Episode 253: The Long History of Conservatorships

Lisa: Hi, I'm Lisa Hernandez.

Lizzy: And I'm Lizzy Ghedi-Ehrlich.

Lisa: And we are your hosts for Scholars Strategy Network's No Jargon. Each month we will discuss an American policy problem with one of the nation's top researchers without jargon. And this month we are talking about involuntary care for mental health patients.

Lizzy: Known as conservatorships. Which, niche issue, but very much in the news these days.

Lisa: I mean I think we've all, anyone in the U. S. particularly, we've all been paying attention to things happening around the Free Britney movement and everything going on with Britney Spears and Lizzy you already know what I'm about to say. You know, Kara Cunningham said it perfectly: before I'm an American, I'm a Britney fan and I will continue to pay attention to whatever's going on with the Britney Spears family as I have been since I was four years old.

So I'm definitely excited to learn more about this, especially from a different perspective as well.

Lizzy: Right. We know that most people who are under conservatorship are not multi millionaire, world renowned artists with a well known history of inter family power struggles. And therefore I worry that this one example is really taking over the general public consciousness about what this type of care actually is and who it's for so I'm really interested to hear from an expert about that. And of course, I also think of the other part that does touch the lives of a lot of people which is the current fear about unhoused mentally ill people and their place in society and any danger that they may or may not pose and I would posit that that's also not necessarily the typical person who is involved in this type of relationship, so I really want to know more and find out what's, what's the truth here?

What, what is this type of care? Who is it for and what's it doing?

Lisa: Hey, well, we talked to an expert that knows all the nuances of this situation. So for this week's episode, I spoke to Alex Barnard, an assistant professor of sociology at New York University. Professor Barnard's research focuses on inequalities in access to medical care and disability benefits, decision making around involuntary treatment, and changes in institutions providing services to people living with severe mental illnesses.

He also has a new book that just came out this September, titled Conservatorship, Inside California's System of Coercion and Care for Mental Illness. Here's our conversation…

Lisa: Hi, Professor Barnard. Thanks for coming on No Jargon.

Alex: Thank you so much for having me.

Lisa: So you have been studying conservatorships for a really long time. And coincidentally, we are talking to you on the same day that Britney Spears' highly anticipated book, The Woman in Me has just come out, where she does detail what her life was like during this, 13 year conservatorship.

So I'd love for us to start with, could you explain what conservatorships are in the United States and what the criteria is for someone ending up in one?

Alex: So a conservatorship is a legal mechanism by which a person with disabilities (and often that's somebody with a mental illness with a developmental disability or potentially an aging person with dementia or some sort of cognitive impairment) --a conservatorship is a tool by which a judge decides that a third party, which could be a family member, like in the case of Britney Spears, it could be a private conservator, or it could be a public conservator, often a county or a state agency, can make decisions on behalf of that person.

And those decisions could include managing their money. It could be consenting to medical care on their behalf and deciding where they're going to live, which could include a locked psychiatric facility, for example. You asked also about the criteria, it varies by state. That's something that's set by state law.

But my focus in the book is on California. And to be placed on a conservatorship for a mental illness in California, you have to be unable to meet your basic need for food, clothing, or shelter as a result of a mental disorder or chronic alcoholism. But that's actually something that the state has been looking to change for a couple of years and, and very recently did change.

So it's something that's in flux.

Lisa: And how did that change recently?

Alex: So they made two really substantial changes to the criteria for conservatorship. One is that they broadened that mental disorder part to include severe substance use disorders, and that's really thinking about individuals who are struggling with opioid addiction or particularly methamphetamine use are sort of now being potentially included in the conservatorship system. And then in addition to food, clothing and shelter they've added somebody's need for medical care or personal safety, and it remains to be seen how much that's really going to widen the net of conservatorship, but it's certainly something advocates around this issue are watching really closely.

Lisa: So how exactly does government relate to conservatorships? What, what's the relationship there? What is the government's role?

Alex: So the book a little bit departs from a paradox in how government relates to conservatorship. So on one hand, conservatorship is a huge exercise of government power. The ACLU says that it's the second greatest deprivation of civil liberties next to the death penalty. And when you think about the idea that somebody could lose control of where they live, control over medical care.

It's a really, you know, it's a very serious power of the state that it can take people's decision making away, in that fashion. But on the other hand, government actually exercises very little oversight about how its own power is used. What I mean by that in California is even though most of the people who are conserved there, their actual conservator is a public guardian.

So a county official, the conservatorship process really depends on a really fragmented field of public and nonprofit and private actors. So for profit hospitals, you know, rehabilitation facilities that are controlled by a small number of private companies. And so as a result, who actually winds up being conserved is less about the criteria that's written into law and more about the financial incentives of, of these different actors in the system.

And so there's a basic lack of accountability for how the state is again, how this particular state power of conservatorship is actually being used. And that starts with even lack of account. So what is the basis of accountability? You know, to start with, we need to know how many people are conserved.

But the state of California doesn't even publish reliable data on how many people are conserved, where they are or what their outcomes are. So you know, the book is really concerned precisely with, again, this paradox of there are a lot of people being subjected to these rights deprivations through state power, but the state itself is playing a pretty hands off role in terms of making sure that the system is functioning appropriately.

Lisa: Could you actually walk me through some of the history of the government's role in this space and what their role also looks like at this moment?

Alex: Absolutely. So in the mid 20th century mental health care was almost entirely a government or a state responsibility. So there were a half million Americans who were in state mental hospitals, and that was where the majority of psychiatrists worked. And at that time in California, there were about 35, 000 people in state hospitals.

From the 60s forward, we have this process of deinstitutionalization by which care moved out of hospitals and into the community. And California was really a leader in that and reforms to California's conservatorship laws were, part of what drove that process forward. So in the mid 1960s, a couple of legislators did an investigation at the state hospitals and they discovered really shocking abuse and neglect.

They discovered that most of the people in the state hospitals weren't really mentally ill as we'd understand it. There were a lot of elderly people with dementia who simply their families couldn't care for them. Uh, and they pushed forward this law called the Lanterman Petris Short Act, which was hailed after it was passed as the Magna Carta or the Bill of Rights of People with Mental Illness because it put an end to a system by which people could be indefinitely committed to these hospitals based on a clinician saying that they were mentally ill and created this modern conservatorship system. Whereas I was telling you earlier somebody had to be found gravely disabled to be placed on a conservatorship. Which is a much higher standard and it's something that a judge has to review every year. So that's the deinstitutionalization story that I think has been written about pretty extensively. What my book tried to trace is how the closure of the state hospitals was also a moment where the state really progressively took steps, more and more steps back from responsibility for organizing care for those individuals.

So it wasn't just that care for the people who were once in the state hospitals moved to the community. It was also that the state over time exercised less and less oversight and provided less and less funding, for supporting those individuals who had left the state hospitals. I think California was a leader in deinstitutionalization.

One of the questions my book asks is whether California is going to be a leader in kind of a pendulum swing in the other direction. So in the last few years, legislators, democratic legislators have introduced several bills that would expand conservatorship, and this is really targeted and particularly at, the unhoused, unsheltered population.

So these bills to expand conservatorship, and they're coupled with really significant new investments in mental health beds. Uh, some of which will be in locked facilities. So in 2024, California voters are going to have a chance to vote on an initiative by Governor Newsom that would spend 6 billion, a large portion of it on, on locked treatment beds in the state.

So, you know, we can see over time, there's been this, you know, government sort of stepping back from the conservatorship system and now government is stepping in to take a more, kind of aggressive role, particularly in response to homelessness. Like a lot of individuals, you know, my concern is about whether that expansion of government power through conservatorship is going to be coupled with government accountability to make sure that people are really getting the services that they need.

Uh, and that coercion is going to be sort of limited, to the greatest extent possible.

Lisa: Do you mention that, um. , at first, there was a pullback in trying to have government provide this, um, type of care, try to provide, sort of like these treatment facilities. What was the reason for that pullback?

Alex: Well, I think it's important when we have these discussions about psychiatric hospitals and building new beds that we remember that the state hospitals are really awful places. And it's

a good thing that people left them. I think what happened was, you know, the hope was that people with mental illness, they might be provided medication and therapy in the community, but they would become autonomous, able to provide for themselves, house themselves.

And in reality, that's not really how it worked out. And instead, what grew up was a private medication system of for profit boarding homes and nursing homes that used federal revenue, particularly people's social security disability checks to provide for individuals basic needs, but often in a way that, you know, wasn't particularly therapeutic.

And, you know, there's a huge amount of neglect and abuse that happened in these privatized spaces that grew up in the sort of the wake of government's withdrawal from providing for people. And that privatization has really deepened over time as, as the state has sort of shifted more and more responsibilities for mental health down onto county governments, and county governments have then contracted out those services, to these very large private providers, some of which have almost like a monopoly position in, in California in providing locked care.

Lisa: So we've mentioned county and state level governments. Does the federal government play any significant role in involuntary care policies?

Alex: It's a bit of a contradiction because on one hand, the federal government is paying for most of it because involuntary care is often happening in hospitals that are reimbursed through Medicaid. And then, like I said, many of these private facilities in which conservatives might wind up are also being paid for by the federal government through things like social security disability. But in spite of that, the federal government is doing very, very little to actually regulate and manage the conservatorship system. You'd be really hard pressed to find any reporting or data at the national level that suggests that there's any real strategy for what role involuntary mental health treatment should be playing and responding to mental health crises in the U.S.

Lisa: Right. Well, thank you for, thank you for bringing light to that. And of course, we're obviously eager to see what kind of changes take place in California and maybe what other states will emulate based on the changes happening in California.

Alex: And that's one of the things my current research is, is tracking. So with some research assistance, we've been cataloging all the bills on involuntary treatment that have been introduced across the 50 states in the last 12 years. And we're really seeing a pretty strong pattern in terms of it being coastal democratic states with a large homeless population that are really at the forefront of rolling out these involuntary interventions.

So those will be the places to, to watch and to insist on accountability there.

Lisa: Right. Did any patterns in like new policies surprise you at all that you'd like to share?

Alex: I came into this research imagining that more conservative leaning red states would be the ones that were taking a more coercive approach to mental health and, you know, progressive states would be more focused on voluntary services and independent housing.

And that's really not the case. I think the biggest surprise is, has been realizing that California, Oregon, and Washington are, are really in the lead in terms of piloting these involuntary interventions.

Lisa: You talk about this clash within your book between two professions, law and medicine, when it comes to the state's handling of involuntary care of those suffering from debilitating mental illnesses.

So could you talk about this, this tension, and also share a specific example to illustrate how this tension can impact a mental health patient

Alex: So the idea of a clash between law and medicine is in some ways a clash between rights and care. So we can imagine that the medical profession, clinicians, and the conservatorship system, they're generally, we'd like to think that their main concern is the health and wellbeing of the person.

But in order for a conservatorship to be put into place, it needs to be signed off on by, by law. A clinician can request a conservatorship, but ultimately that's something that's going to be put in place by a judge after a hearing in which the conservatee is going to be represented by a public defender.

And certainly their prerogative is to defend somebody's civil rights, including if those rights mean that they should be allowed to refuse treatment that a clinician might think is in their best interest.

Lisa: And within your book as well, you did happen to collect a lot of stories, you talked to a variety of people that were impacted by involuntary care. Can you share some of these stories? I imagine that they're very powerful experiences.

Alex: Yeah, I'm going to share the story of Serge Obolensky. He's an individual who consented to me using his real name. So I feel really comfortable sharing his story and he was very gracious with his time with me. And I think his story gets at some of the incredible moral dilemmas here. So this is an individual.

As a result of an accident when he was younger, he lost both of his hands and one of his eyes and he was homeless on the streets of Hollywood for a decade. And there used to be videos on YouTube showing him accosting passers by, acting in a threatening way. But when you talk to him, it's not just that his behavior was problematic. He was really, really suffering.

And I think, for citizens in California, they look at unhoused individuals like Surge and they ask, well, why isn't somebody doing anything about this individual? And the reality is that in Surge's case, there were a lot of government actors that were intervening in his life. So he was being frequently arrested for various kinds of behavior.

And he's also being transported to ERs and to psychiatric hospitals on what are called holds, which is when a police officer determines that somebody is, a danger to themselves, a danger to others, or gravely disabled, they can bring them to a conservatorship. So he was cycling in and out of ERs, and jails, but not connecting to any kind of long term services.

And in the end, what changed his trajectory was a private citizen, Kerry Morrison, who is head of the Business Improvement District in Hollywood. And she realized that there were all these agencies touching on Surge's life, but no one was really trying to shepherd him through the system. And so she convened some local community stakeholders, charities, churches, things like that.

And they found out everything they could about Surge. Uh, they put it together in a dossier and they arranged in conjunction with the police to have him be placed on a hold and transported to an ER and they camped out in the ER and they provided that dossier of information to the, to the clinician and had him admitted.

And eventually, you know, he worked his way through the system and wound up to be conserved. And when I spoke to Serge, I asked him, you know, what do you wish had worked differently? Because, because I think we want to believe there must have been a better way. And he said at the end, he said, I wish they had conserved me sooner because his life now is so much better. You know, he's housed, he's, he's healthy. He's been donated prosthetic hands. He's got, he got his GED, which he's incredibly proud of. You know, certainly one of the questions I kept asking in my research is, isn't there some sort of a better way for these individuals where government takes a more active role?

It's not dependent on a private citizen. and also that services are in place to get somebody what they need before they've, you know, reached the point where the only intervention we can imagine helping them is a conservatorship.

Lisa: Thank you for sharing that and I think one of the things that stuck out to me with this story is obviously there was a lack of communication from the government actors as well about what that process looks like. Is that something that you found was a pattern within the interviews that you had?

Alex: Absolutely. And I think it's, there's a kind of classic sociological insight that ultimately, you know, public policy is made up by the decisions of individual bureaucrats. And then the conservatorship system, there are a lot of street-level bureaucrats.

So there's the police that are placing people on holds. There are the clinicians in ERs. There's the hospital psychiatrists who have to apply for a conservatorship. It's then evaluated by a county agency called the Public Guardian. Then it goes to a court that has to rule in the conservatorship. And then the person is going to be transferred to a facility, which, as I said, they're usually private and for profit.

And each actor in that chain has its own set of incentives and, and organizational pressures that they're facing. And they often don't line up. So the people that the police most think need to get off the street and get help are often individuals using substances, which the ER's will then immediately discharge and send back to the street.

So I think one of the I guess again, one of the real problems you see in the system is this incredible fragmentation and a lack of alignment in terms of what are the actual purposes of conservatorship and who do we think would benefit from this intervention?

Lisa: Right, and obviously this individual wanted to be or demonstrated that in the end the conservatorship was good for him. He wanted to be in it maybe sooner. But I want to see if you can address, um, some of the downsides of conservatorships and does that have to do with maybe folks that don't necessarily meet the criteria and are forced into conservatorship?

How do you wrestle with the fact that there are other folks who maybe would not want to be put through this system and could be forced into it.

Alex: Yeah, and I think that's an important part of the story that we have to hold on to, because at least in California and policy making right now, a lot of the attention is going towards those people on the street who seem to desperately need help and are not getting some sort of treatment. And so there's a sense that, oh, the conservatorship system is not conserving enough people.

But through my research, I was able to visit some of these locked facilities. I was able to interview people who are on conservatorship, who had been through conservatorship. And there's another part of the story, which is people who are having their rights restricted, sometimes for long periods of time, in ways that are harmful to them and, and really unnecessary if the right kind of supports were in place for them.

I'm thinking about an individual named Thatcher that I interviewed. They were hospitalized, I think, eight or nine times over the course of a couple of years, and every single one of those experiences was incredibly traumatic. They experienced psychiatric hospitals as a place of constant violence and degradation by staff.

They had very little contact with doctors in their time there. And, those are experiences. Those are, you know, that's another part of the story that is, that is really important. And I think what I

tried to convey in the book, but that is really difficult because this is a debate where you have often kind of half of people saying,

it's too hard to get a conservatorship. We need to get more people into conservatorship. And then Britney Spears has raised this idea that maybe there are too many people under conservatorship, is to realize that these are two sides of the same coin, which is the way in which the government has abdicated responsibility for the system means that both of these things can be happening, that we can be having people who are abandoned by the system and also people who are being subjected to repeated and, and traumatic coercion.

Lisa: You know, one thing I'm wondering is, within your studies, have you noticed any racial or gender disparities that are at play when it comes to involuntary treatment, any form of discrimination in this decisionmaking process?

Alex: One of the real challenges here is that there's no good reporting. This is this largely invisible part of the system, and so we don't have what I think would be really helpful, which is a, a baseline number of what the gender breakdown of people conserved actually is. I mean, Britney Spears really revealed the extent to which claims about who is crazy, who is irrational, who lacks capacity to make decisions, have a really strong gendered character.

One place that we do have a little bit more data is around racial disparities in involuntary treatment, and there it's pretty flagrant. So in, in, uh, in San Francisco, 50 percent of the people who have eight or more involuntary holds, so again, that's police taking someone to an ER for evaluation, 50 percent of those individuals are Black in San Francisco, and San Francisco, only 6 percent of the population is Black.

And I think that reflects not just potentially, you know, discrimination in the decision making of police about who to take to the hospital or the decision making of clinicians about who to conserve or not, but also the way that, you know, social determinants of health, the consequences of poverty, homelessness, and mass incarceration are leading certain sets of people to be more likely to be in crisis and therefore to come to the attention of the mental health conservatorship system.

Lisa: I think we've established that there are problems within the way that the conservatorship system runs at large, especially some people who are in need of treatment and are not getting it and others are being subjected to maybe traumatic treatment, what are some solutions that can address the needs of people that have mental health issues in a more effective way?

Alex: So I think, to start with, my research is really, I should say, focused on a really narrow subset of individuals with the most serious mental illnesses, often things like schizophrenia or bipolar disorder. So the recommendations I'm going to put forward are not really about how we fix, kind of the national mental health crisis, but really how do we focus on meeting the needs of this subset of people who are potentially facing involuntary treatment?

I think we need to start with a more realistic approach to engaging people. So our community mental health system, which is supposed to be the alternative to conservatorship, you know, often they're offering people really medicalized services, you know, particularly medication. They're so overwhelmed that as soon as somebody says no to them once or twice, they're going to close their file.

And if that person comes back, they have to be reevaluated and have their file reopened. And I think we need services that are more persistent, that are going to try and engage with people over time, even if they're initially resistant, and that are going to try and meet people and engage in communication.

In terms of the needs that those individuals put forward. So often the real reasons people wind up engaging with the mental health system is not because they have medication, but because they find clinicians who are willing to help them get an ID or get a ride to a primary care physician or help them with housing.

So we need a mental health system that's adapted to that. And that's going to require changes in the way public insurance Medicaid is run at the state and federal level. I think the second thing we need is a full range of residential solutions for people with mental illness. And what I mean by that is, often the debate right now is, is polarized between those who say, for homeless people with mental illness, what we really need is just apartments.

We need housing. The solution to homelessness is housing. And then we have another side, and these are individuals who are advocating for expanding conservatorship, who are really emphasizing the need for more locked places, you know, psychiatric hospitals. In reality, what needs to happen is a whole continuum of care that recognizes that some individuals maybe aren't ready to live in their own apartment right away, but that doesn't mean they need to be in a locked setting, and that actually they should be in residential treatment settings that are unlocked, that are therapeutic, that are focused on getting people skills that will allow them to live independently and manage their symptoms autonomously. So, you know, full continuum of residential care would be the second thing I'd emphasize. And then the third is, I think there's a need for, you know, in the course of doing research for this book, I've really seen the kind of situations where it's difficult to imagine um, okay, resolving this crisis without resorting to some sort of involuntary treatment, you know, individuals who are just in such deep crisis and potentially a danger to themselves or others, and they're, they're simply not able to or not willing to accept services.

But I think we need to be-have a much narrower, and more evidence based approach to how we actually use conservatorship in which we have rigorous evaluation of figuring out, you know, who are the people that this intervention really works for? You know, how can we set criteria to make sure it's targeted and how can we, ensure that those individuals step down off of conservatorship, regain their rights as soon as possible.

Lisa: I really appreciate this vision of care that you've outlined for us today.

I think it's really people centered and I, I always appreciate a vision that puts people's needs first. So thank you again for speaking with us today and sharing that with us.

Alex: Thanks very much for having me.

Lisa: And thanks for listening. For more on Professor Barnard's work, check out our show notes at scholars. org slash no jargon. No Jargon is the podcast of Scholar Strategy Network, a nationwide organization that connects journalists, policymakers, and civic leaders with America's top researchers to improve policy and strengthen democracy.

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