CONTRA COSTA
MENTAL HEALTH COMMISSION

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MENTAL HEALTH
COMMISSION
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cchealth.org/mentalhealth/mhc

Mental Health Commission
Justice Systems Committee Meeting
Tuesday, March 23, 2021, 1:30-3:00 PM
Via: Zoom Teleconference:

https://cchealth.zoom.us/j/6094136195
Meeting number: 609 413 6195

Join by phone:
1 646 518 9805 US
Access code: 609 413 6195

AGENDA

I. **Call to order/Introductions**

II. **Public comments**

III. **Commissioner comments**

IV. **APPROVE minutes from the February 23, 2021 Justice Systems Committee meeting**

V. **Presentation: Working with clients in pre-trial diversion from a therapist's perspective, Kira Monterrey, Owner/Therapist, Healthy Minds Counseling Center**

VI. **DISCUSSION of email from Dr. Megan Della Silva, Chief Psychiatrist, Contra Costa County Detention Health Services**

VII. **REVIEW Presentation: Absent Authority-Evaluating California's Conservatorship Continuum, Alex V. Barnard, Department of Sociology, New York University. Where do we go from here?**

VIII. **Adjourn**

CONSERVATORSHIP ISSUES

Cmsr. Geri Stern email re: Conservatorship Questions:

Response from Megan Della Selva, MD, Chief Psychiatrist, Contra Costa County Detention Health Services

Mental Health Diagnostic Category information, can we have access to this data?

Response: I have looked into the type of data we can pull, but have been informed that while we can obtain general numbers of patients being referred to mental health on a monthly basis, we are not able to sort by specific diagnoses.

Initial intake questions:

During the intake process, is the inmate asked if they are conserved?

Response: In terms of the conservatorship issue, this has been a question we have been thinking about, as well. Our current understanding is that it does not translate to the correctional environment, and as far as I know, we do not ask people this question in intake.

Dr. Hamilton requested a formal legal opinion on this matter from county council a couple of months ago, but we have not yet received this. She plans to follow up with them for an update and I can keep you posted on that.

ABSENT AUTHORITY

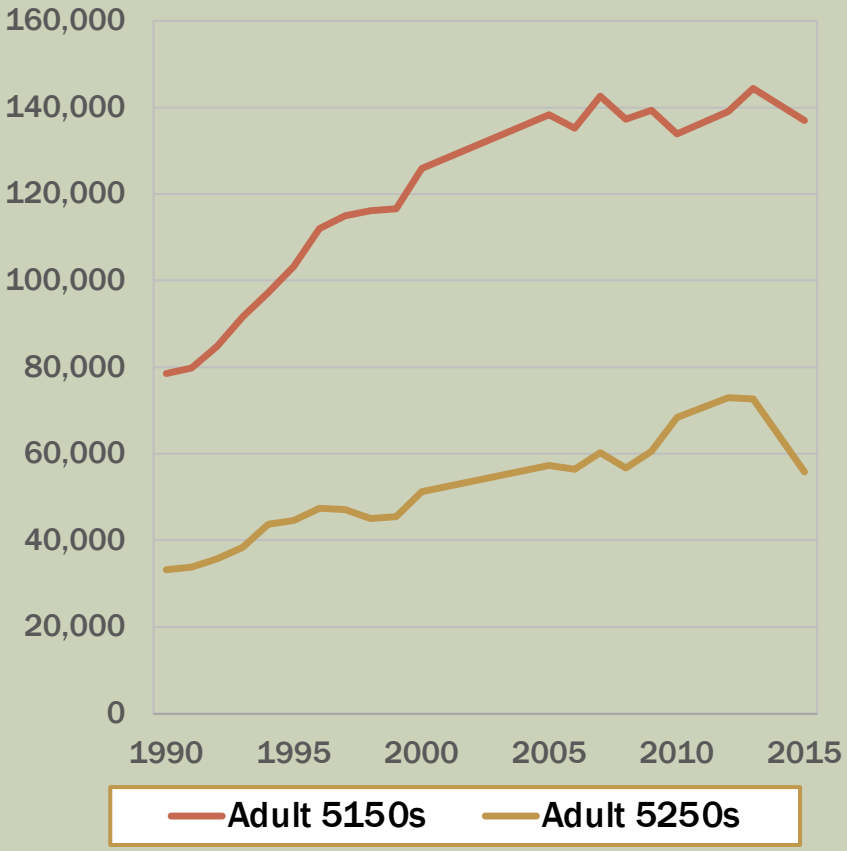
Evaluating California's Conservatorship Continuum

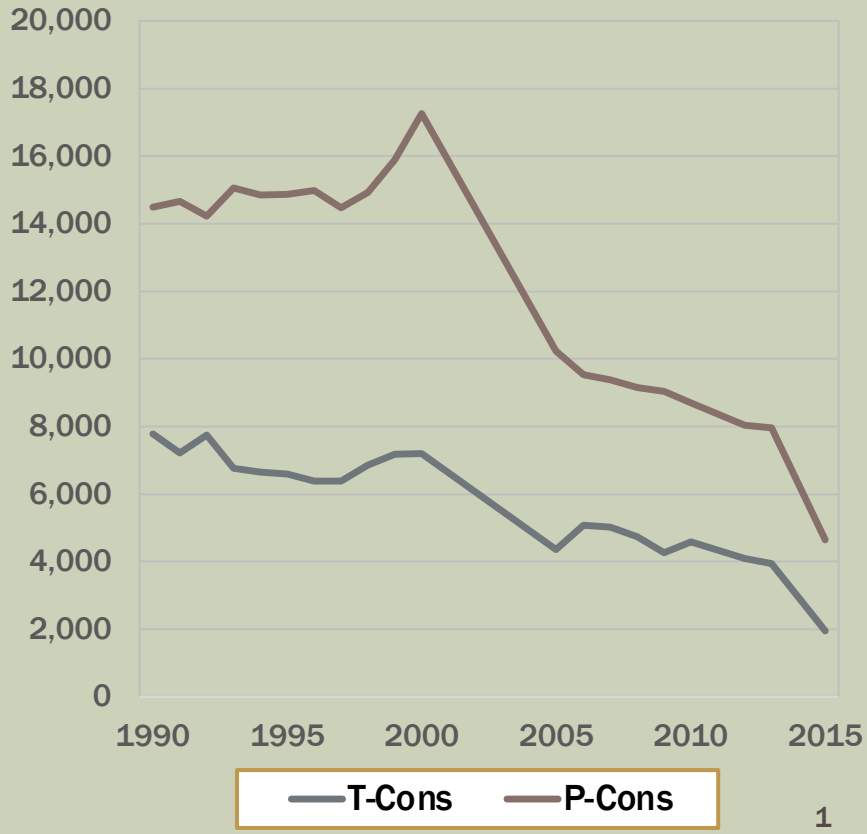
Alex V. Barnard
Department of Sociology

NYU

CHANGING RATES OF INVOLUNTARY TREATMENT

- California is imposing more and more **short-term** 'holds'…
  - …But putting fewer people onto **long-term** conservatorships.





COMPETING EXPLANATIONS

- The criteria are too strict.

EDITORIALS

Mentally ill Californians shouldn't die on the street, untreated. The law must change

BY THE SACRAMENTO BEE EDITORIAL BOARD
FEBRUARY 08, 2018 05:00 AM, UPDATED FEBRUARY 08, 2018 02:51 PM

NEWS

SF supervisors strike deal to expand forced treatment of mentally ill

Trisha Thadani
June 4, 2019 | Updated: June 4, 2019 1:38 p.m.

- We just need more services.

CAL MATTERS

BREAKDOWN: MENTAL HEALTH

Audit: Don't make it easier to force mentally ill Californians into treatment – just improve treatment

BY JOCELYN WIENER
JULY 28, 2020

- We've been having this debate for a long time:

Law Protecting Rights of Mental Patients Hit

BY ROY HAYNES
Times Staff Writer

Mental Health Act: Burden on Public, Police

New State Legislation Stirs Up Complaints but Also Gains Supporters

BY HARRY NELSON
Times Medical Writer

'Civil Rights' Bill on Mental Health Sets High Goals

Sweeping Changes Would Be Made in State System of Committing Patients

BY HARRY NELSON
Times Medical Editor

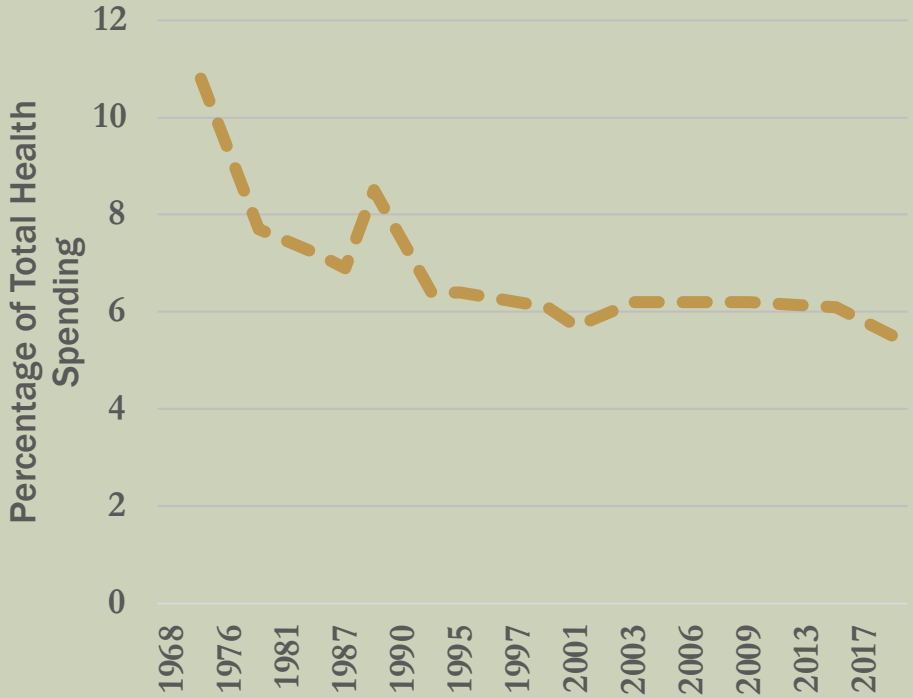
ABSENT AUTHORITY

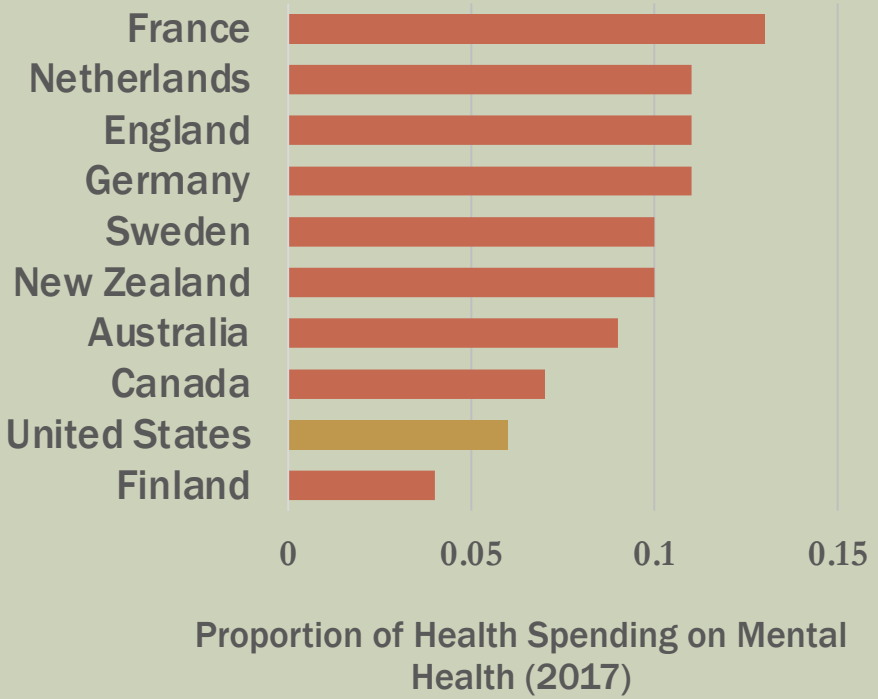
- Today's Argument: Neither new criteria nor new beds is sufficient to address the issue of *"absent authority":*
  - Many people in the "**conservatorship continuum**" can block a conservatorship.
  - No one has clear responsibility and accountability for putting them into place or insuring they achieve positive outcomes.

- Sources of absent authority:
  - **Information:** Regulations and resource constraints lead to superficial and inconsistent decisions.
  - **Coordination:** Decision-making is delegated to a range of public and private actors with different interests and incentives.
  - **Resources:** A lack of placements creates a sense of futility throughout the continuum.

FINANCING

- Mental health accounts for a small and declining share of health spending.
  - Higher overall health spending does not make up the gap.

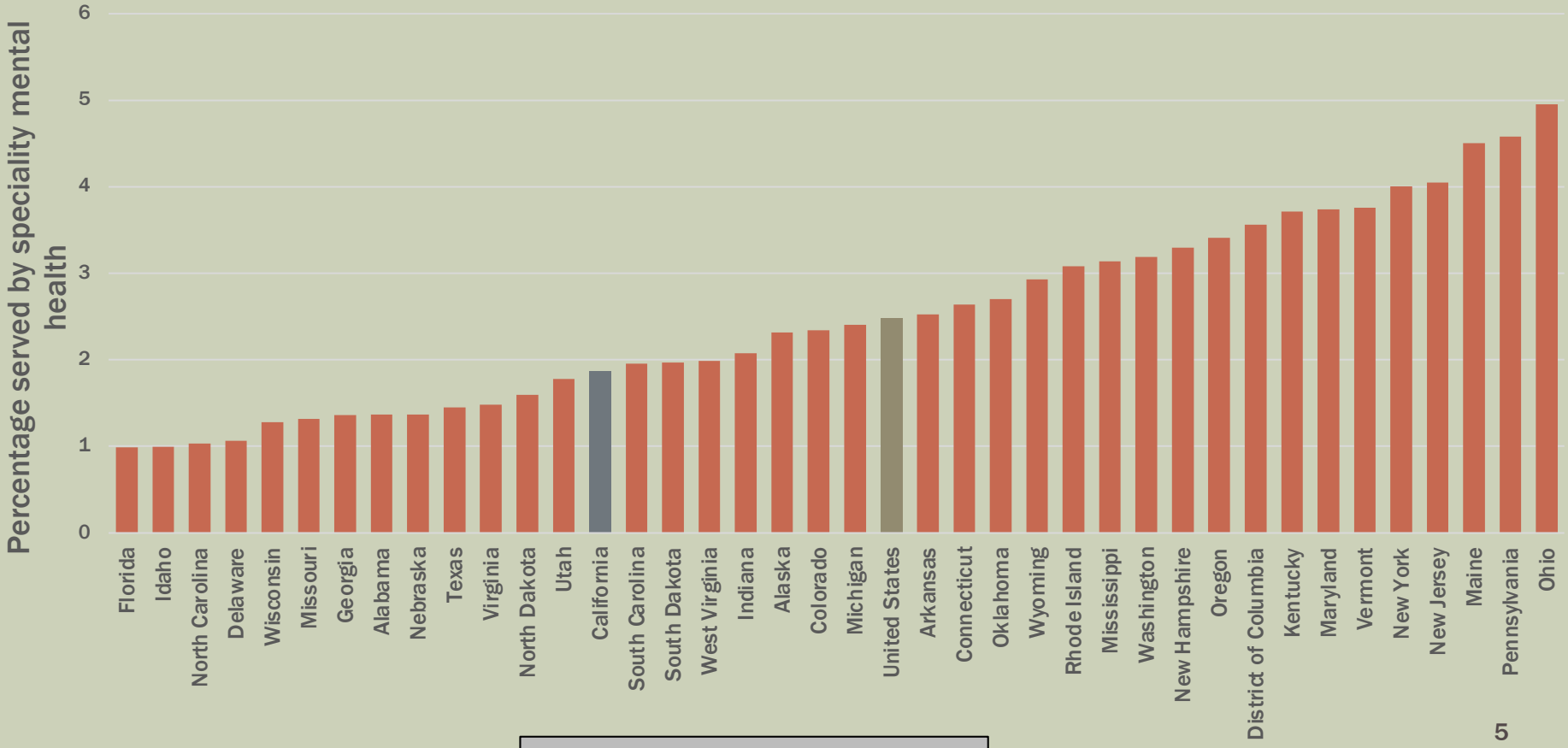




Source: WHO Mental Health Atlas; Mark, Tami L., Tracy Yee, Katharine R. Levit, Jessica Camacho-Cook, Eli Cutler, and Christopher D. Carroll. 2016. "Insurance Financing Increased For Mental Health Conditions But Not For Substance Use Disorders, 1986–2014." *Health Affairs* 35(6):958–65.

SPECIALITY MENTAL HEALTH COVERAGE

- Within the U.S., specialty mental health services in CA reach a comparatively small part of the population.



Source: SAMSAH Uniform Reporting System (2019).

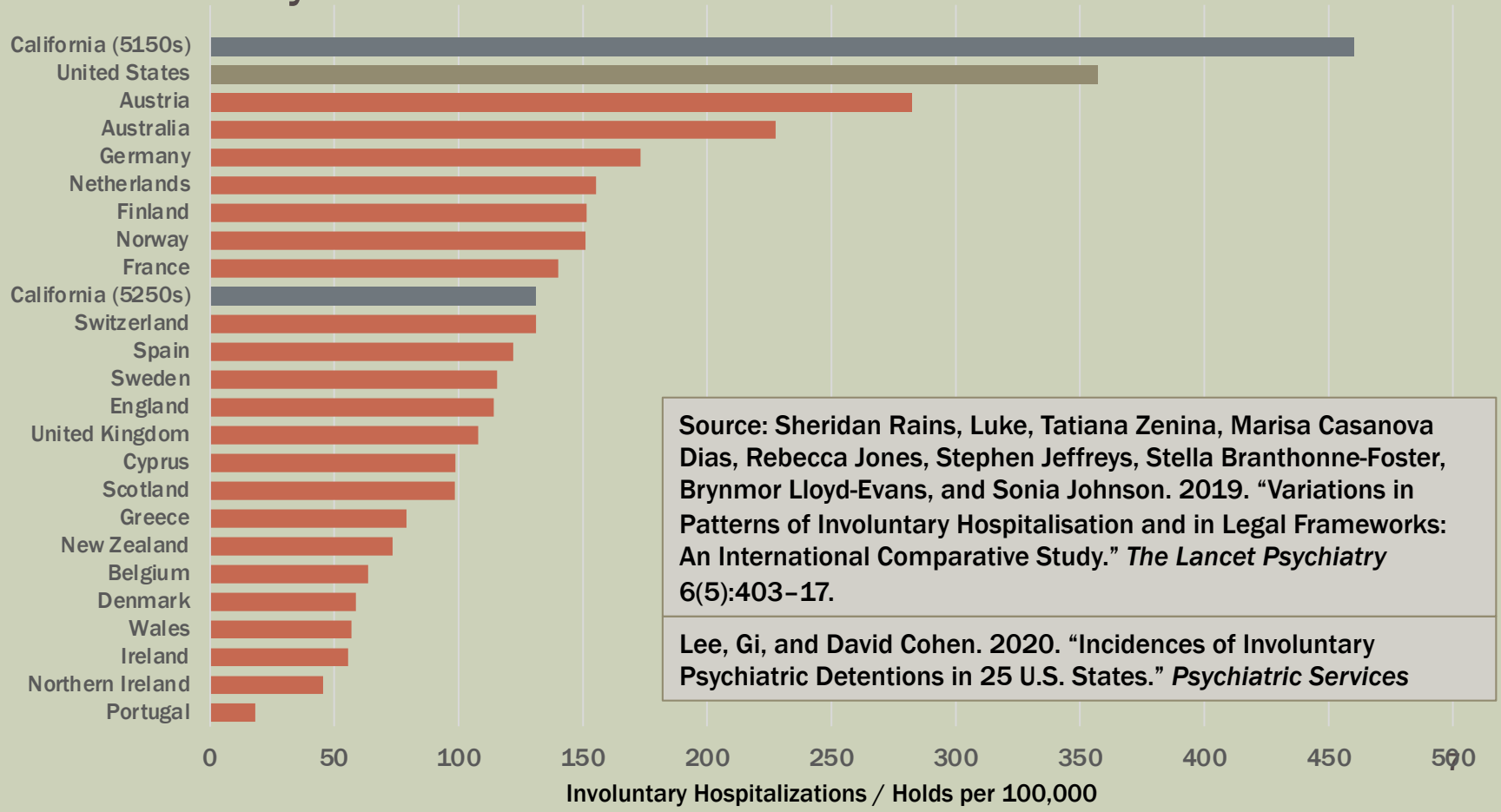
ACUTE CARE BEDS

- Compared to other developed countries, California has fewer psychiatric beds per capita.
  - This is more dramatic if we take out forensic beds.

Source: OECD Health State ; California Hospital Association(2019)

INVOLUNTARY CARE

- But California uses *high* rates of short- and medium-term involuntary treatment.



Source: Sheridan Rains, Luke, Tatiana Zenina, Marisa Casanova Dias, Rebecca Jones, Stephen Jeffreys, Stella Branthonne-Foster, Brynmor Lloyd-Evans, and Sonia Johnson. 2019. "Variations in Patterns of Involuntary Hospitalisation and in Legal Frameworks: An International Comparative Study." *The Lancet Psychiatry* 6(5):403–17.

Lee, Gi, and David Cohen. 2020. "Incidences of Involuntary Psychiatric Detentions in 25 U.S. States." *Psychiatric Services*

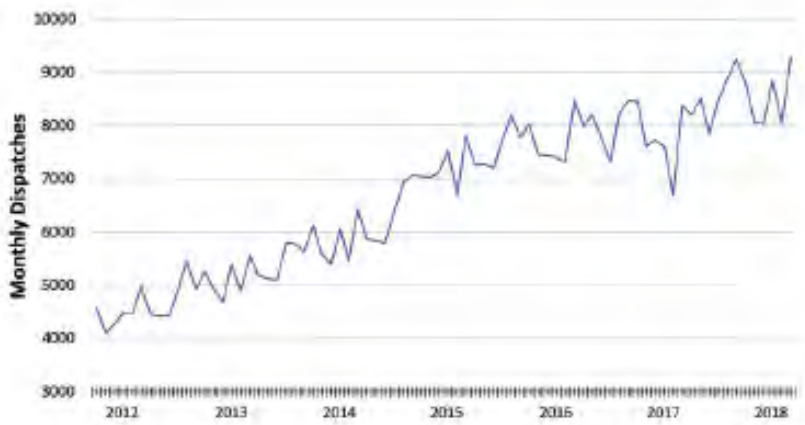
QUALITATIVE STUDY OF CONSERVATORSHIPS

Table 1: Interviewees			
Field		Profession	
Advocacy	11	Psychiatrist	20
Hospital	23	Lawyer	23
Outpatient	20	Social Worker	28
Housing	10	Psychologist	12
Public Guardian	20	Nurse	6
Courts	21	Other M.D.	5
Professional Org.	5	Judge	7
Family Advocate	18	Advocate	34
Government	11	**TOTAL**	**136**

- Additional Sources:
  - Published literature on LPS.
  - ~600 newspaper articles on LPS, 1967-present.
  - Administrative statistics.
  - Observations with FSP Team.
  - Participation in working groups: conservatorship, long-term care.

5150'S AND COMMUNITY EVALUATIONS

- Use of 5150s to address ***visibly*** **disruptive** street behavior.



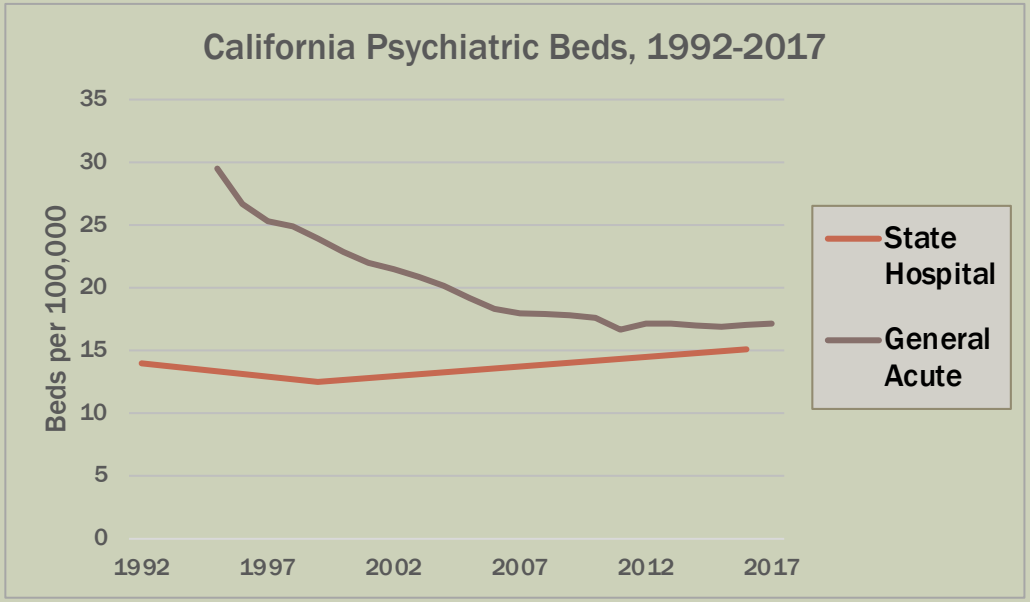
SF PD Dispatches for "Homeless Complaints" (Source: Herring 2019)

"Police see people who are high, and a 5150 is an easy way to get them off the street. The ER won't admit them, and they come back. The system is kind of functionally-dysfunctioning."
– County MH Director

- Difficult to use 5150s for ***invisible deterioration*** at home or in shelters.
  - Quick and **superficial evaluations** by police and mobile crisis teams.
  - Need for **private initiative** to overcome lack of public authority.

EMERGENCY DEPARTMENTS

- Simplest reason for low ER admit rates: **bed availability:**

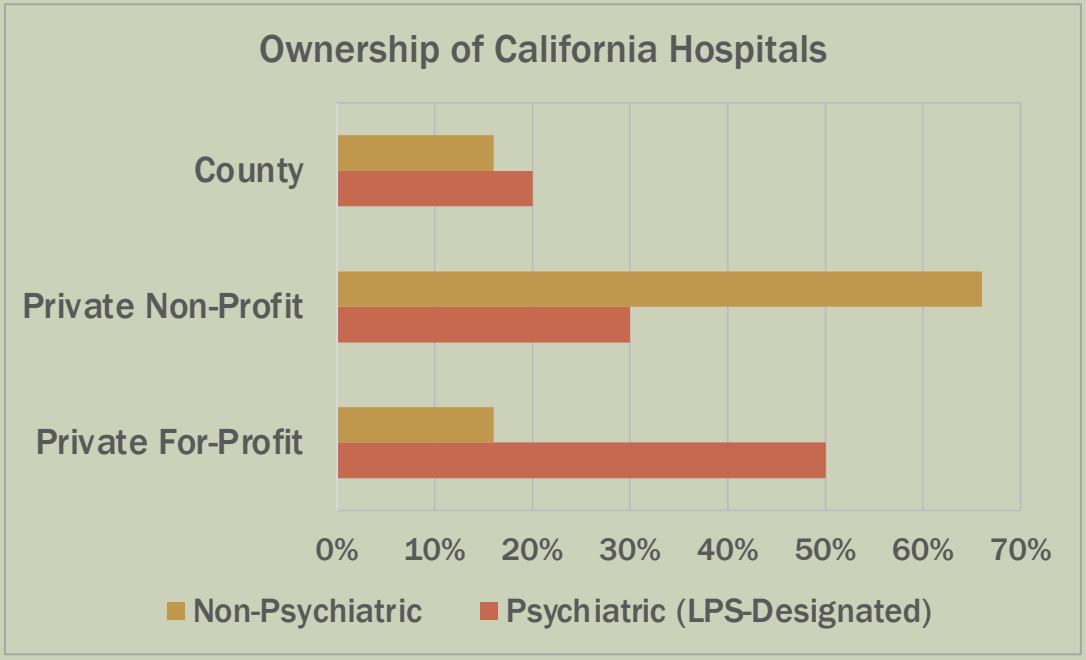


"If I'm filling out a 5150, I have to check a box, and I'll almost always do danger to self or danger to others. Those are more likely to get them in than [GD]. [GD], they [ER doctors] are not impressed by that"
– FSP Psychiatrist

- But ER **decision-making** also de-favors conservatees:
  - Emphasis on 'danger' over 'disability'
  - Skepticism of 'addicts,' 'frequent flyers' or 'incarceritis'
  - Sense of futility for potential conservatees.

INPATIENT HOSPITALS

- Extreme **financial disincentives** to applying
  - For-profit hospitals extra reluctant to apply?



- Applications based on '**fail repeatedly' principle**… and resource availability.

"The bed availability does affect who ends up getting the care they need… You're not going to send the person to the street if they're completely psychotic, covered in their own feces, but if it's a wobbler, 'okay am I going to apply for conservatorship here? Wow, there's absolutely no beds, it's going to be a six-month waitlist…' It will make me think twice"
– Inpatient Psychiatrist

PUBLIC GUARDIANS

- Unstable funding, sometimes marginalized institutional status, and unclear role and responsibilities.
- Decision-making by Public Guardians:
  - Strong concern for civil rights:

> "Taking away someone's right to self-determination if a big step, it's the last thing you want to do as a conservator" – Public Guardian

  - Focus on identifying 'successfully' vs. 'unsuccessfully' homeless:

> "We've had clients who are homeless by choice…You or I may not feel that's good for them, medical health wise or mental health wise, but it's their choice, and if they can articulate that, 'I go to the soup kitchen, I go to Goodwill, I have Social Security, and I use that income to buy those clothes, and I have a sleeping bag, that's what I want,' well, the doctor may not feel that's appropriate, but if they're able to articulate that…we may reject that referral" – Public Guardian

COURTS

- Some concerns about available resources for legal representation.
- Decision-making in courts:
  - Accepting superficial evidence a person can meet their needs:

> "He was a heavy guy [the conservatee], he wasn't starving, and so we could say 'he's feeding himself, he may be eating out of the garbage, but we know he's eating.' I got that guy off" – Public Defender

  - Most effective defense: showing availability of a '3rd party assist':

- Because of prior screening, courts and conservators have little decision-making discretion:

Estimated Petitions Filed on: 70-95%	Estimated Conservatees Not-Contesting: 50-75%	Estimated Rulings Establishing Cons.: 70-95%

PLACEMENTS

- Allegations of locked IMDs 'cherry-picking' conservatees.
  - Financially-obligated preference for no violence history, justice involvement.
  - Competitive county contracting facilitates cherry-picking.

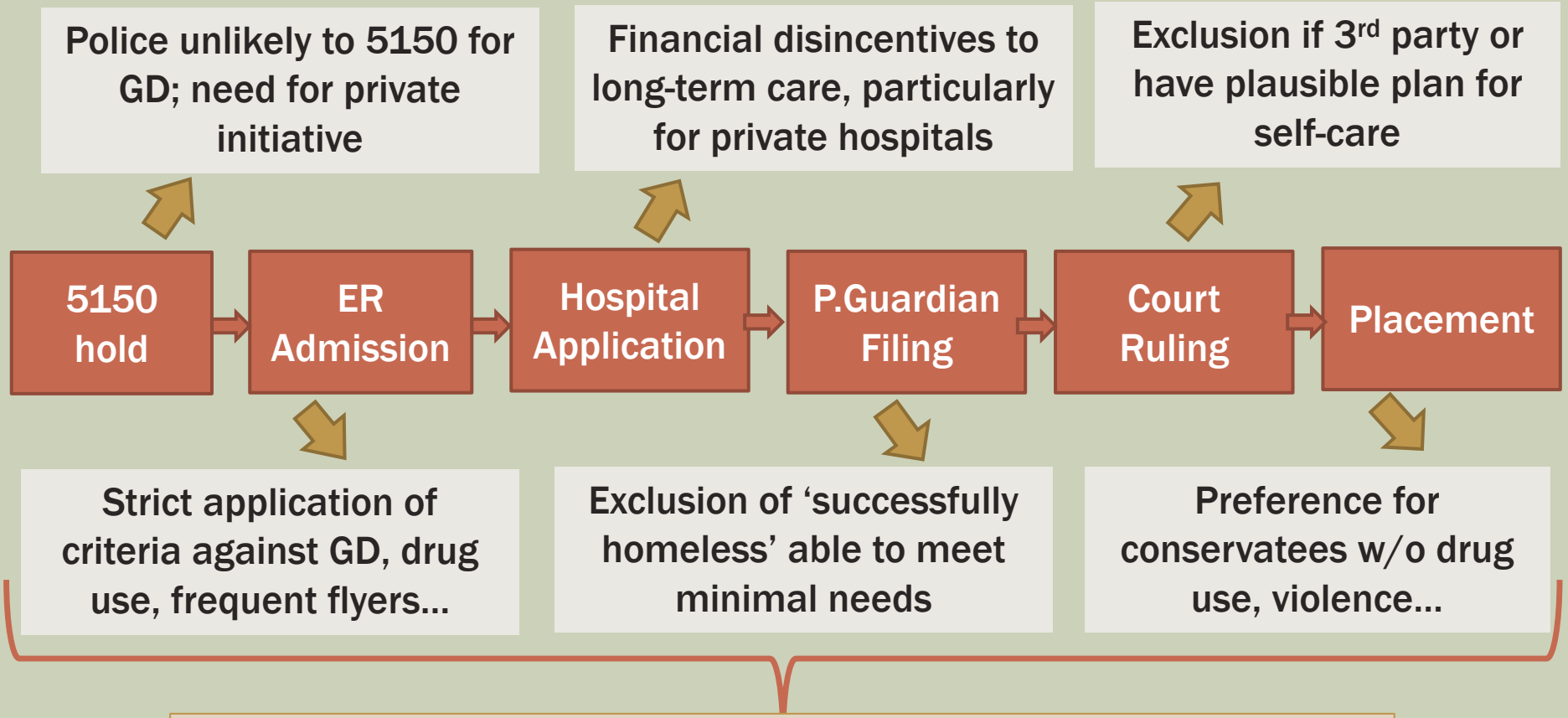
> "We are completely at the mercy of the operators" – Public Guardian

- Variation in whether counties will place in Board and Cares.
  - Also can be selective: no complex medical needs, drug use.

> "We have one Board and Care that takes people near us. I know the guy who runs it very well…he gets to be so picky and so specific because he's the only one. He can practically choose based on the color of someone's hair. And he can certainly say, 'No one with a walker because I just put in new floors'" – Mental Health Department

- Lack of placements drives decision-making throughout continuum.

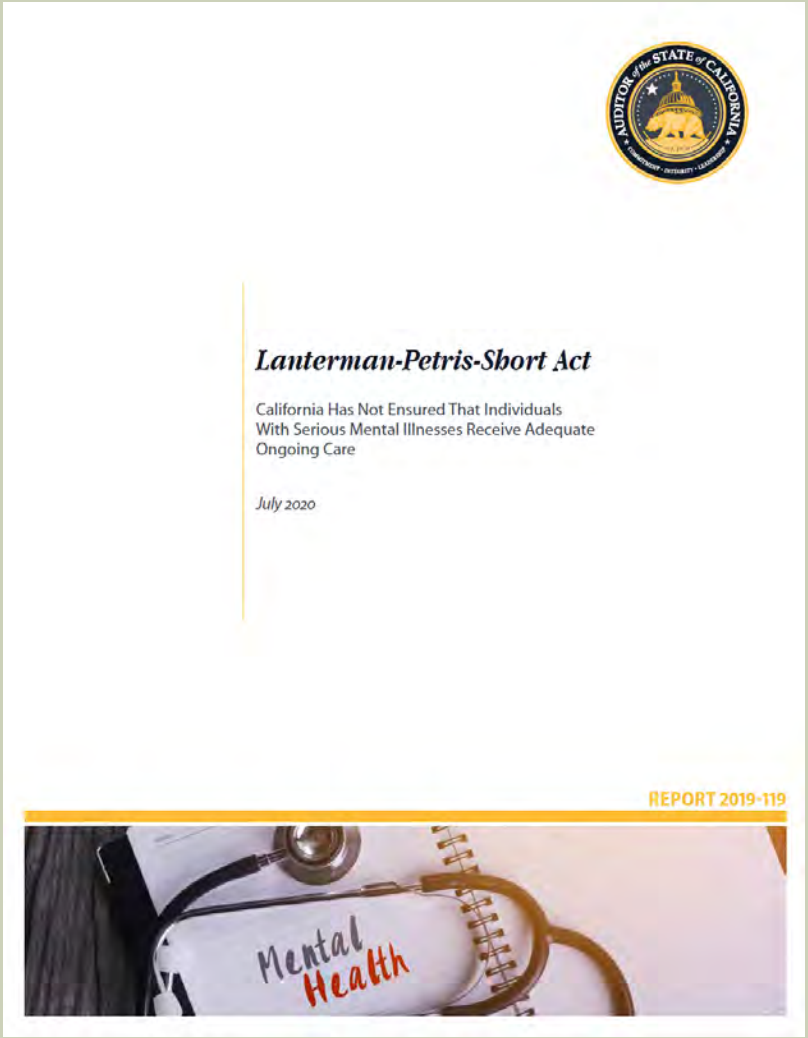
STEPS IN 'ABSENT AUTHORITY'



Absent Authority: No actor has information, resources, or coordinating capacity to mobilize everyone in the continuum.

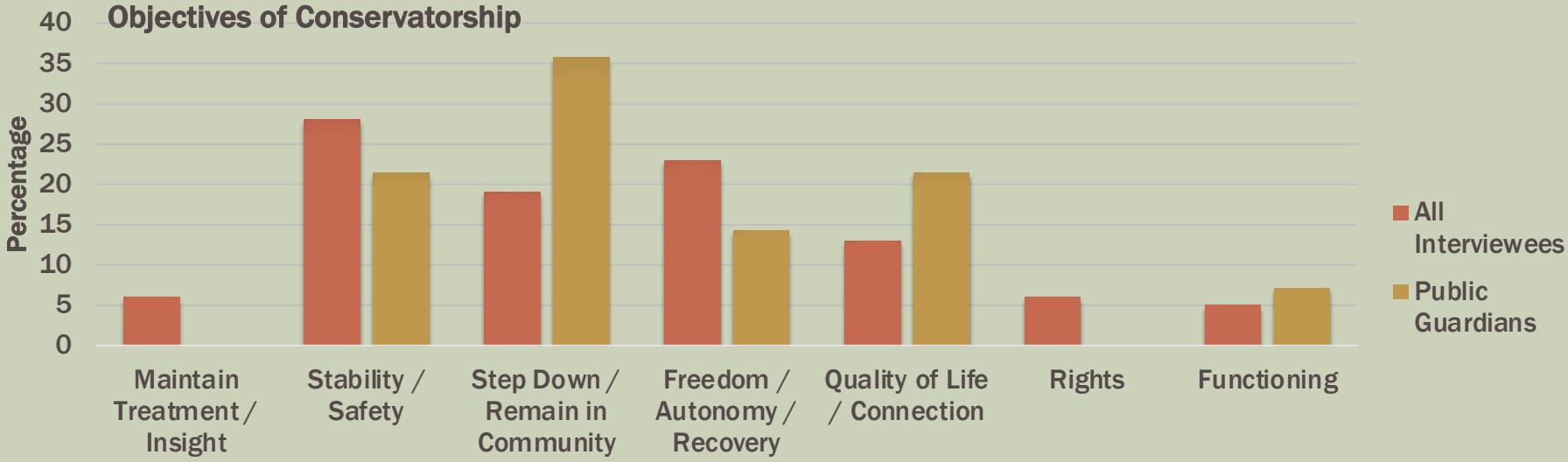
RESEARCH AND EVALUATION

- Recommendation #1: DHCS or foundations should fund a **systematic and comprehensive study** into conservatorship:
  - Trajectories of conservatees
  - Changes in conservatorship over time
  - Evaluating existing programs and new models
- We should not extrapolate from other programs (AoT) to say whether conservatorship 'works'



REGULATION AND OVERSIGHT

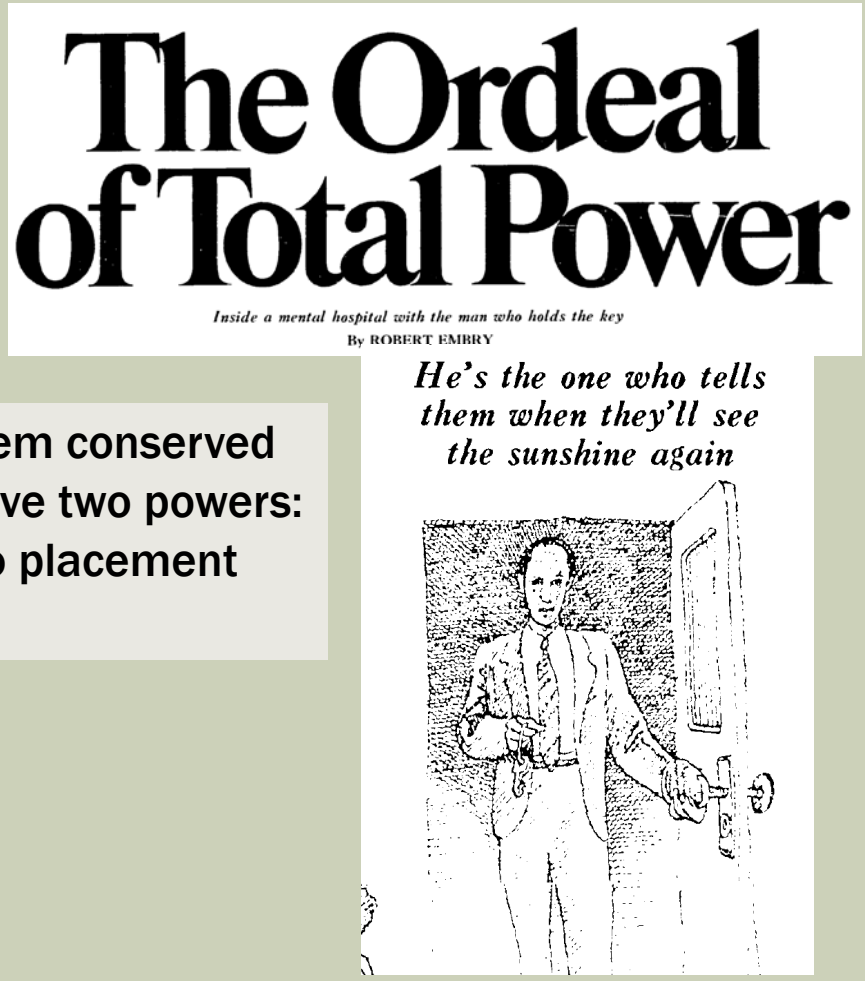
- Recommendation #2: Key state agencies, the legislature, and key stakeholders should create a new **regulatory structure** for conservatorship:
  - There is currently enormous and seemingly unjustified county variation:



- The state should have an **LPS office** setting guidelines around:
  - Service, placement types, conservatorship powers, applying grave disability…

PUBLIC GUARDIANS AND DEFENDERS

- Recommendation #3: Legislature and counties should **fully fund and empower** Public Guardians and Public Defenders
  - Reformers largely overstate what conservators can do:



The Ordeal of Total Power

Inside a mental hospital with the man who holds the key

By ROBERT EMBRY

He's the one who tells them when they'll see the sunshine again

"They think it's a magic wand, 'oh let's get them conserved and then everything will be solved.' We only have two powers: placement and medication, and we have no placement budget" – Public Guardian

  - Better resourced Public Guardians could play a more **proactive role** in the continuum.
  - Public Defenders can find more effective ways to **address concerns** and reduce constraint.

LPS CRITERIA

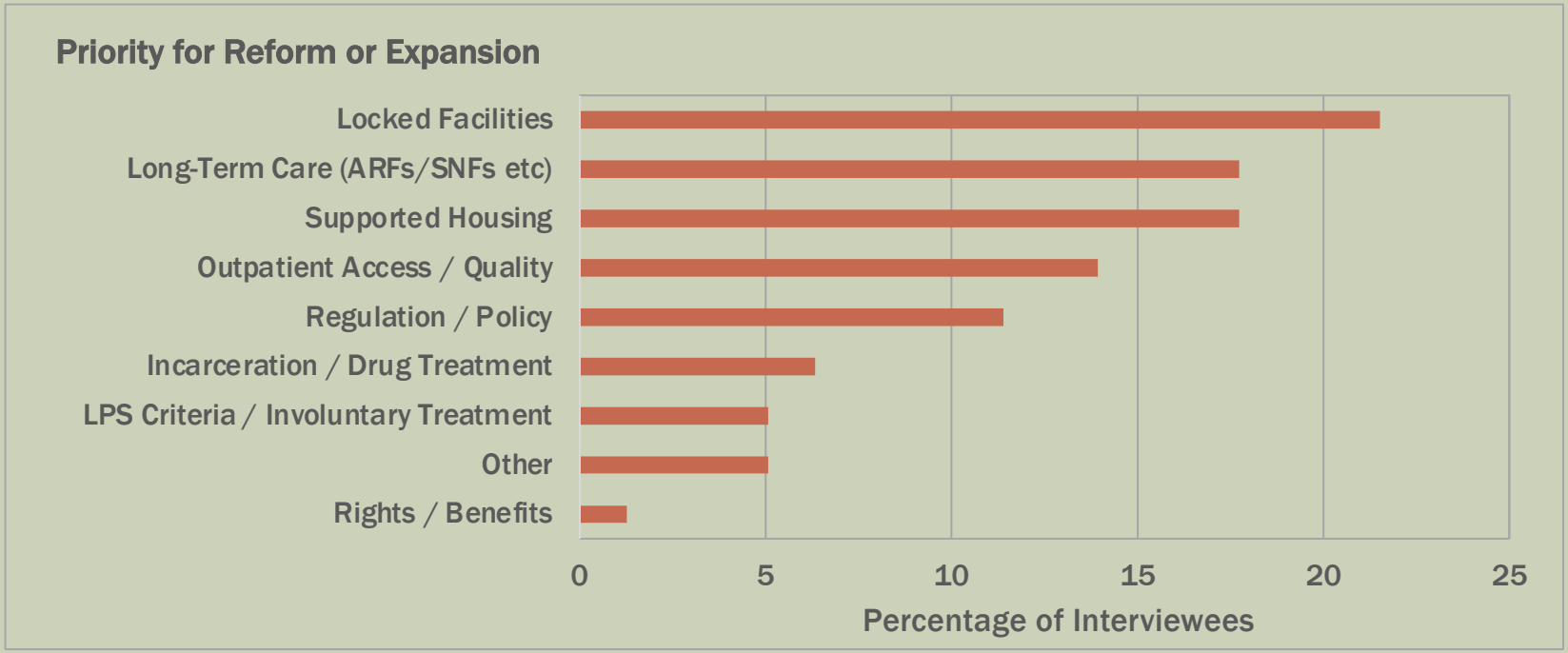
- Recommendation #4: Legislature and DHCS should focus on **improving LPS evaluations** more than changing criteria
  - Is "Grave Disability", in practice, whatever fills available beds?

> "In our county, we have 76 acute psychiatric beds. If all 76 are filled up, then grave disability means one thing. If they've got some beds or they can put some people in a sub-acute to free up some beds, then grave disability means something else. If we built a second acute hospital tomorrow, we doubled our capacity for involuntary acute care, we would find that there's actually now 152 people who meet the criteria for grave disability, and if we shrunk it down to 30, we'd find that a lot of people, it turns out, are not gravely disabled" – Public Defender

  - Risks of changing criteria without new resources (SB 40/1045 in SF)
  - Focus on someone's immediate presentation creates a situation of 'people processing' and 'ambulance welfare.'
- The state should **strengthen mandates** to incorporate history and background, and clarify privacy / evidentiary rules.

FUNDING AND PLACEMENTS

- Recommendation #5: DHCS and county Behavioral Health Departments should **fund higher intensity services:**



- Apply for the **IMD Waiver**, but aim for quality and voluntary care.
- **Use MHSA** funds to bridge conservatees towards recovery.
- Evaluate the right mix of **private innovation** and **public safety net.**

LIMITATIONS

- Methodological limitations
  - Currently underrepresented groups among interviewees: law enforcement, county BH departments, **conservatees**
  - Potential biases introduced by **low response rates** and skew towards larger counties.
  - Reliance on **self-reports** (although remarkable consistency across interviewees) rather than observational data.

Closing Caveat: We ask our mental health system to 'clean up' for America's failure to build a real social safety net, rectify racial and economic inequality, or end mass incarceration. Addressing these issues feels overwhelming, but it has to be on our agenda.

THANK YOU!!!

Alex V. Barnard

New York University

avbarnard@nyu.edu

If you're interested in speaking to me
(on or off the record), please reach out.

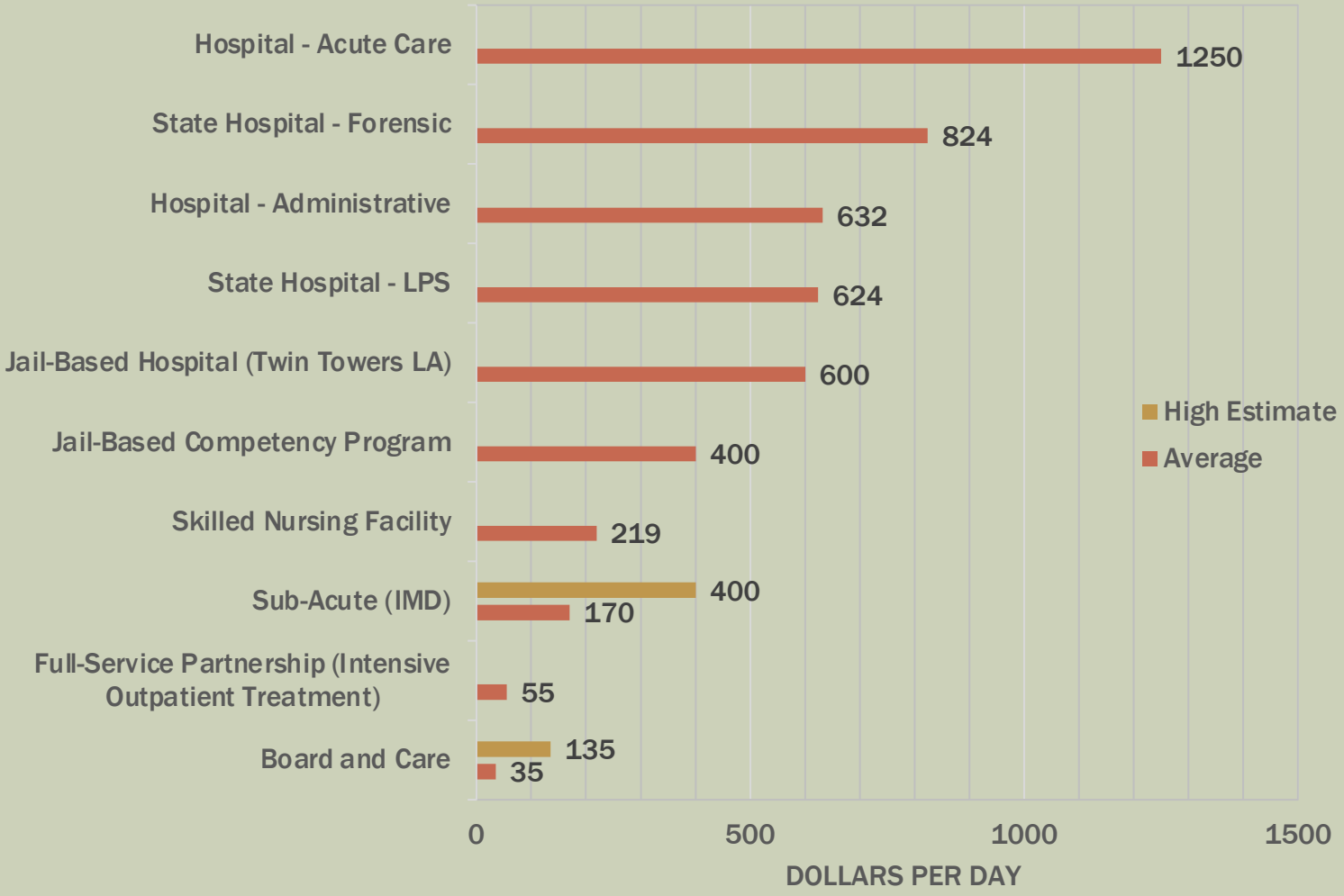
Acknowledgments: I am grateful for the aid of research assistants Sierra Timmons, Kimberly Nielsen, Didi Wu, Michael Long, Yoshi Cohn, Sebastien Le Moing, and Amritha Somasekar. I have also benefited enormously from the advising of Marion Fourcade and Dan Lewis. All mistakes are my own.

Disclaimer: This research received no outside funding outside UCB and NYU. It was not commissioned by any organization.

OTHER SOCIAL SCIENTISTS

- On homelessness in CA:
  - Herring, Chris. 2019. "Complaint-Oriented Policing: Regulating Homelessness in Public Space." *American Sociological Review* 84(5):769–800.
- On outpatient care in CA:
  - Gong, Neil. 2019. "Between Tolerant Containment and Concerted Constraint: Managing Madness for the City and the Privileged Family." *American Sociological Review* 84(4):664–89.
- On front-line medical workers in CA:
  - Seim, Josh. 2019. *Bandage, Sort, and Hustle: Ambulance Crews on the Frontlines of Urban Suffering*. Berkeley, CA: University of California Press.
- On International Mental Health Policy:
  - Perera, Isabel M. 2020. "The Relationship Between Hospital and Community Psychiatry: Complements, Not Substitutes?" *Psychiatric Services* 71(9):964–66.

DAILY RATES FOR PLACEMENTS

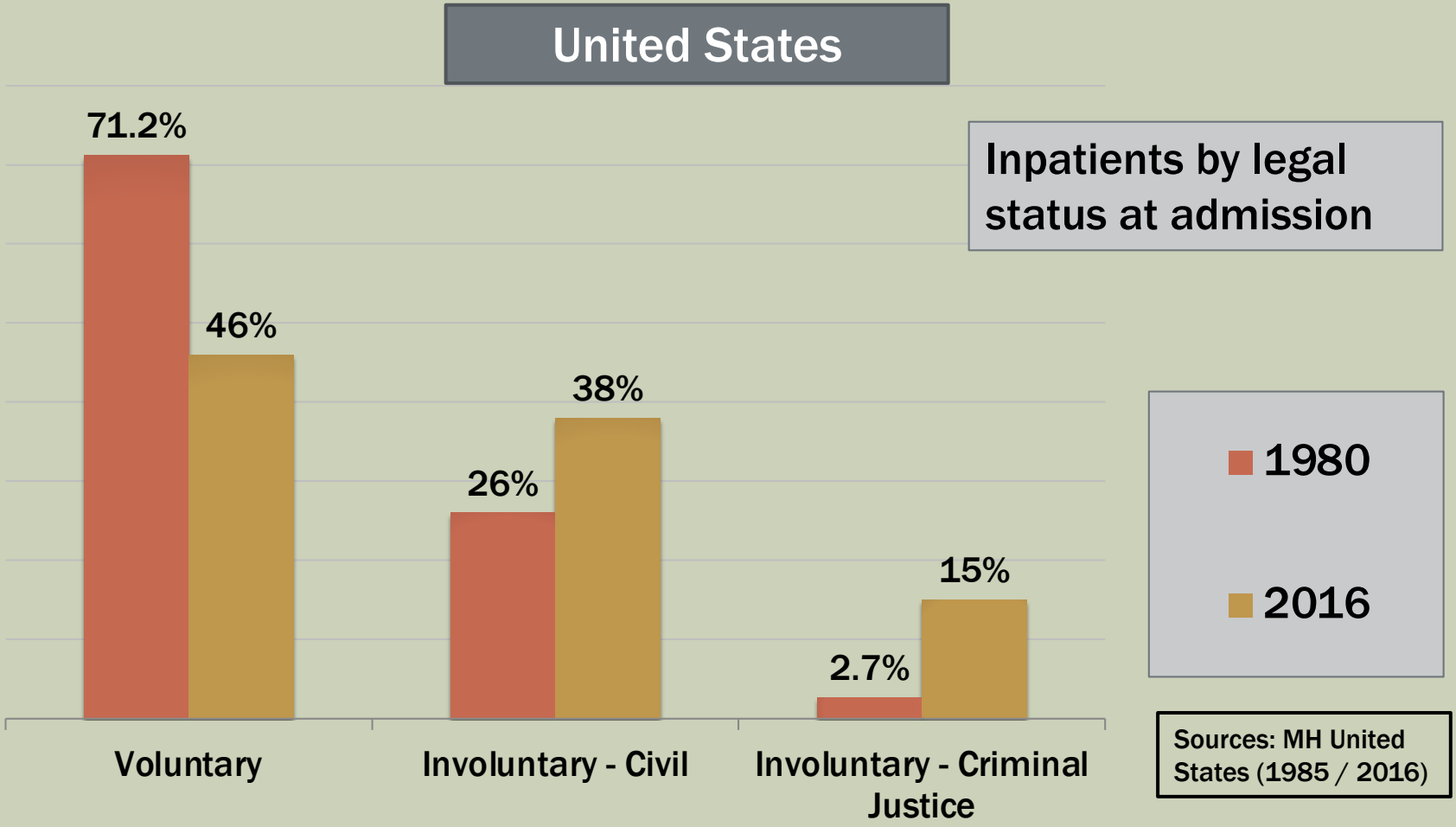


ISSUES IN THE AUDIT

- Problems / Limits in Audit Methodology
  - Focus on only two steps in the continuum: 5150s and conservatorships.
    - What do we know about the people who don't make it to those steps?
  - Retrospective review of documentation
    - What professional *won't* write a good justification for a hold / no hold?
  - Consistency in use of grave disability ≠ consistency in practices
  - No new data about conservatees.

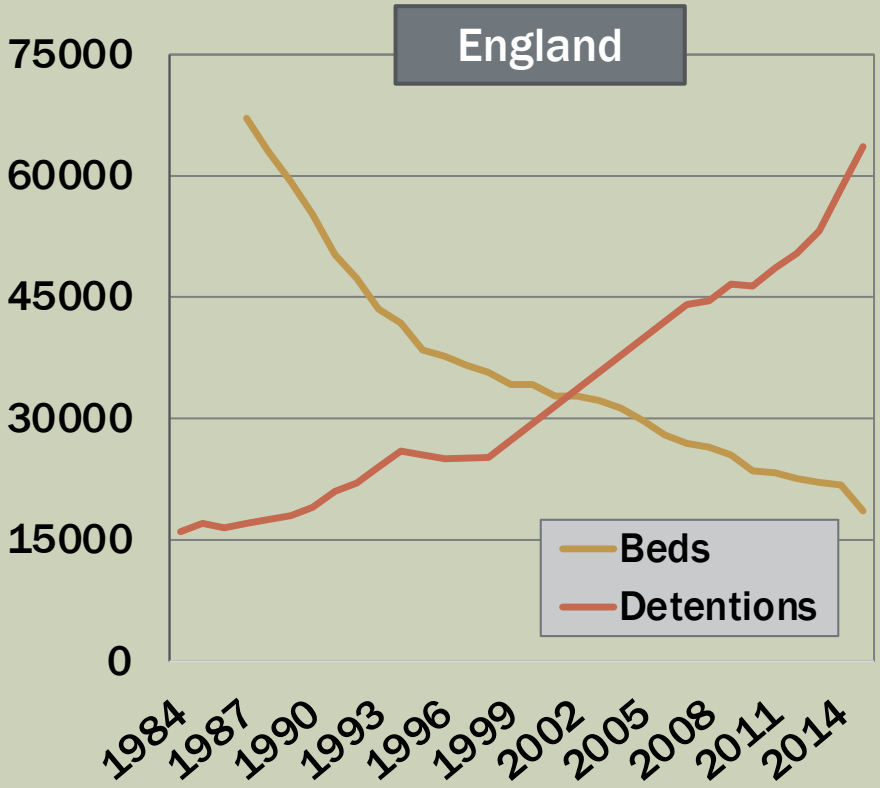
- Audit Recommendation
  - Nothing about the role of Public Defenders / Public Guardians
  - Positive recommendations:
    - Identifying need for beds
    - "Bridging" between conservatorship and voluntary
    - Repurposing MHSA funds

CHANGING RATES

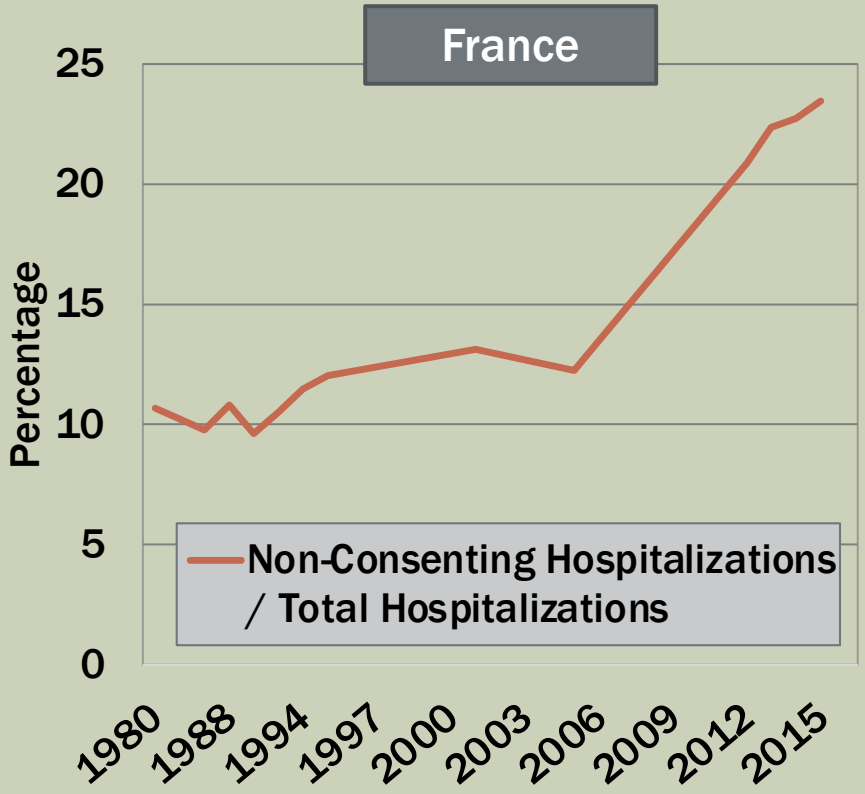


INTERNATIONAL TRENDS

- Rise of involuntary hospitalizations since the 1980s in other countries:



Source: NHS Trusts Reports (1984-2016)



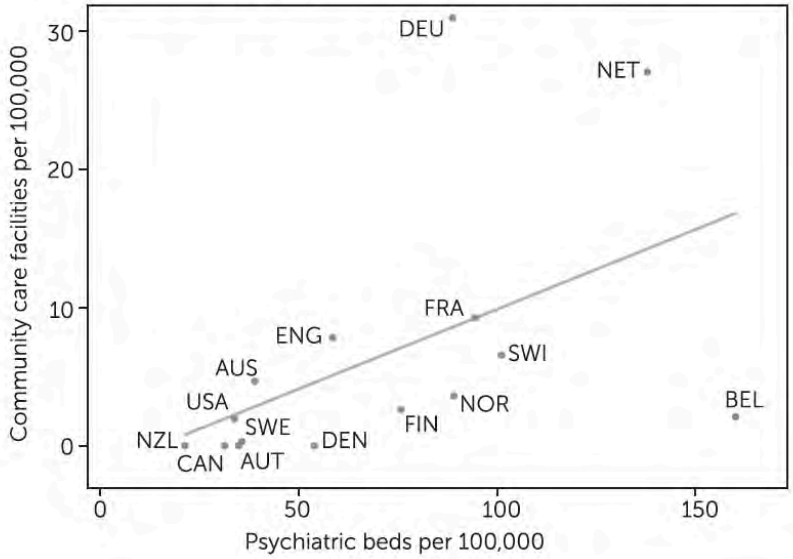
Source: French Statistical Yearbooks (1980-2007); INSEE

THE FRENCH CASE

- Biggest lesson: systems building > treatment innovation

1. Hospitals incorporated into '*secteurs*' serving 70,000 people.
   - Same team in/outpatient
2. Robust public financing based on 'global' budget.
3. 'Need for treatment' commitment criteria.
   - But only about 25% of hospitalizations involuntary.
4. Clear focus of public system on most severe cases.

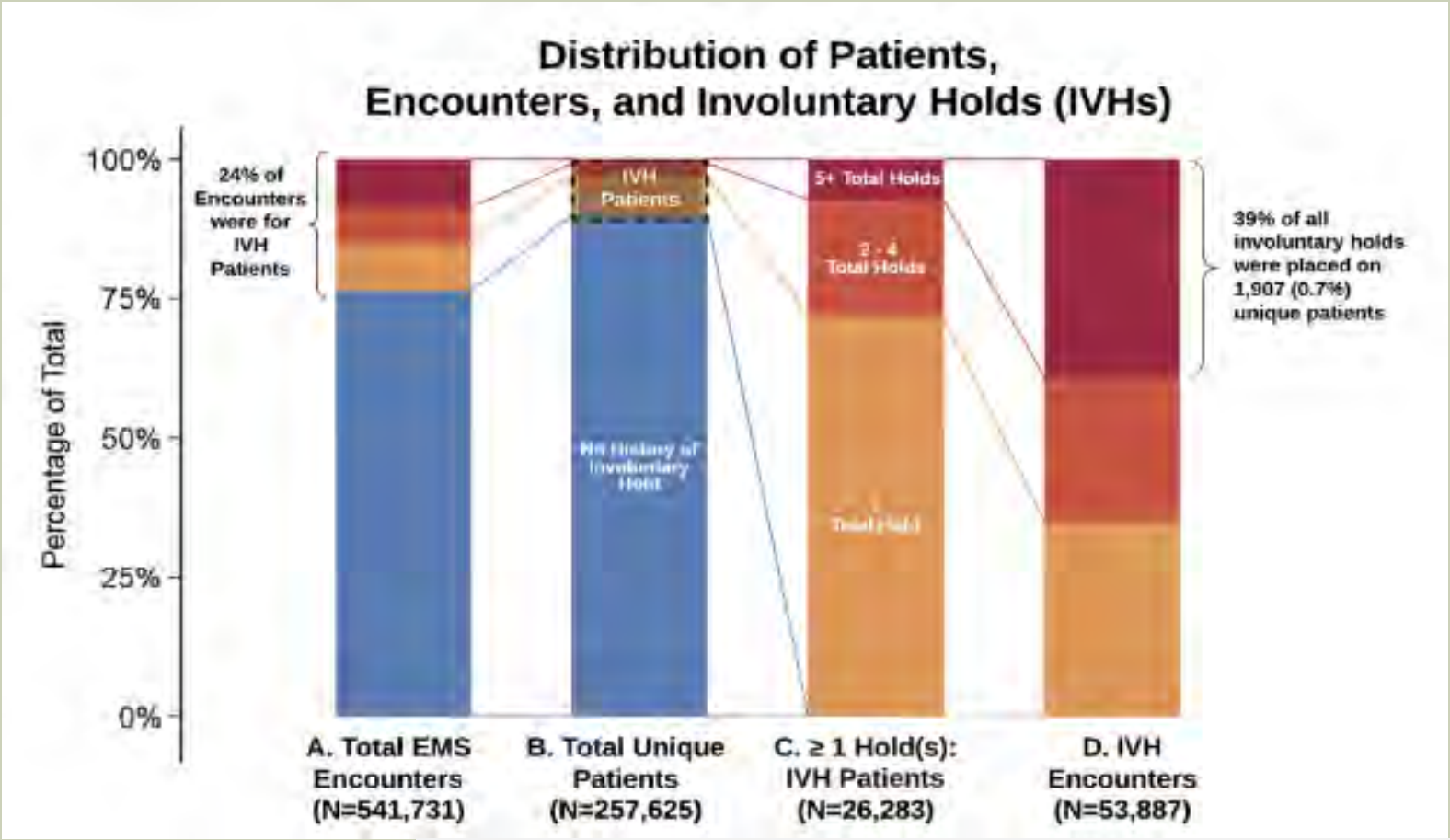
FIGURE 1. Supply of psychiatric beds and community care facilities per 100,000 population across 15 countries, 2011[a]



Perera, Isabel M. 2020. "The Relationship Between Hospital and Community Psychiatry: Complements, Not Substitutes?" *Psychiatric Services* 71(9):964–66.

INVOLUNTARY CARE

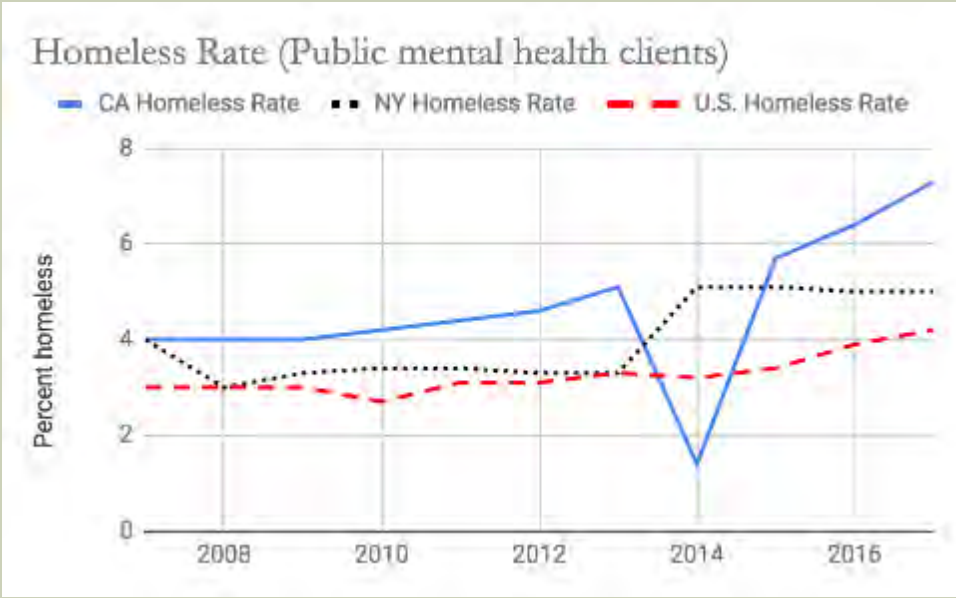
EVIDENCE FOR THE 'REVOLVING DOOR'

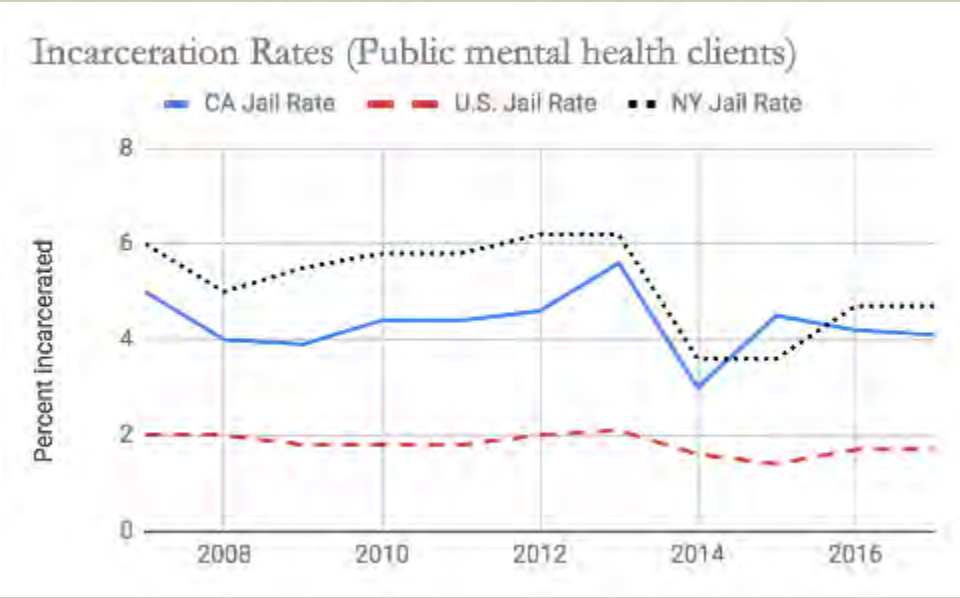


Source: Trivedi, Tarak K., Melody Glenn, Gene Hern, David L. Schriger, and Karl A. Sporer. 2019. "Emergency Medical Services Use Among Patients Receiving Involuntary Psychiatric Holds, 2011 to 2016." *Annals of Emergency Medicine* 73(1):42-51.

THE CALIFORNIA CONTEXT

- California's public mental health serves fewer people, has fewer beds, and has more clients homeless or in jail.





Absent Authority:
Evaluating California's Conservatorship Continuum

Alex V. Barnard
Assistant Professor
Department of Sociology
New York University

This report is a draft. I welcome all comments, criticisms, and corrections. I continue to conduct interviews and collect data from stakeholders in California. Anyone interested in speaking to me on or off the record should feel free to contact me at ab8877@nyu.edu. I am glad to see this report circulated but would be grateful for notification if you share it.

Acknowledgements: I am grateful for the aid in this project by research assistants Sierra Timmons, Kimberly Nielsen, Didi Wu, Michael Long, Yoshi Cohn, Sebastien Le Moing, and Amritha Somasekar. I have also benefited enormously from the advising of Marion Fourcade and Dan Lewis. Although I cannot acknowledge them by name, this report would not be possible without the generosity of my many interviewees who shared with me their time, insights, and expertise. Small details have been changed in some quotations to preserve anonymity.

Absent Authority: Evaluating California's Conservatorship Continuum

Executive Summary

- In California, "conservatorships" under the Lanterman-Petris-Short Act allow a county Public Guardian or family member to place a person with a severe mental illness in a locked facility and mandate they accept medication. Conservatorships constitute an enormous restriction of civil liberties in the name of preserving the life and well-being of people who are "gravely disabled" (unable to meet needs for food, clothing, or shelter as a result of mental illness). Although policymakers in California are currently discussing expanding the use of conservatorships, there is very little research on how conservatorships are currently functioning.
- This research project set out to understand decision-making along the "continuum of constraint"—the series of medical, legal, and bureaucratic steps through which someone is hospitalized, ordered onto a conservatorship by a judge, and placed to a long-term mental health facility. This report draws on over 130 interviews with stakeholders in twenty-three counties, plus documents, media reports, administrative statistics, observations of working groups, and a review of the academic literature.
- I argue that the conservatorship system in California is one of "absent authority." In the conservatorship continuum, many actors can block a conservatorship but no one has clear authority for ensuring they are put into place for people who need high-intensity care. There is a lack of clear responsibility, oversight, evaluation, and coordination in the continuum. The state and counties have not guaranteed that potential conservatees' due-process rights are protected or that the restrictions of civil liberties they face are balanced with appropriate, fully resourced, and high-quality services geared towards enduring transformation.

Findings

- ***California's Context***: California's LPS Act and the public mental health system created by the 1957 Short-Doyle Act made it a leader in protecting the rights of people with mental illness *and* ensuring that they received community-based services. Today, California's commitment laws are considered to be more restrictive than in most states. The state has fewer hospital beds and its public mental health system serves fewer people relative to the population than the national average. The number of conservatorships is going down while the state has a high and increasing rate of short-term involuntary holds, suggesting a rapidly-spinning "revolving door."
- ***Initial 'Holds':*** Some research has found that 72-hour psychiatric holds ("5150s") are used liberally by police to clear streets without resorting to arrest. But both outpatient clinicians and family members reported that getting these holds is extremely difficult when someone is not homeless and not engaged in visibly disruptive behaviors. 5150 evaluations by both police and mobile crisis teams are superficial and pay little attention to someone's condition outside of their immediate presentation. Families feel they had to exaggerate fears of "dangerousness" or stop providing for a family members' basic needs to get help.
- ***Emergency Departments***: Clinicians strictly screen people brought to Emergency Departments. They filter out

many people who social service agencies, outpatient providers, police officers, or family members see as needing conservatorship. They are more likely to admit people who have disruptive or dangerous behaviors than those who are gravely disabled. ERs frequently release people with drug use and people whose needs are seen as more social than medical, even when they have a severe mental illness. As a result, some people accumulate enormous numbers of 5150 holds without ever connecting to long-term treatment.

- *Hospitals*: Hospitals face strong economic incentives to provide only short-term care. Hospitals put intense pressure on the outpatient clinicians, housing providers, and family members which have sought hospitalization to take that person back, often when they are barely stabilized. California's public insurance system, Medi-Cal, penalizes hospitals for holding people while a conservatorship is put in place. These financial disincentives are particularly problematic for-profit private facilities, which account for half of the psychiatric beds in California authorized to take involuntary patients. Inpatient physicians typically require that a person has multiple hospitalizations and failed returns to the community before applying for conservatorship.
- *Counties and Public Guardians*: Public Guardians have a limited budget and mandate to ensure that counties only take responsibility for someone as a last resort. Given the current housing situation, investigations center on whether a person is "successfully managing the homeless lifestyle," or meeting their needs in some minimal way without disturbing those around them. Appropriate conservatees are those essentially at risk of death on the streets. However, because so many people drop off the continuum at earlier steps, public guardians file on most referrals sent to them by hospitals.
- *Courts and Public Defenders:* The formal legal protections for potential conservatees are substantial. However, some public defenders reported that they faced barriers to actualizing these rights because of high caseloads, the difficulty of assessing whether conservatees actually want to contest their conservatorship, and their belief that in some cases only a court order will ensure that clients are given appropriate services. Courts grant the majority of conservatorship petitions. Judges most frequently deny requests for conservatorship when a person can identify a responsible third party to provide for their basic needs.
- *Locked Placements:* Counties varied in whether they expected all conservatees to be in locked facilities. Some private sub-acute placements "cherry pick" conservatees who do not have complex medical needs or violent behaviors. These latter conservatees may put their state license or financial bottom-line at risk. Counties compete with one another for placements, creating absurd outcomes like people placed hundreds of miles away because a nearby facility's beds are contracted to a different county, itself hundreds of miles away.
- *Unlocked Placements:* Some counties also place conservatees in unlocked, community-based facilities. However, such "Board and Care Homes" are evaporating due to rising staffing costs, tightening regulations, and opportunities to convert to serving populations for whom public financing is more favorable (such as people who are homeless or living with developmental disabilities). The remaining operators can also screen out conservatees they see as more problematic, like those with co-occurring substance use issues.

- *Conservatorship Aims and Outcomes:* Resource constraints dictate whether Public Guardians provide intensive oversight and support versus only occasional administrative check-ins. Public Guardians diverged on the goals of conservatorship. Some argued the aim is to promote autonomy and recovery, while others believe their focus was limited to keeping someone alive. They thus also differ in how much they accompany conservatees as they transition to independent placements.
- *Criminal Justice System:* Many interviewees (especially public defenders) believe that diverting more people from the criminal justice system will require expanding *involuntary* treatment. Public Guardians report a substantial increase in referrals for conservatorship from the criminal justice system. Many Public Guardians feel that they lack the training or resources to serve this population, and that there are no appropriate placements available. Reformers who want public guardians to take on new groups of clients may have confused conservators' power over *conservatees* with their limited authority over *conservatorships*, which requires cooperation and financing from a range of other entities.

Recommendations

1. ***The state should significantly expand research, monitoring, and evaluation of conservatorships.*** There is an enormous dearth of data informing contemporary policy debates. A recent state audit did not analyze key steps in the conservatorship process and only covered three counties. Research is needed to track which placements for conservatees are most lacking, for which patient profiles conservatorship is most likely to be beneficial (for example, whether conservatorship is effective for people with co-occuring substance use disorders), and whether new models (like "community" or "housing" conservatorships) improve outcomes. Reformers need to be cautious about extrapolating from different forms of legally-obligated treatment, like Assisted Outpatient Treatment, to make arguments about expanding conservatorship. Conservatees themselves have been glaringly absent from policy discussions
2. ***The state should set much clearer guidelines for the use, goals, and services provided by conservatorship.*** There is enormous variability in how counties use conservatorships, which does not seem justified by actual differences between their socio-economic conditions or demographics. The state should offer much clearer guidance on how to define "grave disability," what kinds of placements should be considered for conservatees, and what the powers of conservators are. Regulators should also make sure that conservatees are regularly re-evaluated and not lingering due to a lack of spots in less restrictive settings. All of this requires that the state Department of Health Care Services has a dedicated office for LPS.
3. ***States and counties need to improve the funding and working conditions of key actors in the conservatorship continuum.*** The recent state audit said almost nothing about public defenders and public guardians, who are charged with protecting conservatees while operating with a tightly constricted budget. Public defenders need smaller caseloads and specialized training to effectively work with people with severe mental illnesses. Public guardians similarly could benefit from resources that would allow them to meet the specific needs of conservatees to help them transition to voluntary care.

4. ***The state needs to create conditions for LPS criteria to be used more effectively.*** A lack of appropriate placements drives decision-making throughout the conservatorship continuum. While some advocates believed that the criterion of "grave disability" needs to be broadened, this legal criterion already expands or contracts depending on what resources are available. Creating mechanisms to ensure that decision-making takes into account past history, future prognosis, and information from families and outpatient clinicians could ensure any new conservatorships are well-targeted.
5. The state and counties need to provide more higher-level placements, but should focus on quality and voluntary care as well as bed quantity. A wide range of stakeholders agree that California needs additional beds in structured settings and that a combination of outpatient care and supported housing is not sufficient for some clients. Interviewees identified the IMD (locked sub-acute) level of care as the biggest blockage in the continuum. Other countries with more robust inpatient systems actually use less involuntary care because hospitalizations last long enough to ensure real improvement. The state should invest in more beds but make increasing the number of people using them voluntarily a key metric. Peoples' objections to conservatorship are frequently more complex than simply 'they lack insight' or 'they do not want treatment.' Improved conditions in hospitals or giving people more choice around the margins (even letting people smoke in locked facilities) may reduce the need for coercion.
6. ***The state should reconsider whether essential public mental health services can best be provided by private entities.*** There has been little reflection about the costs and benefits of who owns and operates facilities. Some interviewees raised concerns about whether private facilities were willing to serve the whole gamut of conserved clients. While many of the most exciting models of care they identified are private and for-profit, good care for conservatees should not depend on private initiative and market forces. Counties will either need to create public facilities or make changes to contracting with private ones to ensure that the neediest cases get served.
7. ***People with severe mental illness should be the priority for funders, regulators, and providers.*** California has followed a national trend in deprioritizing the sickest people in its mental health system. People potentially subject to conservatorship should be the system's biggest concern. Funding streams like MHSA should be able to meet the whole continuum of services for this group. The state should increase funding for these services by asking for a waiver from the IMD exclusion. It should develop services that bridge the gap between institutional services and purely-voluntary outpatient ones. Outcomes for conservatees should be a core metric of the system's success.

Conclusion

- California's conservatorship continuum is in a situation of "absent authority." The system does not provide coordinated interventions that are geared towards long-term outcomes of stability, autonomy, and community integration. Conservatorship should be reimagined as part of a mental health system that is a fully-funded entitlement to meet the whole needs of all people who qualify.

Introduction

In 1967, California passed the Lanterman-Petris-Short (LPS) Act, which advocates hailed as a "magna carta"[1] for people living with severe mental illness.[2] It guaranteed due process rights for users of psychiatric services and imposed limitations on involuntary hospitalizations (or "civil commitments"). In the ensuing decades, social scientists debated whether psychiatrists could accurately assess dangerousness—one criterion for civil commitments under revised laws—and if new legal protections ensured respect for patients in practice.[3] Since then, attention has shifted towards care in the community[4] and in the criminal justice system.[5] With some recent exceptions,[6] discussions of mental health policy have largely ignored the role of inpatient commitments.[7]

This inattention is problematic because long-term involuntary psychiatric care in locked facilities never actually went away. Thousands of people per year in California are subject to "conservatorship," a court-order that transfers legal responsibility for a person onto a county public guardian or family member. Conservators can determine where a person lives, control their assets and income, and obligate them to take medication. Some legal advocates call it "the greatest deprivation of civil liberties beyond the death penalty." Yet there is surprisingly little analysis of how the LPS Act is actually functioning. Such an analysis is especially pertinent now. After a half-century in which LPS has seen only minor tweaks, in the last five years legislators have introduced a flurry of bills proposing to expand conservatorships, particularly to address the nexus of mental illness, drug use, and homelessness.[8]

In this paper, I analyze the current process by which people do or do not enter conservatorships in California. There are no databases that provide reliable data on conservatorship. Instead, I draw on over 130 interviews with clinicians, conservators, public defenders, family members, and government officials throughout the state to understand the "continuum of constraint," or series of steps that lead someone to being conserved. I supplement this with a review of six-hundred newspaper articles, available research, and reports on the LPS Act from 1967 to the present. I also participated in working groups around conservatorship and long-term care, and observed an outpatient treatment team working with clients facing conservatorship.

Virtually everyone I spoke to believed that many people who could benefit from high-intensity care were not getting it. This is consistent with a seeming decline in the number of conservatorships over time (Figure 1, 2), despite increasing rates of short-term,

[1] Nelson, "'Civil Rights' Bill on Mental Health."

[2] Some advocates I interviewed preferred speaking of "brain diseases" to emphasize the neuro-biological basis of conditions like schizophrenia. On the other hand, some "survivors" or "consumers" of mental health treatment have attempted to reclaim the term "mad" to avoid labels that imply a medical problem. Certainly, many of the people under conservatorship contest that they are, in fact, "people with severe mental illness." I use the term because I nonetheless see it as the most neutral option that recognizes the reality of peoples' suffering and signals the need for attention, resources, and understanding from the broader public.

[3] Ennis and Litwack, "Psychiatry and the Presumption of Expertise"; Morris, "Conservatorship for the 'Gravely Disabled'"; Warren, *The Court of Last Resort*.

[4] Brodwin, *Everyday Ethics*; Dobransky, *Managing Madness in the Community*; Gong, "Between Tolerant Containment and Concerted Constraint."

[5] Castellano, "Courting Compliance"; Roth, *Insane*.

[6] Substance Abuse and Mental Health Services Administration, "Civil Commitment and the Mental Health Care Continuum."

[7] The last major federal report on the country's mental health system made no mention whatsoever of civil commitments. President's New Freedom Commission on Mental Health, "Achieving the Promise."

[8] Senate Judiciary Committee, "Conservatorship."

Figure 1: Involuntary Short-Term Holds

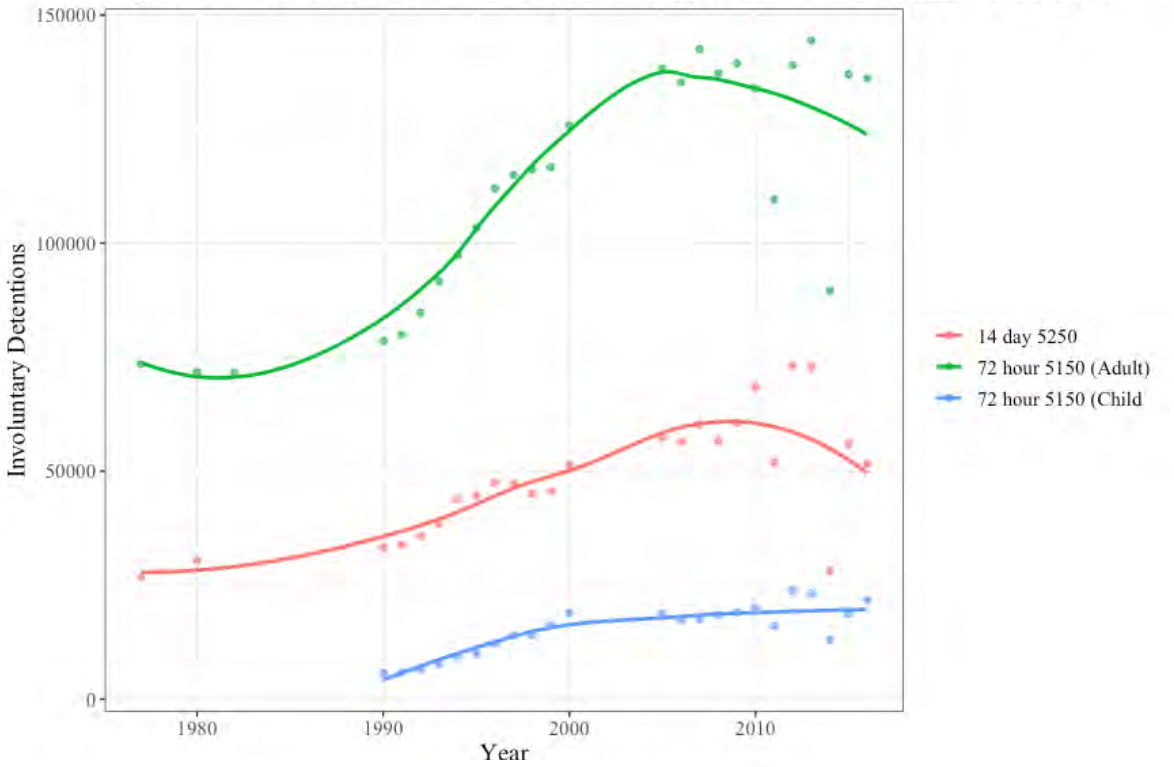
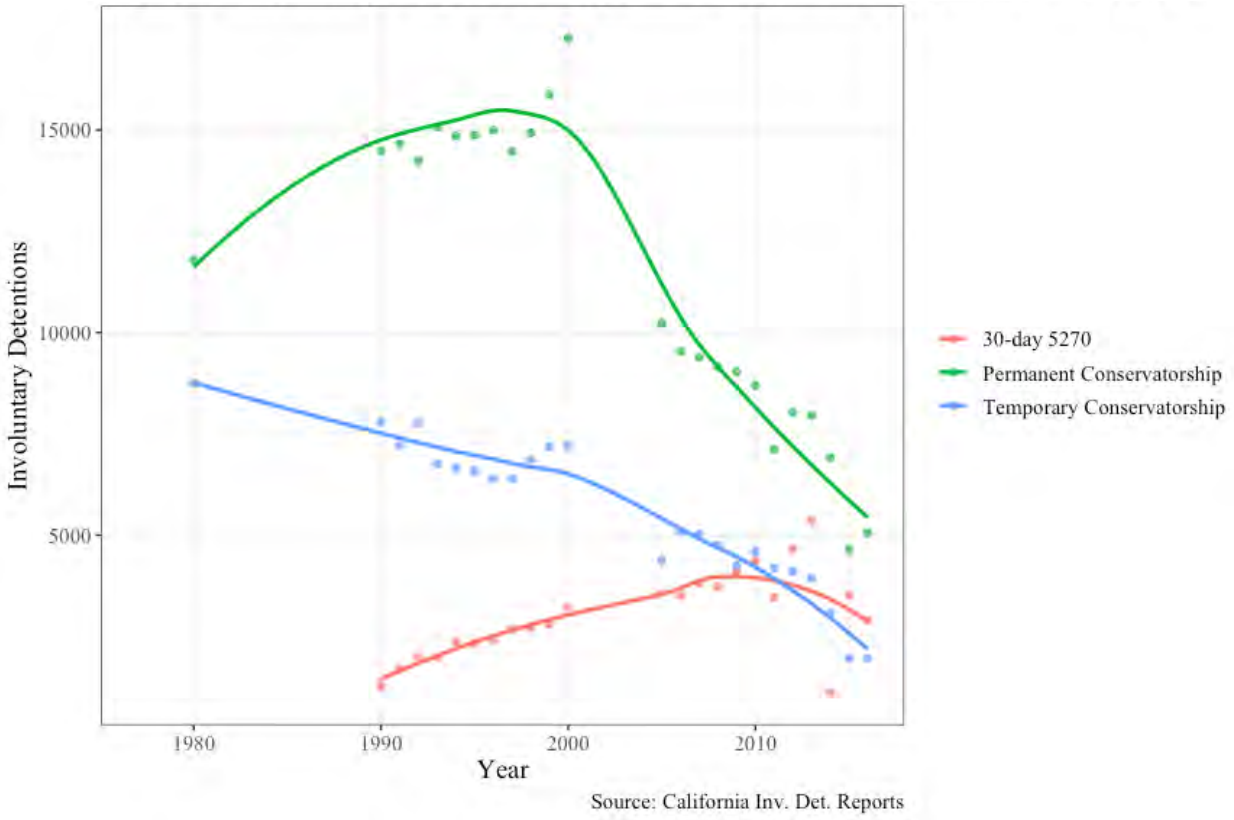


Figure 2: Involuntary Long-Term Holds



involuntary care.[9] Their explanations for why, however, were polarized. Some argue that the root of the problem is the restrictive criteria and procedural protections of the LPS Act itself. Others blame a lack of resources and beds.

I find evidence for both these explanations but emphasize another: California's continuum of constraint is in a situation of what I call *absent authority.* Many actors along the continuum can block a conservatorship, but no one has the authority for ensuring that people who need conservatorship get it or accountability that such deprivations of rights are coupled with a coherent response geared towards enduring transformation.

In this report, I emphasize three different dimensions of absent authority, drawing on social science research on health systems, law, and bureaucratic decision-making. First, conservatorships are emblematic of America's "delegated" welfare state, in which "a complex hybrid of public and private actors engage in social welfare provision [with] convoluted lines of authority and accountability."[10] Getting a conservatorship requires a rare alignment of a range of public, non-profit, and private actors, each operating with their own missions, interpretations, and financial incentives. Second, "street-level bureaucrats" in the conservatorship continuum have to make decisions based on a person's fluctuating momentary state, which prevents them from engaging in a coordinated project to achieve long-term change. Third, these different actors adjust their interpretation of conservatorship criteria based not just on their own sense of who needs conservatorship, but based on their perception of how others elsewhere in an under-resourced continuum will decide. This means, for example, that police officers might decline to pick someone up because they know that there is no guarantee that person will stay long enough for their condition to improve, or an ER clinician might choose not to admit someone to the hospital because they know no private housing provider will take them on discharge. In the end, conservatorship is an enormously powerful government tool that no one seems responsible for using in a consistent way.

My analysis proceeds as follows. I first offer some comparative data to put California's mental health system in context, review the limited available research on conservatorship, and discuss the broader privatization of the mental health system. I then introduce some social science concepts to try to capture the mix of private delegation and bureaucratic discretion that creates a situation of absent authority. The empirical section of this paper traces the multitude of steps along the continuum of constraint that leads to a person being placed (or not) on a conservatorship. In each, I identify the specific mechanisms that drive people out of the continuum. In the conclusion, I consider these results in light of the recent audit of LPS by state government and the implications of these findings for contemporary policy debates.

A caveat: as sociologists, we are trained to be "hard on structures and easy on people." California's LPS system is malfunctioning, not because of the people working in the system, but in spite of them. I've been honored to meet amazingly dedicated clinicians, advocates, policymakers, family members, and service users through this research. In this report I focus on the differences between them, but their shared commitment to achieving the best possible outcomes for some of the most vulnerable and marginalized people in America was, to me, never in doubt.

[9] Both figures may reflect significant undercounts because: 1) some years do not include data from state hospitals; 2) over time a decreasing number of counties are reporting involuntary detentions to the state; 3) data from some smaller counties are dropped by the state to maintain patient confidentiality; 4) certain counties report numbers to the state which are inconsistent with other sources (for example, San Francisco told the state it had 206 conservatorships in 2016, while the city auditor reported 650).

[10] Morgan and Campbell, *The Delegated Welfare State*, 4.

Background: California's "Delegated" Mental Health System

California was once a national and world leader in mental health care. The state's 1957 Short-Doyle Act provided an unprecedented level of state support for outpatient treatment. In 1963, the state commissioned a report into admissions to state hospitals. It concluded that they had become a "bin marked 'miscellaneous'"11 receiving mentally ill, disabled, and elderly people who lacked other supports. These revelations became the basis for the Lanterman-Petris-Short Act in 1967.12

Any time lawmakers consider revisiting the LPS Act, it's worth reminding ourselves what civil commitments looked like before it. As Frank Lanterman recalled in a 1982 interview:

> *A guy walking down the street, talking to himself, would be thrown into a hospital…A policeman could pick him up, take him to the emergency hospital and a judge would railroad him into a state hospital…Our staff members found that the average time for committing a person (in a court hearing) was five minutes. That meant taking away a person's liberty, often for life. Senior citizens were being shoveled into hospitals by many thousands a year. They were not insane under either medical or legal definition.*[13]

Although now remembered as a "Bill of Rights" for its protection against involuntary hospitalization, the actual intentions of policymakers were more complex. The bill's authors explained that "We saw that if we could lodge a huge boulder in the center of that over-used road to the mental hospital, the patients would have to be sent somewhere else, to more appropriate facilities."[14] The bill favored *voluntary* hospitalization in community hospitals and committed the state to covering 90% of the costs of new public outpatient services.

Inpatient, Outpatient and Public Mental Health Services Post-LPS

Even if the legal procedures and criteria for conservatorship under LPS have remained relatively stable, conservatorship exists in a mental health system that has been drastically transformed through the increasingly "delegated" authority for mental illness.

Mental health was long an outlier both in the degree of public financing and scale of direct service provision by governments. Although President Franklin Pierce vetoed an 1854 bill that would sell federal land to finance asylums, the states picked up the slack. By the mid-20th century, state governments spent an average of 8% of their budgets on public hospitals, where 88% of psychiatric hospitalizations took place.[15] In California, the Department of Mental Hygiene was the largest state agency after the University of California, and employed one-fifth of the government's workforce.[16]

LPS was designed not just to shift funds away from state hospitals towards community services, but also from public to private ones. Frank Lanterman believed the bill would facilitate a "pooling of public and private resources."[17] The California Hospital Association "warmly endorsed" the bill, "perceiving an opening for private hospitals to gain access to more paying patients."[18] The bill did not itself legislate the closure of state hospitals, but it provided cover for it. As Governor Reagan stated in 1967, with "the development and expansion of local programs" the state would be able to

[11] Subcommittee on Mental Health, "The Dilemma of Mental Commitments."
[12] For useful summaries of California's mental health history, see Pasquini and Rettagliata, "Housing That Heals"; Padwa et al., "A Mental Health System in Recovery."
[13] Boyarsky, "Changing Policies Affect Care of Sick."
[14] Bardach, *The Skill Factor in Politics*, 103.
[15] Grob and Goldman, *The Dilemma of Federal Mental Health Policy*, 14.
[16] Bardach, *The Skill Factor in Politics*.
[17] Seelye, "Owner Claims Hospital Boycotted."
[18] Bardach, *The Skill Factor in Politics*, 113.

"reduce the size of our [public] mental hospitals."[19] Although all states substantially de-institutionalized starting in the 1950s, California led the country in the rapidity of its bed closures and the subsequent free-fall of spending on mental health as a portion of the state budget.[20]

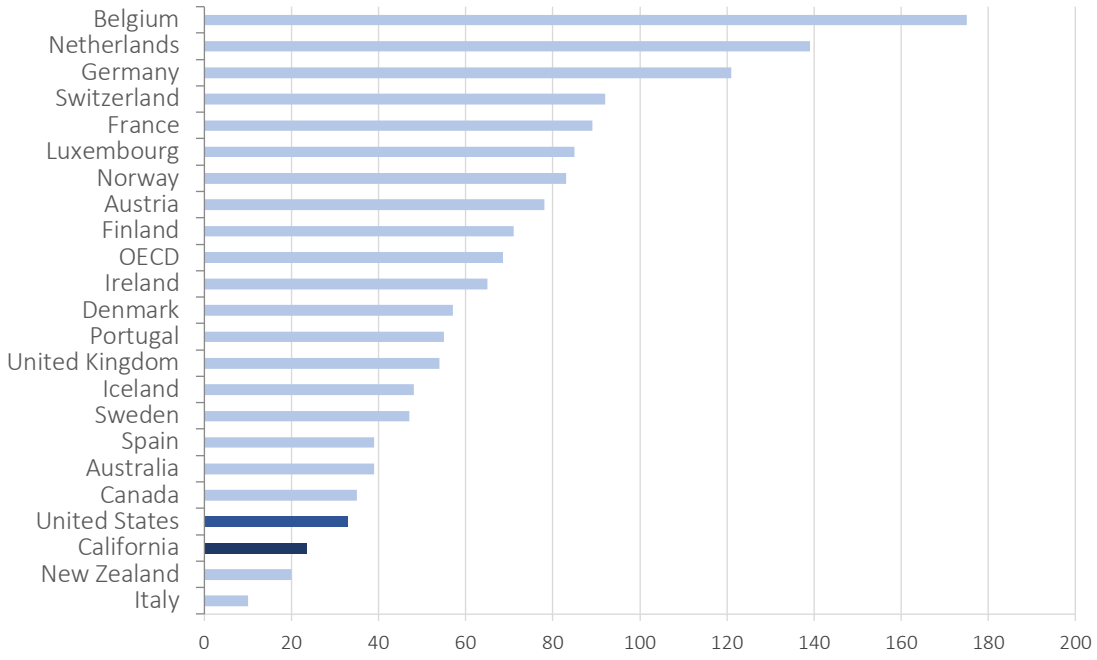
Mental health thus followed a broader pattern in the U.S. of "delegate[ing] responsibility for publicly-funded social welfare provision to non-state actors"[21] to a much greater extent than nearly any European country. Like many of the anti-poverty programs of the '60s and '70s,[22] states relied on contracts with non-profit organizations to provide community mental health services.[23] Community care also depended on another non-governmental entity: the family. Parents and siblings became the default provider of housing and supports in everyday life for people living with chronic mental illnesses.[24] Still, early on, conservatees were an exception. Both early newspaper accounts and my interviews with public guardians who were involved in the system in the 1970s reported that conservatees—the sickest of the sick—largely remained in publicly-financed state and county hospitals.[25]

Over time, however, for-profit organizations have carved out a growing place in this system of delegated welfare. In the shadows of the state hospitals, a network of private "Board and Care" homes grew to harvest the disability checks of people who had been "de-institutionalized."[26] By 1982, California estimated there were 35,000 chronically mentally-ill in such facilities—more than the population of the state hospitals at their peak.[27] That decade also saw intensifying cost controls from public insurance programs like Medicare and the rise of private Health Management Organizations. This pushed private hospital companies to convert general medical beds to psychiatric ones, taking advantage of looser cost containment.[28] By the 1990s, however, financial pressures from public and private insurance turned towards psychiatry as well. The discipline was "more severely walloped by managed care policies than any other branch of medicine."[29] In the U.S., Mental health has gone from capturing over 10% of total health spending in the 1960s to 6.5% in 2014.[30] Even though Medicaid continues to be the primary financer for public hospitals and clinics, these funds too are now run through private insurance plans that strictly limit care.[31]

Today, California has fewer beds than the national average (33 vs. 23 per 100,000), itself lower than in almost any other developed country (Figure 3).[32] Both a paucity of beds and financial incentives have substantially narrowed hospitals' role. Psychiatric hospitals in the U.S. are not integrated with community-based services as they are in European countries like France, where public sector psychiatrists work part time on inpatient and part time outpatient.[33] They are organized and financed to provide only acute stabilization: s one inpatient clinician told an anthropologist, "Here, everyone is an inappropriate admission. I don't admit

[19] Gillam, "Assembly Group OKs Mental Hospital Bill."
[20] Scull, *Decarceration*; Elpers, "Public Mental Health Funding in California, 1959 to 1989."
[21] Morgan and Campbell, *The Delegated Welfare State*, 19.
[22] Smith and Lipsky, *Nonprofits for Hire*.
[23] Hasenfeld, "Community Mental Health Centers"; Hollingsworth, "Falling through the Cracks."
[24] Gong, "Between Tolerant Containment and Concerted Constraint"; Padwa et al., "A Mental Health System in Recovery."
[25] Embry, "The Ordeal of Total Power"; Ray, "Mental Programs: The Shaky Ladder."
[26] Scull, "A New Trade in Lunacy."
[27] Legislative Analyst, "Overview of the Public Mental Health System."
[28] Brown and Cooksey, "Mental Health Monopoly."
[29] Luhrmann, *Of Two Minds*, 243.
[30] Frank and Glied, *Better But Not Well*; Mark et al., "Insurance Financing Increased For Mental Health Conditions."
[31] Scheid, "Managed Care and the Rationalization of Mental Health Services."
[32] Fuller et al., "Going, Going, Gone."
[33] Petitjean, "The Sectorization System in France."

Figure 3: Psychiatric Hospital Beds Per Capita (2011)



patients, I discharge them."[34] This focus is out of sync with their responsibility for placing people with chronic illnesses onto conservatorship.

In any case, what are people being discharged to? The big picture is that, across the United States, an increasing number of people are accessing low-intensity mental health services (like anti-depressants prescribed by generalist doctors).[35] But, the availability of high-intensity services like Assertive Community Treatment, crisis intervention teams, or supported housing has actually decreased (peer supports have increased).[36] California delivers

intensive public mental health services via county mental health plans to a very small proportion of its population (about 1.5%),[37] below the national average (2.3%).[38]

Conservatorships and Commitments Post-LPS

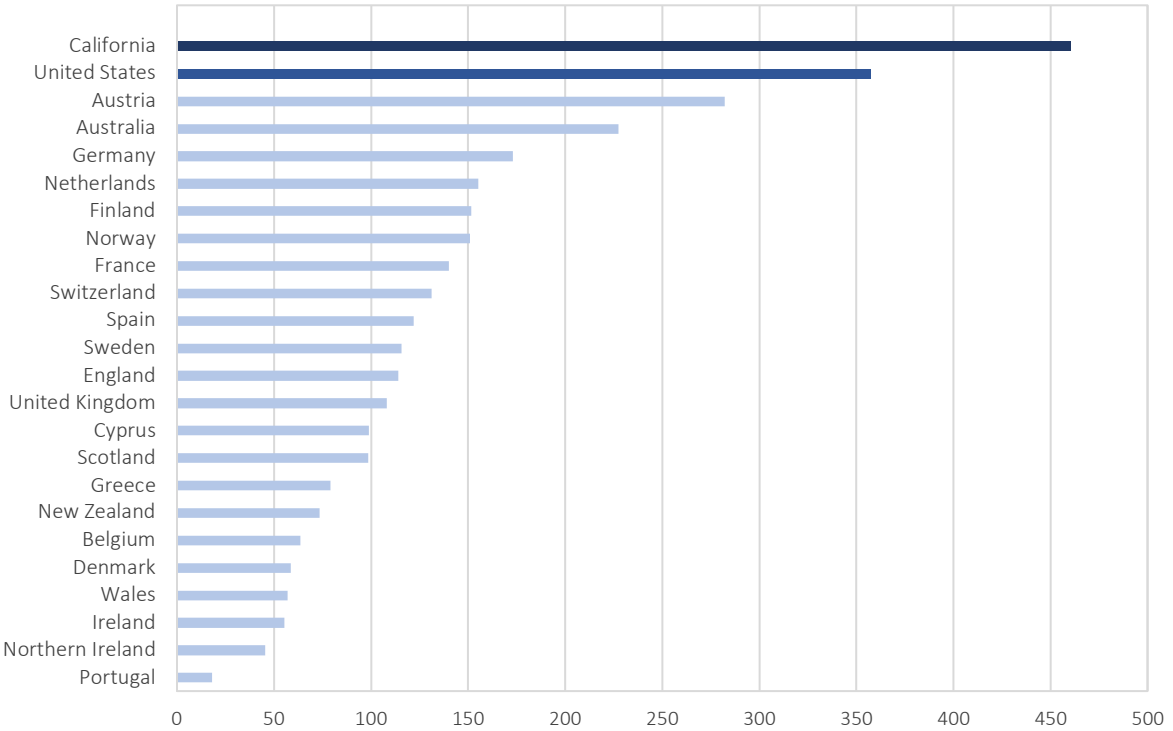
The often-indefinite commitments of people into large, state-run asylums before LPS was an exercise of the state's *parens patriae,* or its obligation to "care" for its most vulnerable citizens. Throughout the 1960s and 1970s, however, civil rights litigation and policy reforms appeared to shift the basis of involuntary civil commitments from the state's *parens patriae* to its "police power," or authority to prevent disruption and disorder.[39] Reform made dangerousness the central criterion for involuntary psychiatric hospitalization in every state.[40] Reformers like Judge David Bazelon believed that bills like LPS would "virtually eliminate" involuntary hospitalizations.[41]

[34] Rhodes, *Emptying Beds*, 41.
[35] Mojtabai and Jorm, "Trends in Psychological Distress, Depressive Episodes and Mental Health Treatment-Seeking in the United States."
[36] Spivak et al., "Distribution and Correlates of ACT"; Cummings et al., "The Changing Landscape of Community Mental Health Care."
[37] Behavioral Health Concepts, Inc., "Medi-Cal Specialty Mental Health," 16.
[38] See SAMSAH, "Uniform Reporting System." Retrieved January 21, 2021 (https://www.samhsa.gov/data/report/2019-uniform-reporting-system-urs-table-california).
[39] Appelbaum, *Almost a Revolution*.
[40] Hedman et al., "State Laws on Emergency Holds."
[41] Bazelon, "Implementing the Right to Treatment," 753.

Surprisingly, however, social scientists and psychiatrists who studied the implementation of new civil commitment laws found that on their own they did to limit hospital admissions.[42] For example, California went from 13,000 civil commitments a year prior to LPS to over 80,000 by 1980.[43] Part of what those expecting an end to involuntary commitments missed is that most states, either through formal statutes or subsequent court rulings, continued to allow hospitalizations in instances where people are deemed "gravely disabled," or unable to meet their basic needs for food, clothing, or shelter, as a result of mental illness.[44] Research in the post-reform period found that grave disability allowed psychiatrists to work around strict new civil commitment laws and to continue to hospitalize people based on assessments of their need for treatment.[45] Early accounts of conservatorship hearings show that the "grave disability" standard used to be quite flexible. As one professional told Holstein during his study, "If we're arguing disability, almost anything goes."[46] This is an important point to emphasize. At least initially, the "grave disability" criterion was supple enough to allow for many more conservatorships than there are today.

Today, California has a higher rate of involuntary commitments than the national average and a much higher rate than any European country (Figure 4).[47] This high rate of holds suggests that California's procedural

Figure 4: Involuntary Holds / Hospitalizations



[42] Appelbaum, *Almost a Revolution*.
[43] Bardach, *The Skill Factor in Politics*, 99; Legislative Analyst, "Overview of the Public Mental Health System."
[44] Hedman et al., "State Laws on Emergency Holds."
[45] Appelbaum, *Almost a Revolution*; Holstein, *Court-Ordered Insanity*; Monahan, "Empirical Analyses of Civil Commitment."
[46] *Court-Ordered Insanity*, 56.
[47] Sheridan Rains et al., "Variations in Patterns of Involuntary Hospitalisation"; Lee and Cohen, "Incidences of Involuntary Psychiatric Detentions."

protections and commitment criteria do not prevent comparatively large numbers of short-term involuntary holds. But these holds are often extremely short, which is why a small number of people cumulate numerous short-term commitments.[48] The state is using lots of involuntary holds that seem to add up to nothing more than more involuntary holds.

Beyond these aggregate numbers, we know little about how conservatorships and civil commitments are functioning in the mental health system today. The last studies on how conservatorships impact those placed on them are based on surveys conducted in the 1980s.[49] There is no complete national data that allows us to compare how the number of beds or the restrictiveness of state laws impact commitment rates.[50] California's state-compiled "Involuntary Detention Reports" are grossly incomplete. Recent reports, for example, have no conservatorship data from Los Angeles and contain four-fold undercounts for others, like San Francisco. The only available recent study focused on court hearings, and found they were perfunctory affairs that afforded little protection to people subject to conservatorships.[51]

Conservatorships are the most extreme endpoint of a continuum of constraint that extends from informally coercive outpatient treatment to short-term hospitalization to long-term institutionalization. The availability of all these levels of care has been constrained by the delegation of public responsibility for mental illness. Yet policymakers are now reconsidering conservatorship as a tool through which to manages disruptive public behavior and homelessness. Conservatorships have also been cited as a potential tool for diverting people from the criminal justice system. Given the hopes and fears attached to expanding conservatorship, it seems timely to analyze how the LPS system is actually functioning.

Literature: Street-Level Discretion and Absent Authority

Scholars have described America's delegated welfare state as a Rube Goldberg machine—a device that performs even simple tasks in a winding and inefficient way.[52] Such a "complex hybrid of public and private actors engaged in social welfare provision" is marked by "convoluted lines of authority and accountability, and a blurring of boundaries between public and private."[53] In this section, I introduce social science concepts that I used to make sense of the "continuum of constraint" and lay out three features of the "absent authority" over that continuum.

Street-Level Bureaucracy

It is a truism among scholars of social policy that the effects of programs come not from the desire of regulators, managers, or legislators but from the bottom up. The decisions of front-line workers "become, or add up to, agency policy."[54] From this perspective, all the key entities and personnel in the conservatorship continuum, including private ones like hospital psychiatrists

[48] Bruckner et al., "Involuntary Civil Commitment."
[49] Frank and Degan, "Conservatorship for the Chronically Mentally Ill"; Lamb and Weinberger, "Therapeutic Use of Conservatorship"; Reynolds and Wilber, "Protecting Persons with Severe Cognitive and Mental Disorders"; Young, Mills, and Sack, "Civil Commitment by Conservatorship."
[50] Morris, "Detention Without Data." Recent research from scholars at UCLA suggests that the total number of short-term involuntary "holds" is over one-million per year, but the data are partial and inconsistent. Lee and Cohen, "Incidences of Involuntary Psychiatric Detentions." National data shows that over 824,000 people with serious mental illness were hospitalized in 2018 and point-in-time counts from 2018 show that 57% of inpatients were admitted involuntarily. Substance Abuse and Mental Health Services Administration, "Results from the 2018 National Survey on Drug Use and Health," Table 8.19A. Substance Abuse and Mental Health Services Administration, "National Mental Health Services Survey (N-MHSS)," 29.
[51] Morris, "Let's Do the Time Warp Again."
[52] Clemens, "Lineages of the Rube Goldberg State."
[53] Morgan and Campbell, *The Delegated Welfare State*, 4.
[54] Lipsky, *Street-Level Bureaucracy*, 3.

and high-status ones like judges, serve as "street-level bureaucrats" (SLBs). SLBs are workers who deliver public services for which the resources available are inevitably insufficient to serve the whole universe of people who, according to criteria defined in law, could receive them.

Precisely because the formal criteria are impossible to use—police can never enforce every law, regulators can never implement every rule, and social workers can never serve every needy person—the exercise of "discretion" is at the core of the work of SLBs.[55] How they exercise that discretion depends not just on available resources but also workers' professional identities, experiences, and beliefs about who is most deserving.[56] Thus, a core part of this report is trying to understand the informal strategies, short-cuts, and criteria used by different SLBs in the conservatorship continuum. In this instance, the policy this "adds up to" is a system of absent authority in which everyone exercises discretion over who to remove from the continuum but no one can ensure someone stays on it.

Absent Authority Feature 1: "Outsourced" Decision-Making to Private Institutions

Sociologists have thought about government agencies as divided between a caring "left hand"—health, housing, welfare—and a coercive "right hand"—courts, police, prisons.[57] Others have divided between state services that are provided directly versus delegated to non-profit or for-profit entities.

Part of what makes involuntary mental health care complicated is that it links different programs and agencies that usually function based on very different principles and incentives. At the front lines of public mental health services in California are non-profit organizations like outpatient clinics. They try to push clients onto conservatorship when they perceive them as too severe for their services (families, in their own way, do the same).[58] The conservatorship continuum also relies on truly public agencies like the public guardian's office and the courts. Both try to ensure that directly-provided government services are reserved for those for whom all other options are exhausted.

I find in this research that a third type of provider, for-profit private institutions, dominate some of the most important points of the continuum. Their interests are shaped by the way that the delegated welfare state has used them to transfer the financial risk of running programs. For example, "for-profit prisons must run their facilities under the contracted budget from the state or their profit margin will suffer."[59] For-profit organizations thus have particularly strong incentives to exercise their discretion to choose the least costly clients from the pool they are contracted to serve, a process referred to as "cherry-picking" or "creaming."[60]

With respect to voluntary welfare services, the state has largely been willing to respect this private discretion. For example, regulators let landlords choose whether to take Section 8 vouchers and doctors whether to take Medicaid patients. With respect to emergency services and social control, however, governments tend to curb discretion: private ambulance companies are obliged to take even uninsured patients and private prisons have to accept whomever the courts send their way.

What creates "absent authority" in this case is that the state largely respects private prerogatives even though conservatorship is exactly the kind of emergency service it usually either provides itself or tightly regulates. Put another way, someone's trajectory on the conservatorship continuum depends heavily on whether a private hospital or private step-down placement wants to take them, based on their own incentives and interests. Conservatorship is

[55] Brodkin, "Reflections on Street-Level Bureaucracy"; Bittner, "Police Discretion in Emergency Apprehension."
[56] Watkins-Hayes, *The New Welfare Bureaucrats*.
[57] Wacquant, "Crafting the Neoliberal State."
[58] Hasenfeld, "Community Mental Health Centers"; Lipsky, *Street-Level Bureaucracy*.
[59] Morgan and Campbell, *The Delegated Welfare State*, 26.
[60] Brodkin, "Reflections on Street-Level Bureaucracy."

supposed to serve people who are literally at risk of death, but strangely the state has largely accepted the discretion of third-parties to decide which dying people merit conservatorship.

Absent Authority Feature 2: Disconnected "People Processing"

Scholars of Street-Level Bureaucracies have distinguished between "people changing" and "people processing" agencies.[61] People changing bureaucracies seek enduring transformations in peoples' behavior or identities. For example, welfare offices were supposed to turn dependent mothers into independent workers following America's 1996 reform.[62] For a people changing bureaucracy, having more details about a person's past or characteristics is an asset. People processing bureaucracies are those like social security offices that determine someone's administrative eligibility for some benefit. For a people processing one, though, the goal is to strip someone down to focus on a few narrowly-defined characteristics. Evaluations by people-processing bureaucracies thus tend to be more rote and shallower.[63]

Most of the professionals in the conservatorship continuum wind up being people *processing*. Judges, police officers, and insurance companies either by necessity or by regulation must make decisions largely based on someone's superficial state at a given moment in time. While they claim to offer treatment, emergency mental health services ultimately provide what one sociologist calls "ambulance welfare": interventions that are as "superficial" as wrapping a wound in gauze.[64]

The paradox, is that the continuum as a whole is supposed to be people *changing*. Indeed, even chronically-ill conservatees are always in a fluctuating state: giving someone an anti-psychotic calms them down, and providing them with food, clothing, and shelter in a hospital makes them look less gravely disabled. This combination of people-processing agencies and changing people means that a person who looks good on the right day—before a judge, or during an insurance utilization review—might leave the continuum, regardless of what is known about their past or predictions for the future. Absent authority leads to changes that are temporary and cyclical—people stabilize, become compliant, are released, become non-compliant, and decompensate again—rather than enduring and directed.

Absent Authority Feature 3: Uncoordinated Criteria

SLBs often make decisions based on typologies.[65] People have a sense of what "kind" of person meets program criteria, and compare specific clients to that type. For example, in Lara-Millan's study of a public emergency room, clinicians were reluctant to give heavy pain killers to African Americans and willing to do it for Hispanics: the same behavior in the former fit into the "type" of drug user and the latter a person likely injured by difficult physical labor. These typologies can be used to engage in what others have called "burden shuffling" of unwanted clients. Seim shows how ambulance crews literally and figuratively shuttle people between nurses who try to send them away by declaring them "criminals" and police officers who orient them back by deeming them "sick."[66]

But the conservatorship continuum is not really a lateral back and forth like that described by Seim. Instead, each step is supposed to be a net intended to screen most people out of conservatorship while leaving a whole for people who really need it to pass through. In some places, I find that professionals have a common typology of what a person appropriate for

[61] Hasenfeld, "People Processing Organizations"; Prottas, *People Processing*.
[62] Dubois, *La Vie Au Guichet*; Watkins-Hayes, *The New Welfare Bureaucrats*.
[63] Bracci and Llewellyn, "Accounting and Accountability in an Italian Social Care Provider."
[64] Seim, *Bandage, Sort, and Hustle*, 28.
[65] Barnard, "Bureaucratically Split Personalities."
[66] *Bandage, Sort, and Hustle*.

conservatorship looks like. Nearly everyone in the continuum would rather burden shift people who seem to be above all "addicts," even when they also have a severe mental illness. In other instances, though, their typologies are contradictory. As I show, certain steps in the continuum seem to be more focused on serving people whose "grave disability" makes them "disruptive" and others are focused on serving those who are "dying." These informal elaborations of criteria at different stages mean that someone qualifying at one step does not at another.

SLBs on the conservatorship continuum do not approach each decision in a vacuum.[67] Instead, they learn over time what informal criteria others further down the line are going to apply. The result is that while they might think a certain person at a given point in time qualifies for conservatorship, they know a professional further along will apply a different set of criteria. So they might not bother applying their own professional judgment. The screening of conservatees thus becomes stricter and less consistent than anyone actually intends it to be.

The result of these three mechanisms is what I call *absent authority*. For some people with severe mental illnesses, conservatorships are put into place and force them to live in a locked institution or take medication. But the use of the passive voice here is intentional: who wields that authority is not actually clear. In theory, courts function to provide "regulation or supervision of these private actors"[68] to which state functions are delegated. But the point is that there is no one to make sure that the styles of decision-making ("processing" versus "changing"), informal criteria ("disruptive" versus "dying"), or delegation (obligatory "public" services versus optional "private" ones) actually line up. Conservatorship is an enormous exercise of government power, but the government itself actually seems "hollow"[69]—many hands intervening in the lives of extremely vulnerable individuals, but no brain coordinating them.

Data and Methods

The primary data for this paper come from 132 in-depth interviews with key informants across 23 of California's 58 counties (Table 1). I contacted public defenders and public guardians directly by calling or e-mailing their county offices. I reached clinicians through year-long observations of an intensive outpatient treatment team in an urban area of California and subsequent referrals. Family members were recruited through advocacy groups and list-serves as well as via referrals.

Interviews are useful for identifying the mechanisms and decision-making heuristics that lead some people to stay on the conservatorship continuum and others to drop out. They do not allow me to make more precise quantitative claims about, say, the proportion of conservatorship hearings that end in a judicial ruling on a conservatorship. This method means I am dependent on what these key actors *say* rather than direct observation of what they actually *do*.[70] There are also important gaps in my interviewees. I tried to speak to people involved in each step of the conservatorship process (see Figure 5), but have not yet connected with law enforcement. Moreover, because of ethical concerns about assessing consent to research at a distance and logistical difficulties, I have unfortunately left conservatees' own voices out of this stage of the research.

Ultimately, the factor that gives me most confidence in the data is that interviewees'

[67] Emerson, "Holistic Effects in Social Control Decision-Making."
[68] Morgan and Campbell, *The Delegated Welfare State*, 8.
[69] Milward and Provan, "Governing the Hollow State."
[70] Jerolmack and Khan, "Talk Is Cheap."

Table 1: Interviewees

Field		Profession	
Advocacy	11	Psychiatrist	19
Hospital	23	Lawyer	23
Outpatient	17	Social Worker	27
Housing	10	Psychologist	12
Public Guardian	20	Nurse	6
Courts	21	Doctor	4
Professional Org.	5	Judge	7
Family Advocate	18	Other	34
Government	10	**TOTAL**	132

descriptions of what is happening are remarkably consistent. Even when they disagreed about what should be done to fix the conservatorship system, professionals with offered similar accounts. Public Guardians say they rarely lose in court; public defenders, their "adversaries," agree that they rarely convince judges to let someone go. And while I did not interview representatives of every key group in the continuum, I nonetheless spoke to people involved in each step of the processes. For example, family members were often eyewitnesses to the decision-making of police officers about whether to transport their loved ones to a hospital.

Additionally, I collected and analyzed 687 newspapers articles referencing the Lanterman-Petris-Short Act or conservatorship, drawn from the Newsbank, Proquest, and LexisUni databases. Although not the primary data for this paper, the articles helped me confirm that many of the patterns I discovered in my interviews are long-running and state-wide. Newspapers also allowed me to track the impact of external forces, like decisions by county governments to limit conservatorships or changes in which hospitals accepted LPS patients. Finally, I collected government reports, hearing transcriptions, and academic literature on LPS.

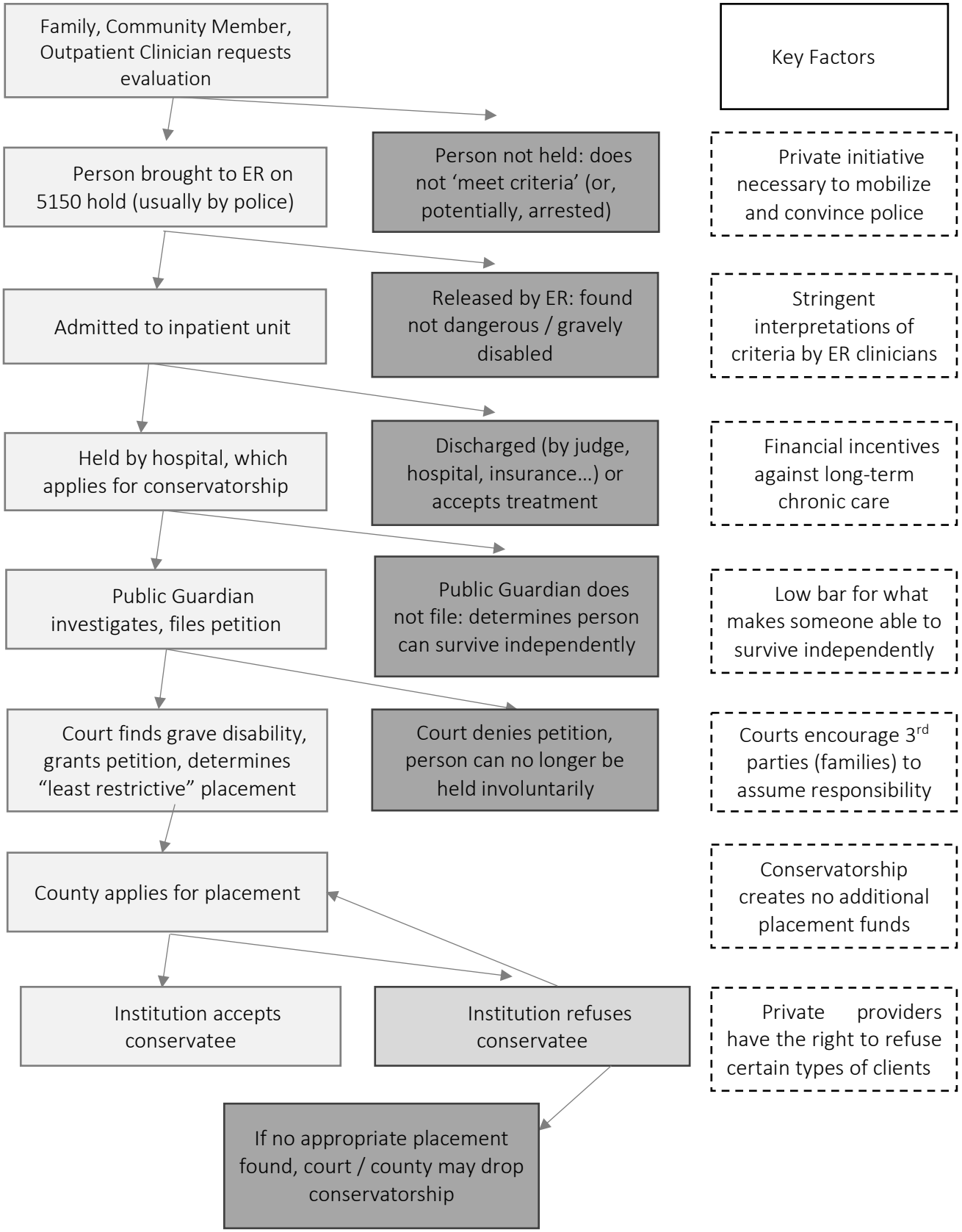
I coded my data in the qualitative analysis software Dedoose, producing over 10,000 labeled units of text. I organized my analysis of the data around what I identified as the six key steps towards getting a conservatorship: being placed on a hold, admitted by an emergency room, held by the hospital to make an application, approved for conservatorship by the county guardian, ordered to be conserved by the courts, and placed in a facility. The rest of this paper traces this pathway and then considers how the entire conservatorship continuum unravels from its end point back up.

Absent Authority in California's Conservatorship Continuum

1. Involuntary 'Holds': Outside Initiative by Families, Clinicians, and Police

Getting placed on a 72-hour hold—colloquially known as "5150s" after the applicable article in the Welfare and Institutions Code—can be either disturbingly easy or distressingly hard depending on where someone is located in the community. LPS empowers clinicians or "peace officers" to place holds; in practice, a majority of 5150s from the

Figure 5: Conservatorship Process



community are written by police officers.[71] In fact, just a few years after the law's inception, commentators were already worried that a huge spike in holds reflected how police were using them to clear the streets of people whose behavior was disruptive but did not merit arrest.[72]

More recent research suggests that while police continue to use 5150s to "burden shuffle" homeless people onto hospitals, they are doing so partly in response to external complaints from neighbors or business owners, with disparate and racially unequal impacts.[73] The head of one county mental health department summarized the situation, "The police are doing a lot of 5150s. They see people who are high, and a 5150 is an easy way to get them off the street. The ER won't admit them, and they come back. The system is kind of functionally-dysfunctioning" (Interview, 6/10/19). This "catch and release" approach helps explain why a small number of people cumulate an extraordinary number of holds. One hearing in San Francisco reported that in four months, nine people visited the public hospital's psychiatric emergency room 168 times (Observation, 5/1/19).[74]

Mobile Crisis Teams: Avoiding Hospitalization

The picture of what happens to people who are not disruptive in the street but instead deteriorating in group homes, homeless shelters, or family members' residences is more complicated. In these cases, getting a 5150 depends enormously on the initiative and persistence of private actors rather than a deliberate exercise of public authority.

For many parents, their first call is to a "Mobile Crisis" or "Psychiatric Emergency Response Team" (at least, in the counties that have them). These teams send either a clinician or clinician-police officer pair to provide rapid evaluations in the community.[75] These requests usually end in disappointment. One mother reported that when her son stopped his medication and left their home: "I called the PERT team right away and said 'you've got to take him to the hospital, he's not right.' And they wouldn't. They saw him on the street and they called and said 'he's fine, he's feeding himself. He doesn't meet the criteria for us to take him in on 5150'" (Interview, 9/9/20). Another woman offered a parallel account: "They claim someone has to be 'imminently' dangerous…I've had this happen where my son is threatening to kill himself, mobile crisis comes, and he won't say it to them so it's not 'imminent'" (Interview, 10/6/20). She added that "they don't use grave disability [as a criterion for a 5150] at all, or hardly at all. I've had mobile crisis, not police, say to me, 'does your son know where there's a garbage can to get food out of? Then not gravely disabled.'"

Their experiences were emblematic of how people operating at different steps in the continuum defined their roles at cross purposes to one another. When I spoke to the director of

[71] Harder & Co. Community Research, "San Francisco Housing Conservatorship." A 2012 investigation of the acute psychiatric hospital in Alameda County found that "virtually all" hospitalizations began with police contact. Connolly, "Emergency Call."

[72] Barber, "Do Police Use Metro as a Jail?"

[73] Herring, "Complaint-Oriented Policing"; Seim, *Bandage, Sort, and Hustle*. A review of 5150 records in San Francisco found that half of 5150s were initiated by strangers with no relationship to the person being held; 34% were from friends or acquaintances, 10% of clinicians or case workers, and 5% directly from law enforcement. San Francisco Housing Conservatorship Working Group. November 16, 2020. "SFPD Incident Report Data." Retrieved December 17, 2020 (https://www.sfdph.org/dph/files/housingconserv/Housing_Conservatorhip_Meeting_11.16_Combined_updated.pdf).

[74] The California State Auditor reported that "from fiscal years 2014–15 through 2018–19, Los Angeles's designated professionals placed more than 500 people on 72-hour holds who had each already been subject to at least 50 prior holds." "Lanterman-Petris-Short Act," 40. Another study found that 7% of people placed on an involuntary hold in Alameda County had five or more in a five year period—and they accounted for 39% of total 5150s. Trivedi et al. "Emergency Medical Services Use."

[75] In surveys of the general public about their willingness to finance mental health care, expanding crisis services like these teams receives the most public support. McGinty et al., "Communicating about Mental Illness and Violence," 204.

a Mobile Crisis Team, she explained that what parents were looking for was the *opposite* of her team's actual mission, which was *avoiding* hospitalizations: "Our goal is always, 'can we have an alternative plan to keep this person in the community?' This might mean sending them back to places where we know they won't get good care…But just being delusional does not get you a 5150" (Interview, 1/18/19). Another clinician was blunter: "We are always looking for a way to walk away and have it not be totally unethical. 'How can we feel okay about this person staying out of the hospital?' We draw up a 'safety plan' and that's it" (Interview, 3/15/19).

These findings are congruent with other research which found that intensive outpatient services in California are more focused on keeping clients invisible and containing problematic behaviors than improving someone's overall mental health or well-being.[76] There are other reasons why mobile clinical teams are not likely to start people on a path to conservatorship. These teams have limited hours,[77] might only cover part of a county,[78] and can refuse to visit if someone is suspected of being dangerous—even though dangerousness is a criterion for a 5150.

Police: Dangerousness over Disability

Dispatchers might also tell callers that police are more likely to get someone who needs it into the hospital anyway.[79] This presents family members, acutely aware of police shootings of mentally ill persons, with a wrenching choice. One woman described her frequent need for an emergency intervention right after her son's hospital discharge:

> *A few times, he [my son] has tried to come home [after the hospital], and he arrives in a cab, and says 'I'm here.' And many times, he is higher than a kite, and so we have to call for assistance to take him to psych emergency. I call the emergency team, but my son is 6'4" and 190 pounds, and I say 'one little clinician and mom and dad are probably not going to be what we need.' But calling in the police is a very traumatic situation for everyone…Honestly, every time I've done it, he end up in handcuffs, and could have died (Interview, 6/10/20).*

Family members know that police act as "people-processing" bureaucrats who make quick, superficial decisions. One interviewee who ran support groups for parents of people with severe mental illness summarized:

> *The minute the police get to the door, all of our loved ones straighten up and sound very coherent. A social worker told me, 'you're going to have to lie, whether you're afraid of him or not, tell the police you're afraid of him' but we couldn't bring ourselves to do that. [They ask] 'Are you in immediate danger?' 'Are you afraid for your life?' That's the game that everybody plays. Exaggerate what happens so that people will think it's bad enough to take them in (Interview, 9/18/20).*

This is an example of one disconnect that creates absent authority. While conservatorship is targeted towards people with chronic illness, evaluations are based on someone's momentary state.

In many cases, parents felt there was no other choice than to accentuate their fear because of how police selectively apply LPS

[76] Gong, "Between Tolerant Containment and Concerted Constraint."

[77] One officer told an author, "I tell my officers, you're social workers, whether you like it or not, because they're not calling their therapists or psychiatrists at three in the morning and getting a response." Miller and Hanson, *Committed*, 77.

[78] For example, in Sonoma County (as of 2018), the Mobile Crisis Team only served a narrow corridor around Highway 101. Walsh, "Shock Corridor."

[79] The Los Angeles Department of Mental Health, for example, started encouraging people to call the police rather than their own emergency teams because facilities were more likely to hospitalize someone brought in by law enforcement. Hennessy-Fiske, "Mental Health Staff Relying on Police."

criteria. Technically, there are three bases for a 5150: "danger to self," "danger to others," and "grave disability." [80] Outpatient clinicians, inpatient psychiatrists, and family members universally believed that "grave disability" was the weakest argument for a 5150. One inpatient psychiatrist explained:

> *Danger to self or others is often viewed as much more urgent than grave disability. If someone is naked walking next to the highway with no shoes on, they're covered in blood, covered in feces, that's going to attract attention, the police will pick them up and bring them in. If you call the police and you say 'I have a patient who has a handgun and says they're going to shoot everyone in the neighborhood' that might be a little different, or 'a patient just swallowed 100 pills in front of me on the virtual visit,' they would go kick in the door to save that person's life. But if you say 'That person is not eating that much' or 'they've left their house at night a couple of times…' they might knock, and if nobody answers, are they going to take a battering ram to the door? Probably not. They'll say 'we tried, we'll stop by later maybe' (Interview, 12/2/20).*

At one meeting, the outpatient team I observed discussed a 70-year-old client with schizo-affective disorder who had stopped her medication. She had called the police concerned that Governor Gavin Newsom had died in her apartment and complaining she was being sexually harassed by Donald Trump.[81]

> Clinic Director*: A 5150 is key here. She needs a hospitalization to get back on meds.*
>
> Mobile Crisis Clinician*: How can mobile crisis assist here?*
>
> Clinician*: There's nothing you can do. Right now, she isn't leaving to get food. She's also at risk for eviction. But we can't evaluate her until she opens the door.*
>
> Mobile Crisis Clinician*: We should go out with police.*
>
> Clinic Director*: They won't be willing to break down the door until there's a medical crisis. I don't know if claiming 'grave disability' is going to cut it here.*

Families who could not conjure evidence of their child's dangerousness found themselves similarly blocked. A woman recounted the steady deterioration of her son:

> *He thought I was a prison guard trying to poison him, so he stopped eating. He lost a huge amount of weight…He wasn't accepting any treatment…I tried to get an ambulance to come out, but they wouldn't come out without the police. I called the police several times. But their evaluation is just a flash. He was locking himself in the garage and he had the door chained, so you couldn't open it. And if he wouldn't come out and they couldn't open the door, then they'd just say 'he's not right, but sorry there's nothing we can do' (Interview 9/21/20).*

She noted that "you get more resistant to even calling, because they're no help." On the sixth call, however:

> *This time, he was lying on the couch, and I got an experienced—he was probably in his fifties—law enforcement officer who came, and I showed him a picture from [my son's] driver's license, and then looking at him, skin and bones, the officer said 'I'm going to call him gravely disabled.' But it took that much. We're talking about 80 pounds, 100 pounds weight loss for it to be addressed.*

[80] The review of 5150 records in San Francisco cited above found that 61% of 5150s were for "danger to self", 38% "danger to others", and 12% "grave disability." Similarly, Seim found that ambulance crews were more likely to see 5150s as "legit" rather than "bullshit" if they involved a risk of violence. *Bandage, Sort, and Hustle*, 107. The state auditor found that in only nine of sixty 5150s they reviewed were based solely on grave disability. California State Auditor, "Lanterman-Petris-Short Act," 20.

[81] Which, admittedly, is not entirely implausible.

This woman was able to mobilize emergency psychiatric care only once a front-line worker saw that her son was not just "disabled" but actually "dying." Ultimately, many parents reported that both the police and support groups advised them to hasten the process by "making your child homeless," deliberately creating a situation where someone is no longer able to meet his or her need for "food, clothing, or shelter."

Holds: Conclusion

In his classic critique of psychiatric asylums, Irving Goffman described a "betrayal tunnel" by which family members, in "coalition" with clinicians, would conspire to permanently strip away the rights of the soon-to-be mental patient.[82] Avoiding this kind of "railroading" into hospitals by families was a central goal of LPS. Today, however, getting someone onto the conservatorship continuum through a 5150 often requires many repeated, desperate, and often ineffectual "betrayals," more likely to be successful in the case of someone who is dangerous or disruptive than one who is disabled and decompensating.

2. Emergency Departments: Strict and Exclusionary Interpretations of Criteria

A core element of absent authority is that key decision-makers choose to advance someone on the conservatorship continuum based not just on whether they think someone merits conservatorship, but based on how they anticipate others will evaluate them. One reason police and mobile teams are reluctant to place people on holds and transport them to hospital Emergency Departments is that they know ERs are one of the strictest filters in the process. For example, only 9% of all people who visit San Francisco General's Psychiatric Emergency Services are ultimately admitted,[83] although the proportion of patients brought in on a hold who are admitted is likely higher.

The easy explanation for why it is so hard to get through an ER is that there is so little left on the other side. ERs are in an impossible situation because de-funding of crisis services in the 2008 recession made them the provider of last resort without adding any additional beds (Interview, 2/4/21).[84] Interpretations of criteria adapt to match the resources available. But this section also details how clinicians' conceptions of what patients are 'deserving' and likely to benefit from psychiatric care stop many potential conservatees before they go 'upstairs' to an inpatient unit.

ER Decision-Making: Disability and Disruption

The limited staff and resources of the ER pushes their focus towards people who are disruptive and away from those who are merely symptomatic. One triage nurse told me, "The best chance they have of getting attention is to have a crisis, start acting out and yelling, screaming" (Interview, 10/19/18). Another nurse concurred, "The person that is sick in the corner, quiet, with a distorted reality of what's happening, keeping to themselves, they're not drawing any attention, and they're not getting any attention" (Interview, 10/20/18). "Grave disability" is not a convincing argument for admission for ER doctors:

> Psychiatrist*: If I'm filling out a 5150, I have to check a box, and I'll almost always do danger to self or danger to others. Those are more likely to get them in than [GD]. [GD], they [ER doctors] are not impressed by that.*
>
> Interviewer*: Because they're strict about whether the person can provide 'food, clothing, or shelter'? Is being homeless a sign you can't provide for shelter?*

[82] "Moral Career of the Mental Patient," 127.

[83] San Francisco Budget and Legislative Analyst, "Performance Audit," v. John George Hospital, a private psychiatric facility in Alameda County, reported a 15.6% admissions rate in 2016. McDede, "Mental Health 911."

[84] Stone et al., "Impact of the Mental Healthcare Delivery System on California Emergency Departments."

> Psychiatrist*: Before I moved here [to California], I would have thought that homelessness is not housing. But if the ER sees you have a backpack and a place in the park, that counts as housing. They [the ER] know that homelessness will not impress a judge enough to keep them, anyway (Interview, 2/19/19).*

The skepticism of judges towards GD leads ER clinicians and then outpatient clinicians to avoid using it. Another outpatient clinician concurred, "When we're making the case to the ER, we always have to emphasize danger to self or others. Grave disability is getting more difficult, because there's no liability for the hospital" (Interview, 12/12/18).[85] These chains of presumptions along the conservatorship continuum interrupt it from the very start.

Another core problem is that ER clinicians believe that attempting to get a conservatorship for some patients might be futile. An ER physician explained:

> *Sometimes I'm like, 'Look, we can admit them, but nothing is going to come of this,' admit them for five days under some bullshit excuse and at the end of the day what's going to happen? This patient doesn't want our help. You and I both know this person has no capacity. This person needs to be conserved, but it doesn't work that way; it takes them months to get conserved. We look at each other and say, 'We don't have another bed. They're going to get discharged one way or another.' After I've fought for these patients, I am beaten to the ground emotionally and mentally. You have to choose your battles [with hospital administration], and if you fight every battle with every patient, you lose your job. To me a trauma case [for example, someone with a gunshot wound] is so easy, quick, know all the steps, works like a well-oiled machine. These cases are where my time, effort, and energy go (Interview, 4/6/18).*

A hospitalization might be able to calm acute psychotic symptoms that put a person at risk, but hospitals have increasingly moved away from addressing chronic psychiatric issues that lead to deterioration and death.

ER Exclusions: Substance Use

The dominant narrative in "behavioral health" policy is that substance abuse and mental illnesses are so intertwined that they should be treated in tandem.[86] Although drug use is not a criterion for involuntary admission in California,[87] it also is not a formal criterion for exclusion.

Professionals don't necessarily see it that way. Almost unequivocally, ER clinicians I interviewed noted that if they believed that a person's psychotic behavior was driven by substance use, they would quickly "drop" a 5150 hold. One nurse framed it in terms of her professional self-conception: "I do want people who are addicted to drugs to have access to treatment. But I have a 'That's not that we're here for' mentality" (Interview, 10/19/18). Another ER clinician fumed, "Some of our patients have, you know, chest pain, broken

[85] A report from the American College of Emergency Physicians agreed that "ED physicians tend to…admit patients for liability risk mitigation rather than for clinical reasons." "Care of the Psychiatric Patient in the Emergency Department."

[86] Many interviewees critiqued the increasingly prominent label of "behavioral health." For both families and clinicians, lumping mental illness and substance abuse together elides important distinctions between the two, and focusing on "behaviors" ignores the underlying origins and subjective suffering caused by conditions like schizophrenia. They have accurately assessed that focusing on "behavioral health" is a justification for insurance companies to tightly regulate treatment and insist on only short-term, surface-level interventions (see Hudson, "Behavioral Mental Health.") Part of my research looks at the public psychiatric system in France, and I've only ever received guffaws when I mention "behavioral health" (*santé comportementale*); nothing could be more superficial and thus, to them, American. Whether the term resonates with people with "behavioral health" problems (versus labels like "brain disease" or "neurological disorder") would be a useful topic for future research.

[87] Christopher et al., "Nature and Utilization of Civil Commitment for Substance Abuse."

bones, sometimes children, very significant injuries, and they're waiting because you've got this person who did a bunch of meth and is acting out" (Interview, 3/24/18).

Regardless of their conceptions of deservingness, clinicians have little motivation to admit such clients. Drugs like methamphetamine will quickly clear out of someone's system and the hospital will be obligated to release them. The clinical team I observed expressed their frustration at a meeting where they reported on a client who had "seven or eight suicide attempts" and who had been "jailed for assaulting a mental health worker." "How the hell is he not getting held?" one social worker asked. "Because he shows up at PES [psychiatric emergency services], he's high, and they let him go" (Observation, 9/17/18). Even if ER clinicians want to give services to substance users, they know the system has a glaring lack of dual-diagnosis residential services that will help them avoid coming back.

ER Exclusions: 'Frequent Flyers' and 'Malingerers'

Two other factors stood out as reasons for de-favoring those who seemed to be more "dying" than "disruptive." First, clinicians are wary of "frequent-flyers": persons who come to the psychiatric emergency room repeatedly for non-medical reasons. In America's bare-bones welfare state, ERs have become a kind of modern-day "almshouse"[88] for those with nowhere else to go, thanks to federal law that obligates them to provide an evaluation for anyone coming in. Clinicians, however, were not enthusiastic about the role. As one nurse confided, "It's kind of unspoken, but we know that some patients are saying what they say because they want food, shelter, a bed. That can definitely create some tension sometimes. We resent them because we want to be treating people" (Interview, 8/2/18). Another nurse explained, "If they're a 'frequent flyer,' we're not going to keep them on a hold. Sometimes they'll throw a tantrum, and [the nurses will] agree we're going to ignore it. Everyone acknowledges it's fake" (Interview, 10/20/18). San Francisco General Hospital's Psychiatric ER even attempted to limit its role as welfare provider of last resort by introducing "vertical therapy," or non-reclining chairs.[89]

For "frequent flyers," the solution is just to push them out repeatedly rather than to search for a long-term solution. One woman said her son had gone to psychiatric emergency services over 100 times in the last year (Interview, 10/2/20). Someone's status as a 'frequent flyer' often normalizes their living situation as a 'baseline' rather than a product of a grave disability. One psychiatrist explained:

> *During my training I was quite disturbed by the degree to which for some people who are chronically homeless and have a chronic mental illness, that will become—according to the medical system or legal system—their life story. It's set. If that person comes into an emergency department and the staff say 'where are you going to sleep?' and the person says 'Under a tree, there is this tree I sleep under' and they'll say 'okay plan for shelter, see ya, this person doesn't meet hold criteria' and discharge them. If you're a student from Berkeley who leaves their dorm to sleep under a tree, that person will set of panic alarms and be kept on a hold (Psych, 12/2/20).*

In fairness, although some psychiatric ERs do have social workers, they are mostly unable to link people to social supports or housing, because these largely do not exist.

Finally, clinicians might be hostile towards persons suffering from "incarceritis,"[90] or a sudden-onset health condition (like suicidality) that means a person needs to go to a hospital rather than jail. The result could be an absurd back-and-forth:

[88] Malone, "Whither the Almshouse?"
[89] Thadani and Fracassa, "SF General Relaxes Policy."
[90] Seim, *Bandage, Sort, and Hustle*.

> *We've had some tug of wars with law enforcement. Like for instance, we get people that we discharge and they don't want to leave, so we have to call law enforcement to remove them from the premises. They approach the guy, then the guy tells them he wants to hurt himself. Then the officer will say, 'I have to put him back on a hold.' We say, 'We will just drop the hold.' And we could do this all day (Interview, Nurse, 10/20/18).*

Outside observers might celebrate a commitment by law enforcement to avoiding criminalizing mental illness. To some ER doctors, though, "diversion" is a new form of patient dumping: "We're operating way over capacity, because the liberality with which police officers are using 5150 is increasing. That's probably because they all got 'crisis intervention training' [intended to divert people from arrest into services] and because of the meth epidemic" (Interview, 4/6/18).

ERs: Conclusion

ER clinicians have wide latitude to interpret LPS criteria in line with organizational imperatives, resource constraints, and professional preferences. This, in turn, gives external parties who want conservatorships two options. In some cases, private parties can aggressively advocate for admission, as the head of a Business Improvement District described:

> *We had someone who just pinged out of ERs and jails, and eventually we decided to put together a dossier with all his history and arrests. We coordinated with the police to get him 5150ed the next time he ran into traffic. We timed it for when there was an ER doctor who we knew would be more sympathetic, and sent someone with the dossier to tell him 'if you let him go, this is the pattern, he's vulnerable' (Interview, 7/3/20).*

In this instance, the effort succeeded and the individual was eventually conserved.

The alternative option, which I saw throughout the system, is simply learned fatalism. The director of an outpatient clinic explained, "We're sending clients to the hospital and hoping to God they keep them so they can re-stabilize, but they turn around in three days and they're in just as bad shape as when they went in" (Interview, 4/4/19). I asked an outpatient psychiatrist if he advocated for patients to be admitted, and he told me, "I used to when it's a really egregious case of someone with multiple 5150s, maybe. But generally, if they're going to be discharged, they're going to be discharged anyway" (Interview, 1/25/19).

All of this intensive screening could have a positive valance. As the psychiatrist in charge of one specialized psychiatric emergency department told me, "We don't want to have anyone in this locked psych facility longer than they need to be…Our goal is always to not hospitalize, but to get people home…to turn an emergency patient into an outpatient" (Interview, 10/12/18). But external data paint a grimmer portrait. 38% of people discharged from San Francisco's public psychiatric ER leave without even a referral.[91] Los Angeles did not provide follow-up services to two-thirds of people with multiple 5150s whose cases were reviewed by the state auditor.[92]

ERs' interpretations of LPS criteria were clearly stricter than those spelled out in the law. But while external audits might decry patients being "dumped" from ERs, no one has the authority to limit this rapid "people processing" and ER clinicians do not have the resources to do anything else.

3. Hospitals: Financial Incentives Towards Short-Term Care

Although screening in the ER is stringent, many interviewees believed that the biggest

[91] San Francisco Budget and Legislative Analyst, "Performance Audit," v.

[92] California State Auditor, "Lanterman-Petris-Short Act," 32.

roadblock to conservatorship was the unwillingness of hospitals to apply for them. After a 72-hour 5150, inpatient psychiatrists must either convince someone to stay voluntarily,[93] release them, or file for a 14-day 5250. The next step is a 30-day "temporary conservatorship" (T-Con), which keeps the person in the hospital while the county public guardian investigates the case, files paperwork with the court, and gets a judicial order imposing a "permanent conservatorship" (which actually lasts for one year). Table 2 uses (very imperfect) data on involuntary hospitalizations in California to show that while the number of 5150s has gone up since 1980 and the number of 5250s remained stable, the number of T-Cons has gone down substantially. [94] This suggests that fewer and fewer people who are hospitalized stay long enough for the conservatorship process to begin.[95]

Hospitals: Insurance Pressures and Acute Stabilization

Fewer conservatorships would be a good thing if it meant hospitals had simply become more effective in healing people. But inpatient clinicians suggest that this pattern mostly reflects intensifying pressures from insurance companies to shorten lengths of stay. Older clinicians told me there used to be a clear distinction between private insurers, which would quickly cut off payments, and public insurance like Medicaid, which was more permissive. But MediCaid (in California, Medi-Cal) is increasingly operated by private companies that use the same techniques to "manage care."[96] A state mental health director overseeing the introduction of private managed care insurance companies explained how his office worked to "educate" clinicians to "understand that someone may have active symptoms, problems with functioning…but still be discharged. The doctors have to accept that they can only help people to a certain extent, that doesn't mean they should stay in the hospital forever" (Interview, 12/16/16).

On the ground, doctors described how insurance pressures, like "doctor-to-doctor" utilization reviews, shaped their practices:

> Psychiatrist*: It's actually easier if they're uninsured. If they're insured, you get so much pressure. There are MDs who work for insurance companies and they want to know in a detailed way why someone isn't*

Table 2: Conversion of Short to Long-Term Holds

	1980	2016
5150s (per 10,000)	28.2	46.0
5250s (per 10,000)	12.0	13.1
5250s Relative to 5150s	42.5%	37.9%
T-Cons (per 10,000)	3.5	0.5
T-Cons Relative to 5250s	28.7%	3.8%
T-Cons Relative to 5150s	12.2%	1.4%

[93] A 2001 RAND study found that 26% of 5150s resulted in a person shifting to a voluntary status. Ridgely, Borum, and Petrila, "Effectiveness of Involuntary Outpatient Treatment," Table E.1. My interviews suggest this number has dropped. Many clinicians reported that someone who was cogent enough to want treatment probably did not meet criteria for a hospitalization.

[94] Legislative Analyst, "Overview of the Public Mental Health System"; Mental Health and Substance Use Disorder Services Division, "California Involuntary Detention Reports."

[95] There is some imprecision in these aggregate numbers of 5150s, 5250s, and T-Cons in the state. Some patients might have multiple 5250s and T-Cons as part of a single hospitalization, which would lower the rate of conversion. On the other hand, some counties report 5150s and 5250s but not T-Cons, which would raise it. The rate of T-Cons has also likely decreased from the use of 5270 30-day holds in some counties.

[96] Morgan and Campbell, *The Delegated Welfare State*.

> *appropriate for outpatient and it's hard to make the case. I don't try too hard.*
>
> Interviewer*: Because you know you're going to lose?*
>
> Psychiatrist*: Yes, I know I'm going to lose. Their mind is made up before they even call.*
>
> Interviewer*: And how does that even get set up?*
>
> Psychiatrist*: They schedule it and give you a specific timeframe, and if you're not available in a ten-minute window, you forfeit your opportunity to argue for a longer length of stay (Interview, 11/30/16).*

Despite these complaints, and earlier research that found resistance from clinicians,[97] most professionals now seem to accept that their role is to provide only short-term stabilization:

> *We had some very old-school psychiatrists for a while for whom the utilization review people would say 'you've got to get them out,' and they would say, 'screw you, I'm going to keep them if I think they need to stay.' They've retired. Now we have pizza parties for the unit that has the shortest length of stay (Interview, Nurse, 10/19/18).*

These pressures help explain a dramatic collapse of the length of psychiatric hospitalizations. In 1990, people stayed an average of 25 days. In 2010, the median stay in community hospitals was six-and-a-half days.[98]

Hospitals: Discharges, Dangerousness, and Disability

My interviews suggested that pressures to discharge quickly have uneven impacts depending on what type of patient is involved. While in the previous two sections, I reported that behaviors that make someone a "danger to self" or "danger to others" are more likely to get someone admitted, inpatient psychiatrists also argued these behaviors were also easier to control and thus these patients easier to discharge.[99] One psychiatrist explained:

> *With insurance, you're talking about risk, not symptoms…They have strict criteria for what people need to look like to be on an inpatient unit…If someone has been acutely suicidal for four days, we schedule things, we may have a family meeting, we change certain things around and they feel better, but if they had a near lethal attempt, I don't think one day of not being suicidal is enough. But some insurance companies will say, 'If they're not suicidal today, they need to go' (Interview, Psychiatrist, 3/12/19).*

Most interviewees told me that these kinds of patients were also most likely to be released at probable cause hearings, which are required for all 5250s within four days and which can also be called on patients' requests. These hearings are based on someone's present state. A patient who can articulate why they are no longer at risk is thus likely to prevail. The legal system favors taking patients at face value. In 2010, courts ruled a hospital was not legally at fault for releasing a woman who died by suicide within 24 hours, because she told the doctor she did not have a plan and received a referral for follow-up.[100]

Patients who, even when "stabilized," remain deeply impaired pose a more difficult challenge. In these cases, hospitals engage in a back-and-forth with the very institutions that sent patients in the first place—shelters, housing providers, and families. The head of a homeless shelter explained:

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[97] Luhrmann, *Of Two Minds*.

[98] Substance Abuse and Mental Health Services Administration, "Mental Health United States"; Substance Abuse and Mental Health Services Administration, "Behavioral Health United States," 131.

[99] Although LPS has mechanisms for extended treatment for people who are acutely suicidal or dangerous to others beyond a 5250, they are used far less frequently than conservatorships. For example, in 2016 California reported only 30 180-day certifications for Danger-to-Others and 689 additional 14-day holds for suicidality. Mental Health and Substance Use Disorder Services Division, "California Involuntary Detention Reports."

[100] Durand, "Hospital Cleared in Patient's Suicide."

> *We had someone burning paper in the dormitory as 'art.' We hospitalized the individual because we can't start fires in the shelter. They were going to send her back in 72 hours. I was talking to the hospital, like 'You can't send her back. Is she going to start a fire again?' And the doctor was like, 'No, no. We got her under medication. She is going to do fine.' Later, she started another fire, back to the same hospital…We have had incredibly violent clients who have hit someone, hit staff members, hit other clients, brutally assaulted other folks, get sent to the hospital and get sent back within a couple of hours. In the front door and out the front door and back to our shelter (Interview, 12/14/16).*

This pressure falls hardest on families. If their family member is released by a judge, they often felt they had no choice but to re-assume responsibility. A woman, whose son had only been hospitalized after she decided to play up the fact that he had a hammer under his bed, explained what happened when her son was let out by a hearing officer:

> *We were in contact with a social worker [at the hospital], and it looked like he was going to stay in there for longer than 72 hours. The next thing we know, they call and say we need to pick him up, he's being released. I go down there, and the nurse comes out, and I say 'how can you let my son out, you see how ill he is, he needs medication and he needs help?' And she was very sympathetic but said she couldn't do anything…I bring him home, he's raving that he made billions of dollars, completely psychotic. It had taken six months to get him taken to get treatment. I was beside myself (Interview, 9/9/20).*

If it was a doctor, not a judge, pushing for a discharge, families could try to block the process. The facilitator of a support group explained how parents could learn to throw a wrench into the gears of the rapid people-processing machine of the acute-care hospital:

> *I probably get about 50 calls a year from parents…[and] it's the most tearful, heart-wrenching conversations…Because families have to get smart enough to make sure that when they [the hospital] calls up and say, 'We're releasing so and so from the hospital' you say, 'I'm sorry, I'm not coming to get him' (Interview, 6/10/20).*

Sometimes, to get a conservatorship, families need to be active participants—in rendering their family member unable to provide food, clothing, and shelter by withdrawing it from them.

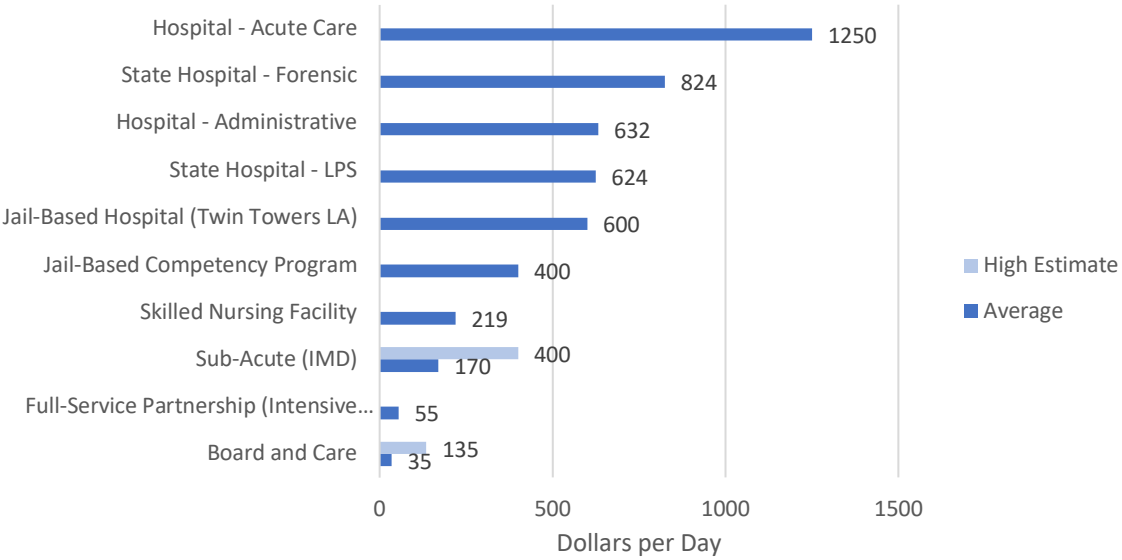
Hospitals: Financial Disincentives to Conservatorship

To put in place a conservatorship, a hospital usually has to keep a person until they have a hearing on a conservatorship—at least 47 days—and find a vanishingly rare "step-down" placement. This process can take months and leaves the hospital at the mercy of other private providers who may or may not take the patient (discussed in later sections). Meanwhile, public insurance (MediCal) cuts daily payments to hospitals in half if a patient no longer meets "medical necessity" criteria for "acute" care but is instead staying for "administrative" reasons, like waiting for a bed (see Figure 6).[101]

The medical director of a private psychiatric hospital explained: "Sometimes, MediCal can refuse to keep you in the hospital based on acuity, even if the legal criteria are met. In this kind of a situation, you have a doctor, a judge,

[101] Lundstrom and Reese, "Shifting Population in California Nursing Homes Creates 'Dangerous Mix'"; Kelly et al., "A Call to Action"; Perry, "More Than Half Of LA County Inmates Who Are Mentally Ill Don't Need To Be in Jail, Study Finds." Department of Health Care Services; Department of State Hospitals.

Figure 6: Estimated Day Rates



and maybe the person in the community who hospitalized the person who are all in agreement, but insurance isn't." Again, the system de-favors keeping people who are disabled but not dangerous: "When someone is no longer a danger to self or others, but just gravely disabled, we are no longer paid at the acute-care rate. When they're is just waiting for a bed somewhere else, it's the administrative rate. In that case, we might have to discharge them" (Interview, 4/4/18).

One issue that came up in interviews but which is difficult to evaluate is the impact of the type of hospital on willingness to apply for conservatorship. California has "delegated" care for involuntary psychiatric patients to private for-profit hospitals, which constitute a much greater proportion of acute psychiatric beds than hospital beds in general (Table 3).[102] When private companies entered the field of psychiatric hospitals in the '80s and '90s, they seemed enthusiastic about involuntary patients. One report claimed that "unregulated private PMRT [Psychiatric Mobile Response Teams]" would "round up clients and then bring them back to the facility against their will."[103]

Now, however, some interviewees perceived private facilities as less likely to make applications for conservatorship. One judge reported: "There's clearly an economic problem. The for-profit hospitals, they're very circumspect [about applying], we get very few. There's an impression among them that they shouldn't even bother. It's clearly a roadblock" (Interview, 12/16/20). The barriers go beyond the risks of having payments reduced because patients waiting for conservatorship no longer qualify for acute care. Depending on how vigorously a patient exercises his or her due process rights, a conservatorship can require five separate days of testimony from a psychiatrist (Interview, Family Advocate, 6/15/20). As one newspaper reported, "psychiatrists who work for private hospitals sometimes don't show up to testify about their detained patients, so the patients are released…The problem is that the doctors often aren't being paid for their time, by the county or anyone else. They resent waiting in court while

[102] Department of Health Care Services. "County LPS Designated Facilities. Retrieved October 19, 2020 (https://www.dhcs.ca.gov/county-lps-designated-facilities).

[103] Troy Gabrielson. June 21, 2010. "Oral History: Barbara Demming Lurie." UCLA Oral History Project. Retrieved October 7, 2020. See also LPS Reform Task Force, "A New Vision for Mental Health."

Table 3: Ownership of Psychiatric and Non-Psychiatric Acute/Community Hospital Beds

	Psychiatric (LPS-Designated	Non-Psychiatric
Private For-Profit	50%	16%
Private Non-Profit	30%	66%
County	20%	16%

their private patients go unattended."[104] Recently, some private hospitals have opted to drop the certification that allows them to accept LPS patients entirely. They have refocused on voluntary—and easier to discharge—ones.[105]

Public Guardians reported that, instead, the majority of their referrals came from a much smaller number of county hospitals (Interview, 11/5/20). Public hospitals under pressure from county government might decide to keep patients while the conservatorship process moves forward, but the direct costs are substantial. For example, from 2016-2018, psychiatric beds at San Francisco General Hospital were only occupied 21% of the time by people whose care was fully reimbursed as "acute." In 2018, the county spent $21.4 million paying for individuals who were occupying scarce beds while waiting for a conservatorship and a spot in another facility.[106]

Hospitals: Defining Grave Disability

Given these barriers, when do hospitals decide to apply for conservatorship? Partly, this varied by county depending on the formal or informal criteria they had for conservatorship. Because patients are frequently hospitalized in counties other than the one where they live (and thus would be conserved), this created frustrating inconsistencies for psychiatrists:

> *One thing that's really important to recognize is that this process is very complicated and confusing because it's very county-dependent…We always tell our staff on inpatient, 'the moment you think this person might need a conservatorship, call the county to figure out what the process is' because they all have different processes, different forms (Interview, 12/2/20).*

He went on to explain that their decision might also be shaped by perceptions of the resources available in a given county:

> *I remember during residency, certain people who were really sick, might need a conservatorship, and social work [in the hospital] would say, 'They're from SF, they're going to be on a waitlist for six months so it's not even worth applying.' The bed availability does affect who ends up getting the care they need… You're not going to send the person to the street if they're completely psychotic, covered in their own feces, but if it's a wobbler, or 'okay am I going to apply for conservatorship here? Wow, there's absolutely no beds, it's going to be a six-month waitlist, and this a county or a region that talks about 'successful homeless people' and it being a 'lifestyle choice' it will make me think twice about what's the likelihood that this will go through, and what other options there are.*

This is another example of absent authority, in which psychiatrists pursued conservatorship not based on their own assessment of patient need, but under the assumption that others in the continuum would not act to put a conservatorship into place.

In the end, applications from hospitals come either as a last resort—to put a positive valence

[104] Marquis and Morain, "The Broken Contract."
[105] Carcamo, "Fewer Beds for Mentally Ill"; Inland Valley Daily Bulletin, "Psychiatric Center Stops Adolescent Program."
[106] San Francisco Budget and Legislative Analyst, "Review of LPS Conservatorship," A-15.

on it—or as part of a "fail first" system. One inpatient psychiatrist explained:

> *It [conservatorship] is for people who have failed at all lower levels of care. They've been working with an outpatient team, we've tried an Acute Diversion Unit, residential placement, tried to live independently, and repeatedly come to the emergency room, and they just have trouble with medication compliance and they wind up in different cycles of care and don't seem to maintain outside of a structured environment (Interview, 3/12/19).*

According to one source, Los Angeles County's Department of Mental Health even formalized this expectation in directives stating that someone needed to be hospitalized three times before the county would consider them for conservatorship (Interviews, 6/15/20); a pilot study of 26 conservatees in the county found that they had been hospitalized an average of 9.2 times prior to conservatorship.[107] Because the system is not integrated, families may need to prove to hospitals that the person has failed elsewhere. By this point, one Public Guardian put it, "Every contact with the mental health system has become a trauma" (Interview, 8/4/17).

Hospitals: Conclusion

Getting a conservatorship application, like getting into the hospital, thus frequently hinges on the initiative of private actors. Families need to both ensure that patients do not have a safe discharge plan and to provide hospitals with information about patients' past failures. Hospitals often use additional informal and formal criteria that go beyond "grave disability as a result of mental illness" and differ from those used by police or ER clinicians. And applications also face the headwinds created by a system that delegates a public mission of providing care for chronically-ill individuals to private hospitals for whom providing that care might hurt their financial bottom line. No one has clear authority for ensuring that a person clears these high hurdles.

4. Public Guardians: Determining Public and Personal Responsibility

When a hospital eventually applies for a conservatorship it triggers an "investigation" by the county Public Guardian's office, which decides whether to pass the case on to the courts. "Public Guardian" or "county conservator" is an ambiguous role. Most guardians are trained as social workers but fell into the role by happenstance. Their agency can be attached to the county department of mental health, human services, or aging.[108] Public Guardians have only limited state oversight and reporting requirements.

Guardians perceived themselves as institutionally marginalized within county government and hampered by a budget that was fixed, regardless of the number of people referred to them. Many also felt that family members or politicians often have a mistaken image of the powers of Public Guardians. Although they have significant control of conservatees themselves, they have only limited control of the conservatorship process—which is precisely what creates a situation of absent authority.

Public Guardians: Initial Screening

Public Guardians articulated a strong civil rights discourse. They explained their role as ensuring that conservatorship was a last resort for people who were literally (if not imminently) dying, not just those who were disruptive or disturbed by psychosis. "Taking away someone's right to self-determination if a big step," one told me, "it's the last thing you want to do as a conservator" (Interview, 2/6/19). In some ways,

[107] Evanguelidi, Gail, Judish Hennessey, and Theodore Bell. n.d. "The LPS Conservatorship Study." *Obtained through personal communication.*

[108] San Francisco Budget and Legislative Analyst, "Review of LPS Conservatorship," A-19.

this creates an alignment between the interests of counties and hospitals. Hospitals only want to assume the cost of keeping someone while a conservatorship is filed if they have repeatedly failed out of every more straightforward discharge option. Public Guardians similarly ensure that the public sector plays only a residual role in the mental health system by first ensuring that no one else, be it a family, an outpatient clinic, or a homeless shelter, can assume responsibility.

Public guardians can decide not to file on a referral for a variety of reasons. They might determine that the person is actually a resident of another county and thus "burden shuffle" them spatially. A person who does not have a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder—or who cumulates that diagnosis with substance abuse or a personality disorder—might also be deemed inappropriate. One guardian explained:

> *We have some people [referred to us] who are primarily substance use, but if they haven't completely fried their brain, they're smart enough to get out of public conservatorship, because they know that means a locked placement, which means they can't use [drugs]…So we try not to put those clients onto conservatorship, because they'll get our other clients in trouble and create issues (Interview, 4/24/19).*

Different counties appear to have different standards as to whether someone with dementia could qualify for an LPS conservatorship (one said the state had official determined that the answer was "yes" but that his boss in behavioral health was not happy to take on the additional clients (Interview, 5/23/19)). In any case, they can cite such organic brain disorders or developmental disabilities and refer a person to a "probate" conservatorship, which sometimes falls on another agency.

Public Guardians: Evaluating 'Successful' Homelessness

Unsurprisingly, the crux of a conservatorship investigation is whether a person who is universally deemed "mentally ill" has a "grave disability" as a result of it. Of the three components of "food, clothing, or shelter," many counties focus on a person's ability to take personal responsibility for their final basic need: shelter. In counties like San Francisco, I was told, homelessness is a virtual requirement for being conserved (Interview, 10/2/20). But being homeless is not enough. As one Public Guardian explained:

> *We've had clients who are homeless by choice, so not being able to provide for food clothing or shelter, and we have someone who says 'I want to be homeless, I like living in the woods.' You or I may not feel that's good for them, medical health wise or mental health wise, but it's their choice, and if they can articulate that, 'I go to the soup kitchen, I get my food, I go to Goodwill, I have Social Security, and I use that income to buy those clothes, and I have a sleeping bag, I live in the woods and that's what I want,' well, the doctor may not feel that's appropriate, but if they're able to articulate that…we may reject that referral (Interview, 12/5/18).*

Conservatorship evaluations are thus an exercise in "people processing." The focus is on whether a person can articulate a coherent plan in the moment, even though evaluations take place in a peculiar context—when the person is hospitalized, taking medication, and having their basic needs met—which may give a false sense of their capability of surviving in the community.

My discussions about conservatorship investigations introduced me to a new distinction of particular relevance amidst California's housing crisis: that between

"successful" and "unsuccessful" homeless.[109] Noted one interviewee:

> *There's this idea of successfully homeless, meaning you know where to live, you know where to get food, you know where the cops aren't going to harass you, you know when the weather gets cold to put on a jacket. Even if you're mentally ill, you have the wherewithal to be able to survive on the street…[Appropriate conservatees] cannot deal with the process of having to apply to stay at homeless shelter, they would not put on a jacket in 30 degree weather (Interview, Public Defender, 11/9/18).*

Someone could be 'successful' even if they were gradually killing themselves through exposure:

> *I remember an individual who had been homeless most of his last adult years… his problem primarily was chronic alcoholism although that was not the triggering diagnosis, and in my court report I put that, in my opinion, the doctors believed the patient was gravely disabled but I did not believe that the conservatorship would change much for him. He was harming nobody but himself, he said 'I'm going to go live on the street' which he liked to do. The court denied the conservatorship (Interview, 5/23/19).*

Guardians rooted their focus on autonomy as a contrast to the approach of doctors: "Doctors have this paternalistic idea, 'we want to protect people, we don't want them to hurt themselves,' but people have a right to make decisions, even if they're poor ones" (Interview, 12/4/18).

Public Guardians: External Pressures

From an administrative standpoint, public guardians enact a general norm of not making public charges out of people able to exercise a modicum of self-management. The external pressures they face are variable. In the budget crises of the early 2000s, some county governments "tightened the screws" by insisting that guardians not "rubber-stamp" referrals from hospitals and instead conduct an independent psychiatric evaluation.[110] As a representative of the California Hospital Association described it, "Every county has sort of crafted the rules that meet their needs best"—with "needs" defined often in terms of "resource constraints"—which has led to "very divergent applications of people's civil rights from county to county."[111]

According to my interviewees, in the face of the homelessness crisis today most of the pressure goes the other way (even if funding has not followed). In fact, multiple family members claimed that they counties had recently increased their filings for conservatorship in response to letter-writing campaigns that bypassed the Public Guardian to go straight to county supervisors (Interview, 6/15/20, 6/17/20). The Director of Behavioral Health, whose office included that small county's Public Guardian, admitted:

> *99% of the time, there will be community members and other agency stakeholders that are beginning to put some pressure on County Behavioral Health to think about a conservatorship. It may be family members who are just exasperated, it may be the local sheriff who is intervening regularly and really getting tired of it. It may be merchants where the individual is hanging out and being disruptive (Interview, 3/26/19).*

In small counties, this might lead to a coordinated, authoritative response that mobilized multiple government agencies:

> *The sheriff called 'where's that guy we see on the way to work.' County employees usually give him a couple dollars, but we say 'I*

[109] Conservators here are on strong legal grounds, since courts have clarified that grave disability excludes "unusual or nonconformist lifestyles" (Conservatorship of Chambers (1977) 71 Cal.App.3d 277.).

[110] A'Dair, "More County Service."

[111] Sewell, "The Ordeal of His Illness."

> *haven't seen him.' We do a welfare check on the guy. I have mental health jump on him and it will appear that the person has decompensated and they recommend a 5150, the person gets hospitalized, and we see that their baseline is not someone who can manage their affairs, so we think that they're a good candidate for conservatorship (Interview, Conservator, 10/24/18).*

Again, though, even in these cases, external initiative is often necessary to shift responsibility from private entities—usually, the potential conservatee him or herself, who is managing the homeless lifestyle more-or-less successfully—onto public ones.

Public Guardians: Conclusion

All of this makes it seem like the pipeline from hospitals' conservatorship applications to county filings with the courts has quite a few leaks. In truth, most people flow smoothly through it. Freedom of Information Act requests from the Los Angeles Times determined that Alameda County and Los Angeles filed on all referrals[112]; a recent report from the San Francisco Budget and Legislative Analysis reported the same thing.[113] All nineteen county conservators I interviewed concurred that they petitioned the courts on a large majority of the applications they received.[114]

Before someone gets to a Public Guardian, they've stayed on the continuum despite the ruthless and rapid discharge criteria of acute hospitals, stringent screening by ER doctors, and unwillingness of police to wrest deeply psychotic people from their homes. This means that Public Guardians, nominally the public agency with the biggest stake in determining who will be conserved, actually has limited discretion over the process. The people whose files arrive on their desks are those who, as one advocate put it, already "have nothing left between death and conservatorship" (Interview, 7/3/20).

5. Courts: Evaluating Survival Plans and External Aid

On paper, courts are another narrow passage point for LPS conservatorships. Appellate courts have defined conservatorship as an extreme measure meriting strict legal protections for those subject to it:

> *From the perspective of the person who resists this confinement, there is little to distinguish it from incarceration in a penal institution. Because the mental facility is authorized to administer drugs to him against his will, detention there might be considered more severe than confinement in a penal institution.*[115]

Long-term placement in a locked facility is "not any less involuntary because the state called incarceration by one name [civil commitment] than another [criminal imprisonment]."[116] The courts have concluded that potential conservatees have a right to counsel and mandated that judges or a unanimous jury must find that a person is gravely disabled "beyond a reasonable doubt," the legal system's highest evidentiary standard.[117]

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[112] Some sources give discrepant figures: an article from 2017 claims that LA only establishes conservatorships on 2/3rds of referrals. Marcellino, "L.A. County to Re-Evaluate Conservatorship Rules"; Sewell, "The Ordeal of His Illness."

[113] "Review of LPS Conservatorship," A-10.

[114] There are also ongoing legal challenges over whether courts can *force* counties to file a conservatorship petitions (Interview, 3/12/18), an unresolved question which date back at least to the 1990s. Mason, "Agencies Argue Over Disabled Man's Fate."

[115] *Doe v. Gallinot* (C.D.Cal. 1979) 486 F.Supp. 983, 991-992, aff'd, (9th Cir. 1981) 657 F2.d 1017.

[116] Public Guardians report that many conservatees perceived conservatorship in precisely this way: "Often they think they're being judged for a criminal act. They'll say 'I don't know why you guys conserved me, I didn't do anything wrong, the police took me to jail [the hospital]'" (Interview, 10/11/18). It's worth reflecting on whether forced psychiatric hospitalization intrinsically feels like incarceration, or if this reflects the underfunding of California's psychiatric hospitals.

[117] *Conservatorship of Roulet* (1979) 23 Cal.3d 219, 235. "Beyond a reasonable doubt" is a stricter standard than that applied in hearings on 5250 holds, "probable cause." The authors of LPS envisioned just such a "graduated approach of

Courts: Balancing 'Best' and 'Stated' Interests

Rights have little meaning unless there is someone to vigorously advocate for them. In California, that role usually falls on county public defenders. In some depictions, this "LPS Circuit" is an undesirable temporary rotation. As one attorney admitted, "I went part time because I had kids, so I wound up taking these cases because they're supposed to be easier, they call it the 'mommy track'" (Interview, 4/23/18). Another commented on his lack of specialized training in these cases: "We're not really qualified to do this, and we're pretty isolated. Some counties say, 'If you've done a death penalty trial, you can take a break and do conservatorship'" (Interview, 4/25/18). For judges, these cases might not be much more appealing. One told a reporter that civil commitment cases were "the worst assignment in the whole district," "the pits," and "the equivalent of being shipped off to Siberia."[118] Judges have "absolutely zero" training for LPS cases (Interview, 12/17/20).

"Low status" does not mean "low effort." Some public defenders decided to stick to the LPS circuit when their ordinary rotation was finished, arguing that no one needs a watchful legal protector more than people with a serious mental illness. One judge told me:

> *This was the least prestigious assignment there is, and I didn't want it. But I realized that the people who are before this court are incredibly compelling, the experts [psychiatrists] are amazing and kind, the Public Defenders do a great job. I thought 'this is the most important thing I do in my life beyond raising kids' (Interview, 12/17/20).*

He added that, despite appellate courts defining conservatorship as similar to incarceration, "There's a lot less acrimony her than in criminal cases. Mental health, there are contested issues, but the end of the day, we're all trying to decide 'does this person need help?' and if they do 'how are we going to get help for this person?'"

Still, there are barriers that might prevent hearings from effectively safeguarding potential conservatees' civil rights. Conservatorship cases are on a tight timeline and potential conservatees can be in facilities in another county. Public defenders can show up the day of hearings having only talked to the client once over the phone. Even more complicated are the moral dilemmas conservatorship cases pose for lawyers who have been trained to strenuously advocate for whatever their clients want:

> *Our goal is to support our client's choices, whether that's being in treatment or not, whatever they see as their 'best life'…Sometimes, it's about bringing them to court and fighting for their right not to take medicine even if they need to take medicine. We are in the position of being their own advocate sometimes, and our role is not to be a parent (Interview, 4/17/19).*

In practice, he elaborated, it was not so simple:

> *It's a very different practice from felonies, in terms of winning and losing, what constitutes a win, you're not fighting cops and DAs who are trying to imprison your client, you're fighting doctors who are trying to help your client. There's a very different perspective about what it means. What is doing right by them? Getting their ultimate freedom? I've had clients commit suicide, die from any number of causes…It's a government agency taking away peoples' freedoms and rights, locking them up when they haven't committed a crime, but sometimes I have clients that require that level of care. It's about finding your foothold to help a person,*

intensifying scrutiny." Bardach, *The Skill Factor in Politics*, 185. But, as some judges pointed out, this can create confusion if someone who has shown no improvement nonetheless ceases to qualify for continued involuntary care.

[118] Stolberg, "Where Patients Fight for Dignity."

but not to the point where they hurt themselves.

Another public defender confided, "My argument is always 'this is a constitutional issue, everyone has a right to be crazy if they want, there's a lot of people with these disorders running around who are not conserved.'" But, she noted, "While I'm saying this, in my mind, I'm going 'I'm not sure if it's safe to let this person out'" (Interview, 7/22/19).

Courts: Contesting and Submitting to Conservatorship

There was another, more surprising, factor shaping legal proceedings for conservatees. By some accounts, in up to three-quarters of cases, judges determine that a person is not contesting their conservatorship and so a full hearing does not need to take place (this seems particularly common for renew.[119] Interviewees suggested this is particularly common for renewing permanent conservatorship already in place.[120]

Three explanations came up in my interviews. First, public defenders frequently told their clients they were unlikely to win, and so their clients might decide not to bother coming to court:

I try to explain to them exactly what the hearing will look like. If they say they want to contest the conservatorship, I tell them, 'they'll ask about what's your plan if you're not on conservatorship.' If they're not coming up with good answers, I say 'It sounds like conservatorship is helpful for you, your plan isn't very good, you haven't figured this out, probably the court won't let you off.' When you present it that way, some people say 'okay, then, I can live with the conservatorship' (Interview, 9/11/18).

In a second set of circumstances, clients might be so sick that their preferences are unclear. A county counsel explained that this could be interpreted as "submitting" to conservatorship:

I would say, for the initial appointment [of a conservatorship], probably 75% are not opposed…The Public Defender has tried to have a conversation with their client about the LPS conservatorship and the answer they get is something along the lines of 'quiet, I just landed on the moon'…They [Public Defender] tell the judge, 'I tried to talk to him, I just didn't get anywhere. There's no indication they understood anything I was saying.' That's a submittal, in our county (Interview, 11/16/18).

We should be cautious about this claim that conservatees simply can't articulate any preference with respect to conservatorship. Depending on their training, caseload, and resources, Public Defenders might be able to work with even very psychotic clients to ascertain whether they want to contest their conservatorship.[121]

Finally, some public defenders felt that, in a mental health system that frequently fails to provide for their clients, the legal system might be the only lever for forcing providers to, well, provide. A legal advocate told me, "I've heard attorneys [public defenders] say 'It doesn't make sense for them to be conserved, but if they're conserved, the county is probably going to house them somewhere'" (Interview, 3/19/18). Public Defenders reported that some clients felt the same way:

You would expect that if anybody is being told 'you're on a psychiatric hold…' [they would contest it] but if the alternative is 'I

[119] Morris, "Let's Do the Time Warp Again."

[120] The LA LPS Conservatorship study (see Footnote 106) found that 7 of 27 conservatees contested their initial conservatorship, and only 2 of 18 contested the yearly renewal of their conservatorship.

[121] This has been discussed extensively in discussions in law reviews about the role of attorneys for people with mental illness in civil commitment cases. Wolf, "The Ethical Dilemmas Faced by Attorneys Representing the Mentally Ill"; Perlin, "Fatal Assumption"; Cook, "Good Lawyering and Bad Role Models."

> *have nowhere to go, I need help finding housing,' or just generally, 'I don't have the support, I'm not doing well,' a lot of people are willing to stay when they're getting three meals a day, there's shelter, and nursing for their medical needs (Interview, Public Defender, 4/17/19).*

We should give mental health providers their due. Both attorneys and judges stated that some potential conservatees might resist their initial placement but be pleased enough with the quality of services and commitment of the professionals treating them that, by the time a hearing arrives, they're happy to stay.

The legal system could also move into people-processing mode and trade immediate, superficial compliance for future freedom. As conservatorship cases marched towards a hearing, public defenders could search for a "mini settlement" (Interview, 4/25/19) with the person that would save the county the burden for caring for someone. A public defender explained, "The doctors can call and say, 'if he keeps improving for two weeks, we can dismiss the conservatorship.' I convey that the client and they say, 'great, I'll take my meds for two weeks.' And then they'll just… go away" (Interview, 11/9/18).

Finally, some PDs also found that bargaining for seemingly small changes to patients' terms of internment could assuage clients' complaints: "A huge objection that I get all the time is that they're not allowed to smoke in the locked facilities. So, some of my clients will tell me, 'if they'll just move me to a Board and Care where I can smoke, then I'll agree to the conservatorship'" (Interview, 8/27/19). Other attorneys said they have had clients who simply wanted Doritos, their own clothes, or to leave their locked facility once to go to a concert (Interview, 4/25/18). This suggests that 'meeting clients where they are at' and being attentive to their specific desires, as well as tapping to what capacity they do have, can help limit the duration and intensity of legal coercion and constraint.

Courts: Assessing 'Plans' and 'Third-Party Assist'

In cases where a client insists on going to trial, the hearing is not likely to be a lengthy debate about a person's medical history, reason and capacity, or future trajectory. Rather, courts function as people-processing institutions that evaluate whether, in a given moment, a person appears able to present a plausible plan for maintaining themselves outside of an institution.[122] Reported a county attorney who represented the conservator's office:

> *I win 95% of the time. I've only lost twice, and it was for the same person. He was the 'successfully homeless.' He was as crazy as crazy could be. He believed he was really from another planet. He believed there was a mechanical device in his chest that called him to do things he didn't want to do, he believed the president was Grover Cleveland. But he could articulate very well how to get food. [He could say] that he has SSI [social security disability] and that he would budget and wouldn't buy tenderloin and run out of money. He was street smart. He was familiar with the shelter system, and able to articulate to the satisfaction to the jury that he could provide for food, clothing, or shelter (Interview, 11/16/18).*

One public defender confirmed that, just as families complained, some judges accept a person's ability to dumpster dive as a sign they need neither coercion nor care: "He was a heavy guy [the conservatee], he wasn't starving, and so we could say 'he's feeding himself, he may be

[122] Appellate courts have concluded that "[i]f LPS conservatorship may be reestablished because of a perceived likelihood of future relapse, many conservatees who would not relapse will be deprived of liberty based on probabilistic pessimism." In their extremely optimistic rendering of the responsiveness of the system, the court explained that "this cost is unwarranted in view of the statutory procedures available to rapidly invoke LPS conservatorship if required." *Conservatorship of Benevuto* (1986) 180 Cal.App.3d 1030.

eating out of the garbage, but we know he's eating.' I got that guy off" (Interview, 7/22/19). In Holstein's now thirty-year-old study of commitment hearings in California, he found courts were more likely to release patients if they had "institutional living arrangements" rather than "fragile independent ones."[123] Today, clearly, fragile and independent situations will satisfy many judges and juries.

Although courts can take into account a person's history of (not) meeting needs for food, clothing, and shelter, in practice judges decide based on the person's stated ability to do so in the here-and-now. One psychiatrist with extensive experience testifying told me:

> *One of the central Catch 22's of how LPS is designed is that the moment somebody gets good treatment and they're on medications and they're doing better, then we say 'okay they don't need any of this conservatorship stuff anymore' and throw it all away and the person is back on the street. You can have someone who's ordered to take their meds, they're taking their meds, they're no longer hallucinating, they're doing great, and they say 'I'll live in this shelter, I'm going to get a job' and it's like 'awesome' and because they're going to do that, we're going to overturn the conservatorship, and more often than not they stop taking their meds. It reminds me of the quote, 'throwing away the umbrella in a thunderstorm because you're not getting wet anymore' (Interview, 12/2/20).*

Judges, on the other hand, spun this in a positive way as recognizing peoples' capacity for change:

> *The fact that they have failed in the past is not necessarily a basis to say 'well, I still believe that you're going to continue.' We have to determine beyond a reasonable doubt, and sometimes peoples' insight expands or changes, especially when they get different medications. We have to look at it and say, 'Yes they failed on another medication, and they went back to the hospital, but maybe this time the person is coming off a lot better, they have a reason to go get their healthcare, they want to take long-acting injectables.' Those are the people I would be more inclined to not find them gravely disabled (Judge, 12/16/20).*

He added, "Families and treatment teams often don't understand the ins and outs of conservatorship as a legal proceeding. They want to see someone get stabilized and well, but the person has a constitutional right not to be confined if they don't meet the qualification of grave disability."

For individuals not able to show how they can survive on their own, the best strategy for public defenders is finding a "third-party assist," usually from a family member. Appellate rulings establish that "A person is not gravely disabled…if the person is capable of safely surviving in freedom with the help of willing and responsible family members, friends, or third parties."[124] Even if they are adversaries within hearings, public defenders and Public Guardians have a shared interest in finding (or creating) "willing and responsible" family members. Noted one attorney:

> *The best way to get somebody off is third party assistance…Often, what will happen is someone will tell me maybe mom and dad or brother and sister will care for them. If I tell that to the Public Guardian, they're excited. They would try to make that happen, if the relatives will do it (Interview, 9/11/18).*

Judges are bound by this standard. In one prominent case, a judge (unhappily) sent a man to his mother's home, despite the worrying indicators that he had attacked a police officer with a knife, called himself "the executioner,"

[123] *Court-Ordered Insanity*, 146.

[124] *Conservatorship of Early* (1983) 35 Cal.App.3d 244.

and was rated as a "moderate" homicide risk by his doctors.[125]

The phrasing of "third-party assistance" is revelatory of the broader logic of the conservatorship continuum: public services are available only when private ones are fully exhausted. Indeed, while in some European countries families would be provided services and compensation for providing this essential service, in the U.S. it usually comes off as the public system washing its hands of an unwanted person.

Courts: Conclusion

Some research[126] and media reports[127] from the 1970s and '80s found that courts denied conservatorship petitions between 25 and 50% of the time. But the rate now is almost certainly much lower. In one large county, four judges all estimated that they ruled in favor of putting a conservatorship in place about 3/4ths of the time. In other counties, victories for patients are so rare that, as public defender described the single instance where she won, "I almost fell out of my chair" (Interview, 7/22/19).

The reason for this high rate of rulings in favor of conservatorship despite apparently strict legal standards should be apparent. The series of prior screenings mean that people before the courts are not inconvenient persons just "annoying the cops" (Interview, Conservator, 10/11/18). They are rather people for whom, as one public defender put it, "they [parents or psychiatrists] will tell you, 'if he wins, he's going to die.' And sometimes it's true" (Interview, 4/23/18).

6. Placements: The Prerogatives of Private Providers

Alongside consenting to medication and controlling someone's (usually limited) assets, the "principal power" of a conservator is the ability to "place a conservatee in an institution."[128] A key finding of this research is that this phrasing significantly overstates Public Guardians' authority. A court can rule that a person should live in a certain kind of institution and mandate a conservator to put them there. But this declaration only has teeth if a specific institution is willing to accept that person.

Going to a locked placement might feel like incarceration, but the process of getting there is starkly different. Mental health facilities have a right to refuse to take a given conservatee in a way that prisons do not. This accommodation of private prerogatives means that conservatees are more akin to the holders of a Section 8 housing vouchers that no landlord wants to take, rather than the recipients of emergency and obligatory services intended to keep them alive.

Placements: State Hospitals

In the early years of the LPS system, the primary destination for conservatees was that most public of mental health facilities, the state hospital. Today, 90% of California's remaining state hospital beds are dedicated to "forensic" patients (people found incompetent to stand trial, not guilty by reason of insanity, or transferred from prisons for psychiatric care).[129] Individuals referred for these reasons have legal priority over those on civil commitments.

The paucity of beds at this highest level of care creates frustration throughout the system. Counties have no control over state hospital waitlists, on which most patients linger for over a year.[130] A psychiatrist at an acute-care hospital described the uncertainty of holding conserved clients:

> *We now have a weekly meeting with the county's 'transitions' team which is supposed to help us discharge to these other places.*

[125] McCoy, "Mentally Ill Man Released to Mother's Home."
[126] Holstein, *Court-Ordered Insanity*; Warren, *The Court of Last Resort*.
[127] Fenly, "Gravely Disabled?"
[128] *Conservatorship of Roulet* (1979) 23 Cal.3d 219.
[129] Wik and Hollen, "Forensic Patients."
[130] California State Auditor, "Lanterman-Petris-Short Act," 22.

> *But it's ridiculous because they never have any news for us. 'He is 42 on the [State Hospital] waitlist.' Okay, he was 42 three months ago" (Interview, 9/10/18).*

The paradox, as the LPS audit observes, is that state hospital beds are blocked because they are filled with people who no longer need to be there. A physician explained:

> *At our facility, we accepted every patient, whether you were released from jail, if you're pregnant, you're aggressive, you have HIV, all these patients come to our unit…But when we're trying to send people out, some say 'we only take danger to self' or 'we don't take pregnant,' or 'we don't take violent patients.' They have these restrictions, but at State Hospital, we take everyone (Interview, 1/26/21).*

As he pointed out, defining the public system as taking all the "toughest cases" almost by definition creates problems when the step-down placements are private:

> *When we're talking in our team members, the social worker will say 'we've applied to this place, this place, this place' and I can put in my notes that the person is ready to go, but the limiting factor could be those other facilities. Their criteria for admission might be different from mine. They might look at a person's history and say 'this person did such and such back in the day' or 'they're no longer able to come here because they did such and such here.'…I can put in my notes for a long period of time 'they're ready to go, they're ready to go' but I'm limited by the sheer availability of beds…It's all operator dependent, facility dependent, we can try out best, but we can't make a facility take a patient.*

The difficulty of stepping down could become a self-fulfilling prophecy, as he observed: "Patients backslide, and if they make any mistake, we have to document it, and that goes to the placement…" One woman recounted how her son's disappointment at being stuck in the state hospital despite being ready to step down led to a violent incident that finally earned him a transfer—to the forensic ward (Interview, 6/12/20). This disconnect between public and providers along the continuum a core problem identified in this part of the report.

In any case, given that even placement at a "state" hospital costs counties $600 a day, Public Guardians face strong pressures to find another option (Interview, Conservator, 3/12/18). Most estimated that fewer than 5% of their clients are in state hospitals.

Placements: IMDs

Particularly in larger counties, that alternative is primarily locked, sub-acute "Mental Health Rehabilitation Centers."[131] MHRCs are colloquially known as "IMDs" or "Institutes for Mental Disease," a reference to the Medicaid regulation that bars federal funds from going to specialized psychiatric facilities with more than 16 beds. Put another way, a defining feature of IMDs is that their cost, ranging from $200-400 a day, falls directly on counties (unlike outpatient care or shorter hospital stays, which can be billed to public insurance).[132] For smaller counties, a single person with a long IMD stay can eat up their entire "placement budget" for housing public mental health clients, conserved or not (Interview, County Mental Health Director, 3/26/19).

IMD clinicians described their admissions criteria in ways that were parallel to those used to identify people for conservatorship elsewhere

[131] Some interviewees told me, incorrectly, that LPS conservatees *had* to be in a locked facility. Others acknowledged that it was simply their county's practice to drop a conservatorship as soon as a person stepped down to an unlocked facility (Interview, 3/23/18).

[132] Kelly et al., "A Call to Action." Another report estimates the cost as $177,208 a year, or $485/day. SF DPH "Behavioral Health Bed Optimization Project," 8.

in the continuum. A therapist who handled admissions for one explained:

> *In order for somebody to go into an IMD, they have to go into an acute hospital setting, and continue—despite being sober, no meth, and also taking medication—to have symptoms and behaviors that make them unable to successfully live in the community and abide by basic rules to keep themselves or others safe (Interview, 4/18/18).*

But, she noted, a crunch on the number of IMD beds means that they can "cherry pick" clients and screen out individuals with a history of disruptive behaviors:

> *The IMD always has the right to deny. Say for example, I'm at an IMD, and John Doe was just at my facility, and he attacked one of my staff and broke their nose. If that person went to the acute hospital and they call me three days later, 'Hey, John Doe is looking good, will you take him back?' then it becomes, 'Well, he just assaulted my staff a few days ago. I can't take him back'…So they need to refer that person to another IMD.*

The mismatch here is telling. The fact that this IMD could successfully re-hospitalize "John Doe" is a sign that being "disruptive" is a surer route into an inpatient bed than mere "disability." But when *leaving* the hospital, it can be a barrier to finding a place further down in the continuum.

This clinician's mention of "referr[ing] that person to another IMD" is complicated by the fact that California's IMDs are almost entirely for-profit. Moreover, their ownership is highly concentrated: two companies, Telecare and Crestwood, control two-thirds of IMD places.[133] To be clear, there is no question that these IMDs take extremely difficult cases. But a patient can quickly gain a reputation with one of the two companies as someone whose behaviors makes them much costlier than others on their never-empty waitlist. A mother who had worked closely with her conservator to find an IMD for her son noted, "My son 'bombed' out of several [company] facilities, and so it became 'nope, he can't come back.'…He wound up back in an acute hospital, and they said 'okay, it has to be a state hospital, he's been everywhere else'…The private organizations get to decide who they'll take, and they cherry pick" (Interview, 6/12/20).

The private structure of the IMD field poses another, structural problem. Public guardians cannot just place their conservatees in "an IMD." They usually have to find an IMD that has a contract with their county—contracts that are established by the mental health department, which may or may not see conservatees as a priority for limited funds. Counties bid against each other for spots based on their own, unequal resources. As one public guardian lamented:

> *We tried to get a contract with [IMD]—it has a real recovery model, they care about their clients. We got my boss [head of the county Department of Health and Human Services] to take a tour. But we didn't get it, because we don't pay as much as other counties. We lost six beds in the last year, and it was very clear that it was because [large county] paid more…We are completely at the mercy of the operators (Interview, 4/24/19).*

Another conservator summarized the situation is his county:

> *Our county has only one locked institution, and that institution has 120 beds. We only get four of them. So the rest of our people go out of county, away from their family and friends, away from their support system, into an environment and climate that's totally different. It's not great (Interview, 4/25/18).*

Nearly all counties place some people outside their borders. Estimates ranged from all of them in some small counties to 70% in San Francisco to "only" a quarter in some of the largest ones. This distancing has obvious and universally-

[133] Department of Health Care Services. "Institute for Mental Disease List." Retrieved October 22, 2020 (https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-IMD_List.aspx).

acknowledged negative impacts on the ability of conservators, public defenders, and family members to maintain regular contact with conservatees.

Placements: Board and Cares

Locked IMDs cater almost exclusively to conserved clients (Interview, IMD, 4/2/18). For slightly less gravely-disabled cases, conservators might attempt to place them into a Board and Care home. "Board and Cares" capture a vast range of facilities, from 100-bed institutions with a range of programming and professionals on staff to converted single-family homes run as family businesses. In the eyes of many of the professionals I interviewed, they are "absolute shitholes" (to quote one regulator—Interview, 4/4/18).[134] Yet Board and Cares are nonetheless an appealing placement for conservatees for two reasons. First, as unlocked facilities, they meet legal mandates to place people in the "least restrictive" environment possible.[135] Second, conservators can pay for most Board and Cares with the conservatee's own social security disability (SSI) check, with additional county funds in some cases.

As a recent report out of LA county signaled, this often-derided "precious housing resource" is disappearing at an "alarming rate."[136] Rising staffing costs, tighter regulation, and a push to flip beds towards populations that receive greater public financing—such as people with developmental disabilities or homeless—have contributed to the loss of as much of a quarter of the state's stock in five years (Observation, ARF Forum, 4/18/19). As for-profit institutions that are increasingly unprofitable, Board and Cares, like IMDs, have strong incentives to choose their residents carefully. This creates clear gaps in the continuum. For example, two operators told me that they had stopped taking clients directly from hospitals, because hospitals were discharging people before they were sufficiently stabilized.

For Board and Care operators, conserved clients have some advantages vis-à-vis the broader universe of severely mentally ill people. Conservators can help ensure medication compliance and, by controlling a person's disability check, guarantee that operators receive their paltry payment of $35 a day. But operators of Board and Cares, like IMDs, can still be choosy about what *kind* of conservatees they take.[137] Most operators I spoke with described active substance abuse or a history of violence towards other residents as criteria for flat rejection. Their resistance to people who were "disruptive" was coupled with reticence towards the actively "dying." One conservator recounted:

> *We had a difficult time finding a placement for a lady who had substance abuse—that really typically complicates things, facilities don't want someone who uses substances. She also had a colostomy bag, so she didn't have good hygiene, she had been homeless before she was conserved, and so she had some real medical needs, and that was a barrier (Interview, 10/24/18).*

The social worker who handled discharges for a hospital described a similar situation for people whose time on the streets and on heavy medications caused medical problems:

> *We have one Board and Care that takes people near us. I know the guy who runs it very well…he gets to be so picky and so specific because he's the only one. He can practically choose based on the color of*

[134] When pressed, most interviewees admitted that there was, in fact, a range of quality in facilities—a point that could be made for just about any other institution in the mental health field.

[135] CA Welfare & Institutions Code § 5358(c)(1) (2016).

[136] Kelly et al., "A Call to Action," 5,7; see, also, California Mental Health Planning Council, "Adult Residential Facilities."

[137] As one consultant's report commissioned by a county noted, "Due to the limited amount of Board and Care Homes, providers may be less likely to accept individuals with more intensive needs" as a result of the "availability of individuals…who are relatively easier to serve" Research Development Associates, "Yolo County Board & Care Study," 7.

> *someone's hair. And he can certainly say, 'No one with a walker because I just put in new floors.' I spend a lot of my time trying to convince them to take people (Observation, Adult Residential Facilities Forum, 1/26/18).*

The result is what interviewees characterized as a "human logjam"[138] of people lingering in state hospitals, general hospitals, and IMDs. All are looking to discharge clients who are no longer sufficiently acute for their level of care but who are *too* acute (or otherwise unappealing) for the level of care directly below them.

Placements: Conclusion

As this section suggests, public guardians have enormous power over *conservatees.* But they do not necessarily have this authority over the *conservatorship continuum*. Instead, they depend on county mental health departments to find and finance placements, which in turn struggle to push people into or pull people out of autonomous private institutions. As a public guardian summarized, "We're the ones with the quote unquote legal authority to put someone somewhere…but after 15 years of battling those battles [with institutions and the behavioral health department], I've sort of given up and decided we don't have the authority that we're given legally" (Interview, 11/5/20).

7. Conservatorships: Variable Services and Divergent Outcomes

Although this report has documented county-by-county variation at every step in the conservatorship continuum, what happens after someone is conserved seems to vary particularly radically. I left my interviews with no clear sense of what services are "standard" to provide to conservatees, what objectives the various parties involved in conservatorship (Public Guardians, Behavioral Health Departments, providers, and conservatees themselves) are working towards, and under what circumstances someone should step down out of conservatorship. Here, authority is doubly absent: Public Guardians frequently do not have the resources to provide what at least some see as the gold standard for their work, and the state has not used its regulatory authority to bring clarity to what the end point of the conservatorship continuum is actually supposed to be.

Conservatorships: Variable Services, Uneven Powers

County conservators wear many hats, but just how many depends. In one small county, the Public Guardian described his job as "placement to their medication, consent, advocacy, everything about their lives, I'm the one responsible for managing it" (Interview, 10/11/18). "It's like being a parent to an adult," another said (Interview, 3/20/19).

Indeed, some Public Guardians, in their own words, are helicopter parents: "We're very involved in the lives of our clients. We're going above and beyond to make sure their needs are met. We got one client into college and off of conservatorship, and she still calls her conservator asking for advice" (Interview, 2/14/19). Some guardians proudly felt that their counties allowed them to wear their "social worker hat" to ensure that treatment teams recognized where conservatees *did* have capacity to manage their own lives:

> *I have an appreciation of how people have decisional capacity for different things, and having a real commitment to social work values, it's very cheesy, but things like self-determination are very central to the conversations I have with staff about how we're going to handle a case…Once it gets to that point, no one is at the best point of their life. As a social worker, I think I try to treat people with dignity and respect, that's the basic criteria (Cons, 10/24/18).*

[138] Pasquini and Rettagliata, "Housing That Heals," 15.

These Public Guardians often took a highly incremental approach to developing clients' autonomy, ensuring that they received small but expanding privileges, like a little spending money or short trips out of the facility.

Other Public Guardians were, by necessity, more like absent parents and their clients latchkey kids. In larger counties, Public Guardians were quite frank that, with caseloads of 80 to 100 per guardian and many clients placed out of county, direct contact might be only twice a year with a quarterly phone call. Some external observers (perhaps, not fairly recognizing these resource limitations) were critical of conservators. One family member who had been through multiple guardians for her son said:

> *It depended on the conservator. Some of them were less willing to engage…They're pretty much just bureaucratic figures [sighs]. Some of them never even met my son. There was one who was quite helpful, this was a time where the hospital had decided to discharge him, but his [outpatient] treatment team was not wanting him to be released, I was not wanting him, we knew he wasn't ready to be released. And that conservator actually came and met with the social worker from the hospital and me and my son and did a good cop bad cop thing and said 'I don't think you're ready to be released' hoping in some way to impress upon my son that he would wind up back in the hospital if he didn't stay in treatment. But mostly I would say that the conservators have almost no engagement with the patients. Some will talk to the families, some won't. (Interviews, 10/6/20).*

One outpatient clinician similarly reported, "Conservatorship is usually useless because the conservator does basically nothing" (Interview, 12/18/18).

These observers might have been misled by depictions in the media and policy debates that suggest Public Guardians are in an all-powerful position vis-à-vis conservatees. One actually told a newspaper in 1972, "We take over most of the conservatee's civil rights. They have no powers, really, except to live and breathe."[139] All the conservators I talked to today very much wanted outside parties to understand that this was *not* the case. As one Public Guardian explained, "When you're a guardian, the law only gives you two powers: placing someone in a locked setting or consenting to medication. Many people think we have the power things we can't actually do" (Interview, 12/5/18).

Actually, as I discovered, even with respect to one of these two powers—medication—there was disagreement. Some Guardians said this power was basically absolute. When I asked one how he dealt with non-compliant conservatees, he said:

> *The most powerful authority we have is medication, I can order anybody to the hospital, and I can say 'off to the hospital you go' and shoot them up with medications. It's a powerful deterrent, which we don't frequently have to use. Most clients, they're in settings where they comply. They either comply willingly or they comply with a 'show of support' is how they like to say it [laughs]. In other words, get a bunch of burly nurses around them and say 'you're going to take that pill now' or 'you're going to take that shot.' You're going to comply (Interview, 11/5/20).*

In other counties, however, Public Guardians said that they needed to go back to the courts before administering medication involuntarily. In any case, like everything else in the system, this power of conservators depends on the availability of beds in hospitals willing to take conservatees (some LPS-designated facilities, I was told, don't) and police willing to transport

[139] Embry, "The Ordeal of Total Power."

them there. Even the threat of forced medication may in some instances be an idle one.

Because clinicians and housing providers often work with Public Guardians from multiple counties, these differences make the system seem confusing and incoherent. One Board and Care operator reported, "[County] allows the client to sign a consent for whomever is going to be involved in their treatment. In others the Public Guardian controls all of that and tells us 'Keep the family up to date'" (Interview, 4/4/18). A doctor in a state hospital said that some counties routinely allowed conservatees to continue to consent (or not) to medication (Interview, 1/26/21).

There is a glaring need to clarify conservators' powers—and therefore, the degree to which conservatees' rights are restricted—with respect to medication, hospitalization, medical treatment, money, and the release of information. And, of course, there also needs to be ongoing analysis of what collaborators conservators need to make the powers granted to them meaningful.

Conservatorships: Divergent Objectives

Some counties have been reluctant to specify a set of goals for conservatorship because, as the San Francisco Budget and Legislative Analyst said in its audit, the appropriate ones depend on the specific situation of the conservatee.[140] The conservators I talked to nonetheless had a general philosophy of what they were working towards—one which varied enormously from county to county. Indeed, people all through the conservatorship continuum have very different visions of the aims of the public mental health system towards chronically ill individuals (see Figure 7).

One set of guardians described their goals in straightforward, administrative terms. The goal of conservatorship was to "get them to the lowest level of care and, if possible, off conservatorship" (Interview, 4/24/19). The hope was for conservatees to "stay out of institutions and stay alive" (Interview, 4/2/18).

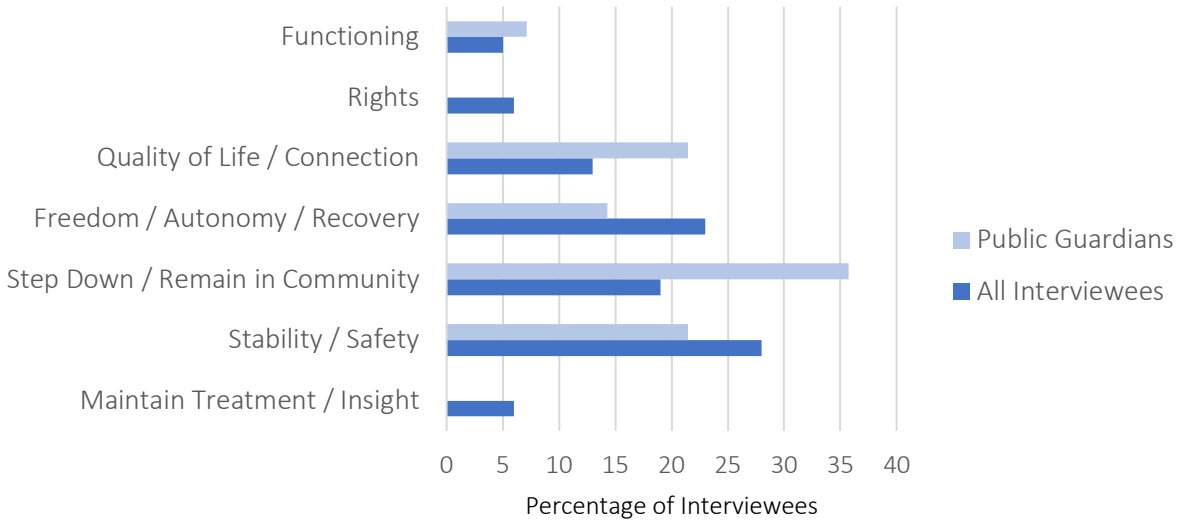
Another set of interviewees focused on achieving a minimum level of stability and functioning without expectation for long-term improvement. "When we get an application, it means it's someone with no hope for recovery and no change of participating in normal life activities" (Interview, 2/6/19). Harsh as this may sound, Guardians like this one were calling attention to the existence of a population that policymakers and planners in California have preferred to deny exist—people who might need intensive, institutional care for their entire lives. One clinician who worked in a 'Super' Board and Care (with residential and medical supports) explained:

> *I'd say 20% of our clients need that level of support indefinitely. .In my mind that used to be this huge defeat but I started to realize that advocating to get them off conservatorship would be unfair and a disservice. I think back when I started here one of our goals is 'how do we get these clients off conservatorship and make them independent?' and you start to realize that's great for some, but you realize the question should be 'how do we make sure people's needs are being met?'…So, there are clients here that might be on conservatorship for the rest of their lives and I don't think that's hyperbole (Interview, 4/2/18).*

As this interviewee pointed out, in such cases quality of life thus becomes a focus: "We're not focused on 'recovery' but more wellness and where that person wants to live. How can we put little things in their life that are meaningful to them? We threw a surprise birthday party for

[140] San Francisco Budget and Legislative Analyst, "Performance Audit," 12.

Figure 7: Objectives of Conservatorship



one of our clients the other day. She's not a hugging type of person, but she hugged everyone" (Interview, 10/24/18).

Some conservators did, however, embrace the discourse of "recovery" that has increasingly become the dominant framework for thinking about outcomes in the public mental health system. One explained, "LPS conservatorships are not like probate [guardianships for people with dementia or developmental disabilities]; they're supposed to be temporary, and the goal is autonomy and self-determination" (Interview, 4/23/19). Some of the push to expand conservatorship is precisely on the basis of the dramatic life transformations it seems to sometimes spark. One community member who had fought to get a homeless person hospitalized visited him months later:

> *My jaw was just in my lap…I was seeing a person with severe mental illness who could be so completely transformed as a human being, from being in their feces, hasn't washed in months, very intimidating, to being someone that you would want to hug…Conservatorship put him in a place, got him on a medication ritual that brought his personality out, calmed him down, made him lucid. He could talk about his future (Interview, 7/3/20).*

Some variation in goals seems appropriate. Many conservatees cited the different objectives for young people on a first break versus persons whose condition was already chronic.

Conservatorships: Stepping Down

Still, a lack of a shared sense of what the outcomes the conservatorship continuum is working towards can exacerbate the lack of coordination within it. This is particularly visible when we consider how people get off conservatorship.

Overall, most interviewees cited periods of medication compliance as the number one factor they evaluated in determining if someone was ready to go:

> *We're looking above all for a period of stability on a medication regimen. If they're on the same medications, they're doing well, and they've been compliant—that's the biggest issue. If they're stable but they've had several med changes in the last few months, we're not comfortable with moving them down. We try to say, stable for 4-6 months at least (Interview, 10/11/18).*

But a locked IMD is likely unwilling to keep a person that long. For some counties, then, someone's readiness to leave conservatorship depended on them succeeding in a much less structured setting:

> *If they're taking their medications, they're stable in [independent] housing—and we want to see them stable not for two weeks, but they're actually managing their life, they're going to their appointments, they're seeing the doctor, they're taking their medications, they're not causing any trouble in the community…If they can do that at six months and if they're providing for their own food clothing and shelter, we will come together as a county—the Guardian, Behavioral Health, the doctor—and we will have this meeting and say 'do we think they can manage not being on conservatorship?' (Interview, 12/5/18)*

As this example suggests, for some counties the conservatorship continuum reached down to independent supported housing.

In others, Public Guardians would only maintain conservatorship petitions if someone was in a locked facility. Decision-making was thus effectively outsourced to private facilities with little input from the county. One public defender from a large county reported:

> *It's fair to say, at least in our county, that if you're on a conservatorship and you're doing okay, the conservator would—maybe it's because of budget and fiscal realities—but they'll terminate the conservatorship pretty quickly. The people that are rolling over year to year are the more seriously ill, chronically ill folks that are less likely to contest their conservatorship, because the ones that might have contested, hey, they were terminated three months ago before they even got to the yearly thing. That's one of the dynamics (Interview, 10/21/20).*

The quote pointed to two dynamics that emerged in interviews. The first was that, if a doctor decided to renew a conservatorship after a year, courts were very likely to grant it. One public defender observed, "Once you get in [to conservatorship] it's very hard to get out [via a hearing]. You're already behind in any hearing, there's a presumption [of grave disability]."

Second, conservatorships themselves can become another 'revolving door' in the system. Both interviewees and available reports show that most people who go onto conservatorship leave quickly, and many of them come back, but Public Guardians' caseloads are made up primarily of people who have been on conservatorship for years. For example, in San Francisco 60% of conservatees have been in the program for at least 5 years, and 37% for ten.[141] Because counties differ in how they define the objectives of conservatorship, what to do with these long-term clients varies. For some, keeping people stable in this way is the point; others might declare that conservatorship is not helping them and push to have them removed by their treating physicians or courts.

Conservatorships: Conclusion

I found very little consensus throughout the conservatorship continuum on crucial questions about what should happen to conservatees. Depending on your county, the Public Guardian might exercise different powers, focus on different goals, and provide you different services for a different period of time. Some small counties seem to provide the most intensive oversight. There is no apparent justification for these differences other than long-running county traditions and resources.

8. Criminal Justice Conservatees: Unraveling the Continuum

As I have shown throughout this report, the public actors in the continuum (like guardians

[141] San Francisco Budget and Legislative Analyst, "Review of LPS Conservatorship," A-10.

and courts) are constrained by private providers' preferences, both in terms of their willingness to build and maintain beds and their choices about with whom they want to fill them. The example of people with severe mental illness and a history of criminal justice-involvement encapsulates how this deference ultimately shapes how decision-makers exercise discretion throughout the continuum. It reveals how the placement tail ultimately wags the conservatorship dog.

Under LPS, the "professional person in charge of providing mental health treatment at a county jail" can apply for conservatorship. Counties can also receive applications when a state hospital determines that a person sent to them as incompetent to stand trial has not been restored to competency after three years.[142] More recently, California has moved to reduce its prison population by diverting more people with criminal justice contact into mental health services, including onto conservatorship.[143] Many public defenders I spoke with described actively pushing the courts to conserve their own clients. One told me that, on the morning of our interview, he had won a hearing to get a client released from jail—and had called the behavioral health department to meet him at the door to take him away on a 5150 (Interview, 4/30/18). Across the board, public guardians reported a dramatic increase in referrals from criminal justice institutions, in many counties to around 20% of their total.[144] They saw this as the most significant trend in the conservatorship caseload.

Guardians did not perceive themselves as a valued partner in reducing mass incarceration, however. They instead feared becoming a dumping ground for populations that, imprisoned or not, society found troublesome:

> *We sometimes get the feeling that the court system and law enforcement want us to take people off their hands, because they're a nuisance. And I understand that they're a nuisance, but that's not what we're looking at in terms of conservatorship. Just because you have a mental illness and you come to the attention of law enforcement all the time, that does not mean you need to be conserved (Interview, 10/11/18).*

Given the "cherry picking" (Interview, Public Guardian, 8/4/17) I described in the previous section, it is unsurprising that conservators reported these new referrals were extremely difficult to place. One Public Guardian lamented:

> *The biggest trend that I've seen over the last 5-10 years, industry wide…[is] an enormous shift of the criminal justice cases over to conservatorship…That has an enormous impact on the system as a whole. We've witnessed and we struggle with it. We're not prepared for those types of individuals, we don't have the skill-set…There aren't any places to put people, especially people with challenging behaviors. The remaining facilities can take the cream of the crop. They're not going to take the guy with a history of rape. They're not even going to talk to you about him (Interview, 3/12/18).*

The lack of "safe placements" was confirmed by Board and Care or IMD operators I spoke with. Clients who might commit a violent act exposed them to liability and a client who ran away could put them in the cross-hairs of regulators (Interview, 2/27/18). If conservators tried to foist dangerous clients on providers, they risked losing their county's contract with them. Noted one, "Some of these clients, if I try to get them conserved and place them, it could jeopardize *all* our placements" (Interview, 3/20/19).

One endgame for such difficult-to-place conservatees was simply to try to push them off of conservatorship:

> *I have a client who has a long history of assaultive behaviors and he's been banned from our hospital, he's been banned from*

[142] Simpson, "When Restoration Fails."
[143] Hodson, "Diversion Program for Mentally Ill Criminals."
[144] see also California State Auditor, "Lanterman-Petris-Short Act," 75.

> *[IMD], and he's been banned from everywhere…The problem with this guy is, well, many of us don't really believe he's mentally ill. He doesn't have a thought disorder, he has a very serious personality disorder…That's one of those people that I advocate for saying 'there's nothing we can do for this person, we have no placements to offer him, no place will accept him'…So you're stuck because the hospital says 'he doesn't need to be here' and the community placement says 'well we don't want him.' He's probably going to end up taken care of by the judicial system, not the mental health system. Even the state hospitals really don't want him back (Interview, 11/5/20).*

An alternative is to return to the courts. A public defender explained her current work for a client lingering in a hospital:

> *I can demand a placement review and request the court to hold the Department of Mental Health and Public Guardian in contempt for violating the court order by keeping someone in a locked facility, because the judge determined that person's least restrictive option is a Board and Care, and they're not in it (Interview, 4/23/18).*

Frustrated judges might look at the situation, and ask, "What are you going to do with these people if I conserve them? You're not providing the necessary services!" and throw out the case. The issue, a state disability rights advocate noted, was "not about the legal standard… it's the mental health system" (Interview, 3/19/18).

At this point, however, we can see how the absence of authority for ensuring that conservatees get needed services—or at a most basic level, that the needed services even exist—impacts the entire system. Conservatorship offices avoid problems with the judge by simply not filing for conservatorship for people they do not believe they can place. One conservator explained, "We had a case of a young arsonist with inappropriate sexual behavior. We said that if there is no placement available, we will refuse to file until behavioral health services gets that [a spot in an appropriate facility]" (Interview, 2/6/19).

And since they knew that public guardians wouldn't file, hospital psychiatrists might not bother applying—whether or not they thought a person met criteria. One inpatient psychiatrist summarized:

> *We always weigh the realistic limitations of the system. Where is the patient going to go once we put him on conservatorship, are there any places for him to go? A lot of times there aren't. It's almost not worth putting him on conservatorship, even if they need it…I wish it could be idealistic like that, 'we can put everybody who meets this criterion on it [conservatorship] and there'd be a place for them.' But there simply isn't. You think down the line, 'is there a long-term stabilization, sub-acute hospital that the [county] contracts with, maybe out of county? Would they take this patient?' You think, 'that waitlist can be three to six months, this patient is going to be in the hospital waiting…' (Interview, 9/10/18).*

As she emphasized, whether or not a person is 'gravely disabled' is not really the issue; rather, it is whether they are the right kind of 'gravely disabled' to be placed somewhere. The result, explained an exasperated conservator, is that "Everyone in the system has referral fatigue. Everyone realizes, 'we send in plenty of referrals"—for hospitalizations, for conservatorships, for placements—"and it doesn't work" (Interview, 8/4/17).

It is thus here, at the very end of a long chain of steps intended to stabilize the institutional trajectory of people suffering from the most chronic and unstable mental illnesses, that the continuums' gaps become most visible. The inability of the legal mandate of conservators to overcome the private prerogatives and financial interests of providers in a delegated system flows upward, shaping the exercise of discretion all through it. If there is some evidence

(corroborated by many interviewees) that the number of conservatorships has decreased in some counties since the 1990s, there is no sign of strict new regulations or legal guidelines to explain it. Instead, counties increasingly believe they cannot meet the "two-sided coin" of conservatorship: "if you're going to take away someone's rights, then you have a duty to provide for them whatever the thing is that you think they couldn't for themselves" (Interview, 3/19/18). In most cases, it is ultimately easier and cheaper to protect someone's rights than to meet their needs.

Discussion and Recommendations

Evaluating the Audit and Proposals for Reform

After 50 years in which the LPS has been spared major revisions, the last five years have brought a welter of attempts to expand the use of involuntary psychiatric care in California. Proposals include broadening the definition of "grave disability" to include a person's "inability to provide for their own medical care" or their capacity to make "informed decisions" that would avoid "dangerous worsening" of physical illness.[145] A recently-enacted pilot program in San Francisco targets people with eight-or-more 5150s in the last year and co-occurring mental illness and substance abuse disorders; colloquially, professionals refer to these as "meth conservatorships."[146] In effect, the latter law broadens the net for the subset of persons usually identified as "disruptive" while the former targets the "dying." Such reforms are in keeping with the views of many family members that the LPS criteria are currently at the core of problems with public mental health care in California: "That's [LPS criteria] the single biggest thing preventing entry into a care system. Yes, we have problems all along the line of the continuum of care, everything, but if you can't even get through the door, you're not even going to have a chance to get treatment" (Interview, 9/9/20).

Yet these discussions happen against a backdrop of a striking dearth of research on how LPS is actually functioning. Many advocates for reform to LPS criteria pinned their hopes on a review by the California State Auditor, which after a long delay released its report in July 2020. It was clear from interviews I conducted after its release that many were disappointed. Based on a review of documentation of 60 5150 holds and 60 conservatorship cases across three California counties, the audit concluded that "the LPS Act's criteria appropriately enabled the designated professionals and courts to place people who needed involuntary treatment on LPS Act holds or conservatorships."[147] There was thus "no evidence to justify" loosening criteria, which "could potentially infringe on people's liberties." The state noted, however, that "California has not ensured adequate care for individuals with serious mental illnesses in its broader mental health care system." No one disputes this last point.

My interviewees offered a mixed take on these claims. On one hand, most interviewees believed, as one county mental health director put it, that "we need to do a little more forced care" (Interview, 4/27/18). This was particularly striking to hear from people providing the voluntary, community-based services that are supposed to be the alternative to mandated treatment. One nurse who worked on a team specialized in caring for homeless people with mental illness confided, "Every person we treat needs a higher level of care" (Interview, 5/1/19).

On the other hand, only 31% of interviewees (and only 15% of conservators) stated their full support for proposed expansion of

[145] Senate Judiciary Committee, "Conservatorship."
[146] qtd. in Sawyer, "Mental Health, Homelessness and Civil Rights."
[147] California State Auditor, "Lanterman-Petris-Short Act," 1.

conservatorship. The majority of those opposed, however, did not cite civil liberties concerns. They instead explained their resistance based on a lack of resources and placements that would allow them to translate revised criteria into care. One public defender summarized his position on San Francisco's conservatorship pilot: "It's not that they can't already conserve the people they're trying to target. They can already catch those people. It's that we don't have that [sub-acute] bed to send them to after they stabilize." He went on, "That's the main problem I see with trying to expand the ability to take away peoples' rights. They have that ability and it's not judges denying that. It's the system deciding that we can't help these people, so we're not going to bring them in because they'll just languish in placements [acute care hospitals] they don't need to be in" (Interview, 4/17/19).

This paper enters into these debates by arguing that there are problems in the conservatorship continuum that cannot neatly be summarized as "lack of resources" or "strict legal criteria." These are related to the lack of public authority to ensure coordination and cooperation across a complex chain of actors. Conservatorships are an enormous exercise of state power, and thousands of Californians are subject to them. Yet it is not actually clear who is responsible for its appropriate exercise. True authority is absent, and thus so, too, is accountability. Below, I point out what I see as the limitations of the audit while offering six recommendations that build on it.

Recommendation 1: The state should significantly expand research, monitoring, and evaluation of conservatorships.

It is boring and predictable for an academic to say 'more research is needed,' but in this case it is true: there is a real dearth of evidence informing the current policy debate around LPS. The interview methodology of this report allows me to identify four main questions for analysis but not answer them.

First, we need to know how the aggregate number and demographics of people on conservatorships has been changing over time. It would be outrageous if the state did not know how many people are incarcerated in state prisons, but this is currently the case for involuntary commitments around the U.S.[148] Although California publishes yearly statistics on the number of involuntary psychiatric holds, hospitalizations, and conservatorships, these data are unreliable and inconsistent. Some counties report in some years but not others.[149] Reported numbers are wildly inconsistent with my interviews and other sources. For example, the auditor "found" twice as many conservatorships in San Francisco as reported by the state report.[150] Better data at the county level could allow us to analyze how the number of conservatorships differs based on county characteristics or placement availability. It also crucial for understanding if and how conservatorship unequally impacts different populations by race or economic status.

Second, we need to better understand where people are exiting the continuum. The audit's methodology is flawed because it focuses on only two points in the continuum: initial holds and conservatorships requested by counties. This misses that at both sites, many people are screened out prior to what would be captured in their analysis. Families or outpatient clinicians don't call 911 if they know it won't lead anywhere. Counties can only file on applications made to them by the hospital, but hospitals may be making decisions not based on LPS criteria but financial constraints. Research should also identify which placements (e.g. IMDs or Board and Cares) seem to be creating the worst

[148] see, also, Morris, "Detention Without Data."
[149] Mental Health and Substance Use Disorder Services Division, "California Involuntary Detention Reports."
[150] "Lanterman-Petris-Short Act."

"human logjam" and which profiles are hardest to place.

Third, research should better identify for whom conservatorship is most effective, based on what intervention, and by what metrics. Many professionals seem to think that conservatorship does not work for people with serious substance abuse problems, yet these are precisely the target of the San Francisco pilot. There are similar unresolved debates about people with a long history in the criminal justice system. Reformers need to be cautious about extrapolating data from different forms of legally-obligated treatment. While many reformers cite Assisted Outpatient Treatment's use of the (disputed) "black robe effect" to get medication compliance,[151] interviewees pointed out that conservatees are almost by definition in a worse state that might make this authoritative encouragement less effective. The rise of "community conservatorships" in San Francisco, Los Angeles, and Alameda Counties presents a unique opportunity to consider which element of conservatorship (oversight by the judge, an obligation to take medication, or a placement) has the most positive impact.[152]

Finally, a glaring absence in policy discussions (and this report) is the views of conservatees themselves. Many peoples' objections to conservatorship seem more complex than simply a lack of insight and complete opposition to psychiatric care. Better understanding their objections could help professionals more rapidly move individuals to less restrictive care and better calibrate involuntary interventions. And ultimately only conservatees can determine the relative importance of gearing conservatorship towards independence, autonomy, recovery, stability, community integration, or some other aim.

Recommendation 2: The state should set much clearer guidelines for the use, goals, and services provided by conservatorship.

The LPS Audit found that professionals "generally interpreted and applied the LPS Act criteria similarly" across counties with some "reasonable variation."[153] My research suggests these differences are actually substantial and difficult to justify. Partly, the audit's focus on *just* 5150s or *just* conservatorships misses that, within the continuum of a county, the use of criteria vary wildly: police officers and ER clinicians seem much less willing to use "grave disability" (versus danger to self or others) than professionals downstream. Whether or not counties give the same guidance on defining grave disability, their rules around when to terminate conservatorships or what services to provide diverge in unjustifiable ways. The same person should not have a Guardian focused solely on keeping them alive if they are in one county, and a Guardian working to achieve recovery and autonomy in another.

The state has clearly abdicated its role in helping counties define the purposes and limits of conservatorship. The California Department of Mental Hygiene apparently once had a person assigned to oversee the use of LPS; when the department merged into the Department of Health Care Services, the position disappeared (Interview, Conservator, 4/23/19). The state needs a designated LPS office to identify:

- The levels of placements (locked, community) that can be used for conservatees.

[151] see Kisely and Campbell, "Compulsory Community and Involuntary Outpatient Treatment"; Schneeberger et al., "Effects of Assisted Outpatient Treatment."

[152] Although some experiments, like San Francisco's "Housing Conservatorships" for people with co-occuring disorders and 8 5150s in a twelve-month period appear already unsuccessful. After dozens of hearings and a year of mobilizing stakeholders and consultants, the program still has not conserved anyone. For a summary of recommendations on the topic, see Alex Barnard and Neil Gong. 2020. "Reform with Care." *Scholars Strategy Network* (https://scholars.org/contribution/reform-care-expanding-mental-health-conservatorships-california).

[153] California State Auditor, "Lanterman-Petris-Short Act," 20.

- The powers conservatorships have (hospitalization, medication).
- The informal criteria that can be added to grave disability (number of hospitalizations, homelessness) for determining eligibility.
- The level and period of stability someone should have before leaving conservatorship.

It is neither possible nor desirable to eliminate the use of discretion by street-level bureaucrats.[154] However, setting standards is crucial for both evaluation and planning. They would allow, at a minimum, to roughly identify the population of people appropriate for conservatorship and thus better determine how much resources need to be allocated to it.

Recommendation 3: The state and counties need to improve the funding and working conditions of key actors in the conservatorship continuum.

As Los Angeles County pointed out in its response to the audit, the auditor bizarrely did not consider the functioning of two key public actors in the conservatorship continuum: Public Guardians and Public Defenders. Informants in the legislature said that both these groups have been largely left out of discussions of reforms to conservatorship (Interview, 6/9/20).

Public Guardians' offices differ along many dimensions: whether they are part of or independent from Mental Health Departments, which professional profiles they hire, and whether they separate or combine the multiple roles Guardians might play (handling administrative issues, conducting investigations, or providing close oversight of treatment and placements). Future audits should evaluate the strengths and disadvantages of these different models. Unsurprisingly, caseloads and budgets came up in all interviews with guardians. Ultimately, what caseload is appropriate for Public Guardians depends on what role we assign to them: for example, the budget for Public Guardians needs to be larger if their role is to act as truly "people changing" actors who accompany people in community placements, versus providing short term "ambulance welfare" that terminates as soon as they leave locked facilities.

A more radical revisiting of the role of Public Guardians would be to empower them, as *Public* Guardians, to oversee the entire conservatorship process on behalf of the best interests of the person and the community. This would include facilitating applications from the community and coordinating admissions to inpatient facilities. It would require moving from funding them at counties' discretion—which effectively allows Supervisors to indirectly set how narrowly or widely to define grave disability—into an entitlement like MediCaid, where resources expand to meet need.

Whether the formal legal protections granted to conservatees protect them in practice depends less on the letter of the law and more on who advocates to enforce it. I heard mostly positive things about public defenders from the judges, psychiatrists, and guardians who worked with them. Still, they themselves pointed out difficulties posed by their lack of specialized training, difficulty accessing clients (particularly when placed out of county), insufficient time to assess whether clients really want to object to conservatees, and, of course, caseloads. In New York, people subject to involuntary psychiatric care are represented by a dedicated public agency, the Mental Hygiene Legal Services.[155] If California expands the use of involuntary treatment, it should also consider enhancing representation through a similar service.

[154] Sandfort, "Moving Beyond Discretion and Outcomes"; Bracci and Llewellyn, "Accounting and Accountability in an Italian Social Care Provider."

[155] Shea, "The Mental Hygiene Legal Service at 50"; Tartour and Barnard, "Démocratie sanitaire à New York."

Recommendation 4: The state needs to create conditions for LPS criteria to be used more effectively.

Even after over 130 interviews, I am unsure whether revamping the conservatorship system requires a wholesale change in criteria. Clearly, the LPS criteria are not a barrier to huge numbers of short-term holds (again, much higher than in most countries, including those with "need for treatment" standards like France). They did not block a much larger number of people from being conserved in the past.

Many interviewees predicted—and I agree—that, in a state where hundreds of homeless people are literally dying in the streets,[156] the criteria "grave disability" is likely to expand to fill any places that are available. A public defender speculated:

> *In our county, we have 76 acute psychiatric beds. If all 76 are filled up, then grave disability means one thing. If they've got some beds or they can put some people in a sub-acute to free up some beds, then grave disability means something else. If we built a second acute hospital tomorrow, we doubled our capacity for involuntary acute care, I think we would find that there's actually now 152 people who meet the criteria for grave disability, and if we shrunk it down to 30, we'd find that a lot of people, it turns out, are not gravely disabled. It's such a mushy concept and I really think it turns on capacity (Interview, 10/21/20).*

Advocates may find that in a system where police officers, ER clinicians, or judges believe that a person will get needed services further down the line, the criteria themselves will loosen.

But will even new beds fill up first with those who most need them? My research found that how different information is applied to determine if someone meets criteria may pose more of an issue than the criteria themselves. Both regulations and practices that focus on patients' current state makes it difficult to hold them for periods long enough that treatment is likely to have a meaningful effect. This is unfortunate, because some studies suggest that slightly longer civil commitments may actually help avert repeated ones in the future.[157]

If criteria or procedures are to be changed, I believe it should go towards incorporating more consideration of patients' history and likely future trajectory. Involuntary care should be geared towards a long-term trajectory towards voluntary care, not endless cycles of stabilization and decompensation. This almost certainly means creating and enforcing regulations requiring decision-makers to contact and incorporate information from families and outpatient providers.[158] This might also mean recognizing when someone is on a "revolving door" of repeated conservatorships which have been ineffective and considering other options. Counties could also use longer civil commitments to avoid repeated ones by expanding 30-day 5270 holds as a less cumbersome alternative to conservatorship.

Recommendation 5: The state and counties need to provide more higher-level placements, but should focus on quality and voluntary care as well as bed quantity.

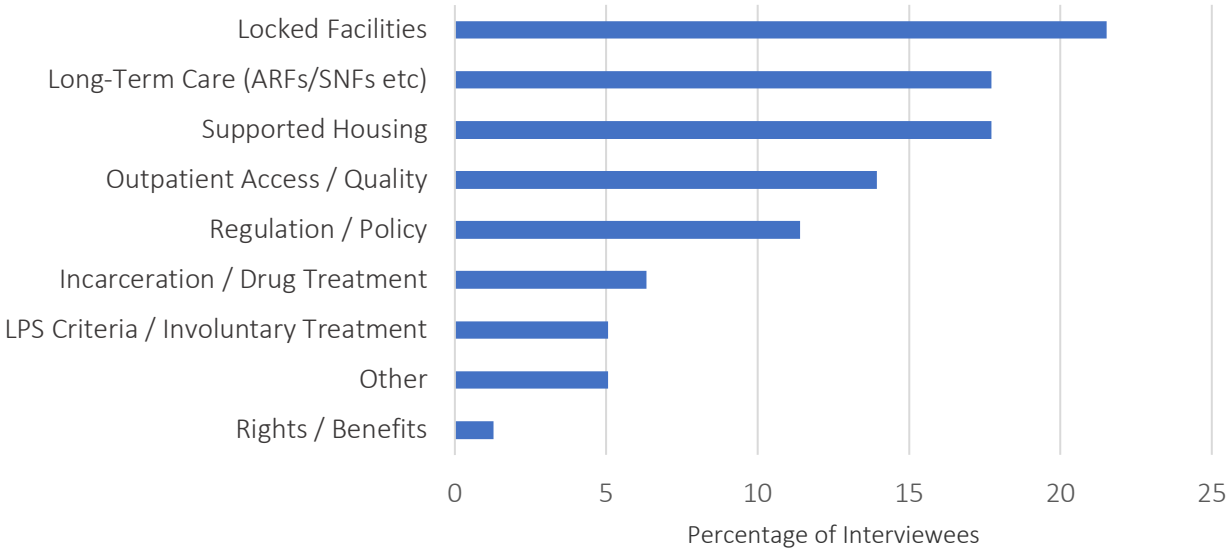
When asked what was the most pressing change required to the public mental health

[156] Gorman and Rowan, "The Homeless Are Dying In Record Numbers On The Streets Of L.A."; Thadani, "If COVID-19 Isn't Driving a Dramatic Increase in Homeless Deaths in SF, Then What Is?"

[157] Morris, "Reasonable or Random"; Wanchek and Bonnie, "Use of Longer Periods of Temporary Detention."

[158] Although AB 1424 and 1194, passed in 2002 and 2015, obligate hospitals and judges to consider such information as provided by families or outside clinicians, many family members felt that hospitals do not follow the law in practice. Judges are also limited in the hearsay they can consider by the *People v. Sanchez* (63 Cal 4th 665) decision (Interview, Judge, 12/16/20).

Figure 8: Priority for Reform or Expansion



system, only 14% cited outpatient care and 17% independent supported housing. A greater number—21%—believed instead there was a need for *locked* facilities and another 18% for long-term facilities like Board and Cares (the remainder cited issues like regulation, funding, or stigma) (Figure 8). In the eyes of a host of stakeholders, many people currently need more intensive care than peers support, a weekly visit with an outpatient clinician, and an independent apartment.

If the state and counties invest in more beds, we owe it to the people occupying them to rethink how they are used. Currently, the number of beds is so scarce that, as many professionals told me, someone who *wants* inpatient care is probably not sick enough to qualify for it. Data from abroad suggest that having more hospital beds may allow clinicians to reconsider this. Some studies suggests that more beds may *reduce* involuntary treatment as patients gain access to intensive services earlier in a psychotic decompensation.[159] California has largely missed the possibility that inpatient care, if it is high-quality, might actually be something that people want. If the state ensured that hospitals were still taking the toughest cases, it could make the ratio of *voluntary* to involuntary care a new measure of tracking improvements in the system over time.

The fear of some advocates is always that investing in inpatient care necessarily takes money away from outpatient services, but this is not necessarily supported by the evidence. California has very little of both, and cross-national evidence suggests that in robust mental health systems inpatient and outpatient care usually complement each other.[160] The countries with the most developed outpatient services built them on top of hospitals, rather than replacing them.

Recommendation 6: The state should reconsider having essential public mental health services provided by private entities.

While the State Audit joined a growing chorus calling for new beds, there has been little

[159] Gandré et al., "Involuntary Psychiatric Admissions"; Allison, Bastiampillai, and Fuller, "Should the Government Change the Mental Health Act."

[160] Perera, "The Relationship Between Hospital and Community Psychiatry."

reflection on what *kinds* of facilities should build them. This research points to serious problems created by "cherry-picking" among clients by private long-term care providers (whether IMDs or Board and Cares) that leads to people being inappropriately placed in truly "public" institutions (like state hospitals or jails). It has also identified extremely unfavorable financial incentives for hospitals that push them not to take involuntary patients who might need conservatorship. This is consistent with past findings that showed private hospitals "are not likely to compensate for public inpatient declines" because they are "less likely to serve…involuntary patients."[161] As a result, research has found that a shift towards private beds is correlated with an increasing number of people incarcerated.[162]

For my interviewees, some of the most exciting and innovative projects serving conservatees are programs like Psynergy or Everwell Health, which are private and for-profit. Some owners of these projects have taken on millions of dollars of debt as part of a commitment to getting some of the toughest clients out of locked placements. But while the private sector can be a useful source of innovation, essential life-saving public services should not depend on it. Mental health systems, more than other disciplines of medicine, depend on robust public financing, because their clients are complex and responses to treatment are unpredictable.[163]

The history of state hospitals, of course, does not offer a glorious face for publicly-run facilities, as much as nostalgia for them seems to be growing.[164] However, state hospitals did have the merit that people who "needed" their care were entitled to it. Some conservators pointed out that a less radical restructuring could shift the existing system in this direction:

> *This initiative [to build beds] is completely one-sided. They need to say, 'Okay, we're going to build this facility, this is how many beds it's going to have, and only people on conservatorship are going to be allowed into this facility.' And if the operator says, 'well, we only want this kind of person, we're only going to get this kind of license…' you tell them they have to take them, that's it (Interview, 4/24/19).*

In countries like France, involuntary commitments can only take place in public hospitals or non-profit hospitals operating following the same rules.[165] The licensing of a hospital to take LPS patients should include an obligation that they accept conservatees and make conservatorship applications when needed. If the conservatorship system is going to serve traditionally "undesirable" clients with substance use or long histories of violence or criminal justice contact, it may require a more robust system of direct public provisioning.[166]

Recommendation 7: People with severe mental illness should be the priority for funders, regulators, and providers.

By the 1970s, it was already clear that the innovative mental health system in California did "not yet know how to deal with the chronically mentally ill person."[167] In 1980, the Federal Government observed that "persons disabled by chronic mental illness" had been "victimized by a lack of consistent policies…in the planning,

[161] Yoon, "Effect of Increased Private Share of Inpatient Psychiatric Resources," 448.
[162] Yoon et al., "The Impact of Changes in Psychiatric Bed Supply."
[163] Perera, "Is Psychiatry Different?"
[164] Sisti, Segal, and Emanuel, "Improving Long-Term Psychiatric Care."
[165] Gourevitch et al., "Laws Regulating Psychiatric Commitment."
[166] A recent report from San Francisco's Department of Public Health notes that "many counties share contracted facilities, which often leads to delays in client placement and a lack of transparency about the length of those delays for DPH clients." It recommends that the city have facilities dedicated to its own clients. "Behavioral Health Bed Optimization Project," 6.
[167] Stall and Levett, "Mental Health Care Dilemma Persists."

coordination, implementation, funding, monitoring, and evaluation of a coherent system of care" who were a "low priority" in new community services.[168]

This situation has only gotten worse. Conservatorship has been left out of new funding streams like the Mental Health Services Act of 2004.[169] The public mental health system's commitment to voluntary, recovery-oriented services partly depends on simply ignoring the sorts of people who end up on conservatorship. As I saw in my own observations, intensive outpatient teams are *expected* to quickly drop clients when they start refusing services, rather than doubling down on their efforts to engage them. Qualitative research shows that "recovery" itself puts an enormous burden on people who may not be able to support themselves independently or live autonomously.[170]

If people with conservatorship are so disabled by mental illness that they cannot eat or clothe themselves and might die as a result, they should be the central preoccupation of the public mental health system. MHSA funds should be available to meet their needs; the Act's commitment to purely-voluntary services should be modified to include services *aimed towards* getting people to voluntarily consent to care. My research across multiple agencies in two countries consistently finds that engagement comes from long-term clinical relationships, including in institutional settings. The state should apply for a waiver of the IMD exclusion to finance these settings. Counties should make sure that this group's basic needs for housing and social support in the community are met, so that money spent on inpatient services is matched with long-term community support.

People with severe mentally ill are marginalized in the health, welfare, and judicial systems and so need a mental health system specifically attentive to their needs. They should be recognized as a health disparities category for planning, research and monitoring; the fact that the current death rate from COVID at Patton State Hospital is ten times the overall rate in California makes this point particularly starkly. Other countries have clearly identified treating people with severe mental illness as the core of the public mental health system. The state should lead by example to send a clear signal to professionals that providing for their care is a high and respected calling; it should emphasize to conservatees themselves that they are citizens whose rights extend beyond procedural protections *against* unwanted treatment (which are important!) but also rights *to* quality care.

Conclusion: Conservatorship as a Public Entitlement

California's conservatorship continuum is a bizarre hybrid. It provides emergency, coercive services to people on the edge of death. This is usually a realm where the otherwise limited American welfare state invests the necessary minimum of funds and effort. But conservatorship operates in a public mental health system that is largely farmed out to non-state organizations and which provides care only "to the extent resources are available."[171] The

[168] Steering Committee on the Chronically Mentally Ill, "Toward a National Plan for the Chronically Mentally Ill," 1–6.

[169] One conservator told me, "When Prop. 63 [MHSA] passed, I was involved in the strategic plan, trying to get more services. I can tell you this, I worked the room to get people to talk about how to help us with conservatorships. I could not get one person who wanted to support us. They're interested in housing, socialization, peer counseling, vocational rehab. And conservatees were not going to be allowed to participate in those programs" (Interview, 4/23/19).

[170] Some social scientists have critiqued "recovery" as placing a great deal of a burden for achieving independence and self-sufficiency on clients while absolving society of responsibility for providing long-term supports and care. Myers, "Culture, Stress and Recovery from Schizophrenia"; Jenkins, *Extraordinary Conditions*.

[171] Little Hoover Commission, "Being There: Making a Commitment to Mental Health," ii.

continuum is made up of professionals attempting to create a profound change in someone's rapidly declining life chances, but individual "street-level bureaucrats" are expected to "people process" based on someone's momentary state. Conservatorship hinges on a simple criterion of "grave disability," but its use is narrowed in inconsistent ways. People working at each step in the continuum adjust their use of discretion not based on their own clinical judgment, but their assumptions about what "burden shuffling" will happen further down the continuum.

An alternative conceptualization would be thinking of conservatorship less as an option, and more as an entitlement. This would mean the legal designation of conservatorship creates resources for conservatorship offices and placements that make that conservatorship meaningful. It would require counties to coordinate providers to put in place conservatorships when they are needed, rather than an opportunity to do so if the fiscal and bureaucratic stars align. It would have to be matched by a more robust system of legal advocates with the resources and training to protect people subject to conservatorships. Debates would need to shift from defining the criteria under which someone *can* be placed under a conservatorship and towards asking when they *should be* and what transformations that *should* lead to in someone's life. It would commit the state to providing other entitlements, like housing and social supports, on the other side, to make the enormous changes we ask conservatees to make worth it.

It is crucial to note that there is an alternative interpretation of my results. Many civil rights advocates and certainly some conservatees might see "absent authority" and conclude the system is working as intended. As the California courts themselves noted, "Before a person may be found to be gravely disabled and subject to a year-long, the LPS Act provides for a carefully calibrated series of temporary detentions for evaluation and treatment."[172] The resultant model is "lengthy, multi-layered, non-therapeutic, cumbersome and costly" and arguably "the most complicated and 'Byzantine' in the nation."[173] This, to some, is the point.

But even if the shared goal is to keep people off conservatorship, such life-or-death decisions should not be left to the vagaries of insurance reimbursements, market forces that determine the number of placements available, and the ability of families to turn advocating for treatment into a full-time job. In a reformed system, both placing people on conservatorship and keeping them off of it should be a conscious decision by publicly accountable agencies with adequate resources and based on consistent criteria.

[172] Conservatorship of Ben C. (2007) 40 Cal.4th 529, 541.

[173] LPS Reform Task Force II, "The Case For Updating California's Mental Health Treatment Law," 11.

Glossary

- ***Absent Authority***: Situation in which many parties can block the implementation of a policy, but no one has authority or responsibility for putting it into place.
- ***Ambulance Welfare:*** Emergency services that provide superficial interventions to stabilize crises or prevent harm. In the U.S., these programs are usually funded as entitlements (e.g. Ambulances), unlike other kinds of programs.
- ***Burden Shuffling:*** Practice of pushing unwanted clients onto other agencies, often by redefining them (e.g. a mental health provider declaring someone an "addict").
- ***Cherry-Picking:*** Choosing clients who are the least costly or easiest to treat. Practices of 'cherry-picking' are frequently associated with for-profit providers, but not all engage in cherry-picking and public agencies can also practice cherry-picking (or 'creaming').
- ***Conservatorship Continuum or Continuum of Constraint:*** The series of medical, bureaucratic, and judicial steps required to take someone from the community and put them on conservatorship. Conservatorship requires collaboration across a range of agencies along the continuum.
- ***Delegated Welfare***: Delivery of public services through private actors. The public mental health system 'delegates' to contracted clinics, private hospitals and housing providers, managed care insurance companies, and families. Delegation is usually justified by claims of the greater efficiency of the private sector, but can create problems in terms of access, regulation, or accountability.
- ***People Processing vs. People Changing:*** Two different styles of bureaucratic decision-making. The first determines eligibility for a benefit based on a few simple criteria (e.g. a social security office or, frequently, ER). People changing focuses on transforming someone's behaviors, social situation, or mentality. It usually requires more extensive knowledge of the person.
- ***Street-Level Bureaucrats***: Front line service providers—police, judges, clinicians—whose actions, taken together, create the impacts of government policies. SLBs invariably have insufficient resources to meet their official mandate, and thus exercise *discretion* in determining program eligibility.

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