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“Let’s Do the Time Warp Again”: Assessing the Competence of Counsel in Mental Health Conservatorship Proceedings

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“Let’s Do the Time Warp Again”: Assessing the Competence of Counsel in Mental Health Conservatorship Proceedings

GRANT H. MORRIS*

TABLE OF CONTENTS

I.	INTRODUCTION	284
II.	THE INADEQUACY OF COUNSEL FOR MENTALLY DISORDERED PERSONS IN CIVIL COMMITMENT HEARINGS.....	286
III.	THE INADEQUACY OF COUNSEL FOR MENTALLY DISORDERED PERSONS IN HEARINGS TO IMPOSE INVOLUNTARY TREATMENT	293
IV.	THE USE OF MENTAL HEALTH CONSERVATORSHIPS TO ACHIEVE CIVIL COMMITMENT AND INVOLUNTARY TREATMENT IN CALIFORNIA.....	302
V.	MEASURING THE ADEQUACY OF COUNSEL IN CONSERVATORSHIP HEARINGS CONDUCTED IN 1975 AND THE CALIFORNIA SUPREME COURT’S RESPONSE TO ATTORNEY INADEQUACY	311
VI.	MEASURING THE ADEQUACY OF COUNSEL IN CONSERVATORSHIP HEARINGS CONDUCTED IN 2007–2008.....	316
	A. <i>Uncontested or Stipulated Cases</i>	318
	B. <i>Contested Cases</i>	328
VII.	ZEALOUS ADVOCACY FOR MENTALLY DISORDERED CLIENTS: REALITY OR DELUSION?.....	337

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“The more things change, the more they remain the same.”¹

I. INTRODUCTION

How important is counsel in representing a mentally disordered person in a court proceeding to determine whether that person can be subjected to involuntary civil commitment or in a court proceeding to determine whether psychotropic medication can be administered to a civilly committed mental patient over that patient’s objection? Michael Perlin, author of the definitive five volume treatise on mental disability law² and the foremost authority on the subject, has asserted that the quality of counsel is “the single most important factor in the disposition of involuntary civil commitment cases”³ and is “of critical importance in the disposition of right-to-refuse treatment cases as well.”⁴

This Article explores how well counsel has performed this function historically and whether deficiencies in performance have been eliminated over time. Part II discusses empirical studies of attorney performance in civil commitment proceedings conducted in the 1960s and 1970s. Those studies revealed a consistent failure of attorneys to advocate actively for their mentally disordered clients in those proceedings. Although numerous commentators have relied upon those studies to denounce attorney passivity and to urge attorneys to aggressively resist involuntary civil commitment of their clients, inadequate performance by attorneys continues to be the rule today, rather than the exception.

Part III discusses the doctrine of informed consent and its applicability to civilly committed mental patients who wish to refuse treatment with psychotropic medication. Scholars have asserted, and numerous courts have ruled, that mentally disordered persons, even mentally disordered persons who have been involuntarily committed, may, nevertheless, be competent to rationally evaluate the treatment proposed for their mental

1. ALPHONSE KARR, LES GUÉPES (1849), *quoted in* JOHN BARTLETT, FAMILIAR QUOTATIONS: A COLLECTION OF PASSAGES, PHRASES, AND PROVERBS TRACED TO THEIR SOURCES IN ANCIENT AND MODERN LITERATURE 443 (Justin Kaplan ed., 16th ed. 1992). Consider also this quotation: “Those who cannot remember the past are condemned to repeat it.” GEORGE SANTAYANA, 1 THE LIFE OF REASON (1905–06), *quoted in* BARTLETT, *supra*, at 588.

2. MICHAEL L. PERLIN, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL (2d ed. 1998); *see also* Virginia Aldige Hiday, *Reformed Commitment Procedures: An Empirical Study in the Courtroom*, 11 LAW & SOC’Y REV. 651, 663 (1977) (reporting that when counsel challenged evidence that the proposed patient’s mental condition met the criteria for involuntary civil commitment, decisions to civilly commit were significantly reduced).

3. 2 PERLIN, *supra* note 2, § 3B-11, at 362–63.

4. *Id.* at 363.

condition. If they are competent, their informed consent to treatment should be required, just as it is for any other competent patient. Although the right of competent mental patients to refuse treatment has been articulated and accepted—at least theoretically—almost no attention has been devoted to the adequacy of attorneys who represent patients in hearings to determine their competency to withhold consent to treatment. If lawyers do not advocate zealously for their mentally disordered clients to avoid involuntary civil commitment, one can assume they are less likely to advocate zealously for their civilly committed, mentally disordered clients who wish to refuse treatment prescribed by their doctors that may improve their mental condition sufficiently to allow them to be released.

Part IV discusses civil commitment in California, focusing on mental health conservatorships that are used—almost exclusively—to achieve long-term civil commitment of mentally disordered individuals. In addition to permitting the conservator to involuntarily confine the conservatee in a mental hospital, the law also allows the conservator to impose involuntary treatment on the conservatee—even though the conservatee has not been adjudicated incompetent to make treatment decisions.

Part V discusses an empirical study of attorney performance in representing proposed conservatees in conservatorship hearings conducted in San Diego in 1975, more than thirty years ago. As reported in that study, the attorneys’ performance was abysmal. Part V also discusses a California Supreme Court case decided one year after the study was published.⁵ In reaching its decision to impose certain stringent due process safeguards in the conservatorship hearing process, the court relied in part on the results of this early study.

Part VI reports on a second study of attorney performance in representing proposed conservatees in conservatorship hearings conducted in December of 2007 and the spring of 2008. This study attempted to replicate the study conducted more than thirty years earlier. Although there were changes in the way hearings were conducted and the qualifications of attorneys who represented proposed conservatees, attorney performance remained abysmal. As I observed these hearings, I felt that I had entered a time warp—I was transported back to 1975, observing hearings conducted

5. Conservatorship of Roulet, 590 P.2d 1 (Cal. 1979).

in the earlier study. The words of Yogi Berra came to my mind: “This is like déjà vu all over again.”⁶

Part VII concludes the Article by discussing the changes that must occur in order to improve attorney performance. In 2001, the Montana Supreme Court appropriately characterized the ineffective assistance of counsel in civil commitment proceedings as a “systemic failure”⁷ and issued practice guidelines to ensure that attorneys perform as vigorous advocates safeguarding the rights and liberties of their mentally disordered clients.⁸ I can only hope that the Montana model will be emulated nationally, and that it will not take another thirty years for passive paternalism to be replaced by zealous advocacy.

II. THE INADEQUACY OF COUNSEL FOR MENTALLY DISORDERED PERSONS IN CIVIL COMMITMENT HEARINGS

In 1966, Fred Cohen reported that attorneys representing prospective mental patients in civil commitment proceedings performed perfunctorily, deferring to the judgment of the psychiatrists who recommended commitment.⁹ In essence, the attorneys viewed their function as ceremonial.¹⁰ In a study of one day’s activity in Travis County, Texas, Professor Cohen found that one attorney was appointed to represent the forty patients at the commitment hearings scheduled for that day, that the attorney asked no questions of the doctors and offered no evidence to controvert their recommendations, and that all forty patients were civilly committed for an indefinite period of time and found to be mentally incompetent.¹¹ The forty hearings were conducted in a total of seventy-five minutes.¹²

In 1970, an investigation of the Iowa civil commitment process revealed that “in the normal case appointed counsel makes no pre-

6. QuoteDB, <http://www.quotedb.com/quotes/1304> (last visited Apr. 1, 2009). *Déjà vu*, which is also known as *paramnesia*, is defined as “the illusion that one has previously had an experience that is actually new to one.” WEBSTER’S NEW WORLD DICTIONARY OF THE AMERICAN LANGUAGE 372 (David B. Guralnik ed., 2d college ed. 1970).

7. *In re Mental Health of K.G.F.*, 29 P.3d 485, 494 (Mont. 2001).

8. *Id.* at 497–500.

9. Fred Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 TEX. L. REV. 424, 424–25 (1966).

10. *Id.* at 425.

11. *Id.* at 427–30. A far more extensive examination of judicial hearings involving applications for civil commitment, conducted in St. Louis, Missouri, in the 1960s, revealed that the mentally disordered person was not civilly committed in only two of the 1700 cases studied. George E. Dix, *Acute Psychiatric Hospitalization of the Mentally Ill in the Metropolis: An Empirical Study*, 1968 WASH. U. L.Q. 485, 540.

12. Cohen, *supra* note 9, at 430. The attorney was compensated at the rate of ten dollars per case and thus received four hundred dollars for his “efforts.” *Id.*

hearing preparation nor does he meet with his client in advance of the day of the hearing."¹³ The attorneys were "neither aware of nor concerned about their client's desires."¹⁴ They viewed their function as simply to ensure that their client would not be improperly "railroaded" into an institution by a person motivated by hostility or vindictiveness.¹⁵ Once the lawyer concluded that the client was not being "railroaded," the lawyer did not actively defend the client from the state's exercise of power to involuntarily commit the patient.¹⁶ Although a criminal defense attorney "is not deterred from his goal of preventing a determination that his client is criminally responsible . . . [i]n the involuntary hospitalization area, however, most attorneys accept the proposition that the expert in mental health is better prepared to determine what is in the best interests of their client."¹⁷ The authors found that effective decisionmaking power is allocated "to the medical profession with the legal process and the attorney assuming a ceremonial function."¹⁸

Three years after this study was published, the Iowa Legislature enacted comprehensive legislation¹⁹ substantially revising the state's civil commitment process.²⁰ In direct response to the problem of inadequate legal representation of proposed patients, the 1975 legislation clarified that the attorney

is the primary guarantor of the respondent's procedural and substantive rights. . . . The attorney's responsibility, in view of these considerations, is to hold the state to its burden of proof, and to fully raise all relevant evidence and arguments bearing on the respondent's suitability for involuntary treatment. . . . Counsel is given ample means to serve this role, including continuing rights to notice, discovery, independent expert evaluation, presentation of evidence, and cross-examination.²¹

13. Note, *Contemporary Studies Project: Facts and Fallacies About Iowa Civil Commitment*, 55 IOWA L. REV. 895, 914 (1970) [hereinafter *Contemporary Studies Project*].

14. *Id.* at 920.

15. *Id.*

16. *Id.* at 921.

17. *Id.*

18. *Id.* at 922.

19. An Act Relating to Hospitalization of the Mentally Ill, ch. 139, 1975 Iowa Acts 350 (codified with subsequent revisions at IOWA CODE ch. 229).

20. See generally Randall P. Bezanson, *Involuntary Treatment of the Mentally Ill in Iowa: The 1975 Legislation*, 61 IOWA L. REV. 261 (1975) (describing, analyzing, and interpreting the civil commitment legislation enacted in Iowa in 1975).

21. *Id.* at 365-66.

Despite this legislative clarification of the attorney's role, a study of the Iowa civil commitment process, published four years after the legislation was enacted, revealed that nearly three-fourths of the hearings continued to be conducted in a nonadversarial manner.²² Although the decisionmaker typically relied upon the physician's report and examination as the main source of evidence, in over 99% of the cases, the attorney representing the proposed patient—whether in an adversarial or nonadversarial hearing—did not request a second medical opinion.²³ Cross-examination of the physician who testified for commitment either did not occur or was “of doubtful quality.”²⁴ “[W]hen the physician recommends commitment, the defense attorney often agrees with the finding instead of following the statute and assembling a defense with the many tools that the statute provides.”²⁵ The authors of this 1979 study concluded: “At no stage in the commitment process have the attorneys consistently fulfilled the duties created by the statute. . . . Instead, the attorneys do little more than appear at the hearing and draw their fee.”²⁶

In 1974, David Wexler and Stanley Scoville reported similar results in a study of civil commitment hearings in Arizona's Maricopa and Pima Counties.²⁷ Typically, a single attorney was appointed to represent all of the indigent individuals in civil commitment cases conducted in one day.²⁸ If the attorney believed the individual met the commitment criteria, then “[u]nlike a criminal action where an attorney generally seems untroubled by zealously seeking his client's acquittal despite a personal belief in the client's guilt and dangerous character, attorneys representing patients in commitment hearings usually do little or nothing to obtain the client's release.”²⁹ Even if the attorney, based on a brief interview with the patient, believes that civil commitment is unwarranted, the attorney “will usually rely on the psychiatric report more than on his own intuitive reaction or the unsupported word of his client.”³⁰ In fact,

22. Serena D. Stier & Kurt J. Stoebe, Contemporary Studies Project, *Involuntary Hospitalization of the Mentally Ill in Iowa: The Failure of the 1975 Legislation*, 64 IOWA L. REV. 1284, 1344 (1979).

23. *Id.* at 1347. Attorney preparation for civil commitment hearings was characterized as “minimal,” even for adversarial hearings. *Id.* at 1350.

24. *Id.* at 1348.

25. *Id.* at 1353.

26. *Id.* at 1352.

27. See David B. Wexler & Stanley E. Scoville, *The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 1, 32–35, 53–55 (1971).

28. *Id.* at 33. In Maricopa County, appointed counsel were paid ten dollars per case; in Pima County, appointed counsel were paid five dollars per case. *Id.* at 34. Eventually, Pima County replaced private attorneys as appointed counsel with the Public Defender. *Id.*

29. *Id.* at 35.

30. *Id.* at 34.

Wexler and Scoville reported that, in Maricopa County, attorneys not only fail to act as advocates resisting the civil commitment of their client, but rather, they promote commitment "by virtually presenting the case *against* the patient."³¹

In 1974, Elliott Andalman and David Chambers,³² after reviewing the previously published studies of civil commitment proceedings in Texas,³³ Iowa,³⁴ and Arizona,³⁵ asserted that attorneys who "did virtually nothing except stand passively at a hearing and add a falsely reassuring patina of respectability to the proceedings . . . may in fact worsen the client's chances for release. The passive attorney may induce the judge to believe that she concurs with the judge's inclination to commit . . ."³⁶

The failure of counsel to act as adversary counsel—advocating actively on behalf of a client to resist involuntary civil commitment—is particularly acute among lawyers from the private bar who are appointed shortly before the civil commitment hearing. These lawyers typically have inadequate time to prepare, are inadequately compensated for their efforts, lack experience in challenging psychiatric judgments, are reluctant to appear foolish before the judge, and are uncertain as to their

31. *Id.* at 53.

32. Elliott Andalman & David L. Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal*, 45 MISS. L.J. 43 (1974).

33. *Id.* at 58–59 (discussing civil commitment proceedings in Austin, Texas, as reported by Cohen, *supra* note 9, at 427–31, 445, 450).

34. *Id.* at 57 (discussing civil commitment proceedings in Iowa, as reported by *Contemporary Studies Project*, *supra* note 13, at 913–23). Because the Andalman and Chambers article was published before the Iowa civil commitment statutes were revised, they did not discuss the statutory changes, which were enacted in 1975, or the study of attorney performance under the new statutes, which was published in 1979.

35. *Id.* at 55–57 (discussing civil commitment proceedings in Phoenix, Arizona, as reported by Wexler & Scoville, *supra* note 27, at 32–35, 38–42, 51–60). Andalman and Chambers also reported on their study of civil commitment proceedings in four cities—New York, Chicago, Cleveland, and Memphis. *Id.* at 59–72. Hearings in the four cities were personally observed by Elliott Andalman. *Id.* at 54 & n.38. He also interviewed attorneys involved in those hearings. *Id.* at 54.

36. *Id.* at 72. In reaching their judgment about the effect of passive attorneys, Andalman and Chambers also discussed and relied upon civil commitment proceedings in Austin, Texas, as reported by Cohen, *supra* note 9, at 427–31, 445, 450, Iowa, as reported by *Contemporary Studies Project*, *supra* note 13, at 913–23, and Phoenix, Arizona, as reported by Wexler & Scoville, *supra* note 27, at 32–35, 38–42, 51–60. Andalman & Chambers, *supra* note 32, at 55–59. *But cf.* Dennis L. Wenger & C. Richard Fletcher, *The Effect of Legal Counsel on Admissions to a State Mental Hospital: A Confrontation of Professions*, 10 J. HEALTH & SOC. BEHAV. 66, 70 (1969) (reporting that in a study of eighty-one civil commitment hearings in Ohio, "[p]atients with legal counsel were much less likely to be hospitalized than those without legal counsel").

proper role in the proceeding.³⁷ Nevertheless, in an early study of civil commitment hearings conducted at Bellevue Hospital in New York City, Thomas Litwack reported that the attorneys in the Mental Health Information Service, who work full-time representing patients, only “provide forceful representation in cases where they feel the patient should and may be released by the court, but they provide weaker representation in less hopeful cases.”³⁸ In essence, these lawyers did not always advocate for what the client perceived as the client’s self-interest. Rather, the lawyers attempted to determine what they perceived as being in their client’s best interest, “tacitly decid[ing] how ‘well’ or ‘sick’ a particular client is—and how much the client needs hospitalization—and then adjust[ing] their efforts at representation accordingly.”³⁹

Over the years, numerous authors have responded to these and other early studies⁴⁰ of attorney performance—or more accurately,

37. Thomas R. Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 CAL. L. REV. 816, 827–31 (1974). Even when such attorneys received specialized training—training on how to aggressively challenge the psychiatric expert who testifies for commitment—they “were reluctant to take an adversarial stance, even with explicit support by the court.” Norman G. Poythress, Jr., *Psychiatric Expertise in Civil Commitment: Training Attorneys to Cope with Expert Testimony*, 2 LAW & HUM. BEHAV. 1, 17 (1978). Attorneys continued to take “a more traditional, passive, paternal stance toward the proposed patients.” *Id.* at 15.

38. Litwack, *supra* note 37, at 832; *see also* Andalman & Chambers, *supra* note 32, at 69.

39. Litwack, *supra* note 37, at 832. Litwack also suggested that even if the Mental Health Information Service attorney did not believe that his or her client’s mental condition met the statutory criteria for involuntary commitment, the attorney would hesitate to argue forcefully before a judge and lose that judge’s respect, if the attorney thought that the judge believed that commitment was appropriate in the case. Thus, if the client acted out in court or exhibited delusions of persecution—which might not justify commitment under the statute but might well induce a judge to order commitment—the attorney would not advocate vigorously that commitment was not warranted. *Id.* at 833; *see also* Virginia Aldige Hiday, *The Attorney’s Role in Involuntary Civil Commitment*, 60 N.C. L. REV. 1027, 1036, 1048 (1982) (reporting that in a study of 479 civil commitment hearings conducted in North Carolina, not all full-time civil commitment advocates chose an adversarial role for all cases).

40. *See, e.g.*, George E. Dix, *Hospitalization of the Mentally Ill in Wisconsin: A Need for a Reexamination*, 51 MARQ. L. REV. 1, 33 (1967) (asserting that, in Wisconsin, appointed counsel for prospective mental patients evaluate what they perceive to be in the best interests of their clients and proceed to accomplish that objective regardless of the will of their clients); Virginia Aldige Hiday, *The Role of Counsel in Civil Commitment: Changes, Effects, and Determinants*, 5 J. PSYCHIATRY & L. 551, 559 (1977) (finding that counsel for the proposed patient assumed an advocate’s role in fewer than half of the contested civil commitment cases studied in North Carolina). “If the role of counsel is to protect clients from involuntary confinement in mental institutions . . . then it appears that in the majority of contested cases counsel is not functioning as it should.” *Id.* at 560; Hiday, *supra* note 2, at 665 (“[A]ttorneys . . . defer to psychiatric opinion because they feel they lack the requisite expertise and want to obtain help for those in need.”); Thomas K. Zander, *Civil Commitment in Wisconsin: The Impact of Lessard v. Schmidt*, 1976 WIS. L. REV. 503, 528 (finding that counsel for proposed patients do not conduct

nonperformance—in civil commitment hearings, by challenging the propriety of an attorney-determined, best-interest-of-the-client model of representation⁴¹ and by asserting that a client-determined, self-interest

extensive cross-examination of the physicians who recommend involuntary commitment and that some trials in Milwaukee County, Wisconsin, are completed in five minutes). Eighty percent of Wisconsin judges who responded to a survey expressed their belief that an attorney representing a proposed patient should act in what the attorney perceives as the client's best interests if the attorney believes that the client is incompetent to make a decision regarding the need for hospitalization, even if the attorney is acting contrary to the client's expressed wishes. *Id.* at 516.

41. A chronological listing of some of these books and articles includes, but is not limited to, the following: RONALD S. ROCK, MARCUS A. JACOBSON & RICHARD M. JANOPAUL, *HOSPITALIZATION AND DISCHARGE OF THE MENTALLY ILL* 160 (1968) ("[T]he actual performance of defense counsel in hearing after hearing is substantially empty, mere pretense at the work of an advocate who has no real work cut out for him."); *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1288 (1974) ("[C]ounsel often functions as no more than a clerk, ratifying the events that transpire rather than influencing them."); Mark Alan Hart, Note, *Civil Commitment of the Mentally Ill in California: The Lanterman-Petris-Short Act*, 7 LOY. L.A. L. REV. 93, 131 (1974) ("The role attorneys actually play in the commitment hearing is indeed disturbing."); CAROL A.B. WARREN, *THE COURT OF LAST RESORT* 140 (1982) ("[A]ttorneys view their clients as crazy and therefore refrain from standing firmly in the way of their involuntary incarceration."); Natalie Wolf, Note, *The Ethical Dilemmas Faced by Attorneys Representing the Mentally Ill in Civil Commitment Proceedings*, 6 GEO. J. LEGAL ETHICS 163, 173 (1992) ("Attorneys who assume a guardian role in the civil commitment process frequently conduct their representation of the allegedly mentally ill individual in disregard of traditional representation obligations and in violation of the standards of professional responsibility."); Bruce J. Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 J. CONTEMP. LEGAL ISSUES 37, 41 (1999) (asserting that attorneys who adopt a paternalistic role in representing their clients in civil commitment hearings have "turned the adversarial model into a farce and a mockery in which procedural rights are accorded in only a formal way so as to effectuate what judges, lawyers, and clinicians perceive to be the best interests of the patient"). Winick characterized such civil commitment hearings as "phony rituals" that "may actually produce feelings of worthlessness and loss of dignity, exacerbating the person's mental illness and perhaps even fostering a form of learned helplessness that can further diminish performance, motivation, and mood in ways that can be antitherapeutic." *Id.* at 45; Donald H. Stone, *Giving a Voice to the Silent Mentally Ill Client: An Empirical Study of the Role of Counsel in the Civil Commitment Hearing*, 70 UMKC L. REV. 603, 608 (2002) ("When the hospital presenter and the client's attorney speak in one voice, in which the doctor knows best and one is to ask no questions, truth is compromised. The medical model, as opposed to the legal model, has no proper place in the civil commitment arena."); James B. (Jim) Gottstein, *Involuntary Commitment and Forced Psychiatric Drugging in the Trial Courts: Rights Violations as a Matter of Course*, 25 ALASKA L. REV. 51, 104 (2008) ("By abandoning the traditional adversarial approach in favor of a paternalistic one—where . . . the lawyers assigned to represent psychiatric respondents assume what the State wants to do to psychiatric respondents is in their best interest—the State's proposed actions are not subjected to the normal litigation crucible.").

model of representation should be employed.⁴² Such a change is necessary to replace attorney passivity with zealous advocacy. Despite this critical commentary, however, passive paternalism perseveres. Michael Perlin, a frequent critic of attorney performance in civil commitment cases,⁴³

42. A chronological listing of some of these books and articles includes, but is not limited to, the following: Hart, *supra* note 41, at 133–34 (“The attorney must force the persons who are trying to commit the client to *prove* their case, as that term is understood in other proceedings, or one is simply not fulfilling necessary obligations to the client; instead of representing them, the lawyer has become a mere adjunct to the client’s adversaries.”); Note, *The Role of Counsel in the Civil Commitment Process: A Theoretical Framework*, 84 YALE L.J. 1540, 1563 (1975) (“If hearings are to be meaningful procedures designed to arrive at fair dispositions based on a full presentation of the facts, the lawyer must act as an adversary. Otherwise, the idea that due process is being accorded the mentally ill individual will stand as little more than pretense.”); James R. Elkins, *Legal Representation of the Mentally Ill*, 82 W. VA. L. REV. 157, 185 (1979) (“Unquestioned deference by the judicial decisionmaker to the psychiatrist must be overcome through a defense which encourages the decisionmaker to focus on the limitations and contradictions in the expert’s testimony.” (footnote omitted)); *id.* at 232 (“The lawyer, to fully represent the patient, must proceed as an *advocate*.”); WARREN, *supra* note 41, at 153 (“In Metropolitan Court, what makes justice seem to the nonparticipant audience not to be done is the obvious lack of correspondence between what trials are supposed to seem like and what they actually are.”); Steven J. Schwartz et al., *Protecting the Rights and Enhancing the Dignity of People with Mental Disabilities: Standards for Effective Legal Advocacy*, 14 RUTGERS L.J. 541, 568 (1983) (“[T]he proper role of legal advocacy for persons with disabilities must focus on the vindication of individual legal rights. Legal advocacy provides the only countervailing force to the medical and social authority that otherwise completely controls the lives of handicapped persons.”); Wolf, *supra* note 41, at 180 (“If attorneys impose their own judgments they defeat the purpose of the hearing and jeopardize the validity of the system.”); Jan C. Costello, “*Why Would I Need a Lawyer?*” *Legal Counsel and Advocacy for People with Mental Disabilities*, in LAW, MENTAL HEALTH, AND MENTAL DISORDER 15, 27 (Bruce D. Sales & Daniel W. Shuman eds., 1996) (asserting that a best interest approach “is fundamentally at odds with the principles underlying the *Model Code [of Professional Responsibility]* and *Model Rules [of Professional Conduct]* and was explicitly rejected by both judges and legislatures before the *Model Rules* were drafted”); Stone, *supra* note 41, at 614 (“The attorney’s role is to challenge the basis of the application for involuntary admission and elicit facts and opinions challenging the need for hospitalization.” (footnote omitted)); Phyllis Coleman & Ronald A. Shellow, *Ineffective Assistance of Counsel: A Call for a Stricter Test in Civil Commitments*, 27 J. LEGAL PROF. 37, 40–41 (2002) (“Because lawyers have the same ethical obligations to [mentally disordered] clients as to any other, one easy way to improve the system is for attorneys to always perform their role of advocate.” (footnote omitted)); Gottstein, *supra* note 41, at 93 (“By engaging in the traditional adversarial process, the courts—and especially the lawyers representing psychiatric respondents—will be the instruments of justice they should be”); *see also* 1 PERLIN, *supra* note 2, § 2B-10.1, at 251 n.434 (citing several additional law review articles favoring an advocacy approach to representation of clients in civil commitment hearings rather than a best interests approach).

43. Michael L. Perlin & Robert L. Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process*, 45 LAW & CONTEMP. PROBS. 161, 164 (Summer 1982) (asserting that the record of counsel providing services to mentally ill clients has never lived up to the standard of ardent defender of the client’s rights and freedoms). “Lawyers who believe that ‘we have no choice but to trust the psychiatrist,’ or who disregard their clients’ position because ‘they’re sick’ simply do not meet sixth amendment due process standards.” *Id.* at 176 (footnotes omitted). “[P]ersons facing involuntary

recently noted that, historically, the promise of counsel has been little more than an illusion.⁴⁴ "And so it remains today. The quality of counsel assigned to represent individuals who face involuntary civil commitment to psychiatric hospitals is, in most United States jurisdictions, mediocre or worse."⁴⁵

III. THE INADEQUACY OF COUNSEL FOR MENTALLY DISORDERED PERSONS IN HEARINGS TO IMPOSE INVOLUNTARY TREATMENT

The doctrine of informed consent imposes a duty on physicians to disclose to the patient the risks and benefits of, and the alternatives to, the proposed treatment and to accept the patient's decision to authorize or refuse that treatment. In *Canterbury v. Spence*,⁴⁶ the leading case on the doctrine, the United States Court of Appeals for the District of Columbia Circuit declared: "[I]t is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie."⁴⁷ Therefore, "the patient's right of self-decision shapes the boundaries of the duty to reveal."⁴⁸ The adequacy of the physician's disclosures to the patient "must be measured by the patient's need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality

civil commitment—and the concomitant loss of liberty—have a right to the same 'traditional, adversarial, partisan' counsel that 'is the hallmark of the American judicial system.'" *Id.* at 180 (footnotes omitted); see also Michael L. Perlin, *Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases*, 16 LAW & HUMAN BEHAV. 39, 43 (1992) ("The record of the legal profession in providing meaningful advocacy services to mentally disabled persons has been grossly inadequate."). "[T]here is little reason to be optimistic about the likelihood of universal invigorated private representation of this population in the near future." *Id.* at 45; 1 PERLIN, *supra* note 2, § 2B-8, at 227–28 (asserting that in representing mentally disabled persons in matters affecting their hospitalization, counsel's performance historically has been inadequate, and courts have passively accepted this inadequacy, ignoring specific ethical problems arising in such representation).

44. Michael L. Perlin, "I Might Need a Good Lawyer, Could Be Your Funeral, My Trial": *Global Clinical Legal Education and the Right to Counsel in Civil Commitment Cases*, 28 WASH. U. J.L. & POL'Y 241, 242 (2008).

45. *Id.* at 243. Professor Perlin added, "If there has been any constant in modern mental disability law in its thirty-five-year history, it is the near-universal reality that counsel assigned to represent individuals at involuntary civil commitment cases is likely to be ineffective." *Id.* at 241 (footnote omitted).

46. 464 F.2d 772 (D.C. Cir. 1972).

47. *Id.* at 781.

48. *Id.* at 786.

to the patient's decision: all risks potentially affecting the decision must be unmasked."⁴⁹

Courts, however, recognize exceptions to patient autonomous judgment. If, for example, the patient is unconscious or in such pain that he or she is incapable of considering information about the proposed treatment or making a decision as to whether to consent, and if treatment is immediately necessary to prevent either death or a serious injury to the patient, the physician is privileged to proceed in order to prevent that disastrous consequence.⁵⁰ In this emergency situation, the law presumes, in the absence of information to the contrary, that the patient would consent to treatment.⁵¹

Even in nonemergency situations, courts recognize an exception to the informed consent requirement for incompetent persons.⁵² If an individual has been adjudicated incompetent and a guardian has been appointed to make personal⁵³ decisions for that individual, the guardian may give informed consent to medical treatment as the incompetent ward's substitute decisionmaker. Even without a court adjudication of incompetence, minor children are conclusively presumed to be incompetent, and their parents, as their legal guardians, may give informed consent to medical treatment for them.⁵⁴

49. *Id.* at 786–87 (footnote omitted). Other courts have articulated the patient's right to medical self-determination in similar terms. *See, e.g.,* *Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972) (“The weighing of [the] risks [inherent in the procedure and the risks of a decision not to undergo the treatment] against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgment reserved to the patient alone.”).

50. *See* Alan Meisel, *The “Exceptions” to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413, 434–38 (discussing the emergency exception).

51. Meisel notes that the patient's implied consent to emergency treatment is premised on the presumption that a reasonable person would consent to emergency treatment and therefore that this patient would also consent. *Id.* at 434. Meisel suggests that such reasoning is “not so much a rationale as it is a restatement of the exception.” *Id.*

52. *See id.* at 439–53 (discussing the incompetency exception).

53. Traditionally, a guardian is appointed for either the person or the estate of the incompetent person. A guardian of the person is authorized to make personal decisions for the incompetent person, including providing for basic necessities of life, such as food, clothing, and housing as well as deciding whether to consent to medical treatment. A guardian of the estate is authorized to make decisions concerning the property of the incompetent person. Sometimes a guardian is appointed for both the person and the estate of the incompetent person.

54. *See, e.g.,* *Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972) (declaring that if the patient is a minor, “the authority to consent is transferred to the patient's legal guardian”). Courts have also recognized a therapeutic exception to the duty to disclose. *See* Meisel, *supra* note 50, at 460–70. If the disclosure would harm the patient, the physician is not required to inflict such harm by making the disclosure. For example, the *Canterbury* court stated that a physician may withhold information if the patient would “become so ill or emotionally distraught on disclosure as to foreclose a rational decision,

The first court decision to fully recognize a mental patient's right to medical self-determination was *Rogers v. Okin*,⁵⁵ decided by a federal district court in 1979. District Judge Joseph Tauro ruled that involuntarily confined mental patients—just as any other patients—have a right to make decisions about their treatment⁵⁶ and may not be forcibly medicated.⁵⁷ Just as with other patients, this right is not absolute, and the patient's informed consent is not required in an emergency or if the patient is incompetent. If no emergency exists justifying treatment, the involuntarily committed mental patient—just as any other patient—has a right to make his or her own analysis of the risks and benefits of, and alternatives to, the proposed treatment that the physician is required to communicate to the patient, and to make his or her own decision to accept or reject that treatment.⁵⁸

The judge refused to equate the decision to involuntarily commit a person with an adjudication of incompetence:⁵⁹

The weight of evidence persuades this court that, although committed mental patients do suffer at least some impairment of their relationship to reality, most are able to appreciate the benefits, risks, and discomfort that may reasonably be

or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient." *Canterbury*, 464 F.2d at 789. The *Canterbury* court cautioned, however, that the therapeutic privilege must be "carefully circumscribed" so that it does not "devour the disclosure rule itself." *Id.* The court specifically rejected the paternalistic notion that the physician may avoid disclosure simply because the physician thinks that the patient, upon such disclosure, might reject the proposed treatment that the physician believes is medically needed. *Id.*

55. 478 F. Supp. 1342 (D. Mass. 1979), *aff'd in part and rev'd in part*, 634 F.2d 650 (1st Cir. 1980), *rev'd and remanded sub nom. Mills v. Rogers*, 457 U.S. 291 (1982), *on remand sub nom. Rogers v. Okin*, 738 F.2d 1 (1st Cir. 1984).

56. *Rogers*, 478 F. Supp. at 1366.

57. *Id.* at 1371.

58. *Id.* at 1367. Judge Tauro noted that establishing a therapeutic alliance between psychiatrist and patient is fundamental for successful treatment. Such an alliance requires the patient to understand and willingly accept the prescribed treatment. *Id.* at 1361. The judge noted that the American Psychiatric Association accepts the requirement that informed consent for treatment be obtained from the mental patient except in emergency situations. *Id.* at 1370 n.37 (citing American Psychiatric Association Task Force on the Right to Treatment, 134 AM. J. PSYCHIATRY 3 (1977)). The quoted material from the American Psychiatric Association Task Force is actually located at 134 AM. J. PSYCHIATRY 355 (1977).

59. *Rogers*, 478 F. Supp. at 1359. In so ruling, Judge Tauro relied on a Department of Mental Health regulation, codified in substance in a state statute, which provides that no person admitted to or committed to a mental health facility shall lose the right to manage his affairs, to contract, to hold a driver's license, to make a will, to marry, to hold or convey property, or to vote unless the person has been adjudicated incompetent. *Id.* See MASS. GEN. LAWS ANN. ch. 123, § 24 (West 2003).

expected from receiving psychotropic medication. This is particularly true for patients who have experienced such medication and, therefore, have some basis for assessing comparative advantages and disadvantages.⁶⁰

The presumption that the patient is competent to make medication decisions prevails, said the court, unless the patient has been adjudicated incompetent by a court after a hearing on that issue.⁶¹ Although the state has an obligation to make treatment available to involuntary patients, the state's interest in providing that treatment does not override the competent patient's fundamental right to refuse treatment in nonemergency situations.⁶²

Judge Tauro's refusal to equate the decision to civilly commit a person with a finding of incompetence is logical. In most states, the commitment laws do not presume or require incompetence as a criterion for civil commitment.⁶³ Merely because the person has been found to be mentally disordered and dangerous to self or others, or unable to provide for basic necessities—the typical criteria for commitment⁶⁴—does not

60. *Rogers*, 478 F. Supp. at 1361.

61. *Id.* The court scoffed at the defendant's argument that a person who was statutorily presumed to be competent to manage his or her affairs and dispose of his or her property might not be presumed competent to decide whether to follow his or her doctor's advice regarding medication. "Such an argument would make a doubter of even the most credulous." *Id.* at 1361 n.12. Although the rights to hold and dispose of one's property are fundamental to any concept of ordered liberty, such rights "pale in comparison to the intimate decision as to whether to accept or refuse psychotropic medication—medication that may or may not make the patient better, and that may or may not cause unpleasant and unwanted side effects." *Id.* at 1366. Judge Tauro also rejected the therapeutic exception to informed consent. Even if disclosure of potential side effects of medication might frighten the patient and therefore might be considered as "not [] in the patient's best interest," failure to provide the patient with sufficient information to make an informed treatment decision is not justified. *Id.* at 1387.

62. *Id.* at 1367, 1370.

63. See Catherine E. Blackburn, *The "Therapeutic Orgy" and the "Right to Rot" Collide: The Right to Refuse Antipsychotic Drugs Under State Law*, 27 HOUS. L. REV. 447, 472 n.88 (1990), for statutes declaring that civil commitment neither raises a presumption of, nor constitutes a finding of, the patient's incompetence. See also Dennis E. Cichon, *The Right to "Just Say No": A History and Analysis of the Right to Refuse Antipsychotic Drugs*, 53 LA. L. REV. 283, 350 n.435 (1992), for court decisions separating the commitment and competence issues. As the Alabama Supreme Court stated: "[A] person involuntarily committed to a mental hospital is not *ipso facto* barred from the invocation of the 'informed consent' doctrine." *Nolen v. Peterson*, 544 So. 2d 863, 867 (Ala. 1989). As of 1985, only eight states even allowed the issues of civil commitment and competency to be determined in the same proceeding. John Parry, *Incompetency, Guardianship, and Restoration*, in SAMUEL JAN BRAKEL ET AL., *THE MENTALLY DISABLED AND THE LAW* 369, 374 n.35, 405–07 (3d ed. 1985).

64. See, e.g., CAL. WELF. & INST. CODE § 5150 (West 1998) (authorizing detention, without court order, for seventy-two hours to evaluate and treat mentally disordered persons who are a danger to self or others or gravely disabled); *id.* § 5200 (authorizing court-ordered detention for seventy-two hours to evaluate and treat persons who are a danger to self or others or gravely disabled); *id.* § 5250 (authorizing certification for fourteen days of intensive treatment for persons who are a danger to self or others or gravely disabled); *id.* § 5260 (authorizing certification for an additional fourteen days of

mean that the person is unable to understand the risks, benefits, and alternatives to the medication that the physician is prescribing to treat his or her condition. A mentally disordered person's dangerousness or inability to provide for basic necessities may justify a deprivation of liberty, but without a separate determination of incompetence, such condition does not justify depriving a patient of the right to refuse treatment and substituting another's judgment for that of the patient.⁶⁵

When the *Rogers* case was appealed,⁶⁶ the United States Court of Appeals for the First Circuit held that Massachusetts recognized substantive and procedural rights for involuntary mental patients that created for them a liberty interest protected under the Fourteenth Amendment's Due Process Clause.⁶⁷ Under Massachusetts law, the involuntary commitment decision is not a determination that the committed person is incompetent

intensive treatment for imminently suicidal persons); *id.* § 5300 (authorizing postcertification for a 180-day detention for persons who present a demonstrated danger of inflicting substantial physical harm upon others).

65. See, e.g., *In re L.A.*, 912 A.2d 977, 980–81 (Vt. 2006) (holding that the standard for determining incompetence to refuse medication is different and more difficult to establish than the standard to determine involuntary commitment, and the mere fact that the patient refuses a medication that might be beneficial does not establish the patient's incompetence to do so); *In re Virgil D.*, 524 N.W.2d 894, 898 (Wis. 1994) (holding that, under the Wisconsin statute, the only standard applied to evaluate a patient's competency to refuse medication is "whether the patient is able to express an understanding of the advantages and disadvantages of, and the alternatives to, accepting medication or treatment").

66. Following Judge Tauro's decision, the *Rogers* case experienced a legal odyssey. The United States Court of Appeals for the First Circuit affirmed the judgment in part and reversed in part, *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980); the United States Supreme Court reversed and remanded to the First Circuit for a determination of whether a case decided by the Massachusetts Supreme Judicial Court, *In re Guardianship of Roe*, 421 N.E.2d 40 (Mass. 1981), while certiorari was pending in *Rogers*, could determine the rights and duties of the parties entirely under state law, *Mills v. Rogers*, 457 U.S. 291, 305–06 (1982). The First Circuit certified nine questions of state law to the Massachusetts Supreme Judicial Court. See *Rogers v. Okin*, 738 F.2d 1, 3 (1st Cir. 1984). The Massachusetts court provided detailed answers to those questions. *Rogers v. Comm'r of Dep't of Mental Health*, 458 N.E.2d 308, 312–23 (Mass. 1983). The questions certified by the First Circuit to the Massachusetts Supreme Court and answered by that court appear at *Rogers*, 458 N.E.2d at 312 n.8 (questions 1 through 3), 315 n.13 (questions 4 and 5), 319 n.23 (questions 6 and 7), 322 n.27 (questions 8 and 9). The First Circuit relied upon those answers in rendering its decision. Specifically, the First Circuit concluded that "the full panoply of rights set forth [by the Massachusetts Supreme Judicial Court in *Rogers*, 458 N.E.2d at 319–20] . . . equal or exceed the rights provided in the federal Constitution." *Rogers*, 738 F.2d at 9 (citation omitted).

67. *Rogers*, 738 F.2d at 9.

to make treatment decisions.⁶⁸ Thus, the patient retains the right to make treatment decisions unless and until a judge adjudicates the patient incompetent to make treatment decisions in proceedings to establish the patient's incompetence.⁶⁹

In many states, the highest appellate courts have adopted right to refuse treatment principles substantially identical to those announced in the *Rogers* case by Judge Tauro in his 1979 district court decision or by the Supreme Judicial Court of Massachusetts four years later.⁷⁰ The

68. *Rogers*, 458 N.E.2d at 312–14. The court noted that the standard for involuntary commitment, that is, that the person is mentally ill and that the failure to commit would create a likelihood of serious harm, is a commitment “for public safety purposes and does not reflect lack of judgmental capacity. [The commitment standard] says nothing concerning [the patient’s] competence to make treatment decisions.” *Id.* at 313.

69. *Id.* at 314. The court rejected the argument that doctors should be able to make treatment decisions for involuntarily committed mental patients, even if such patients are competent. Competent adults have the right to refuse treatment even if the medical profession views their sense of values as unwise. *Id.* (quoting *Harnish v. Children’s Hosp. Med. Ctr.*, 439 N.E.2d 240, 242 (Mass. 1982)). The right to refuse treatment has constitutional and common law origins that protect the individual’s “strong interest in being free from nonconsensual invasion of his bodily integrity.” *Id.* (quoting *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 424 (Mass. 1977)). The state’s police power may be used to override a patient’s refusal of medication only in an emergency situation in which the “patient poses an imminent threat of harm to himself or others, and only if there is no less intrusive alternative to antipsychotic drugs.” *Id.* at 321. The court, quoting *In re Guardianship of Roe*, 421 N.E.2d 40, 55 (Mass. 1981) noted that when such an emergency situation arises, “even the smallest of avoidable delays would be intolerable.” *Rogers*, 458 N.E.2d at 322.

Even if the patient is adjudicated incompetent, treatment may not be imposed unless a judge, making a substituted judgment decision for the patient, decides that the patient would have consented to the treatment if he or she was competent to make the decision. *Rogers*, 458 N.E.2d at 315–16. According to the court, the right to refuse medical treatment extends to incompetent as well as competent patients because both are entitled to human dignity. *Id.* at 315 (quoting *Saikewicz*, 370 N.E.2d at 427). The court rejected decisionmaking determined by what doctors perceive as the patient’s best medical interest. Because the patient bears the risks of treatment, treatment decisions are solely the prerogative of the patient—even for incompetent patients. *Rogers*, 458 N.E.2d at 316. The state’s *parens patriae* power may be used to override a patient’s refusal of medication only in those rare circumstances in which such medication is necessary to prevent the “immediate, substantial, and irreversible deterioration of a serious mental illness.” *Id.* at 322 (quoting *Roe*, 421 N.E.2d at 55).

70. See, e.g., *Goedecke v. State Dep’t of Insts.*, 603 P.2d 123, 125 (Colo. 1979) (relying on the patient’s common law right to give or withhold informed consent to medical treatment and a statute, commonly found in many states, declaring that mental patients do not forfeit any legal rights solely by reason of their involuntary commitment); *People v. Medina*, 705 P.2d 961, 971 (Colo. 1985) (citing the Supreme Judicial Court of Massachusetts’s decision in *Rogers*, and specifically extending the prohibition against forced treatment to incompetent mental patients); *Jarvis v. Levine*, 418 N.W.2d 139, 144–45, 148 (Minn. 1988) (ruling that the involuntary administration of psychotropic medication is “intrusive” treatment that seriously infringes upon the mental patient’s right to privacy protected by the state constitution and that involuntary commitment does not eliminate this fundamental right to the integrity of one’s own body and to consent—or withhold consent—to invasions or alterations of one’s own body); *Rivers v. Katz*, 495

authors of a leading coursebook on mental health law report that "virtually every court that has considered the matter now recognizes a 'right to refuse' psychotropic medication for institutionalized populations, in the process constitutionalizing a version of the informed consent doctrine in that context."⁷¹

In *Washington v. Harper*,⁷² the United States Supreme Court ruled that mentally ill, sentence-serving prisoners possess "a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs."⁷³ If mentally ill prisoners have a right to refuse treatment, mentally ill nonprisoners surely do. In fact, because civilly committed patients have been confined without a criminal trial and without a criminal conviction,

N.E.2d 337, 341 (N.Y. 1986) (holding that the fundamental common law right of a competent individual to make decisions concerning the individual's own body "extends equally to mentally ill persons who are not to be treated as persons of lesser status or dignity because of their illness"); *id.* at 341–42 (ruling that neither the presence of mental illness nor a decision to involuntarily commit the mentally ill person is sufficient, in and of itself, to conclude that the person lacks the mental capacity to comprehend the consequences of a decision to refuse medication); *In re K.K.B.*, 609 P.2d 747, 749, 751 (Okla. 1980) (superseded by repeal of statute and subsequent legislation) (relying on the constitutional right to privacy to uphold an involuntary mental patient's right to refuse treatment); *State ex rel. Jones v. Gerhardstein*, 416 N.W.2d 883, 892–94 (Wis. 1987) (superseded by repeal of statute and subsequent legislation) (relying on the Equal Protection Clause of the state and federal constitutions, the Wisconsin Supreme Court upheld the right of an involuntary mental patient to refuse treatment); *id.* at 894 (clarifying that although a finding of dangerousness is a prerequisite for involuntary commitment, that finding does not establish the incompetence of the patient to accept or refuse psychotropic medication).

71. RALPH REISNER ET AL., *LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS* 923 (4th ed. 2004); *see also* Michael L. Perlin, "May You Stay Forever Young": *Robert Sadoff and the History of Mental Disability Law*, 33 J. AM. ACAD. PSYCHIATRY & L. 236, 242 (2005) (asserting that after the Supreme Court's decision in *Mills v. Rogers*, 457 U.S. 291 (1982), "every state high court that has considered [the question of whether a civilly committed mental patient has a right to refuse treatment] has ruled that there is such a right").

72. 494 U.S. 210 (1990).

73. *Id.* at 221. The Court specifically identified a state administrative policy and the Due Process Clause of the Fourteenth Amendment as the sources of that liberty interest. *Id.* at 221–22. The Court, however, did not require a judicial determination that the prisoner was incompetent to make treatment decisions in order to subject him or her to involuntary treatment. *Id.* at 222, 228. In the Court's judgment, mentally ill prisoners could be distinguished from civilly committed patients. For prisoners, the state's legitimate interest in prison safety and security warranted involuntary treatment of those mentally disordered prisoners who were dangerous to themselves or others without the requirement of a full court hearing. *Id.* at 225; *see* GRANT H. MORRIS, *REFUSING THE RIGHT TO REFUSE: COERCED TREATMENT OF MENTALLY DISORDERED PERSONS* 78–86 (2006) (discussing and critiquing *Harper*).

their decisions to refuse treatment are entitled to special deference. The state has exercised its authority to detain them because of their predicted dangerousness or inability to provide for themselves. The state's legitimate interest in protecting them, and in protecting others from them, is achieved by the confinement itself—without coerced treatment. If the confined individual competently chooses to refuse treatment, even if that decision may prolong his or her confinement, the individual's constitutionally protected liberty interest in refusing treatment should outweigh any claimed governmental interest in coercing treatment. Michael Perlin, citing *Harper* and two other Supreme Court decisions,⁷⁴ asserts that the Court has clearly recognized a qualified right to refuse treatment in the Fourteenth Amendment's Due Process Clause.⁷⁵

Although the development of a mental patient's right to refuse treatment has been a popular subject for legal scholars,⁷⁶ virtually nothing has been written about the role of and adequacy of counsel in representing mentally disordered patients who assert that right. Although Michael Perlin devotes a 102-page unit of his *Mental Disability Law* treatise to the role of counsel in civil commitment proceedings,⁷⁷ he devotes only three pages to the role of counsel in right to refuse treatment proceedings.⁷⁸ Professor Perlin cites only one article that

74. *Riggins v. Nevada*, 504 U.S. 127, 135 (1992) (holding that the Fourteenth Amendment prohibits the forcing of antipsychotic medication on criminal defendants held for trial “absent a finding of overriding justification and a determination of medical appropriateness”); *Sell v. United States*, 539 U.S. 166, 178–83 (2003) (discussing and relying upon *Harper* and *Riggins* as setting the framework for determining whether and under what circumstances the government may forcibly administer antipsychotic medication to render a criminal defendant competent to stand trial); see MORRIS, *supra* note 73, at 86–98 (discussing and critiquing the *Sell* decision).

75. Perlin, *supra* note 71, at 242. But see MORRIS, *supra* note 73, at 29–167, for a discussion of various ways in which a mental patient's right to refuse treatment is undermined. For example, some courts have substituted an informal review of the patient's decision to refuse treatment—conducted by a staff psychiatrist or hospital committee—for a court review of the patient's competency to refuse treatment. See, e.g., *Rennie v. Klein*, 653 F.2d 836, 838, 850–51, 853 (3d Cir. 1981), *vacated and remanded*, 458 U.S. 1119 (1982), *on remand*, 720 F.2d 266 (3d Cir. 1983). Professor Perlin has characterized the *Rennie* professional judgment model as a “limited due process model” as contrasted with the *Rogers* “expanded due process model.” See, e.g., 2 PERLIN, *supra* note 2, § 3B–7.2, at 260–61; Perlin, *supra* note 71, at 242. Nevertheless, I believe that substituting an informal review of a patient's decision to refuse treatment by a staff psychiatrist or hospital committee for a formal hearing on the patient's competency by a judge or other law-trained decisionmaker replaces due process with less than due process. See generally MORRIS, *supra* note 73, at 29–53.

76. See 2 PERLIN, *supra* note 2, §§ 3B–1 to 3B–2, at 155 n.1, 157 n.2, 165–67 nn.27–33 (citing sources); see also Grant H. Morris, *Dr. Szasz or Dr. Seuss: Whose Right to Refuse Mental Health Treatment?*, 9 J. PSYCHIATRY & L. 283 (1981).

77. 1 PERLIN, *supra* note 2, §§ 2B–1 to 2B–15, at 191–292.

78. 2 PERLIN, *supra* note 2, § 3B–11, at 360–63. Incredibly, Professor Perlin's three-page discussion of the adequacy of counsel in right to refuse treatment proceedings

addresses the adequacy of counsel in this context,⁷⁹ and the author of that article urges attorneys to adopt a paternalistic, best interests approach to representing patients who refuse treatment.⁸⁰

In a recent article, Professor Perlin asserted that lawyers perform a “mediocre job”⁸¹ in representing persons in the civil commitment process and an “equally mediocre job”⁸² in representing mental patients in the right to refuse treatment process. It is logical to assume that if lawyers do not actively represent mentally disordered clients in involuntary civil commitment hearings, they are even less likely to actively represent involuntarily committed mental patients in hearings to establish their competence to refuse treatment. If lawyers defer to medical judgment in the decision of whether a mentally disordered person should be involuntarily confined, they are more likely to defer to medical judgment than an involuntarily committed patient who refuses treatment lacks competence to do so. After all, the doctor is the most qualified individual to determine what medication is appropriate to treat the patient’s mental condition. Surely, a decision by the patient to accept the prescribed medication that may result in an improved mental condition with the potential for release from confinement will be viewed by the doctor—as well as by the patient’s lawyer—as the rational decision. If the patient rejects the doctor’s choice, *a fortiori*, the patient is perceived to be incompetent to make that unwise decision.

is located within a 233-page unit devoted to the topic of the right to refuse treatment. *Id.* at §§ 3B-1 to 3B-16, at 153–385.

79. *Id.* § 3B-11, at 360 n.1623 (citing Melvin R. Shaw, *Professional Responsibility of Attorneys Representing Institutionalized Mental Patients in Relation to Psychotropic Medication*, 22 J. HEALTH & HOSP. L. 186 (1989)). In the most recent cumulative supplement to Professor Perlin’s treatise, he cites one other article on the subject. 2 PERLIN, *supra* note 2, § 3B-11, at 360 n.1623 (Supp. 2008) (citing Neal Milner, *The Right to Refuse Treatment: Four Case Studies of Legal Mobilization*, 21 LAW & SOC’Y REV. 447 (1987)). Surprisingly, Milner’s article was published in 1987, two years prior to the publication of Shaw’s article cited in the treatise itself.

80. Shaw, *supra* note 79, at 191. Shaw asserts that attorneys need to consider the medical consequences to patients from their decisions to refuse treatment. *Id.* at 191–92. Without needed medication, patients may “stagnate or deteriorate as inpatients, indefinitely or permanently.” *Id.* at 190. Shaw favors abridging a patient’s right to refuse treatment in order to quickly restore the patient’s health and freedom. *Id.* at 192.

81. Michael L. Perlin, “*And My Best Friend, My Doctor/Won’t Even Say What It Is I’ve Got*”: *The Role and Significance of Counsel in Right to Refuse Treatment Cases*, 42 SAN DIEGO L. REV. 735, 737 (2005).

82. *Id.*

IV. THE USE OF MENTAL HEALTH CONSERVATORSHIPS TO ACHIEVE CIVIL COMMITMENT AND INVOLUNTARY TREATMENT IN CALIFORNIA

In 1967, the California Legislature enacted the Lanterman-Petris-Short Act (LPS), which made fundamental changes in the standards and procedures for civil commitment.⁸³ LPS was hailed as “the Magna Carta of the mentally ill.”⁸⁴ LPS has been commended by writers⁸⁵ and judges,⁸⁶ serving as a model of progressive legislation that has been copied by other state legislatures.⁸⁷ With only some minor tinkering over the years, LPS remains the law today in California. Under LPS, if a person, as a result of mental disorder, is believed to be a danger to others, a danger to himself or herself, or gravely disabled, the person may be detained for an initial seventy-two-hour treatment and evaluation period.⁸⁸ Thereafter, the person may be certified for a fourteen-day

83. Division 5 of the California Welfare and Institutions Code, entitled *Community Mental Health Services*, was added by the California Mental Health Act of 1967, ch. 1667, § 36, 1967 Cal. Stat. 4053, 4074. Division 5 consists of two parts: the Lanterman-Petris-Short Act, CAL. WELF. & INST. CODE §§ 5000–5550 (West 1998 & Supp. 2008), which provides the standards and procedures for civil commitment, and the Bronzan-McCorquodale Act (formerly the Short-Doyle Act), *id.* §§ 5600–5772, which provides the legislative framework for the organizing and financing of “community mental health services for the mentally disordered in every county through locally administered and locally controlled community mental health programs.” *Id.* § 5600 (West 1998).

84. The statement is attributed to Maurice Rodgers, spokesperson for the California State Psychological Association. EUGENE BARDACH, *THE SKILL FACTOR IN POLITICS: REPEALING THE MENTAL COMMITMENT LAWS IN CALIFORNIA* 126 (1972). Other writers also state that LPS has been described as the Magna Carta of the mentally ill, but they do not reveal the source of the statement. *See, e.g., Constitutional Rights of the Mentally Ill: Hearings Before the Subcomm. on Constitutional Rights of the S. Comm. on the Judiciary*, 91st Cong., 1st & 2d Sess. 316 (1970) (statement of Dr. Roger Egeberg, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education and Welfare); Marc F. Abramson, *The Criminalization of Mentally Disordered Behavior: Possible Side-Effect of a New Mental Health Law*, 23 *HOSP. & COMMUNITY PSYCHIATRY* 101, 105 (1972).

85. *See, e.g.,* FRANK W. MILLER ET AL., *THE MENTAL HEALTH PROCESS* xvi (2d ed. 1976) (characterizing the California experiment as “innovative” and declaring that LPS “must be considered throughout any discussion of mental health programs”).

86. *See, e.g.,* David L. Bazelon, *Implementing the Right to Treatment*, 36 *U. CHI. L. REV.* 742, 753 (1969) (“[LPS] promises virtually to eliminate involuntary hospitalization except for short-term crisis situations. . . . The procedural protections it promises are impressive indeed when compared with commitment proceedings in other states.”).

87. *See, e.g.,* WASH. REV. CODE ANN. §§ 71.05.010–71.05.940 (West 2008).

88. CAL. WELF. & INST. CODE § 5150 (West 1998) (authorizing detention, without court order, for seventy-two hours to evaluate and treat mentally disordered persons who are a danger to self or others or gravely disabled); *id.* § 5200 (authorizing court-ordered detention for seventy-two hours to evaluate and treat persons who are a danger to self or others or gravely disabled).

intensive treatment period if he or she is determined to be dangerous or gravely disabled.⁸⁹

LPS eliminates indeterminate commitment of nondangerous, mentally ill persons and uses conservatorships for gravely disabled patients who need assistance in managing their affairs after they have been treated in a mental hospital for seventeen days or less.⁹⁰ For a conservator to be appointed, the court must find that the patient is gravely disabled. "Grave disability" is defined as "[a] condition in which [the] person, as a result of mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter."⁹¹ The conservatorship is established for a one-year period, but it may be reestablished upon proof of continuing grave disability.⁹²

At the time a conservatorship is established, the court may grant the conservator⁹³ the authority to place the conservatee in a mental hospital

89. *Id.* § 5250 (authorizing certification for fourteen days of intensive treatment for persons who are a danger to self or others or gravely disabled).

90. The California legislative subcommittee that recommended revision of California's civil commitment statutes issued a report that served as a resource document for the LPS legislation. That report recommended the creation of LPS conservatorships to provide continuing assistance in managing the affairs of those gravely disabled patients who needed such assistance following treatment during a fourteen-day certification. SUBCOMM. ON MENTAL HEALTH SERVS., ASSEMBLY INTERIM COMM. ON WAYS AND MEANS, CAL. LEGIS., THE DILEMMA OF MENTAL COMMITMENTS IN CALIFORNIA: A BACKGROUND DOCUMENT 133 (1966).

91. CAL. WELF. & INST. CODE § 5008(h)(1)(A) (West 1998).

92. *Id.* § 5361.

93. A statute provides that the selection of a conservator shall be subject to the following list of priorities: (1) the nominee of the proposed conservatee if the proposed conservatee has sufficient capacity to make an intelligent preference; (2) the spouse or domestic partner of the proposed conservatee; (3) an adult child of the proposed conservatee; (4) a parent of the proposed conservatee; (5) a brother or sister of the proposed conservatee; (6) any other person or entity eligible for appointment as a conservator. However, the statute also provides that appointment of a conservator is subject to this list of priorities "unless the officer providing conservatorship investigation recommends otherwise to the superior court." *Id.* § 5350(b)(1) (West Supp. 2008) (incorporating by reference the list of priorities in CAL. PROB. CODE § 1812(b) (West 2002)). In practice, the conservatorship investigator almost invariably recommends the appointment of a public agency—such as the Office of the Public Conservator—as conservator, and the court almost invariably accepts the recommendation. See Grant H. Morris, *Conservatorship for the "Gravely Disabled": California's Nondeclaration of Nonindependence*, 15 SAN DIEGO L. REV. 201, 226–27 (1978) (finding that relatives or friends were selected as conservator in only three of the 461 cases in which LPS conservatorships were established in San Diego County over a nine-month period).

or other mental treatment facility⁹⁴ and to require the conservatee to receive treatment to remedy or prevent the recurrence of the conservatee's condition of grave disability.⁹⁵ Although the court, in appointing a conservator for a gravely disabled person, has discretion to grant or to withhold such authority, the court almost always grants it to the conservator.⁹⁶

California statutes provide that a mentally competent person may apply for voluntary admission to a mental treatment facility, or if the person is a conservatee, the conservatee's conservator may apply if the court has granted the conservator the authority to place the conservatee in such a facility.⁹⁷ However much the conservatee protests, the conservatee is admitted to that facility as a voluntary patient. However much the conservatee protests, the conservatee may be required to take psychotropic medication that the doctor prescribes and that the conservator, exercising a substituted judgment for the conservatee, authorizes.

Elsewhere, I characterize these conservatorship statutes as "California's nondeclaration of nonindependence,"⁹⁸ laws that allow civil commitment and coerced treatment without the crunch.⁹⁹ For conservatees, there is no involuntary civil commitment hearing. For conservatees, there is no right to refuse treatment hearing. Under California's "Magna Carta of the mentally ill," conservators are given carte blanche control over conservatees.

The use of conservatorships to assure involuntary detention and coercive treatment is the option of choice for civilly committed patients whom society deems worthy of long-term control. In the most current report available, the California Department of Mental Health reveals that in the 2005–2006 fiscal year, 138,295 adults were detained on seventy-two-hour evaluation holds as dangerous to self, dangerous to others, or gravely disabled.¹⁰⁰ Of that number, 57,386 were subsequently detained on fourteen-day intensive treatment certifications, using the same commitment criteria.¹⁰¹ How many of those individuals were subsequently detained for a 180-day period as presenting "a demonstrated danger of inflicting

94. CAL. WELF. & INST. CODE § 5358(a)(1), (2) (West 1998). The placement, however, must be "in the least restrictive alternative placement, as designated by the court." *Id.* § 5358(a)(1)(A).

95. *Id.* § 5358(b).

96. See *infra* text accompanying notes 240–41.

97. CAL. WELF. & INST. CODE § 6000(a) (West 1998). Although other voluntary patients may depart the facility by giving notice of a desire to do so, LPS conservatees may depart only if notice is given by their conservators. *Id.* § 6002.

98. Morris, *supra* note 93, at 201.

99. *Id.* at 215.

100. STATISTICS & DATA ANALYSIS, CAL. DEP'T OF MENTAL HEALTH, INVOLUNTARY DETENTION DATA—FISCAL YEAR 2005–2006 (July 1, 2005–June 30, 2006), at 3 tbl.1 (2008), http://www.dmh.ca.gov/Statistics_and_Data_Analysis/docs/InvoluntaryDetention_FY05-06/Rep0506_FINAL.pdf.

101. *Id.* at 5 tbl.3.

substantial physical harm upon others"?¹⁰² Only twenty-one met that standard.¹⁰³ Is it likely that after only seventeen days or less of inpatient hospitalization, there were only twenty-one dangerously mentally disordered people in the entire state of California? Highly doubtful! But many of those who were initially detained as dangerous to others were suddenly found to be gravely disabled and were processed through the conservatorship route.¹⁰⁴ For fiscal year 2005–2006, a total of 10,004 conservatorships were established.¹⁰⁵ Thus, conservatorships were used in 99.8% of cases (that is, 10,004 LPS conservatorships out of 10,025 total cases) in which long-term control over a mentally disordered person (that is, 180 days or longer) was regarded as appropriate. Over thirty years ago, Dr. Alan Stone characterized conservatorships as the "one escape hatch" used to prolong confinement of mentally disordered persons in California.¹⁰⁶ His characterization is equally appropriate today.

This grant of authority to conservators to involuntarily commit their conservatees as "voluntary" patients and to impose treatment upon them

102. CAL. WELF. & INST. CODE § 5300 (West 1998) (establishing the criteria for 180-day involuntary commitment of demonstrably dangerous persons). Although the danger criteria of section 5300 are rarely used to involuntarily commit patients in California, the criteria are frequently used to impose involuntary treatment on patients already committed as mentally disordered offenders. In *In re Qawi*, 81 P.3d 224, 234 (Cal. 2004), the California Supreme Court held that mentally disordered offenders are "the *only* class of LPS patients" that are not afforded the right to refuse treatment; *but see* MORRIS, *supra* note 73, at 123–39 (critiquing the *Qawi* decision).

103. STATISTICS & DATA ANALYSIS, *supra* note 100, at 8 tbl.6.

104. Even in habeas corpus hearings conducted shortly after a person was initially detained as both dangerous to others and gravely disabled, the grounds for confinement were "bargained down" to grave disability only. Carol A.B. Warren, *Involuntary Commitment for Mental Disorder: The Application of California's Lanterman-Petris-Short Act*, 11 LAW & SOC'Y REV. 629, 645 (1977). Grave disability has become the "catchall" category to continue commitment of a patient when it might be difficult to prove that the patient was a danger to others. *Id.* at 646. A dangerous or potentially dangerous patient who has been reclassified as gravely disabled is eligible for a conservatorship. *Id.* at 648.

105. STATISTICS & DATA ANALYSIS, *supra* note 100, at 9 tbl.7. In its statistical report, the Department of Mental Health listed these conservatorships as "permanent conservatorships." *Id.* However, under the LPS statutes, conservatorships are established for a one-year period. CAL. WELF. & INST. CODE § 5361 (West 1998). The conservatorship may be reestablished for successive one-year periods upon a finding that the conservatee continues to be gravely disabled. *Id.* In addition to the 10,004 one-year conservatorships, 5297 temporary conservatorships were established during fiscal year 2005–2006. STATISTICS & DATA ANALYSIS, *supra* note 100, at 9 tbl.7. Temporary conservatorships are established for thirty days pending a determination of whether a one-year conservatorship is appropriate. CAL. WELF. & INST. CODE § 5352.1 (West 1998).

106. ALAN A. STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION 64 (1976).

over their objection cannot be justified. In *Riese v. St. Mary's Hospital & Medical Center*,¹⁰⁷ the California Court of Appeal held that mental patients involuntarily committed pursuant to California's seventy-two-hour treatment and evaluation hold¹⁰⁸ or subsequently certified for fourteen days pursuant to California's intensive treatment hold¹⁰⁹ could not be required to take psychotropic medication against their will in nonemergency situations.¹¹⁰ "It is one of the cardinal principles of LPS," said the court, "that mental patients may not be presumed incompetent solely because of their hospitalization."¹¹¹ The individual's right to give or withhold consent to medical treatment—including treatment with psychotropic medication—"does not disappear upon involuntary commitment."¹¹²

Before treatment can be imposed on an involuntary patient without the patient's consent, the *Riese* court required that "there must be an evidentiary hearing directed to the question whether the patient is able to understand and knowingly and intelligently act upon information required to be given regarding the treatment."¹¹³ The court conducting that hearing must determine the patient's incapacity by clear and convincing evidence.¹¹⁴ If the court determines that the involuntary patient possesses the capacity to give informed consent to psychotropic medication and the

107. 243 Cal. Rptr. 241 (Ct. App. 1987), *review granted*, 751 P.2d 893 (Cal. 1988), *review dismissed and court of appeal opinion ordered published*, 774 P.2d 698 (Cal. 1989), *republished opinion*, 271 Cal. Rptr. 199 (Ct. App. 1987). Hereinafter, the *Riese* case will be cited to the court's republished opinion. For a more detailed discussion of the *Riese* case and its implementation, see Grant H. Morris, *Judging Judgment: Assessing the Competence of Mental Patients to Refuse Treatment*, 32 SAN DIEGO L. REV. 343, 365–84 (1995).

108. CAL. WELF. & INST. CODE § 5150 (West 1998).

109. *Id.* § 5250.

110. *Riese*, 271 Cal. Rptr. at 201 (holding that involuntarily committed patients have the right to exercise informed consent). The *Riese* court relied upon numerous statutory provisions to support the requirement of informed consent by involuntarily committed mental patients. *See id.* at 204–10. The court specifically rejected the argument that the failure of LPS to explicitly grant to involuntary patients the right to refuse psychotropic medication constitutes a basis for denying them that right. *Id.* at 208. Although the court withheld judgment on whether constitutional bases also support informed consent in this context, *id.* at 201, it noted that the right of persons not adjudicated incompetent to give or withhold consent to medical treatment—including treatment with psychotropic medication—is protected both by the common law and by the constitutional right to privacy. *Id.* at 207–08. California courts uphold decisions by competent adults to refuse life-sustaining treatment. *Id.* at 208 (discussing *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 225 (Ct. App. 1984)). Logically, they cannot reject non-life-threatening medication-refusal decisions by competent mental patients.

111. *Riese*, 271 Cal. Rptr. at 206.

112. *Id.* at 213.

113. *Id.* at 211. In so ruling, the court adopted LPS statutory provisions governing the determination of a patient's capacity to consent to electroconvulsive therapy, declaring that those provisions were "equally appropriate" to the determination of a patient's capacity to decide whether to consent to psychotropic medication. *Id.*

114. *Id.*

patient refuses to do so, "the patient may not be required to undergo the treatment."¹¹⁵

In 1991, two years after the *Riese* decision was republished, the California Legislature enacted statutes that confirm and codify, with some modifications,¹¹⁶ *Riese*'s competency hearing requirement.¹¹⁷ The legislation specifically declares that involuntarily committed mental patients have a right to refuse treatment with psychotropic medication.¹¹⁸ Even if a patient is determined to lack the capacity to refuse treatment, the legislation provides that such incapacity remains in effect only for the duration of the seventy-two-hour or fourteen-day detention period.

If a finding of grave disability is not sufficient, in and of itself, to warrant coerced treatment of an involuntarily detained mental patient, then is a finding of grave disability, made in a hearing to establish a conservatorship, sufficient to warrant coerced treatment of a conservatee? The answer, according to the California statutes, is yes. Although the *Riese* court ruled that mental patients are not presumed incompetent solely because of their hospitalization,¹¹⁹ and although the establishment of a conservatorship is not an adjudication that the conservatee is incompetent¹²⁰ or is incapable of making treatment decisions,¹²¹ nevertheless,

115. *Id.* at 212.

116. For example, instead of judicial hearings to determine a patient's capacity to give or withhold informed consent, the statute uses administrative hearings, conducted by a superior court judge, a court-appointed commissioner or referee, or a court-appointed hearing officer. CAL. WELF. & INST. CODE § 5334(c) (West 1998). At such hearings, patients are represented by counsel or by an advocate. *Id.* § 5333(a).

117. Act of Oct. 7, 1991, ch. 681, 1991 Cal. Stat. 3076 (codified at CAL. WELF. & INST. CODE §§ 5008(l)–(m), 5325.2, 5332–5337 (West 1998 & Supp. 2008)).

118. CAL. WELF. & INST. CODE § 5325.2 (West 1998). The right to refuse medication is not absolute; it is subject to statutory limitations. *Id.*

119. *Riese*, 271 Cal. Rptr. at 206.

120. *Id.* at 204 ("Appointment of a conservator under LPS . . . does not involve an adjudication of incompetence . . ."). In *Board of Regents v. Davis*, 533 P.2d 1047 (Cal. 1975), the California Supreme Court noted that LPS conservatorships, which are established for persons who are gravely disabled as a result of mental disorder or impairment by chronic alcoholism, are identical to Probate Code conservatorships established for other reasons. *Id.* at 1053. Probate Code conservatorships were created statutorily in 1957 as an alternative to guardianships in order to avoid the stigma of the label "incompetency." *Id.* at 1051. Conservatorship law should not be interpreted to strip the competent conservatee of decisionmaking authority. *See id.* at 1054. *See generally* Morris, *supra* note 93, at 208–14 (discussing similarities and differences in Probate Code guardianships, Probate Code conservatorships, and LPS conservatorships in California).

121. *Riese*, 271 Cal. Rptr. at 204 ("Appointment of a conservator under LPS . . . does not involve an adjudication of . . . incapacity to make treatment decisions about

in reality, conservatees are presumed incompetent solely because of their status as conservatees. Although the *Riese* court ruled that an individual's right to withhold consent to psychotropic medication "does not disappear upon involuntary commitment,"¹²² that right does disappear for conservatees when their conservators order them to undergo treatment as "voluntary" patients.

Surely, one would assume that the judge establishing the conservatorship is required to make some new finding of fact that the conservatee is incapable of making rational treatment decisions before the judge grants authority to the conservator to place the conservatee in a mental hospital or other mental treatment facility and to require the conservatee to accept treatment. In dicta, the *Riese* court suggested that conservatees retain the right to refuse medical treatment "unless the court, *after making appropriate findings*, specifically denies the conservatee this right in its order and authorizes the conservator to make informed consent decisions."¹²³

one's own body."); *see also* *Keyhea v. Rushen*, 223 Cal. Rptr. 746, 751 (Ct. App. 1986) ("LPS conservatees have a right to refuse involuntary long-term psychotropic medication absent a judicial determination of their incompetency to do so."); 60 Ops. Cal. Att'y Gen. 375, 377 (1977) ("[T]he conservatee is not divested of the right to make his or her own medical decisions absent a specific determination by the court that the conservatee cannot make those decisions.").

122. *Riese*, 271 Cal. Rptr. at 213.

123. *Id.* at 204–05 (emphasis added); *see also* *Keyhea*, 223 Cal. Rptr. at 755 (noting that under LPS, a court determination of incompetency is required before long-term psychotropic medication may be administered without a patient's consent); 60 Ops. Cal. Att'y Gen. 375, 377 (1977) (asserting that the court should not divest the conservatee of the right to make medical decisions "unless it finds that the conservatee lacks the mental capacity to rationally understand the nature of the medical problem, the proposed treatment and the attendant risks").

Because *Riese* was a class action lawsuit involving patients involuntarily detained on seventy-two-hour or fourteen-day holds, the court's statement about rights of conservatees is dictum. Years later, in *In re Qawi*, 81 P.3d 224, 233 (Cal. 2004), the California Supreme Court discussed, approvingly, the *Riese* decision. The *Qawi* court stated: "[T]he reasoning of *Riese* makes clear that the right does not apply solely to short-term LPS patients." *Id.* The *Qawi* court asserted that individuals placed on one-year renewable conservatorships as gravely disabled possess the right to refuse psychotropic medication absent a judicial determination of their incompetence to make treatment decisions. *Id.* at 233–34. The *Qawi* court also cited approvingly *Keyhea v. Rushen*, 223 Cal. Rptr. 746 (Ct. App. 1986), for the proposition that "LPS conservatees have a right to refuse involuntary long-term psychotropic medication absent a judicial determination of their incompetency to do so." *Qawi*, 81 P.3d at 234 (quoting *Keyhea*, 223 Cal. Rptr. at 751). *Qawi*, however, was a case involving a mentally disordered offender, not an LPS conservatee. *Keyhea* was a case involving a mentally ill prisoner, not an LPS conservatee. Neither *Qawi* nor *Keyhea* directly considered whether individuals placed on an LPS conservatorship retain the right to refuse treatment unless they are adjudicated incompetent. Neither *Qawi* nor *Keyhea* directly considered whether, in the absence of legislation specifically mandating a competency hearing, the court establishing the conservatorship is precluded from authorizing the conservator to make treatment decisions for the conservatee without first conducting such a hearing. No other California Supreme Court or California Court of Appeal case has considered or decided these issues. These issues remain for future determination.

LPS conservatorship legislation, however, imposes no obligation on the court that establishes a conservatorship to make "appropriate findings" before granting the conservator placement and treatment authority over the conservatee. LPS conservatorship legislation imposes no obligation on the court to determine that the conservatee is incompetent—that the conservatee lacks the mental capacity to give or withhold informed consent—before it grants the conservator the authority to order treatment that is imposed over the conservatee's objection. In fact, LPS conservatorship legislation does not even require that the court make any additional determination beyond a finding of grave disability. Rather, an LPS conservatorship statute merely provides that the conservatorship investigator's report to the court "shall contain his or her recommendations concerning the powers to be granted to . . . the conservator."¹²⁴ The next statute provides that the conservatorship investigator's report shall recommend for or against the imposition of various disabilities on the conservatee, specifically mentioning as one such disability the right to refuse or consent to treatment related to the conservatee's condition of grave disability.¹²⁵ The statute following that one merely provides that "[a] conservator shall . . . have the right, if specified in the court order, to require his or her conservatee to receive treatment related specifically to remedying or preventing the recurrence of the conservatee's being gravely disabled"¹²⁶ Apparently, the finding of grave disability is sufficient, in and of itself, to warrant the court authorizing the conservator to place the conservatee in a mental hospital or other mental treatment facility and to require the conservatee to accept treatment.¹²⁷

124. CAL. WELF. & INST. CODE § 5356 (West 1998).

125. *Id.* § 5357.

126. *Id.* § 5358(b). The statutory language empowering the conservator to require the conservatee to receive treatment to prevent the recurrence of the conservatee's grave disability seems inappropriate. A conservatorship is established for a person who is currently gravely disabled. If the conservatee is no longer gravely disabled, the conservatorship should terminate. Mere concern that the condition of grave disability might recur is insufficient to continue the conservatorship and to continue the conservator's power to require the conservatee to receive treatment. *See id.* § 5364 (authorizing the conservatee, at six-month intervals, to petition for a rehearing on his or her status as a conservatee).

127. Morris, *supra* note 93, at 228; *see infra* text accompanying notes 239–41 (discussing a recent study conducted in San Diego County that revealed that in every case in which the court established or reestablished a conservatorship, the court authorized the conservator to place the conservatee in a mental hospital or other mental treatment facility and to require the conservatee to receive treatment for his or her mental condition).

One need only examine the facts of the *Riese* case to realize that conservatees, despite their inability to provide for their basic necessities of food, clothing, and shelter, can be competent to make treatment decisions regarding their mental disorder. Eleanor Riese, the named plaintiff in the class action suit, entered St. Mary's Hospital as a voluntary patient. Prior to this admission, she had been treated for chronic schizophrenia with Mellaril,¹²⁸ a psychotropic medication. As a result of that earlier treatment, her bladder had been severely damaged. Nevertheless, the treating doctor prescribed Mellaril, and she consented to its use. When she suffered side effects and refused further treatment with Mellaril, she was forcibly injected and was committed as an involuntary patient. A week later, a conservatorship was recommended, and subsequently a conservatorship was established. The court authorized the conservator to place Ms. Riese in a mental hospital and to require her to accept treatment over her objection. When she refused to ingest medication orally, she was forcibly medicated intramuscularly.¹²⁹ According to the *Riese* court, Ms. Riese "continued to suffer from swollen feet, urinary problems, shaking, memory loss and seizures."¹³⁰

Ms. Riese died on April 6, 1991. She was forty-seven years old. Although no autopsy was performed, her death was attributed to renal failure resulting from the cumulative effects of medication she had received over her lifetime.¹³¹ Was Ms. Riese's refusal to take psychotropic medication a competent decision based on rational reasons? Yes. Was her decision accepted by the treating physicians, by her conservator, and by the court? No. One could easily conclude that conservatorships are not established to provide needed assistance to conservatees who are unable to provide for food, clothing, and shelter. Rather, conservatorships are established in order to subject conservatees to long-term treatment with psychotropic medication despite their protests.

128. Mellaril® was the Sandoz Pharmaceuticals Corporation brand of thioridazine HCl. PHYSICIANS' DESK REFERENCE 2168 (49th ed. 1995). Today, physicians receive a "black box" warning that thioridazine has the "POTENTIAL FOR SIGNIFICANT, POSSIBLY LIFE-THREATENING, PROARRHYTHMIC EFFECTS" and "SHOULD BE RESERVED FOR USE IN THE TREATMENT OF SCHIZOPHRENIC PATIENTS WHO FAIL TO SHOW AN ACCEPTABLE RESPONSE TO ADEQUATE COURSES OF TREATMENT WITH OTHER ANTIPSYCHOTIC DRUGS." PHYSICIANS' DESK REFERENCE 2182 (62d ed. 2008).

129. *Riese v. St. Mary's Hosp. & Med. Ctr.*, 271 Cal. Rptr. 199, 201-02 (Ct. App. 1987).

130. *Id.* at 202.

131. Telephone Interview with Colette Hughes, Protection and Advocacy, Inc., co-counsel for Eleanor Riese in *Riese v. St. Mary's Hosp. & Med. Ctr.* (July 11, 1994).

V. MEASURING THE ADEQUACY OF COUNSEL IN CONSERVATORSHIP
HEARINGS CONDUCTED IN 1975 AND THE CALIFORNIA
SUPREME COURT'S RESPONSE TO ATTORNEY INADEQUACY

Eight years after LPS was enacted into law,¹³² I asked students in my seminar in Law and Mental Disorder to observe the conservatorship proceedings in the San Diego County Superior Court and gather data on the performance of attorneys representing individuals for whom a conservatorship was proposed.¹³³ The students observed sixty-three court hearings and reported the following data.¹³⁴ Eight hearings were one minute or less in duration. Nineteen hearings were between one and two minutes in duration. Nine hearings were between two and three minutes in duration. Thus, more than half the hearings—a total of thirty-six of the sixty-three that were observed—were completed in three minutes or less.¹³⁵ The average duration of these LPS conservatorship hearings—less than three minutes—was actually shorter than the 4.7 minute average duration of civil commitment hearings conducted prior to the adoption of the LPS legislation.¹³⁶

In forty-two of the sixty-three cases, counsel representing a proposed conservatee asked no questions of the reporting psychiatrist. In most of the remaining twenty-one cases, the lawyer asked only one question. In only one case did the proposed conservatee's counsel request either the assistance of a psychiatrist or the examination of the proposed conservatee by another psychiatrist. There was not a single case in which counsel for the proposed conservatee offered testimony of an independent psychiatrist. In fifty-six of the sixty-three cases, no questions were asked of the proposed conservatee.

In fifty-eight of the sixty-three cases, counsel for the proposed conservatee neither proposed alternatives to conservatorship nor even suggested that others explore these possibilities. In only five cases did counsel for the proposed conservatee recommend any specific person be appointed as conservator if a conservatorship was established. In only two cases did counsel for the proposed conservatee request that a conservatorship, if established, terminate sooner than the one-year statutory maximum.

132. Although LPS was enacted in 1967, the operative date of the legislation was July 1, 1969. California Mental Health Act of 1967, ch. 1667, § 36, 1967 Cal. Stat. 4053, 4074.

133. See Morris, *supra* note 93, at 225.

134. See *id.* at 232–33.

135. *Id.* at 232 n.173. Only nine hearings were more than eight minutes in duration. *Id.*

136. SUBCOMM. ON MENTAL HEALTH SERVS., ASSEMBLY INTERIM COMM. ON WAYS AND MEANS, *supra* note 90, at 43.

Among the disabilities that the court, in establishing a conservatorship, may impose upon the conservatee are suspension of the privilege to possess a license to operate a motor vehicle and the right to enter into contracts.¹³⁷ In only one of the sixty-three cases did a lawyer urge that the proposed conservatee be permitted to retain his or her driver's license, and in no case did a lawyer resist the imposition of contractual disability on his or her client. Most significantly, in only two of the sixty-three cases did the lawyer for the proposed conservatee oppose granting authority to the conservator to place the conservatee in a mental treatment facility where he or she would be subjected to involuntary treatment for his or her mental disorder.

Clearly, the conservatorship hearings observed by my students were meaningless formalities, "show" trials, an "empty shell," to borrow words from Michael Perlin and Deborah Dorfman, "offering only an illusion of due process."¹³⁸ Rolling over and playing dead is not competent representation. Rolling over and playing dead is not zealous advocacy on behalf of one's client.

Perhaps, it could be argued, such attorney inaction at the conservatorship hearing was appropriate. The attorney may have made a reasoned decision not to contest conservatorship because the evidence of grave disability was so overwhelming that resistance was both futile and unwarranted. But that is not what occurred. Attorney nonperformance at trial was a direct result of the failure of attorneys to investigate the facts and to fully prepare their clients' cases. At the time of this study, attorneys for proposed conservatees who were indigent—and most were indigent—were appointed approximately once every six months as their names rotated up on an appointments list. They were paid seventy-five dollars per case for their work.¹³⁹ For this small fee, most attorneys made one visit to the client in the facility where the client was

137. CAL. WELF. & INST. CODE § 5357 (West 1998). Other disabilities that can be imposed by the court are disqualification from voting and possessing a firearm, and the right to refuse treatment, whether related or unrelated to the conservatee's condition of grave disability. *Id.*

138. Michael L. Perlin & Deborah A. Dorfman, *Is It More Than "Dodging Lions and Wastin' Time"? Adequacy of Counsel, Questions of Competence, and the Judicial Process in Individual Right to Refuse Treatment Cases*, 2 PSYCHOL. PUB. POL'Y & L. 114, 130 (1996).

139. See Morris, *supra* note 93, at 234 n.177. In 1975, San Diego County paid \$57,975 to lawyers representing proposed conservatees in 742 hearings. These attorneys were paid at a base rate of \$75 per case, an increase from the \$50 per case paid to attorneys in 1974. Extra payment was allowed when continuances were granted or when attorneys were able to convince the judge that extra work or extra expenses warranted such payment. With this extra payment, San Diego County spent an average of \$78.13 per conservatorship case in 1975 (\$57,975 divided by 742 equals \$78.13). Typically, an attorney was assigned to two cases at the time the attorney's name rotated up for appointment. *Id.*

detained, ensured that the papers in the case were in order, and made an appearance at the conservatorship hearing. Some attorneys did even less. Several were observed meeting their clients for the first time at the hearing itself. Appointed counsel almost never attended the psychiatric evaluation of their client that was performed a few days prior to the hearing, although they were permitted to do so. Most attorneys did not even examine the psychiatric report prior to the hearing, even though the report was almost always entered into evidence upon stipulation and was often the most significant evidence in the case supporting the appointment of a conservator. Some attorneys expressed concern that if they “make waves” at the hearing, they could jeopardize their chances of being appointed to represent proposed conservatees in future cases.

In *Conservatorship of Roulet*,¹⁴⁰ decided one year after the study was published, the California Supreme Court held that even though the process to establish an LPS conservatorship is a civil process in which the state is acting benevolently to assist the disabled person, nevertheless, proof beyond a reasonable doubt and jury unanimity are constitutionally mandated standards necessary to ensure that mental health conservatorships are established only for individuals who have been accurately determined to be gravely disabled.¹⁴¹ The court articulated several reasons to justify its decision to impose criminal due process safeguards. First, the court equated the establishment of a conservatorship with involuntary civil commitment. “One of the principal powers which the court may grant a conservator is the right to place a conservatee in an institution.”¹⁴² A conservatee “can be involuntarily confined in a mental hospital for up to a year by his or her conservator, with the possibility of additional year-long extensions.”¹⁴³ Thus, despite its civil label, establishment of a conservatorship “threatens a person’s liberty . . . on as massive a scale as that traditionally associated with criminal prosecutions.”¹⁴⁴

In addition to the loss of freedom from physical restraint, the conservatee is subject to various statutory disabilities—both within the

140. 590 P.2d 1 (Cal. 1979).

141. *Id.* at 11. The court specifically “requir[ed] the state to match its good intentions with proof beyond a reasonable doubt that appellant is in need of the state’s care.” *Id.* at 4.

142. *Id.* at 3.

143. *Id.*

144. *Id.* The court cited *People v. Burnick*, 535 P.2d 352, 360–62 (Cal. 1975), for the proposition that civil commitment threatens a person’s liberty to the extent that occurs with a criminal conviction. The court then asserted that the logic of *Burnick* is “equally applicable” to conservatorships. *Roulet*, 590 P.2d at 3.

LPS statutes and apart from LPS—that may subject the conservatee to an even greater control over his or her life and a more serious deprivation of personal liberty than occurs when a person is convicted of a crime.¹⁴⁵ For example, the court mentioned the potential loss of a license to practice a profession, to hold certain public offices, to remain employed as a teacher, to have custody of children, to marry, to object to sterilization, to refuse medical treatment, to possess a driver’s license, to own or possess firearms, to remain registered to vote, and to enter into contracts.¹⁴⁶ Although the establishment of a conservatorship does not equate to a finding that the conservatee is incompetent,¹⁴⁷ nevertheless, conservators may be granted the powers that are granted to the guardian of an incompetent person.¹⁴⁸

The court also discussed the stigma that attaches when a conservatorship is established for a gravely disabled individual. “There is compelling evidence,” said the court, “that society still views the mentally ill with suspicion.”¹⁴⁹ A finding that the person is gravely disabled also seriously threatens the conservatee’s reputation.¹⁵⁰ A person labeled “gravely disabled” by the state will, upon release from hospitalization, undoubtedly have difficulty securing employment, obtaining admission to school, or even meeting old acquaintances with the person’s reputation fully intact.¹⁵¹

The court then focused on three trial issues that strongly support a requirement of proof beyond a reasonable doubt and jury unanimity as constitutionally mandated standards in court proceedings to establish a conservatorship. “Mental illness,” said the court, “is generally acknowledged to be a vague and uncertain concept. Categories of mental diseases are notoriously unclear, often overlap, and frequently change. The experts themselves often disagree on what is an appropriate diagnosis.”¹⁵² Nevertheless, despite the fallibility of psychiatric testimony, judges and juries, serving as factfinders in civil commitment and conservatorship

145. *Roulet*, 590 P.2d at 6.

146. *Id.* (citing statutes).

147. *See Morris*, *supra* note 93, at 220. LPS conservatorships, established under the Welfare and Institutions Code, are merely one form of conservatorship. *Id.*; *see also id.* at 208–15 (discussing the similarities and differences in guardianships and conservatorships established through the California Probate Code and conservatorships established through the California Welfare and Institutions Code). In *Board of Regents v. Davis*, 533 P.2d 1047, 1054 (Cal. 1975), the California Supreme Court held that absent a specific adjudication of incompetency, the imposition of a Probate Code conservatorship on an individual does not deprive the conservatee of contractual capacity. As the court stated, “[I]f a proposed conservatee is competent, no reason compels a total abolition of his right to contract.” *Id.* at 1054.

148. *Roulet*, 590 P.2d at 5.

149. *Id.* at 6.

150. *Id.* at 7.

151. *Id.*

152. *Id.* at 10 (footnote omitted).

proceedings, typically defer to psychiatric judgments that the person has a mental disorder and that the mental disorder meets the statutory standard for commitment or a conservatorship.¹⁵³ Exacerbating the situation is "the paternalistic attitude of some appointed counsel"¹⁵⁴ in representing persons proposed for conservatorship. The court specifically cited, and quoted from, the study conducted by my students and published the year prior to the court's decision.¹⁵⁵

Obviously, the court was displeased with the failure of counsel for proposed conservatees to vigorously oppose the deprivation of their clients' personal liberty and the loss of reputation that results from a finding of grave disability and the appointment of a conservator. The court cited approvingly a recent decision of the Wisconsin Supreme Court mandating minimum standards for attorneys in civil commitment proceedings.¹⁵⁶ "Those standards call for 'adversary counsel' who must represent a client 'zealously within the bounds of the law.'"¹⁵⁷ By its decision to impose the criminal due process protections of proof beyond a reasonable doubt and jury unanimity, the court was signaling to attorneys that conservatorship proceedings are adversarial in nature—as adversarial as are criminal prosecutions—and that the court would not tolerate a paternalistic approach to the handling of these cases. The notion that conservatorship proceedings are nonadversarial—that "we all work together here"¹⁵⁸ to do what is in the patient's best medical interest—was simply unacceptable. The patient's attorney was expected to actively challenge a psychiatrist's opinion that a conservatorship was warranted and not simply to passively acquiesce in that judgment.

153. *Id.* at 10 n.13, 11.

154. *Id.* at 11.

155. *Id.* at 11 n.17. Elsewhere in its opinion, the court cited studies reporting that counsel appointed to represent proposed patients in civil commitment proceedings "tend to play a paternalistic rather than an advocacy role." *Id.* at 10 (citing Litwack, *supra* note 37, at 827–31, and Andalman & Chambers, *supra* note 32). The court also cited an empirical study of habeas corpus hearings conducted in California. *Roulet*, 590 P.2d at 10 (citing Warren, *supra* note 104, at 633). That study reported that the attorneys for the patients "generally refrained from vigorous advocacy of their clients' legal rights under LPS." Warren, *supra* note 104, at 633.

156. *Roulet*, 590 P.2d at 11 n.16 (citing and quoting *State ex rel. Memmel v. Mundy*, 249 N.W.2d 573, 577 (Wis. 1977)).

157. *Id.*

158. In a study of habeas corpus proceedings under LPS, Carol Warren reported: "A phrase often used by all personnel in the court to refer to the nonadversary nature of the proceedings was: 'we all work together here.'" Warren, *supra* note 104, at 633. The phrase seems equally applicable to the way conservatorship proceedings are processed under LPS.

Five years after the California Supreme Court's decision in *Roulet*, the United States Supreme Court acknowledged the "vital importance"¹⁵⁹ of criminal defense counsel. According to the Court, ineffective assistance of counsel "undermine[s] the proper functioning of the adversarial process [such] that the trial cannot be relied on as having produced a just result."¹⁶⁰ Thus, defense counsel's "overriding mission [is] vigorous advocacy of the defendant's cause."¹⁶¹ Because the loss of liberty and the imposition of disabilities are as great or greater for conservatees than for prisoners, vigorous advocacy is also the overriding mission of attorneys representing individuals subjected to conservatorship proceedings in California. Recently, the California Court of Appeal ruled that "a proposed conservatee has a statutory right to effective assistance of counsel"¹⁶² and that such a right is protected by due process.¹⁶³ The court added: "We see no meaningful distinction between criminal and LPS proceedings insofar as the procedures required to guard against the erroneous deprivation of the right to effective assistance of counsel."¹⁶⁴

VI. MEASURING THE ADEQUACY OF COUNSEL IN CONSERVATORSHIP HEARINGS CONDUCTED IN 2007–2008

Conservatorship proceedings are conducted in San Diego County Superior Court on Tuesday and Thursday mornings. Thus, in the period commencing December 20, 2007, and ending March 27, 2008, proceedings were conducted on twenty-eight days. On twenty-two days during that period, law students who recently completed my course in Law and Mental Disorder attended those sessions and recorded information about those proceedings.¹⁶⁵ Unlike the study conducted in 1975, the calendar for conservatorship proceedings was divided into two parts. Cases that were uncontested or in which the parties stipulated as to the results were

159. *Strickland v. Washington*, 466 U.S. 668, 685 (1984).

160. *Id.* at 686.

161. *Id.* at 689.

162. *In re Conservatorship of David L.*, 79 Cal. Rptr. 3d 530, 536 (Ct. App. 2008). The court ruled that "[t]he duty of counsel to perform in an effective and professional manner is implicit" in the statute providing for the appointment of the public defender or other attorney for the proposed conservatee. *Id.* (interpreting CAL. WELF. & INST. CODE § 5365 (West 1998)).

163. *David L.*, 79 Cal. Rptr. 3d at 536.

164. *Id.* at 537.

165. I wish to thank the following students who volunteered to participate in this study and to acknowledge their contribution to this study. The four students are: Michele Brown, Joy Simon, Kevin Yee, and Douglas Wacker. I extend a special note of thanks to Joy Simon who coordinated the court visits by the students and who attended significantly more times than did other students. Students attended court on two of the three days that court sessions were held in the month of December beginning on December 20, 2007; nine of the nine sessions held in January 2008; five of the eight sessions held in February 2008; and six of the eight sessions held in March 2008.

conducted first; contested cases were conducted subsequently. Each will be discussed separately below. Table One indicates the number and type of cases handled in the twenty-two sessions in which data were gathered and the disposition of those cases.

TABLE ONE

Category	Total Number of Cases	Disposition of Cases in Each Category
Stipulated Cases	186	Conservatorship reestablished in 186 cases
Uncontested Cases	52	Conservatorship established in 52 cases
Continuances	251	Hearing postponed in 251 cases
Terminations	13	Conservatorship terminated in 13 cases
Contested Cases to Establish New Conservatorship	34	Conservatorship established in 34 cases
Contested Cases to Reestablish Conservatorship	13	Conservatorship established in 12 cases
Rehearing on Issue of Grave Disability	1	Conservatorship upheld in 1 case
Contested Case to Establish Conservatorship for Incompetent Criminal Defendant	1	Conservatorship established in 1 case
Totals for All Decided Cases ¹⁶⁶	298	Conservatorships established or reestablished in 284 cases (95.3% of the total)

166. The total of 298 "decided" cases is composed of 52 cases in which new conservatorships were established as uncontested matters, 186 cases in which conservatorships were reestablished through stipulation, 13 cases in which conservatorships were terminated without a hearing, 34 contested cases to establish new conservatorships, and 13 contested cases to reestablish conservatorships. The total excludes the 251 cases in which continuances were requested and were granted. Two other contested cases were not included in the total. In one of those cases, an existing conservatorship was upheld after a rehearing to determine whether the conservatee was gravely disabled. *See infra* text accompanying notes 213–14. In the other case, a conservatorship was established for a criminal defendant who had been found mentally incompetent to stand trial. *See infra* text accompanying note 215.

A. Uncontested or Stipulated Cases

A total of fifty-two new conservatorships were established as uncontested cases in the twenty-two court sessions, an average of 2.4 new conservatorships per session. The highest number of uncontested new conservatorships established in any one session was six; the lowest number in any one session was zero. A total of 186 conservatorships were reestablished¹⁶⁷ for an additional year through stipulation of the parties, an average of 8.5 reestablished conservatorships per session. The highest number of stipulated conservatorships reestablished for an additional year in any one session was thirteen; the lowest number was five. A total of eleven conservatorships were terminated by stipulation of the parties, an average of 0.5 conservatorships per session. The highest number of terminated conservatorships in any one session was two; the lowest number was zero. Continuances were granted in a total of 251 cases, an average of 11.4 per session. The highest number of continuances in any one session was twenty; the lowest was one. The total number of all cases handled in this portion of the court hearings was 502 (including the granting of continuances), an average of 22.8 cases per session. If continuances are excluded, the total number of cases in which a decision was made to establish a new conservatorship, reestablish an existing conservatorship, or terminate a conservatorship was 251, an average of 11.4 per session.

Although the patients' attorneys in the 1975 study of conservatorship hearings did not actively contest the finding of grave disability and the appointment or reappointment of a conservator, the hearings that the students observed that year were not characterized as uncontested or stipulated cases. The development of this portion of the court's calendar—a significant portion, indeed—appears to have occurred since that earlier study. How much time did the court devote to deciding these cases? In the twenty-two court sessions, a total of 292 minutes—less than five hours in all—was spent on the uncontested or stipulated cases, an average of 13.3 minutes per session. The longest time spent in any one session was twenty-nine minutes; the shortest was three minutes. Think of it. A total of 502 cases were considered in 292 minutes. That is an average time of 34.9 seconds spent on each case. Even if the granting of continuances took no time at all, a total of 251 cases to establish, reestablish, or terminate conservatorships were resolved in 292

167. An LPS conservatorship automatically terminates one year after the court appoints a conservator. The conservator may petition the court to reestablish the conservatorship and to be reappointed as conservator for a succeeding one-year period. The same procedure is used to reestablish the conservatorship in subsequent years. CAL. WELF. & INST. CODE § 5362 (West 1998).

minutes. That is an average time of one minute and 9.8 seconds spent on each case.

The large number of continuances (251) is particularly disturbing. In most cases, the request for a continuance was made by the Public Defender who represented the proposed conservatee.¹⁶⁸ The typical reason given by the proposed conservatee's attorney for requesting the continuance was the need for further investigation. But why is more time needed for such investigation? The conservatorship process is initiated by the recommendation of a mental health professional at the facility in which a patient is receiving treatment.¹⁶⁹ Upon receiving the recommendation, a conservatorship investigation officer—in San Diego County, the Office of the Public Conservator is the investigative agency—conducts an evaluation of the patient, and if the officer concurs in the recommendation, petitions the court to establish a conservatorship.¹⁷⁰ The court is required by statute to appoint the Public Defender or another attorney to represent the proposed conservatee within five days after the date of the petition and to conduct a hearing within thirty days of the date of the petition.¹⁷¹ If the proposed conservatee's attorney is appointed within five days after the petition, and the court hearing is conducted three or more weeks later, the lawyer should have ample time to prepare for the hearing. This seems especially true today when, as will be discussed below, the proposed conservatee's attorney conducts only a

168. E-mail from Leonard W. Pollard II, Senior Deputy County Counsel, County of San Diego, to Grant H. Morris, Professor of Law (Sept. 8, 2008, 16:05:59 PDT) (on file with author). In San Diego, Mr. Pollard, on behalf of the Office of County Counsel, often represents the petitioner for the establishment of a conservatorship. Mr. Pollard also reported: "However, sometimes, the Public Conservator court investigator requests a continuance because the plan is not to ultimately establish the conservatorship because the temporary conservatee is improving, but is not yet stable enough for discharge." *Id.* Such a practice is highly questionable. The Public Conservator, acting as conservatorship investigator, is only permitted to petition the court to establish a conservatorship if the Public Conservator determines that the proposed conservatee is gravely disabled. CAL. WELF. & INST. CODE § 5352 (West 1998). Before petitioning for a conservatorship to be established, the Public Conservator is required to "investigate all available alternatives to conservatorship and [to] recommend conservatorship to the court only if no suitable alternatives are available." *Id.* § 5354. The Public Conservator should not be petitioning for the establishment of a conservatorship, and extending the proposed conservatee's involuntary detention through a temporary conservatorship, in situations in which the Public Conservator does not believe that a conservatorship is warranted and does not intend to pursue its establishment.

169. CAL. WELF. & INST. CODE § 5352 (West 1998).

170. *Id.*

171. *Id.* § 5365.

limited cross-examination of the psychiatrist who testifies at the hearing in support of the conservatorship petition, does not seek the assistance of a psychiatrist to evaluate the proposed conservatee or to testify on the proposed conservatee's behalf at the hearing, and does not offer the testimony of a family member or any witness other than the proposed conservatee at the hearing.¹⁷²

Perhaps, it could be argued, that the request for a continuance can be explained as an attempt to avoid the imposition of a conservatorship for as long as possible. However, when the conservatorship investigation officer petitions for conservatorship, the court, relying on the officer's report or the affidavit of the professional who recommended the conservatorship, may issue an ex parte order establishing a temporary conservatorship.¹⁷³ The temporary conservator is statutorily authorized to continue the patient's detention in a mental treatment facility pending the court hearing to determine whether a conservatorship should be established.¹⁷⁴ Although a temporary conservatorship terminates thirty days after it is established, if the proposed conservatee demands a trial on the issue of whether he or she is gravely disabled, the court may extend the temporary conservatorship until that issue is decided.¹⁷⁵ If a conservatorship is established, the one-year duration of that conservatorship does not include any time that the conservatee spent in a temporary conservatorship.¹⁷⁶

Similarly, if a one-year conservatorship has been established, the court must notify the conservatee and the conservatee's attorney at least sixty days before the termination of the one-year period.¹⁷⁷ A petition to reestablish the conservatorship for an additional year must be filed at least thirty days before the automatic termination date.¹⁷⁸ The facility in which the conservatee is detained is authorized to continue detaining the conservatee after the termination date of the conservatorship if proceedings to reestablish the conservatorship have not been completed and the court orders the conservatee to be held there until the proceedings have been completed.¹⁷⁹ The statute that requires a hearing on a petition to establish a conservatorship to be held within thirty days of the petition, and for the

172. See *infra* text accompanying notes 218–41 (discussing the performance of counsel for proposed conservatees in contested hearings observed in this study).

173. CAL. WELF. & INST. CODE § 5352.1 (West 1998).

174. *Id.* § 5353.

175. *Id.* § 5352.1. The court, however, may not extend the temporary conservatorship for a period exceeding six months. *Id.*

176. *Id.* § 5361.

177. *Id.* § 5362.

178. *Id.* § 5361. The statute provides that the conservator petitions the court to be reappointed as conservator for a succeeding year. *Id.*

179. *Id.* § 5361.

Public Defender or other attorney to be appointed within five days after the date of the petition, applies as well to hearings on petitions to reestablish conservatorships.¹⁸⁰ Thus, an attorney representing a conservatee is notified that the conservatorship is due to expire at least sixty days before it expires. If a petition to reestablish the conservatorship is filed, the attorney is notified three weeks or more before a hearing is conducted on that petition.¹⁸¹ Requests for continuances premised on the need to conduct further investigation should not be granted routinely by the court. However, at least in San Diego County, they are.

Perhaps, it could be argued, that the request for a continuance can be explained as a tactical decision by the proposed conservatee's attorney to delay the hearing until the client's mental condition has improved such that the client is a better—more rational—witness at the court hearing, or the petition to establish or reestablish a conservatorship is terminated without a hearing. Such a tactic seems unwarranted for two reasons. First, the tactic requires the attorney to make a decision to subject the client to continued involuntary confinement and continued involuntary treatment until the hearing is held. The client's important liberty interests are sacrificed by the absence of a timely hearing to determine whether such loss of liberty is warranted. An attorney's ethical obligation to advocate zealously for his or her client in a hearing to prevent such loss is surely undermined by the attorney's decision to request a continuance—which allows such loss to occur without the hearing. Second, the tactic, if used, is rarely successful. In the twenty-two days of hearings that my students observed, 298 cases were resolved. Conservatorships were not established or were terminated in only thirteen cases. Thus, conservatorships were either established or reestablished in 95.6% of the cases studied, whether or not a continuance was obtained to delay the hearing date.

The large number of uncontested cases involving the establishment of conservatorships (fifty-two) and the even larger number of stipulated cases involving the reestablishment of conservatorships (186) are extremely problematic. The statute provides that the mental health professional who recommends that a conservatorship be established must first determine not only that the person is gravely disabled but that he or she "is unwilling to accept, or incapable of accepting, treatment

180. *Id.* § 5365.

181. *See* SAN DIEGO SUP. CT. R. 8.2.32(B) (adopted July 1, 2006) (providing for a hearing on a petition to reestablish a conservatorship to be calendared "to be heard no less than 21 days nor more than 30 days from the date of filing of the written request").

voluntarily.”¹⁸² The conservatorship investigating officer may only petition for a conservatorship to be established if the officer concurs with the recommendation. If a person is unwilling to accept treatment voluntarily, then how can that individual be willing to accept the establishment or reestablishment of a conservatorship in which the court, in virtually every case, abrogates his or her right to refuse treatment¹⁸³ and authorizes the conservator to impose treatment over the conservatee’s objection?¹⁸⁴ And if the person is incapable of accepting treatment voluntarily, then how can that person be capable of voluntarily waiving the hearing at which his or her incapacity to accept treatment voluntarily will be determined? Stated theoretically, the capacity to evaluate the risks, benefits, and alternatives to proposed therapy may differ from the capacity to waive a hearing at which the person’s capacity to evaluate the risks, benefits, and alternatives to proposed therapy is determined. But realistically, persons whose mental disorders so affect their rational thought processes such that they are incapable of deciding whether to accept treatment voluntarily are also likely to be so severely mentally disordered as to be incapable of competently waiving a hearing. At a minimum, the court should conduct a careful examination of the proposed conservatee’s willingness and capacity to waive a hearing to establish or reestablish a conservatorship.

In the hearings observed in this study, the judge did not perform the analysis that is required. Rather, the judge simply accepted the two or three sentence explanation offered by the proposed conservatee’s attorney for why the case was not contested. Typically, the attorney would merely state that he or she met with the proposed conservatee, that the proposed conservatee understands the nature of the conservatorship and the treatment, does not want to come to court, and does not object to the Public Defender appearing on the proposed conservatee’s behalf. Sometimes the attorney would offer a seemingly opposite reason for not contesting the proposed conservatorship. For example, in one case, the attorney testified that the client lacked insight and could not understand the situation. In others, the attorney testified that the client was decompensating and was uncontrollable or that the client was agitated and not directable. Sometimes, the attorney reported the client’s ambivalence toward the proceeding: “She didn’t want to be on a conservatorship but knew she

182. CAL. WELF. & INST. CODE § 5352 (West 1998).

183. *See id.* § 5357 (providing that the conservatorship investigating officer’s report shall recommend for or against the imposition of various disabilities on the proposed conservatee, including “[t]he right to refuse or consent to treatment related specifically to the conservatee’s being gravely disabled”).

184. *Id.* § 5358(b) (“A conservator shall also have the right, if specified in the court order, to require his or her conservatee to receive treatment related specifically to remedying . . . the conservatee’s being gravely disabled . . .”).

needed help." In all cases, the court accepted the attorney's explanation and decided the matter without further inquiry.

Perhaps the failure of the court to distinguish between these different situations can be explained by a San Diego Superior Court rule that allows the court to proceed in the absence of the client if the attorney who requests the court to waive the client's presence represents that the attorney has been in contact with the client and "that, in the attorney's opinion, it is not in the best interests of the conservatee-client to be present in court or for the court to convene where the conservatee is then housed."¹⁸⁵ The rule places the attorney in the untenable position of reporting to the court the attorney's assessment of the client's best interests in a situation in which the client's best interests, as assessed by the client's attorney, conflict with the client's legal right to oppose the establishment or reestablishment of a conservatorship and also conflict with the attorney's obligation to assist the client in asserting that right. In discussing the proposed conservatee's right to a court hearing on the issues of placement, disabilities to be imposed on the conservatee, and the powers of the conservator, the California Court of Appeal noted that the proposed conservatee's attorney is charged with "protect[ing] the client's rights and achiev[ing] the client's fundamental goals."¹⁸⁶ The court added, "[T]he attorney may not, without the consent of his or her client, enter into an agreement that 'impair[s] the client's substantial rights or the cause of action itself.'¹⁸⁷ The San Diego County Superior Court rule, which deviates from the court of appeal's decision, should be repealed.

Several California Court of Appeal cases, originating in San Diego County, have considered the circumstances under which counsel for a proposed conservatee may communicate his or her client's waiver of the right to be present at the hearing to establish a conservatorship. For example, in *Conservatorship of Moore*, the court held that because conservatees are not automatically considered incompetent, their ability to knowingly and intelligently waive their right to a hearing on a petition

185. SAN DIEGO SUP. CT. R. 8.2.13 (adopted July 1, 2006).

186. *In re Conservatorship of Christopher A.*, 43 Cal. Rptr. 3d 427, 433 (Ct. App. 2006) (quoting *Linsk v. Linsk*, 449 P.2d 760, 764 (Cal. 1969)). Although *Linsk* was a divorce case, the case was quoted by the California Court of Appeal in *Christopher A.* as authority for expressing the proper role of attorneys litigating conservatorship cases.

187. *Id.* (quoting, in part, *Linsk v. Linsk*, 449 P.2d 760, 762 (Cal. 1969)). In 2007, the California Court of Appeal reiterated its *Christopher A.* decision by including the quotations from *Christopher A.* in *In re Conservatorship of Tian L.*, 57 Cal. Rptr. 3d 382, 388 (Ct. App. 2007).

for reestablishment of the conservatorship is a question of fact.¹⁸⁸ The proposed conservatee's attorney is required to contact the client, ascertain whether the client wants a hearing to oppose the reestablishment, and directly communicate the client's decision to the court through a sworn affidavit.¹⁸⁹ The court assumed that the client's voluntary and intelligent waiver of rights can be inferred when the attorney is present in court.¹⁹⁰ Upon the waiver of a hearing, the trial court may act on its own motion and grant the reestablishment petition *ex parte*.¹⁹¹

In *Moore*, the court of appeal asserted that even if the trial court erred in reestablishing the conservatorship, the conservatee's loss of liberty would be *de minimus* because the conservatee can challenge the reestablishment through a statutory provision that allows the conservatee to petition the court for a rehearing as to his or her status as a conservatee or through a writ of habeas corpus.¹⁹² However, the court failed to consider that the conservatee bears the burden of proof in a rehearing on the conservatee's status and in a habeas corpus hearing.¹⁹³ For a conservatee who bears the burden of establishing that he or she is not gravely disabled, the potential for a loss of liberty is surely greater than that for a conservatee who the petitioner must prove, beyond a reasonable doubt, to be gravely disabled. The two proceedings cannot be equated.

In 2006, the California Court of Appeal held that in considering a petition to *establish* a conservatorship, the trial court, before accepting a stipulated judgment on placement of the conservatee, on disabilities to be imposed on the conservatee, and on powers of the conservator, "must consult with the conservatee to instruct him or her on the consequences of the stipulation and obtain the conservatee's express consent to the

188. 229 Cal. Rptr. 875, 884 (Ct. App. 1986).

189. *Id.* at 882.

190. *Id.* at 884 (quoting *Conservatorship of Chambers*, 139 Cal. Rptr. 357, 364 (Ct. App. 1977)).

191. *Id.* at 883 (holding that when the conservatee chooses not to contest the proceeding, the *ex parte* reestablishment of the conservatorship "offends neither the state nor federal constitutional requirements for due process").

192. *Id.* at 882. The court cited CAL. WELF. & INST. CODE § 5364 (West 1998), which authorizes a conservatee to petition for a rehearing as to his or her status as a conservatee. The court also cited CAL. WELF. & INST. CODE § 5362 (West 1998), which merely authorizes a conservatee to request a court hearing to contest a petition to reestablish a conservatorship. The court failed to explain why this statute remains available to a conservatee after the trial court has already waived the hearing at the request of the conservatee's attorney and has ordered the conservatorship reestablished through its *ex parte* decision.

193. In a rehearing on the conservatee's status, conducted pursuant to CAL. WELF. & INST. CODE § 5364 (West 1998), SAN DIEGO SUP. CT. R. 8.2.22(A) (adopted July 1, 2006) specifically places the burden of proof upon the conservatee to establish, by a preponderance of the evidence, that the conservatee is no longer gravely disabled.

stipulation on those issues.”¹⁹⁴ Less than one year later, that same court held that in considering a petition to *reestablish* a conservatorship, the trial court may reestablish the conservatorship without a court hearing, relying upon the sworn statement of the attorney that the client knowingly and willingly consented to the reestablishment of the conservatorship by stipulation and without a formal court hearing.¹⁹⁵ The form signed by the attorney did not contain any indication that the issues of placement of the conservatee or disabilities to be imposed on the conservatee had been discussed with the client, and the attorney did not represent that she spoke to her client about those issues and that the conservatee had agreed to the proposed placement and the imposition of disabilities.¹⁹⁶ Unlike the case involving the establishment of a conservatorship, here the court of appeal did not require the trial court to consult with the conservatee to instruct her on the consequences of stipulating to the reestablishment and to obtain the conservatee’s express consent to the stipulation on those consequences. The court simply assumed that when the attorney indicated on the form that she “discussed reestablishment” with the client, the attorney presumably discussed the issues of placement and disabilities because, in the court’s words, those issues are “central to reestablishment.”¹⁹⁷ Thus, for reestablishment of a conservatorship, there is no requirement that the trial court consult with the conservatee to instruct the conservatee on the consequences of stipulating and obtain the conservatee’s express consent to the stipulation, and there is no requirement that the trial court inquire of the attorney as to what was discussed with the client when the attorney swears that the attorney “discussed reestablishment” of the conservatorship with the client.

The distinction is untenable. A statute provides that a conservatorship “shall automatically terminate one year after the appointment of the conservator by the superior court.”¹⁹⁸ Thus, a petition to reestablish a conservatorship is not a petition to continue an existing conservatorship. Rather, it is a petition to establish a new conservatorship when the existing conservatorship terminates. The court’s obligations to consult with the

194. *In re Conservatorship of Christopher A.*, 43 Cal. Rptr. 3d 427, 433 (Ct. App. 2006).

195. *In re Conservatorship of Tian L.*, 57 Cal. Rptr. 3d 382, 384 (Ct. App. 2007).

196. *Id.* at 387. The court simply acknowledged that “the form could be improved by including a space to . . . show those issues were discussed and the conservatee agreed to their imposition without a hearing.” *Id.*

197. *Id.* at 387–88.

198. CAL. WELF. & INST. CODE § 5361 (West 1998).

proposed conservatee to fully inform him or her of the consequences of a conservatorship, including placement and disabilities, and to obtain the proposed conservatee's competent waiver of a hearing, should be identical for both proceedings. After all, a proposed conservatee faces the same potential loss of liberty and stigmatization whether the proceeding is to establish a new conservatorship or to reestablish a conservatorship that is about to expire.¹⁹⁹

Recently, the California Supreme Court agreed to review the decision in *In re Conservatorship of John L.*,²⁰⁰ a case from San Diego County decided by the California Court of Appeal.²⁰¹ In *John L.*, the appellate court ruled that in a reestablishment proceeding, the trial court may rely upon the *unsworn* representation of the proposed conservatee's counsel that the client's waiver of a hearing was knowing and intelligent.²⁰² If the *John L.* decision is affirmed, the trial court will not be obligated to conduct its own evaluation to ensure that the proposed conservatee understands the consequences of a conservatorship and that the conservatee made a knowing and intelligent waiver of a court hearing. If this decision is affirmed, the trial court will not even be required to obtain a sworn statement from the proposed conservatee's attorney that the attorney fully informed the proposed conservatee of the consequences of a conservatorship, including placement and disabilities, and that the proposed conservatee made a knowing and competent waiver of a hearing.

In reaching its judgment, the court of appeal asserted that the cost of implementing a proposed safeguard of unwaivable mandatory presence of the proposed conservatee in court outweighed the additional protection accorded to the proposed conservatee "particularly given the presence of counsel, who we presume to be competent."²⁰³ But can the attorney's

199. It should be noted, however, that the very next statute distinguishes the establishment of new conservatorships from the reestablishment of conservatorships by requiring a court hearing or a jury trial on the reestablishment only if requested by the conservatee or the conservatee's attorney. CAL. WELF. & INST. CODE § 5362 (West 1998). For new conservatorships, a court hearing occurs without such request, unless the hearing is waived by the conservatee. See CAL. WELF. & INST. CODE § 5358(a)(1) (West 1998). If a petition to reestablish a conservatorship is not a petition to continue an existing conservatorship, but rather, is a petition to establish a new conservatorship when the existing conservatorship terminates, then section 5362 should be amended to equate the proceedings by eliminating the requirement of a request for a court hearing or jury trial in conservatorship reestablishment proceedings.

200. 172 P.3d 400 (Cal. 2007).

201. *In re Conservatorship of John L.*, 65 Cal. Rptr. 3d 393 (Ct. App. 2007), review granted and opinion superseded by 172 P.3d 400 (Cal. 2007). The California Court of Appeal decision may not be cited.

202. *Id.* at 408. The court stated, "[H]ere, counsel represented to the court that John had consented to his conservatorship and elected to waive his presence at the hearing." *Id.* at 409.

203. *Id.* at 407.

competence be presumed? The large number of conservatorships reestablished through stipulation of counsel—186 cases in this study of twenty-two court sessions—and the insignificant amount of time spent to decide those cases—one minute and 9.8 seconds per case—strongly suggests that trial courts are not devoting the attention to conservatorship reestablishment cases that those cases properly deserve.²⁰⁴ In the *John L.* case, for example, the conservatorship investigator's report indicated that the investigator had met with John, and that "he 'made it clear that he did not want a Conservator and thought that he did not need any assistance.'"²⁰⁵ At the hearing conducted one month and one day after the investigator met with John, John's attorney stated, "When we met[, John] indicated that at this time he was not contesting the conservatorship. He did not want to be present in court. So we would ask the court to excuse his presence."²⁰⁶ The trial judge immediately responded, "His presence is excused."²⁰⁷ John's lawyer offered no explanation of why John's attitude toward the conservatorship had changed, and the judge asked for none. John's lawyer then stipulated to the admission of the medical report and the conservatorship investigator's report, and the trial court ordered the conservatorship reestablished.²⁰⁸

In her petition to the California Supreme Court for review of the court of appeal decision, John's appellate attorney noted that judges are tempted to proceed as did the trial court in John's case "because it was expeditious—the entire case was concluded in less than a minute or two."²⁰⁹ However, the attorney aptly observed, "But the conveyor-belt aura of the proceedings does not inspire confidence that John's rights were adequately protected, given the conflicting evidence regarding his wishes."²¹⁰

Hopefully, the California Supreme Court will use the *John L.* case to slow the conveyor belt, if not disengage it completely. Although the

204. By way of comparison, only fifty-two new conservatorships were established in uncontested cases. Consider also that in the twenty-two court sessions, only thirteen cases for reestablishment of conservatorships were contested cases, compared with thirty-four contested cases involving new conservatorships. Thus, in this study, stipulation of reestablishment of conservatorship occurred in 93.4% of the cases, compared with 60.5% of new conservatorships. See *supra* Table One.

205. *John L.*, 65 Cal. Rptr. 3d at 397.

206. *Id.* at 397–98.

207. *Id.* at 398.

208. *Id.*

209. Petition for Review at *18, Conservatorship of John L., No. D048654, 2007 WL 3265719 (Cal. Oct. 10, 2007), review granted, 172 P.3d 400 (Cal. 2007).

210. *Id.*

court could decide the case on the narrow issue of whether the trial court may rely upon the attorney's unsworn representation of the client's waiver of the right to a hearing, a broader consideration of the duties of the proposed conservatee's counsel and of the trial court is surely warranted. Stated simply, due process is not trumped by a desire to handle cases expeditiously. As the California Supreme Court declared in *Conservatorship of Roulet*, "The easier the path to commitment, the more likely becomes the possibility of mistake."²¹¹ In order to counteract potentially erroneous decisions to deprive proposed conservatees of their liberty and to inflict stigma upon them, the *Roulet* court imposed criminal process safeguards of proof beyond a reasonable doubt and jury unanimity in proceedings to establish or reestablish conservatorships.²¹² The possibility of an erroneous decision remains high when an attorney reports that his or her client waives the due process right to be present at the hearing and either does not contest the establishment of a new conservatorship or stipulates to the reestablishment of a conservatorship. Did the attorney inform the client of the disabilities that could be imposed on him or her and that the conservatee was likely to be placed in a mental treatment facility where treatment would be imposed over the client's objection? Did the attorney consciously or subconsciously discourage the client from attending the hearing because the attorney believed the client would not succeed in the hearing and that it was not in the client's best interests to attend? If the client makes a competent, voluntary, and informed decision to waive the hearing and acquiesces in the establishment or reestablishment of a conservatorship, then is the client agreeing to accept treatment voluntarily, in which case the establishment or reestablishment of a conservatorship is unnecessary and an inappropriate *involuntary* commitment? The trial court needs to consider and answer these questions, not avoid them in the quest for expediency.

B. Contested Cases

A total of thirty-four new conservatorships were established in contested cases in the twenty-two court sessions, an average of 1.5 new conservatorships per session. The highest number of new conservatorships established in contested cases in any one session was four; the lowest number in any one session was zero. A total of twelve conservatorships were reestablished for an additional year in contested cases in the

211. 590 P.2d 1, 9 (Cal. 1979).

212. See *supra* text accompanying notes 140–58. The *Roulet* case involved a proceeding to reestablish a conservatorship. *Roulet*, 590 P.2d at 2. The court applied its due process safeguards to all conservatorship proceedings. *Id.* at 11.

twenty-two court sessions, an average of 0.5 reestablished conservatorships per session. The highest number of conservatorships reestablished in contested cases in any one session was two; the lowest number in any one session was zero. In one contested case, the court ruled that the conservatorship would not be reestablished. This case was the only one of a total of forty-seven contested cases observed in this study in which the court ruled against the establishment or reestablishment of a conservatorship. Thus, conservatorships were established or reestablished in 97.9% of all contested cases.

Two other matters were considered as contested cases. In one case, a conservatee petitioned the court for a rehearing as to his status as a conservatee.²¹³ In this rehearing, the court held that the conservatee remained gravely disabled and that the conservatorship would be continued. However, the court also ruled that the least restrictive placement for the patient was a board and care facility instead of a closed, locked facility where the conservatee had been housed previously.²¹⁴ Because this case did not involve the establishment of a new conservatorship or the reestablishment of a conservatorship that was about to expire, this case was not included in the study data. The second case involved the establishment of a conservatorship for a criminal defendant who had been charged with a serious felony and found permanently incompetent to stand trial. In 1974, the California Legislature enacted legislation that added an alternative definition of "gravely disabled" to enable a conservatorship to be established for such an individual.²¹⁵ Because a

213. See CAL. WELF. & INST. CODE § 5364 (West 1998) (authorizing a conservatee to petition the superior court for a rehearing on the conservatee's status). Although the conservatee may petition the court for a rehearing at any time, if the conservatee is unsuccessful in the rehearing, the conservatee is not permitted to petition the court again for a period of six months. *Id.* In a rehearing on the conservatee's status, SAN DIEGO SUP. CT. R. 8.2.22(A) (adopted July 1, 2006) specifically places the burden of proof upon the conservatee to establish, by a preponderance of the evidence, that the conservatee is no longer gravely disabled. See *supra* text accompanying notes 192–93.

214. See CAL. WELF. & INST. CODE § 5358(a)(1)(A) (West 1998) (requiring the court to designate the least restrictive alternative placement for a conservatee).

215. Act of Sept. 26, 1974, ch. 1511, § 12, 1974 Cal. Stat. 3316, 3322. As renumbered, and with some minor technical amendments, the statute has been codified at CAL. WELF. & INST. CODE § 5008(h)(1)(B) (West 1998). The California Supreme Court has upheld the validity of this legislation. *Conservatorship of Hofferber*, 616 P.2d 836 (Cal. 1980). *But see* Grant H. Morris & J. Reid Meloy, *Out of Mind? Out of Sight: The Uncivil Commitment of Permanently Incompetent Criminal Defendants*, 27 U.C. DAVIS L. REV. 1, 26–32 (1993) (strongly critiquing the 1974 legislation and the California Supreme Court's decision in *Hofferber*).

finding of grave disability for a permanently incompetent criminal defendant is not dependent upon proof of a functional inability to provide for food, clothing, and shelter, this case was not included in the study data.

In the twenty-two court sessions, a total of 1046 minutes—17.4 hours—was spent on contested cases—an average of forty-eight minutes per session and 22.3 minutes per contested case.²¹⁶ The longest hearing lasted forty-four minutes; the shortest lasted seven minutes. The thirty-four hearings to establish new conservatorships averaged 23.7 minutes per hearing, just over five minutes longer than the 18.5 minute average duration of the thirteen hearings to reestablish conservatorships.²¹⁷

Because the average duration of contested hearings in the 2007–2008 study—22.3 minutes per case—is substantially longer than the average duration of contested hearings in the 1975 study—less than three minutes per case²¹⁸—one might suppose that the quality of attorney representation of proposed conservatees today has improved significantly. However, a closer examination of the cases suggests that such supposition is unfounded.

In the typical contested case involving the establishment of a new conservatorship, County Counsel, acting on behalf of the petitioner, introduced into evidence the Public Conservator's report recommending that a new conservatorship be established. In the typical contested case involving the reestablishment of a conservatorship, County Counsel, acting on behalf of the petitioner, introduced into evidence the petition of the conservator, which included the opinion of two physicians or psychologists that the conservatee was still gravely disabled.²¹⁹ In addition, in all cases, County Counsel introduced into evidence the testimony of a psychiatrist—either the patient's treating doctor or a psychiatrist from the Forensic Psychiatry Clinic of the San Diego County Superior Court who examined the proposed conservatee prior to the hearing.

In forty-three of the forty-seven cases studied, the Public Defender, who represented the proposed conservatee in all forty-seven cases, introduced into evidence the testimony of the proposed conservatee. In none of the forty-seven cases studied did the Public Defender request an evaluation of the proposed conservatee by another psychiatrist. In none

216. A total of 806 minutes was devoted to the thirty-four cases to establish a new conservatorship. A total of 240 minutes was devoted to the thirteen cases to reestablish a conservatorship.

217. Both the longest hearing (forty-four minutes) and the shortest hearing (seven minutes) involved hearings to establish new conservatorships. The longest hearing to reestablish a conservatorship was forty minutes; the shortest was nine minutes.

218. See *supra* text accompanying note 136.

219. CAL. WELF. & INST. CODE § 5361 (West 1998).

of the forty-seven cases studied did the Public Defender request that the court appoint a psychiatrist to assist him or her in preparing for or conducting the hearing. In none of the forty-seven case studied did the Public Defender offer the testimony of a psychiatrist to controvert the expert opinion of the psychiatrist who testified for the petitioner. In only one of the forty-seven cases studied did the Public Defender offer the testimony of a family member or any other witness to support the proposed conservatee’s testimony that the conservatee was not gravely disabled and that a conservatorship was inappropriate. In fact, in one case, the mother of the proposed conservatee interrupted the hearing, stating to the judge that she wanted the proposed conservatee to live with her. The judge asked the Public Defender whether she wanted to speak to the mother. The Public Defender stated that she did not wish to do so, but that if the judge required her to, she would. The judge stated that she would not require the attorney to speak with her. After this exchange, the judge allowed County Counsel to recall the psychiatrist who had previously testified that the proposed conservatee was gravely disabled. The psychiatrist stated that if the mother would take care of the proposed conservatee, then the proposed conservatee would not meet the standard of grave disability. At the conclusion of the hearing, the judge ruled that the proposed conservatee was gravely disabled and that a conservatorship would be established.

Thus, in the typical case, the only witnesses were the psychiatrist who examined or treated the proposed conservatee and who testified that the proposed conservatee was mentally disordered and met the criteria for grave disability, and the proposed conservatee, who testified that he or she was not mentally disordered or, if mentally disordered, did not meet the criteria for grave disability. Although the Public Defender usually asked a few questions of the psychiatrist on cross-examination, the questions characteristically did not probe for significant weaknesses in the psychiatrist’s stated opinion, but rather, merely permitted the psychiatrist to restate his or her conclusion and to clarify or embellish upon the reasons for the psychiatrist’s judgment.

Dr. Ansar Haroun, Supervisor of the Forensic Psychiatry Clinic, acknowledged that a psychiatrist’s opinion that a proposed conservatee is gravely disabled should be easily challengeable on cross-examination.²²⁰

220. Interview with Ansar M. Haroun, M.D., Supervisor, Forensic Psychiatry Clinic of the San Diego County Superior Court, in San Diego, Cal. (May 29, 2008).

If a person has a normal ability to provide for food, clothing, and shelter, that person is able to provide for his or her basic needs. If the person has difficulties in providing for those needs because of a mental disorder, that person is disabled. Often, Dr. Haroun asserted, psychiatrists will conclude that the person is gravely disabled if the impairment in providing for basic necessities is severe. However, to meet the statutory definition of “grave disability,” the person, as a result of mental disorder, must be *unable* to provide for food, clothing, or shelter.²²¹ Inability to provide for basic needs means more than experiencing difficulty in providing for them. If the statutory standard of “grave disability” is literally applied by the court, a person who is not on the verge of starving to death even if the person eats out of a trash can, who has at least some clothes to wear no matter how tattered and dirty their condition, and who knows enough to get out of the rain even if the person is homeless, should not be found to be gravely disabled. Nevertheless, psychiatrists will express their opinion that a person is gravely disabled even if he or she is not unable to provide for food, clothing, and shelter, and lawyers for proposed conservatees do not challenge those opinions on cross-examination.

Because, in the typical case, the judge only heard the testimony of the psychiatrist—with no effective cross-examination by the Public Defender—and the testimony of the proposed conservatee, the results of the hearings could easily be anticipated. In forty-six of the forty-seven contested cases—97.9% of the cases studied—the court ruled in favor of the petitioner and ordered that the conservatorship be established or reestablished.²²²

In the hearings, the Public Defender rarely questioned whether disabilities²²³ should be imposed on the proposed conservatee if the court should decide to order that a conservatorship be established or reestablished. In only three of the forty-seven cases did the Public Defender challenge either the potential loss of the proposed conservatee’s privilege of possessing a license to operate a motor vehicle or the proposed conservatee’s right to refuse or consent to routine medical treatment unrelated to the person’s condition of grave disability. In only two of the forty-seven cases did the Public Defender challenge the

221. See CAL. WELF. & INST. CODE § 5008(h)(1)(A) (West 1998).

222. In the one case in which the judge ruled that a conservatorship would not be reestablished, the individual testified that he currently takes his medication because it makes him feel better and improves his sleep and his mood, and that he attends a day program and will continue to attend that program to help him in dealing with problems he has with his mental illness. The patient also submitted a letter outlining his housing arrangements and future plans.

223. See CAL. WELF. & INST. CODE § 5357 (West 1998) (identifying the disabilities that can be imposed on a conservatee).

potential loss of the proposed conservatee’s right to enter into contracts, the potential conservatee’s right to vote, or the proposed conservatee’s right to refuse or consent to treatment related specifically to the proposed conservatee’s condition of grave disability. In none of the forty-seven cases did the Public Defender challenge the potential loss of the proposed conservatee’s right to possess a firearm.

In all forty-six cases in which a conservatorship was established or reestablished—100% of the cases—the court imposed all of the following disabilities on the conservatee: loss of driver’s license, loss of the right to enter into contracts, loss of the right to refuse or consent to treatment related specifically to the conservatee’s condition of grave disability, loss of the right to refuse or consent to routine medical treatment unrelated to the person’s condition of grave disability, and loss of the proposed conservatee’s right to possess a firearm. In sharp contrast, the court disqualified the conservatee from voting in only three of the forty-six cases—only 6.5% of the cases in which a conservatorship was established. Typically, the testifying psychiatrist would simply state that the conservatee was able to complete a voter registration form or could identify the President and thus should not be disqualified from voting. Dr. Haroun informed me that his predecessor as Supervisor of the Forensic Psychiatry Clinic had expressed concern that efforts to disqualify conservatees from voting might be challenged by the American Civil Liberties Union, and that to avoid such potential litigation, psychiatrists working in the Forensic Clinic should not seek to impose this disability.²²⁴ This informal policy continues to be employed. Thus, psychiatrists in the Forensic Clinic typically seek to have all statutory disabilities imposed except disqualification from voting, and the court typically imposes all disabilities except disqualification from voting. This disparity suggests that individual cases are not being separately considered on their merits, but rather, are processed as a routine matter with anticipated, if not predetermined, results.

The failure of the Public Defender to advocate effectively that the proposed conservatee should be permitted to retain various rights surely contributed to the court’s decision to remove those rights when the conservatorship was established or reestablished. The unchallenged loss of the conservatee’s right to refuse or consent to treatment related to the

224. Interview with Ansar M. Haroun, M.D., Supervisor, Forensic Psychiatry Clinic of the San Diego County Superior Court, in San Diego, Cal. (May 29, 2008).

conservatee's condition of grave disability is especially troubling. A judge's decision that the proposed conservatee is gravely disabled and that a conservatorship be established or reestablished is not, in and of itself, an adjudication that the conservatee is mentally incompetent generally or lacks the capacity to make treatment decisions.²²⁵ The court is required to "mak[e] appropriate findings" in order to deny the conservatee the right to give or withhold consent to treatment for the conservatee's condition.²²⁶ Substantial evidence of a conservatee's competence to make treatment decisions may be available in some, and perhaps many, cases. For example, in a study of mental patient decisionmaking, the most frequently cited reason by patients for refusing medication was side effects experienced from previous administration of that medication.²²⁷

Psychotropic medications are powerful drugs that may produce temporary and permanent side effects that are discomforting,²²⁸ painful,²²⁹ disabling,²³⁰ and even deadly.²³¹ Even the newer atypical antipsychotic medications, such as Clozaril, Risperidal, and Zyprexa, increase a patient's

225. See *supra* text accompanying notes 120–21.

226. *Riese v. St. Mary's Hosp. & Med. Ctr.*, 271 Cal. Rptr. 199, 204 (Ct. App. 1987).

227. *Morris*, *supra* note 107, at 404.

228. Sedation is a common non-neurological side effect of psychotropic medication. Sedated patients experience drowsiness and fatigue. *Cichon*, *supra* note 63, at 297. Other non-neurological side effects include anticholinergic disturbances such as blurred vision, dry mouth, urinary retention, and constipation. *Id.* at 297–98.

229. Akathisia is an extrapyramidal side effect of psychotropic medication. Akathisia "is characterized by a painful irritability and a persistent desire to move. Symptoms can include a constant tapping of feet, alteration of posture and shifting of legs, fidgeting, pacing, and an inability to feel comfortable in any position." *Id.* at 301 (footnote omitted). Dystonias are another extrapyramidal side effect. "Dystonic reactions often involve acute and very painful spasms of muscle groups including those in the neck, face, eyes, pelvis, trunk, and the extremities." *Id.* at 303.

230. Tardive dyskinesia is a side effect of psychotropic medication that is characterized by "uncontrollable repetitive movements principally affecting the face, tongue, mouth, trunk (including respiratory muscles), upper and lower extremities, neck, shoulders, and pelvis. In the more pronounced cases, patients may have difficulty in swallowing (resulting in weight loss), talking, and breathing . . ." *Id.* at 304. Parkinsonism is an extrapyramidal side effect of psychotropic medication. "Its symptoms include a mask-like face, tremors of the limbs, muscle rigidity, spasms, drooling, a stooped and shuffling gait, and a general slowing of motor responses." *Id.* at 300. Akinesia is a subcategory of Parkinsonism, "characterized by a decrease in spontaneous mobility and speech along with a general feeling of listlessness and apathy." *Id.* at 301. Other disabling side effects include obstructed vision, blindness, and sexual dysfunction. *Id.* at 298, 303.

231. Neuroleptic malignant syndrome is a side effect of psychotropic medication. Its symptoms include "hyperthermia (fever), severe skeletal rigidity, elevated blood pressure, tachycardia, and alterations in consciousness including delirium, mutism, stupor, and coma. . . . This disorder is fatal in twenty to thirty percent of the cases . . ." *Id.* at 308 (citation omitted). Dyscrasias are potentially fatal blood disorders that may occur as side effects of psychotropic medication. *Id.* at 298–99.

risk of diabetes, obesity, and heart disease.²³² Although competent decisionmaking requires the individual to weigh the potential benefits of a proposed medication as well as the risks, nevertheless, a patient's concern about side effects—particularly if those side effects have been experienced previously—may be a rational basis for that patient to refuse administration of that medication. Some treating psychiatrists, however, do not consider mental patients' concerns about side effects in assessing their competence to refuse medication. When psychiatrists make a professional judgment that a medication is medically appropriate to treat the patient's disorder, they often view any patient objections as irrational.²³³

Additionally, many psychiatrists do not provide mental patients with needed information about medication side effects and treatment alternatives to the medication they are prescribing.²³⁴ One study reported that the failure of psychiatrists to inform patients was not limited to a few isolated incidents, but rather, was pervasive.²³⁵ When psychiatrists withhold or otherwise manipulate²³⁶ information about risks and alternatives, they

232. *Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes*, 27 *DIABETES CARE* 596, 597–98, 600 (2004). Participants in the conference included the American Diabetes Association, the American Psychiatric Association, the North American Association for the Study of Obesity, and the American Association of Clinical Endocrinologists. *Id.* at 596.

233. Similarly, psychiatrists are also too quick to claim that a patient's denial that he or she has a mental disorder determines the patient's incapacity to make treatment decisions. Sometimes a patient's seemingly irrational objections to medication are, in fact, rationally based. For example, does the patient who appears to deny a mental disorder acknowledge in nonmedical terms that the patient is experiencing a problem? Is the patient denying mental disorder in order to maintain control over his or her life and to avoid being thrust into the dependent role of a mental patient? Is the patient denying mental disorder because the patient has experienced medication side effects previously and is more concerned about those effects than the therapeutic potential of the medication? Is the denial an attempt to avoid a catch-22 situation, that is, by admitting mental disorder the patient strengthens the psychiatrist's assertion that medication is the appropriate remedy? Is the patient's hostility toward the psychiatrist a rational reaction either to the patient's involuntary detention or to the lack of communication between the psychiatrist and the patient?

234. *See, e.g.*, Morris, *supra* note 107, at 425–29.

235. *Id.* at 429.

236. Examples of manipulation include informing patients only about medication benefits; or discussing risks only in general terms, informing patients only that any medication can have detrimental as well as beneficial effects; or discussing some lesser, non-neurological side effects, such as sedation, dry mouth, blurred vision, urinary retention, and constipation, but omitting any discussion of neurological side effects such as dystonia, Parkinsonism, akathisia, akinesia, and tardive dyskinesia. *Id.* at 426–27.

undermine their patients' abilities to make competent decisions.²³⁷ To obtain a competent patient's informed consent, the California Supreme Court requires doctors to divulge "all information relevant to a meaningful decisional process."²³⁸ Psychiatrists should not be allowed to circumvent their disclosure obligation by asserting that whenever a patient refuses prescribed medication, that patient lacks the capacity to make treatment decisions.

In the hearings observed in this study, the psychiatrist's judgment that the proposed conservatee should lose the right to make treatment decisions regarding the proposed conservatee's mental disorder was not challenged by the Public Defender. Was the patient refusing medication because of a rational concern about side effects? Did the psychiatrist fulfill the psychiatrist's disclosure obligation to fully inform the patient about side effects that may be experienced? These issues were not addressed in cross-examination. They should have been.

The failure of the Public Defender to contest the imposition of the treatment decisionmaking disability on his or her client cannot be justified. The deprivation of liberty that occurs when that right is lost is truly significant. In all forty-six cases in which the court abrogated the conservatee's right to make treatment decisions, the court transferred that decisionmaking authority to the conservator.²³⁹ In all forty-six cases, the court specifically granted the conservator the authority to place the conservatee in a mental hospital or other treatment facility²⁴⁰ and to require the conservatee to receive treatment for his or her mental disorder.²⁴¹ From the conservatee's perspective, the government's unwanted assistance

237. John S. Carroll, *Consent to Mental Health Treatment: A Theoretical Analysis of Coercion, Freedom, and Control*, 9 BEHAV. SCI. & L. 129, 132 (1991); see also Loren H. Roth, *The Right to Refuse Psychiatric Treatment: Law and Medicine at the Interface*, 35 EMORY L.J. 139, 143 (1986) ("Information is given to patients largely to achieve their compliance, not to involve the patient in decision making."). To make a competent decision, a patient must analyze relevant information in terms of the patient's own knowledge, beliefs, and goals. Carroll, *supra*, at 132.

238. *Cobbs v. Grant*, 502 P.2d 1, 10 (Cal. 1972). The court summarized the physician's disclosure duty as follows:

In sum, the patient's right of self-decision is the measure of the physician's duty to reveal. That right can be effectively exercised only if the patient possesses adequate information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is whatever information is material to the decision. Thus the test for determining whether a potential peril must be divulged is its materiality to the patient's decision.

Id. at 11.

239. In only eight of the forty-six cases did the Public Defender challenge the transfer of the conservatee's treatment decisionmaking authority to the conservator.

240. CAL. WELF. & INST. CODE § 5358(a)(1), (2) (West 1998).

241. *Id.* § 5358(b).

resulted in the conservatee's involuntary confinement and coerced treatment.

VII. ZEALOUS ADVOCACY FOR MENTALLY DISORDERED CLIENTS: REALITY OR DELUSION?

In 1979, the California Supreme Court imposed a requirement of proof beyond a reasonable doubt and jury unanimity in proceedings to establish mental health conservatorships.²⁴² The court did so, in part, because of "the paternalistic attitude of some appointed counsel"²⁴³ in representing proposed conservatees. Despite the court's decision, the recent study of attorney performance in conservatorship cases reveals that the paternalistic attitude of counsel representing proposed conservatees has not changed. Paternalism existed thirty years ago; paternalism persists today.

In the article reporting on the 1975 study of conservatorship hearings in San Diego County, I recommended that instead of "using large numbers of private practitioners who handle conservatorship cases only sporadically, consideration should be given to creating a full-time conservatee attorney service."²⁴⁴ I cited approvingly the public defender model employing a small group of attorneys who would develop expertise in preparing and presenting cases and who would "pursue those cases with appropriate dedication."²⁴⁵ But I was wrong.²⁴⁶ Although a small group of attorneys from the Office of the Public Defender now represents proposed conservatees in conservatorship hearings in San Diego County, the recent study reveals that cases are not pursued by those attorneys with appropriate dedication. Although replacing occasional counsel with organized and regularized counsel is an important prerequisite to adequate representation of mentally disordered clients, such reform does

242. Conservatorship of Roulet, 590 P.2d 1, 11 (Cal. 1979). See *supra* text accompanying notes 140–58 (discussing *Roulet*).

243. *Roulet*, 590 P.2d at 11.

244. Morris, *supra* note 93, at 237.

245. *Id.*

246. In defense of my proposal, I note that I included in my recommendation that this small group of attorneys representing proposed conservatees would "have adequate psychiatric and social work services to assist them." *Id.* The attorneys from the Office of the Public Defender who represent proposed conservatees in San Diego County do not have, and have not requested, that needed assistance.

not ensure that paternalism will be replaced with zealous advocacy.²⁴⁷ What is needed is a change in attitude.

When the government seeks to civilly commit a mentally disordered individual, the role of the attorney is to zealously advocate for that individual in an attempt to prevent the loss of the client's liberty. After all, detention of the individual through civil commitment is an involuntary detention. When the government seeks to determine that the mentally disordered individual is incapable of making treatment decisions regarding his or her disorder, the role of the attorney is to zealously advocate for that individual in an attempt to prevent the loss of the client's right to make autonomous treatment decisions. After all, treatment of the individual without his or her consent is involuntary treatment. When the government seeks to establish a conservatorship for a mentally disordered individual in order to empower a conservator to place the conservatee in a mental hospital or other mental treatment facility and require the conservatee to accept treatment for the conservatee's mental disorder, the role of the attorney is to zealously advocate for that individual in an attempt to prevent the involuntary detention and involuntary treatment of the client.

Lawyers are charged with protecting their client's legal rights,²⁴⁸ not with acquiescing in governmental attempts to deprive their client of those rights in order to provide unwanted assistance that will, in the government's view, benefit the client. As aptly stated by the Montana Supreme Court in *In re Mental Health of K.G.F.*:²⁴⁹

247. Michael Perlin has repeatedly urged the use of organized and regularized counsel for mentally disabled persons in civil commitment hearings and in hearings to determine a mental patient's treatment decisionmaking capacity. See, e.g., 1 PERLIN, *supra* note 2, § 2B-4, at 214 ("[I]t appears beyond dispute that an organized and regularized scheme for providing such counsel comes closest to guaranteeing at least minimally adequate counsel."). By comparison, Perlin states, "The track record for 'occasional' counsel continues to be shoddy." *Id.* § 2B-6, at 222. He notes, however, that although some public defender "programs have traditionally provided effective legal services to persons with mental disabilities, the track record of others has been, to be charitable, mixed." *Id.* § 2B-5, at 216-17 (footnotes omitted). See also Andalman & Chambers, *supra* note 32, at 62 (reporting that the Public Defender in Chicago who represented mentally disordered persons in civil commitment hearings "did advocate [for] the release of his clients, though he appeared to press less vigorously for those clients whom he believed needed hospitalization, even if the client wanted her freedom").

248. See, e.g., *In re Conservatorship of Christopher A.*, 43 Cal. Rptr. 3d 427, 433 (Ct. App. 2006) (quoting *Linsk v. Linsk*, 449 P.2d 760, 764 (Cal. 1969)). See *supra* text accompanying note 187.

249. 29 P.3d 485 (Mont. 2001).

[W]e must . . . be cautious and critical of signs of paternalism legitimized by the *parens patriae* doctrine, where State actors purport to have an absolute understanding of what is in the best interests of an individual, whose liberty, dignity and privacy are at issue, and whose voice is muted by the swift and overriding authority of court-appointed professionals.²⁵⁰

If we truly believe that lawyers today are doing an adequate job in representing their mentally disordered clients—if we are willing to accept that belief as our reality—then we are deluding ourselves.²⁵¹ In focusing on the question of whether a mental patient had received effective assistance of counsel in a civil commitment proceeding, the Montana Supreme Court proclaimed that the involuntary civil commitment hearing process is an “obvious systemic failure [T]he ordinary course of the efficient administration of a legal process threatens to supplant an individual’s due process rights that serve to safeguard . . . fundamental liberty interests”²⁵² The court characterized a civil commitment hearing as “a proceeding that routinely accepts—and even requires—an unreasonably low standard of legal assistance and generally disdains zealous, adversarial confrontation.”²⁵³

The Montana Supreme Court did more than merely indict lawyers who represent mentally disordered clients in civil commitment proceedings and judges who condone—and even encourage—ineffective assistance of counsel in those proceedings. The court adopted specific guidelines for lawyers to ensure that mentally disordered clients receive effective assistance of counsel in civil commitment proceedings.²⁵⁴ For example, to be eligible for appointment, attorneys are required to “have specialized course training, or have received supervised on-the-job training in the duties, skills, and ethics of representing civil commitment

250. *Id.* at 496.

251. A delusion is defined as “a false, persistent belief not substantiated by sensory or objective evidence.” WEBSTER’S NEW WORLD DICTIONARY OF THE AMERICAN LANGUAGE, *supra* note 6, at 374.

252. *K.G.F.*, 29 P.3d at 494.

253. *Id.* at 492. In describing the existing “perfunctory process” of a civil commitment hearing, the court acknowledged, “[O]ur legal system of judges, lawyers, and clinicians has seemingly lost its way in vigilantly protecting the fundamental rights of [mentally disordered] individuals.” *Id.* at 493.

254. *Id.* at 497. The court adopted, and expanded upon, guidelines for legal representation in civil commitment proceedings developed and promulgated by the National Center for State Courts. See National Center for State Courts, *Guidelines for Involuntary Civil Commitment*, 10 A.B.A. MENTAL & PHYSICAL DISABILITY L. REP. 409, 464–91 (1986) (parts E and F) [hereinafter *Guidelines*].

respondents.”²⁵⁵ Counsel for a mentally disordered client is expected to “conduct a thorough review of all available records”²⁵⁶ and be “prepared to discuss with his or her client the available options in light of such investigations.”²⁵⁷ Counsel is required to meet with his or her client and “[t]he initial client interview should be conducted in private and should be held sufficiently before any scheduled hearings to permit effective preparation and prehearing assistance to the client.”²⁵⁸ Counsel is required “to facilitate the exercise of the client’s right . . . to ‘be examined by a professional person of the person’s choice.’”²⁵⁹ Most importantly, the court stated “that the proper role of the attorney is to ‘represent the perspective of the [client] and to serve as a vigorous advocate for the [client’s] wishes.’”²⁶⁰ Lest there be any doubt, the court added: “In the courtroom, an attorney should engage in all aspects of advocacy and vigorously argue to the best of his or her ability for the ends desired by the client.”²⁶¹ If counsel independently advocates for, or acquiesces in involuntary commitment—absent a voluntary and knowing consent by the patient—such conduct “will establish the presumption that counsel was ineffective.”²⁶²

The data from the recent study of conservatorship proceedings in San Diego County support a similar presumption of counsel ineffectiveness in those proceedings. In 238 cases, counsel for the proposed conservatee either did not contest the establishment of a conservatorship or stipulated to the reestablishment of a conservatorship.²⁶³ During those same proceedings, the establishment or reestablishment of a conservatorship was contested in only forty-seven cases. Thus, counsel for the proposed conservatee either acquiesced in, or independently advocated for, a conservatorship in 83.5% of the 285 cases.

The data also confirm that the conservatorship hearing process, just as the civil commitment process in Montana, is an “obvious systemic

255. *K.G.F.*, 29 P.3d at 498.

256. *Id.*

257. *Id.*

258. *Id.* at 499 (emphasis omitted).

259. *Id.* (quoting MONT. CODE ANN. § 53-21-115(9) (2007) and citing *id.* § 53-21-124(3)).

260. *K.G.F.*, 29 P.3d at 500 (quoting *Guidelines*, *supra* note 254, at 465). If the client is unwilling or unable to express his or her personal wishes, “the attorney should advocate the position that best safeguards and advances the client’s interest.” *Id.* (quoting *Guidelines*, *supra* note 254, at 465). The *Guidelines* specifically identify the client’s interest “in liberty” as the interest that should be safeguarded and advanced by the attorney. *Guidelines*, *supra* note 254, at 466.

261. *K.G.F.*, 29 P.3d at 500 (quoting *Guidelines*, *supra* note 254, at 483).

262. *Id.*

263. *See supra* text accompanying notes 182–212.

failure”²⁶⁴ “that routinely accepts—and even requires—an unreasonably low standard of legal assistance and generally disdains zealous, adversarial confrontation.”²⁶⁵ Even when counsel for proposed conservatees “contested” the establishment or reestablishment of a conservatorship, they typically engaged in no probing cross-examination of the psychiatrist who testified in favor of the conservatorship and for the imposition of disabilities being imposed on their client if a conservatorship was established or reestablished.²⁶⁶ They did not introduce the testimony of a psychiatrist, a family member, or a friend to counter that of the psychiatrist who testified in favor of the conservatorship. The only witness called by counsel for the proposed conservatee was the proposed conservatee himself or herself.²⁶⁷ Leading a lamb to the slaughter does not constitute zealous advocacy on behalf of the lamb.²⁶⁸ When trial judges tolerate—and even encourage—this unreasonably low standard of legal assistance, they undermine the proposed conservatee’s right to effective assistance of counsel in the adversarial process that is required before society deprives a person of liberty and of basic human rights, including the right to medical self-determination.²⁶⁹

In re Mental Health of K.G.F. was—or should have been—a landmark decision. However, in the eight years since the case was decided, it has only been cited on the competency of counsel issue in two appellate court cases—and both cases cited *K.G.F.* negatively. In 2004, the Court of Appeals of Washington disagreed with the Montana Supreme Court’s refusal to presume the effectiveness of counsel in civil commitment proceedings, stating: “We do not share the Montana Supreme Court’s dim view of the quality of civil commitment proceedings . . . in the state of Washington.”²⁷⁰ In 2006, the Ohio Court of Appeals, citing the

264. Quoting from *K.G.F.*, 29 P.3d at 494.

265. *Id.* at 492.

266. See *supra* text accompanying notes 220–21 (reporting on Dr. Haroun’s suggested, but unused, method of cross-examining psychiatrists who testify that a proposed conservatee is gravely disabled and that a conservatorship should be established or reestablished).

267. See *supra* text following note 220.

268. See *Isaiah* 53:7 (“As a lamb that is led to the slaughter . . .”).

269. See *supra* text accompanying notes 159–64 (discussing the requirement of effective assistance of counsel in conservatorship proceedings). The data from the recent study of conservatorship proceedings in San Diego County demonstrate that the performance of counsel for proposed conservatees falls below the objective standard of reasonably effective assistance of criminal defense counsel established by the United States Supreme Court in *Strickland v. Washington*, 466 U.S. 668, 687–88 (1984).

270. *In re T.A. H.-L.*, 97 P.3d 767, 771 (Wash. Ct. App. 2004).

Washington Court of Appeals decision, declined to follow *K.G.F.*, stating: “Likewise, we do not share the Supreme Court of Montana’s view”²⁷¹ Apparently, in Washington, Ohio, and in most of the United States, a lawyer who acquiesces in or advocates for the involuntary commitment of his or her client, or for requiring the client to accept medication that he or she does not wish to take, or for imposing a conservatorship that will allow the conservator to “volunteer” the client for placement in a mental treatment facility and to authorize unwanted treatment, will not be presumed to be providing ineffective assistance of counsel. The failure of appellate courts throughout the United States to demand zealous advocacy by attorneys for their mentally disordered clients suggests that paternalism does not merely persist, but rather, that paternalism prevails.

Most persons, upon observing *The Rocky Horror Picture Show*, consider the highlight of that cult movie classic to be the performance of “The Time Warp,” a marvelous song and dance number. The lyrics of that song contain two distinct references to mental disorder: “Madness takes its toll,” and “[I]t’s the pelvic thrust that really drives you insane.”²⁷² The lyrics contain one reference to treatment of mental illness: “You’re spaced out on sensation, like you’re under sedation.”²⁷³ And the lyrics contain one reference to the meaningless passage of time: “Time meant nothing, never would again.”²⁷⁴ Most lawyers, in representing a mentally disordered client in proceedings to determine whether civil commitment is warranted, in proceedings to impose treatment over the client’s objection, and in proceedings to establish a mental health conservatorship, perform as inadequately as lawyers performed thirty or forty years ago. Unless lawyers are required to act as zealous advocates for their clients, they will be guided only by the song’s oft repeated refrain: “Let’s do the Time Warp again!”²⁷⁵

271. *In re L.G.*, No. 06AP-453, 2006 WL 2780157, at *8 (Ohio Ct. App. Sept. 28, 2006). In the only other appellate court decision citing *K.G.F.*, the Supreme Court of Montana distinguished the case on the question of whether the trial court lacked subject matter jurisdiction because the issues were moot. *In re R.E.A.*, 127 P.3d 517, 519 (Mont. 2006).

272. The Time Warp, in *THE ROCKY HORROR PICTURE SHOW* (1975), available at SLL Lyrics, <http://www.stlyrics.com/lyrics/therockyhorrorpictureshow/thetimewarp.htm> (last visited Apr. 2, 2009).

273. *Id.*

274. *Id.*

275. *Id.* “The Time Warp” is a most appropriate song for this Article. As I wrote in the introduction to this Article, when I observed the inadequate performance of attorneys in conservatorship hearings in December of 2007 and the spring of 2008, I felt that I had entered a time warp—I was transported back to 1975, observing the inadequate performance of attorneys in conservatorship hearings that I had observed more than thirty years earlier. *The Rocky Picture Horror Show*, the movie that contains this song, was first released in 1975.