservatee's death or it is terminated by court order. (Prob. Code, § 1860). There is no one-year automatic termination, like in the case of an LPS conservatorship. Moreover, in the probate context, the party petitioning for termination bears the burden of showing that it is no longer required.


40. Id.


43. See generally Conservatorship of Wendland (2001) 26 Cal.4th 519, 545-550 (discussing where the use of the clear and convincing evidence standard is appropriate and necessary); see also Conservatorship of Waltz (1986) 180 Cal. App.3d 722, 733 and Lillian F. v. Superior Court (1984) 160 Cal.App.3d 314, 324 (holding that clear and convincing evidence must be present to demonstrate conservatee's incompetence to accept or reject treatment, as a prerequisite to permitting involuntary electroconvulsive therapy).

44. Id.


46. Id. at p. 326.


49. Sen. Bill No. 1481, Senator Mello, 8/28/86, Arguments in Support: "The author's office notes that, currently, most courts will not grant a [probate] conservator the authority to ... authorize administration of [psychotropic] medications, unless the family places the conservatee in an LPS conservatorship."

50. When the LPS Act became law in 1967, the medicines available to treat mental illness were significantly more limited with significantly greater side effects. Over the past 40 years, there has been vast improvement in psychotropic medicines with corresponding reductions in side effects. (U.S. Department of Veterans Affairs, Mental Illness Research, Education and Clinical Center, Reform of the Lanterman, Petris, Short Act, "A New Vision for Mental Health Laws: A Report of the LPS Reform Task Force," available at http://www.desertpacific.mircceva.gov/news/1ps-reform.shtml).


52. Prob. Code, § 2356.5, subd. (k).


55. Prob. Code, § 2357, subd. (c).

56. Prob. Code, § 2357, subd. (h) et seq.; Technically, with the consent of counsel for the conservatee and counsel for the petitioner, Probate Code § 2357 (g) permits issues of lack of capacity to be submitted for determination to the court upon proper and sufficient medical affidavits, provided both counsel stipulate that there are not issues of fact to be determined. These authors believe that, in the case of the involuntary administration of psychotropic medications, where the conservatee clearly objects, any attempt to submit on affidavits would deprive the conservatee of his day in court and right to testify, thereby defeating his due process rights. The use of § 2357 (g) may be appropriate in cases where the conservatee lacks the actual ability to object and express a desire for a hearing.


58. Adult guardianships in other states are the equivalent to conservatorships in California.


63. Conservatorship of Foster (Minn. 1996) 547 N.W.2d 81.
psychotic patients, those who were provided with outpatient treatment pursuant to an outpatient commitment order for not less than 180 days after release, had 72% fewer readmissions. (Marvin S. Swartz et al., Can Involuntary Outpatient Commitment Reduce Hospital Recidivism?: Findings From a Randomized Trial With Severely Mentally III Individuals (Dec. 1999) 156 Am J Psychiatry 1968-1975).

79. An individual found guilty of contempt may be punished by a fine not exceeding $1,000 or by imprisonment for not more than five days, or both. Cal. Civ. Proc., § 1218, subd. (a). However, in the case of an individual's refusal to perform a court-ordered action within that individual's power to perform, a judge may also order imprisonment until the individual complies with the court-ordered treatment. Cal. Civ. Proc., § 1219, subd. (a).

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