Civil Commitment by Conservatorship: The Workings of California's Law

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This article summarizes the conservatorship provisions of the California Civil Commitment Statute, the Lanterman-Petris-Short (LPS) Act and reviews the major findings from previous studies. By studying the hospital records of eighty-five gravely disabled patients affected by LPS, the authors address issues raised by these reports. The results indicate that the law's provisions work unevenly. Patients with acute and current disability received conservatorships more frequently than those who had been disabled in the past. There is some evidence that the process is used to confine threatening patients and does not function equally well for all diagnostic groups.

Involuntary commitment of the mentally ill continues to attract professional attention, with endeavor to strike a balance between individual rights, clinical needs, and social concerns.[1-6] Comparing legislative intent and actual experience, recent critiques identify both advances and shortcomings of well-intentioned law.[7,8] The resulting combination of experience and reflection shapes legislative reform.[9-12]

The purpose of this study is to further explore what happens to the largest subgroup of patients under the most influential commitment law, the California Civil Commitment Statute, or Lanterman-Petris-Short (LPS) Act, *California Welfare and Institutions Code* 5000-5466. That patient subgroup is the gravely disabled (GD), defined as "unable to provide for his or her basic needs for food, clothing, or shelter" due to a mental disorder. After acute treatment, LPS provides for continuity of care through the court appointment of a conservator.

LPS Conservatorship Procedures for GD Patients

Conservatorship proceedings may be initiated while a GD patient is involuntarily confined, or at other times, for example in the course of disposition.

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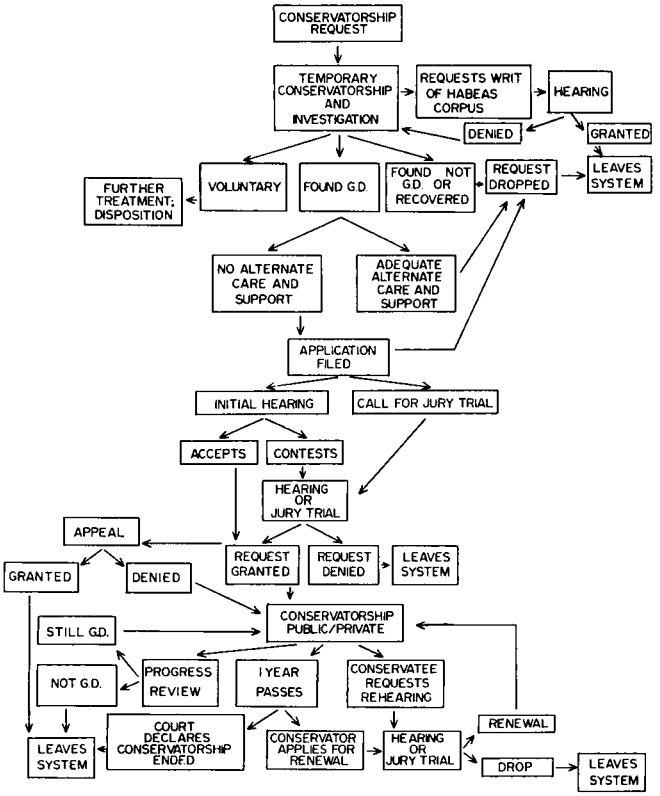

Figure 1. Steps of conservatorship proceedings under the LPS Act.

The process, summarized in Figure 1, begins with a petition from the county public guardian's office to the superior court judge, who, upon finding sufficient evidence, appoints a temporary conservator. The appointment triggers an investigation, usually by the temporary conservator, of ongoing need for conservatorship. Meanwhile, the patient may file a writ of *habeas corpus*. The temporary conservatorship is for 30 days, with extension up to six months for court proceedings.

The investigator submits a report to the court for an initial hearing. If the evidence does not show grave disability, the matter is usually dropped. Otherwise, the investigator evaluates alternatives to conservatorship.[13] If the judge finds grave disability with need for conservatorship, the individual may either accept or contest the decision. If the decision is contested, a further hearing or a jury trial is scheduled. Before the conservatorship hearing, the patient may call for a jury trial on the issue of grave disability.

LPS directs the court's selection of a conservator to follow a priority listing: the proposed conservatee's spouse, adult child, parent, brother or sister, a nominee of any of these relatives, and then any other qualified person. The investigator includes in his report the most

suitable conservator and that person's agreement to accept the task. If necessary, the same is done for a conservator of the estate.

Appointments are for one year and require annual renewal. Once appointed, the conservator is to arrange the least restrictive alternative[1] for needed care. Within 10 days a treatment plan is required, specifying goals, interventions, criteria for measuring progress, and a timetable for progress reviews. If a review finds the conservatee no longer GD, the court is to be so advised in order to terminate the conservatorship. The conservatee may call directly for a court review at any time, after an initial waiting period of six months.

Evaluations of LPS

Empirical studies on the impact of LPS, summarized in Table 1, shaped the present study.[14–19] These early reports both left information to be desired and pointed up problems to be explored or confirmed. Specific documentation of the conservatees' background demographics and clinical history and their relationship to grave disability was rarely included. The influence of local relatives as potential alternative support was not well described. Information about discharge dispositions and readmission rates was sparse. Evidence of abuses such as temporary conservatorship overruns, failure to utilize the results of costly conservatorship investigation, and use of conservatorship procedures to involuntarily confine violent individuals not GD called for further investigation. In sum, there was a need to correlate patients' characteristics and the outcome of their conservatorship proceedings. This report does so.

Methods

Subjects We selected from the administrative records of a Veterans Administration (VA) Medical Center those patients who had experienced their first LPS proceedings during the calendar year 1975. This interval served to avoid seasonal variation and intrusion by secular factors. There were 85 individuals: 80 men and 5 women ranging in age from 20 to 76, with a mean age of 44 and a median age of 48 years, in a bimodal distribution similar to that found by Spensley and Werme.[19] Nearly four fifths of the population were white, not quite 15 percent were black; and 7 percent were of other minorities. The sample's geographic distribution was wide, with 66 percent born in the West or Midwest and 19 percent in the East or abroad.

Record Review After an interval of two years to allow completion of conservatorship proceedings, we anonymously encoded a uniform set of relevant demographic, clinical, and legal data from each patient's hospital record. These were tabulated; appropriate means and medians computed; and contingency tables prepared. The chi-square test was applied both to confirm the sample's validity and to examine relationships between patient characteristics and outcome of the conservatorship process.

Results

Resources and Support The records provided abundant information. As de-

Table 1
Evaluations of the LPS Act

Reference	Subjects	Methods	Major Findings
14	236 patients hospitalized involuntarily before LPS; 335 after LPS	Interview of patients and relatives; chart review; statistical comparisons from courts and Department of Mental Health; survey of legal and mental health professionals; observations in courtrooms and legislature	Shorter hospitalizations; more new admissions; patient movement from state to local facilities; unchanged emergency commitment rate; more police involvement with the mentally disturbed; unchanged patient and family perceptions of admission process; local administrative variations; prolonged temporary conservatorships; discharge of temporary conservatees
15	226 involuntary admissions to one hospital discharged during 1971	Chart review	Majority remained involuntary for only 3 to 5 days; predominance of schizophrenia; predominance of police referrals; patients accepting voluntary status persevered in treatment
16	Patients in state and local public mental health facilities	Statistical review	Patient movement from state to local facilities; diversity of services and high quality of care at the local level
17	100 involuntary patients who filed writs of *habeas corpus*	Observation of hearings; visits to emergency rooms; visits to inpatient units	Predominance of schizophrenia; lack of vigorous advocacy by lawyers for involuntary patients; preference for GD as a basis for involuntary confinement; denial of writ associated with previous hospitalization, noncompliance, family rejection, conservatorship proceeding, and poor financial management; granting of writ associated with clinical improvement and link with outpatient care
18	45 proposed conservatees before one court during spring of 1975	Review of court documents; observation of hearings; statistical review	Inadequate legal representation; use of conservatorship to confine threatening patients not GD; extreme local variations in rates for LPS proceedings; most patients confined during proceedings; minimal use of nonpublic conservators; predominance of younger patients; inadequate treatment of conservatees

Table 1 (continued)

Reference	Subjects	Methods	Major Findings
19	All 922 conservatees in one county between July 1969 and July 1976	Review of court and public conservator's records; statistical review	Bimodal age distribution; equal sex distribution; predominance of schizophrenia and organic brain syndrome; referrals predominantly private; no variables related to outcome of conservatorship proceedings; annual increase in proceedings; substantial use of private conservators; substantial use of low challenge dispositions; 52% terminated after 1 year; most others continued another 2 years

tailed in Table 2, two thirds of the sample had at least a high school education and had entered a full range of occupations, but most were unemployed on admission. Incomes were modest, ranging from $200 to $600 monthly for half of the subjects and even less for another third; Social Security was by far the dominant source. Single patients were in the majority at 55 percent, and 25 percent were divorced or separated. The married numbered 14 percent and widowed 6 percent.

Notably, half of the sample had one or more adult siblings living locally, while one third had one or both parents. At least one adult child was available to 17 of the 30 who had any children. Nine of the 12 married patients had a nearby spouse. Two of the patients also had stepchildren present locally.

To discover who was available for each patient, we computed combined support scores, giving one point for the local presence of one or more adult relatives in each of the four categories that LPS designates for the role of conservator. The same was also done omitting parents. This analysis revealed that 66 individuals, nearly 80 percent of the group, and one or more local relatives. Also, 20 of the 27 patients with one or both parents nearby also had other local adult relatives.

Clinical Evaluation by DSM-III diagnoses revealed that 73 percent of the sample were diagnosed schizophrenic, predominantly paranoid (32%) or undifferentiated (26%). An organic mental disorder was assigned to 8 percent of the sample, and an alcohol-related disorder to another 8 percent. For the remaining 11 percent other diagnoses were recorded, including 5 percent with bipolar affective disorder. In addition to their primary diagnoses, 14 (16%) of the patients carried secondary diagnoses. Half of these were related to alcohol abuse, while the remainder formed a scattered pattern. A third diagnosis was assigned

Table 2
Demographic Assets of Study Population (N = 85)

Education	%
Graduate or professional training	4
College, 4 years	5
College, fewer than 4 years	27
High school, 4 years	26
High school, fewer than 4 years	14
Junior high school	14
Grammar school, fewer than 7 years	4
Unknown	7

Occupation	Usual (%)	On Admission (%)
Professional	13	2
Business	12	
Skilled	7	
Semiskilled	19	
Unskilled	2	1
Student		1
Retired		5
Unemployed	18	87
Unknown	8	4

	% of Study Population with Adult Relatives Locally Available			
No. of Relatives	Spouse	Children	Parents	Sibs
0	89	80	67	51
1	11	6	13	22
2		5	20	10
3		4		11
4 or more		6		7

Combined Support Score (As Defined in Text)	Spouse + Parents + Sibs + Children	Spouse + Sibs + Children
0	22	31
1	40	54
2	34	14
3	4	1

to four of the individuals, two of them alcohol related.

The distribution of primary diagnostic categories was similar for each of the counties from which most of the patients came, as well as for their places of birth. The same was true for race. Not surprisingly, patients with organic mental disorder were older and schizophrenics were younger. The pattern of educational accomplishment was similar for the four diagnostic categories, as were amounts and primary sources of income. Schizophrenics and alcoholics appeared somewhat lower on the list of usual occupations (as ranked in Table 2) than did those with organic mental disorder and other diagnoses. One alcoholic patient and two with organic mental disorder were retired at the time of admission; one schizophrenic and three with other diagnoses were the only patients working when they were admitted.

In contrast to the patients with other

diagnoses, schizophrenics were for the most part unmarried ($p < .01$) and childless ($p < .001$), and among those who did marry the majority were divorced or separated. Very few of the patients with diagnoses of organic mental disorder, alcholism, or other disorders had parents living in the area. However, nearly half of the schizophrenics did, reflecting to some degree their relative youthfulness. Unlike most of the patients in the other diagnostic groups, over one third of the schizophrenics had no local relatives.

Psychiatric problems were severe and chronic. All but four of the 85-member cohort had one or more psychiatric admissions before the study, with a mean number of six, a standard deviation of six, a median of five, and a range of up to 36. These dated as far back as 35 years, more than 10 years for 30 of the cases. Total length, in weeks, ranged up to 500, with a mean of 58, a median of 18, and a standard deviation of 94. Prior admissions did not vary significantly across the diagnostic groups. The records further indicated that 40 (47%) of the patients had mental health problems on discharge from the service; nine (11%) of these also had medical problems. These were connected to military service for 36 (42%) individuals, 24 of whom rated at 100% disability. Of these 24, 21 carried a diagnosis of schizophrenia.

When the 85 records were examined for a history of violence to self, 31 (36%) examples were found. A history of violence to others was noted in the records of 44 patients (52%). A total of 25 (29%) patients had gone to jail for crimes such as disturbance, assault, inebriation, drug possession, or theft. These figures did not vary significantly with diagnosis.

Table 3 presents the cohort's experience during and after the study admission. The majority of discharged patients, 52 (61%), was referred to the hospital's outpatient division for continued treatment. Another 18 (21%) were discharged from the system on a regular basis, while eight (9%) were given irregular discharges, with most likely failing their appointments. At the time of dis-

Table 3
Admission Data during Study

Study Admission Duration (weeks)	
Mean	27
SD	24
Median	20
Range	142

Disposition	
Challenge Level	N
High	
Home to spouse	7
Home alone	6
Home to parents	4
Home, other	4
Escape	7
Halfway House	3
Low	
Board and care home	33
Locked facility	5
Nursing home	4
Remained in hospital	3
Transfer	3
Not Classified	
Other	3
Unknown	3

	Subsequent Admissions	
	No.	Total Duration (weeks)
Mean	1	8
SD	2	15
Range	5	56

charge from the hospital, 38 (45%) of the patients were listed as improved, and 29 (34%) as unchanged. A total of 52 (61%) were regarded as unemployable, and 11 (13%) as actually or potentially employable at the time of discharge. At the same time, 14 (16%) were assessed as competent for VA purposes or able to handle their own funds and 41 (48%) as not so. (This point was not covered in the records of the other cases.) Readmissions to the same hospital were rather numerous during the interval of two years between the initiation of conservatorship proceedings and the data collection. There was no significant trend among these observations with respect to diagnosis, except that no alcoholics or organic mental disorder patients were considered employable at the time of discharge ($p < .05$).

Legal As expected, the largest group, 41 (48%), entered the medical center involuntarily. A surprisingly large number, 23 (27%), entered voluntarily. Legal status on admission was recorded as unclear for eight (9%) and as other for 13 (16%); these individuals may have entered already on temporary conservatorships or labeled as dangerous to self (DS) or danagerous to others (DO). Twenty-six patients (31%) came from an agency or institution. Next, in descending order, were 19 (22%) police referrals, 18 (21%) self referrals, and 13 (15%) family referrals. This information was missing in four cases, and the remaining five were scattered among diverse referral sources.

The 41 clearly involuntary admissions came with a varied pattern of legal labels. A scant 18 of the individuals received only the designation GD. Another 16 were given the GD label along with one or both of the dangerousness labels, DO and DS; the remaining seven were considered DO and/or DS but not GD.

Following the legal procedure described above, the relevant county superior courts appointed temporary conservators of person for 82 (96%) of the 85 proposed conservatees. For the vast majority, 70 (82%), the temporary conservator was a public official designated according to each county's procedures. Nine patients (11%), however, did have a relative assigned for this role: five siblings, two parents, one spouse, and one child. The remaining three had some other person assigned on a private basis. The courts also appointed temporary conservators of estate for 46 (54%) patients, including 35 public conservators, seven relatives, and four others, of whom one was an attorney.

The proceedings that followed these temporary conservatorship appointments and the investigations of need for conservatorships led to the results shown in Table 4. The table also shows the distribution of these results with respect to patient variables that bore a statistically significant relationship to them at the $p < 0.05$ chi-square test. Variables found unrelated on this basis are also listed.

Discussion

Conservatorship proceeding outcomes were significantly related to diagnosis. The diverse group of patients in the category labeled other showed by far

Table 4
Conservatorship Application Outcomes and Their Relationships to Patient Variables

Disposition of 85 Conservatorship Applications	
Petition granted by court	63
Petition dropped by hospital	9
Petition refused by court	6
Result missing in record	7

Individual Appointed as Conservator	Of Person	Of Estate
Public	50	33
Spouse	1	1
Parent	2	2
Sibling	5	3
Attorney		1
Other	3	3
Not stated	2	

Patient Variable	Outcome of Conservatorship Application†			
	Granted	Dropped or Refused	Unstated	$p<$
Legal status on admission				
Voluntary	39	5	1	
Involuntary	24	10	6	.025
Temporary conservator of estate				
Assigned	39	6	1	
Not assigned	24	9	6	.025
Employment status on admission				
Not working	62	10	5	
Working	0	4	0	.001
Place of birth				
West or Midwest	44	9	3	
East or abroad	8	5	3	.05
Marital status				
Never married	38	8	1	
Ever married	25	7	6	.05
Combined support score				
0	18	6	2	
1	39	5	2	
2 or 3	6	4	3	.01
Primary diagnosis				
Schizophrenia	49	11	2	
Organic mental disorder	5	0	2	
Alcoholism	5	0	2	
Other	4	4	1	.01
Jailed for Crime				
No	49	7	4	
Yes	14	8	3	.01
Length of Study Admission				
Over 1 year	18	0	0	
Under 1 year	44	15	6	.025
Competent for VA purposes				
No	35	4	2	
Yes	6	6	2	.01
Challenge level of disposition				
Low	42	3	3	

Table 4 (continued)

Patient Variable	Outcome of Conservatorship Application†			
	Granted	Dropped or Refused	Unstated	$p<$
High	19	9	3	.001
Type of discharge				
Regular	55	11	6	
Irregular	3	4	1	.05

* The following patient variables were not related to outcome of conservatorship application: race, age, gender, education, income, usual occupation, county of residence, referral source, problems leaving military service, history of violence, number and length of prior admissions, degree of improvement on discharge, and employability on discharge.
† Totals vary because not all data were available for each case.

the highest probability of having their applications dropped. Those with organic mental disorder and alcohol-related problems showed the largest proportion of incomplete proceedings but no dropped applications. These diagnostic groups, then, appear to pose problems for the system.

Our results provide indications that the LPS procedures work as intended. This act deliberately narrows the use of involuntary status to those patients most strongly opposed to becoming conservatees, giving weight to the assertion[20] that many voluntary patients are not really so. Those who were clearly involuntary did better than their voluntary counterparts in having their applications dropped.

Whether or not a person's conservatorship application will be turned down seems to be influenced by several factors. A striking observation was that all four patients who were holding jobs on admission had their conservatorship applications turned down. Functioning at a job is incongruent with grave disability. Another indicator of ability to care for one's basic needs was the informal classification of patients as competent for VA purposes or not. The patients considered competent in this regard did significantly better than their counterparts at having their conservatorship applications refused. A parallel finding was the tendency of patients assigned temporary conservators of estate to be ultimately assigned permanent conservators of their persons. Likewise, longer hospitalizations and less challenging dispositions suggest greater disability and correspond with significantly higher rates of conservatorship assignment. On the other hand, such indicators of premorbid level of functioning as education and usual job were not related to the outcome of conservatorship proceedings. The same was true for such indicators of chronicity as the number of prior psychiatric admissions, the year of first psychiatric admission, and both the presence and degree of psychiatric disability upon discharge from military service.

One exception was notable. A history of being jailed for crime showed a statistically significant association with denial of a permanent conservatorship. Therefore, initiation of conservatorship proceedings served in some cases as a means for temporary confinement in a mental

hospital of individuals who were not ultimately found by the court to be GD. The same was not true, however, for individuals who merely had a history of violence ($p > .10$). Uncompleted conservatorship applications were twice as frequent among formerly suicidal patients as among individuals without such a history, a notable trend although not large enough for statistical significance ($p > .10$). In addition, none of the four patients given all three labels (DS, DO, and GD) on admission received a permanent conservator. Taken together, these observations support the suspicion of the use of LPS to extend confinement of threatening patients who were not GD. Corroborating this result is the finding of Yesavage *et al.*[21] that an initial DO label does not correlate with its use as a basis for 14-day certification. Not surprisingly, civil commitment reformers continue to have serious difficulty in their attempts to deal with the mentally ill who also appear to be dangerous.[22] Public tolerance for restricting the rights of such patients seems to be reflected in recent litigation regarding the right to refuse treatment.[23] Along these lines, Wilbert *et al.*[24] have described evaluation of grave disability based on current functioning.

The 8 percent incidence (seven cases) of unstated outcomes strongly suggests that this proportion of proceedings extended significantly beyond the intended few weeks' time. However, because six of the seven cases involved showed an admission of less than one year (Table 4), one can infer either that these extensions were fairly brief or that they did not preclude discharge. It is difficult to obtain the complex data needed to decide this important question. The patient cohort experienced the LPS procedures as blind to age and race and apparently to gender.

The law's stress on involvement of family members seemed at least moderately successful. A significant plurality of patients with a rich supply of local relatives did not receive conservators, suggesting that some of them provided an alternative to conservatorship, as the law intends. Nonetheless the number was very small compared with the number of potentially available relatives, with siblings in particular both locally available and potentially underused both as conservators and as alternatives to conservatorship. More effective use of relatives is clearly a worthwhile goal for legislative reform, including practical use of the patient's perspective.[25] Finally, the high proportion of public conservators suggests that private conservatorships should be encouraged.

The procedural complexity of LPS is evident in Figure 1. Complexity itself may be adding to length of stay. Because LPS procedures are intended to allow full exercise of patients' rights, this effect is ironic. Unfortunately, the explanation may lie in the fear of litigation.[26] This observation calls for closer collaboration of psychiatrists with lawyers.

The importance of continuity in aftercare is acknowledged in the recent addition to LPS of the conservator's authority to require outpatient treatment. This theme can be developed further, using, perhaps, Axes IV and V of DSM-III.[27] A mandatory ceiling on public conservators' caseloads might facilitate their

achieving stronger continuity of care, bringing to bear the sophistication required to achieve the least restrictive alternatives for their clients.[28,29]

Reports published after those summarized in Table 1 point out the paucity of continued research in this area,[30,31] and we have found no further general empirical studies of LPS conservatorship. The present results clearly identify areas for further research. Although general comparisons have been done between voluntary and committed patients,[32–35] and although conservatorship cannot be applied on a random double-blind prospective basis, the thoughtful use of variously matched control groups would be illuminating. In this way, the interaction of variables independently identified as important in this and other studies could be usefully explored. This includes the complex interplay between spouses and other relatives, as well as such interdependent variables as diagnosis, age, and marital status.

The VA health care system is the country's largest, with 10% of all psychiatric beds; yet its population appears to be distinct.[36] Thus, the group studied here is relevant, but it remains important to explore the experience of state and private hospital populations. There is evidence that local variations are important and amenable to study.[37,38] For example, this study does not confirm the observation[39] that ethnic minorities are overrepresented in the subject populations of California institutions.

Above all, a several-year followup study of LPS conservatees should be done to compare their courses with what happens to proposed conservatees not given conservatorship. Likewise, comparison with similar patients who happened not to be proposed for conservatorship would be useful. Such data would shed light on the moral challenges posed by involuntary commitment.[40] Sadly enough, it is not yet known whether conservatees themselves believe that the legislative aims of LPS have been achieved in their own regard.

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