conservatorships:

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coercion without care or control

by alex v. barnard

Phil, like millions of Americans, watched the Britney Spears case with disbelief. In 2007, the pop star was placed under a conservatorship—a legal measure in which a court grants a third party the power to decide where a person with a disability lives, what treatment they receive, and how they spend their money. Thirteen years later, thanks to a *New York Times* documentary and the #FreeBritney movement, the public discovered how a conservatorship could enable a range of abuses: forced psychiatric treatment, restrictions on sexuality and reproduction, and cruel separation from friends or children.

Spears's case was exemplary of how the conservatorship system is infused with what disability theorist Liat Ben-Moshe calls "carceral logics," which mask coercion behind a façade of care.

But while everyone was "pouring their bleeding hearts out for Britney Spears" and the overbearing control she was facing, Phil told me, his own conservatorship over his son Jacob gave him frustratingly little authority to determine Jacob's care.

Jacob was hospitalized for schizophrenia four times over the course of his 20s, each time released with a new medication he quickly stopped taking. The fifth time, Phil convinced the doctor to apply for a court-ordered conservatorship mandating that Jacob continue his medication after his discharge.

A conservatorship offered stability, but no cure. When we first spoke, Phil told me his son, who was "once the smartest [kid] in his class," was now just "sitting in a chair in his room all day" staring at the wall. After a few years, Jacob asked for his medication to be lowered, as it was causing debilitating side effects. Phil was skeptical, but his son's yearly conservatorship renewal was coming up. He didn't want the judge to think he was an abusive conservator like Britney Spears's dad.

Cutting Jacob's dose didn't go well. Jacob declined to the point where he wouldn't sleep for days and stopped eating. So, Phil decided to use two of the most potent powers granted to him by California's conservatorship laws: having his conservatee re-hospitalized and ordering that Jacob switch to a more powerful anti-psychotic, Clozaril.

Those powers proved less mighty in practice. For instance, when Phil called 911 for help getting his son to the hospital, Jacob would run away as soon as the police arrived. They eventually caught Jacob one day when he'd just woken up and was too groggy to flee. "You really think it's a panacea to get them into a hospital," Phil admitted, "but it's not." Phil was convinced his son could benefit from Clozaril, but the doctor claimed it was too complicated to conduct the necessary blood draws to monitor its potentially harmful side effects. "He's in a hospital!" Phil raged.

The hospital was planning to keep Jacob for a few months before sending him to a locked subacute facility—what, to Phil, sounded like a warehouse. Although Phil, as the conservator, could veto the plan, he lacked the power to get his son into a more therapeutic-sounding program. Moreover, the county said the only facility available was far from home, which would make it difficult for Phil to visit. Jacob was being subjected to a serious deprivation of his fundamental civil liberties—and it all seemed pretty pointless. "I have all these powers [as conservator]," Phil noted, "but I can't enforce them."

Since 2018, I've been trying to understand the system Phil struggled to navigate. I've interviewed nearly 300 stakeholders—from clinicians to families to service users themselves. I've shadowed first responders and street medicine teams, visited supported housing complexes and locked hospitals, and observed conservatorship hearings.

Social scientists often talk about mental health institutions as "regulating," "disciplining," or "governing" marginalized individuals. More radical critics decry conservatorship as an extension of incarceration beyond the criminal-legal system. But while I've seen first-hand how people with mental illness are subjected to a range of coercive practices, the result often looks more like chaos than systematic control. Fixing the system will require more than investing in voluntary services and supports to diminish the need for conservatorship. It will also require rethinking the role of government authority in ensuring care for people who are under conservatorship but continue to careen between hospitals, jails, and homeless shelters nonetheless.

public abdication, private power

"Involuntary civil commitment and forced psychotropic drugging" are, according to sociologist Anthony Hatch, "two of the government's most potent weapons." Both are enabled

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by a court-ordered conservatorship. Yet, as Hatch points out in his analysis of private prison medical services, that government power is often delegated to for-profit actors. And while California law gives state governments the authority to adopt any "rules, regulations, and standards as necessary" for overseeing private mental health providers, you'd be hard-pressed to identify what rules, regulations, or standards exist to protect conservatees like Alec from the more unscrupulous among them.

Alec, now in his 30s, has been on and off of conservatorship multiple times, he tells me, but insists it never stopped him from being "just kind of rebellious." For her part, Alec's conservator, his mother, told me she believed that with "lifelong medication," Alec could "get a job, get married, and fulfill his dreams." But from the very first time he went to the hospital for schizophrenia, Alec said he was "afraid of the medication" his doctors were offering him: "I saw it turn people into zombies. My proudest achievement was in education, and I felt like that would be taken away if I was drugged in a stupor."

Once a judge placed Alec on a conservatorship, refusing medication was no longer an option. Indeed, involuntary medication is a key tool for hospitals to keep order, especially in the private for-profit facilities that control over half of California's inpatient psychiatric beds and have cut staffing to the bone. As Mike Phillips, a Patients' Rights Advocate from San Diego, told me, "The reality is, in these facilities, if it's late, and the facility is short-staffed, and you're loud and slamming doors, you're going to be held down and have a needle stuck in you. And if you're someone who has a history of trauma or domestic violence, [being forcibly medicated] is going to be really awful."

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A conservatorship also meant that Alec had no say when he was transferred from a hospital to a "mental health rehabilitation center." These long-term care facilities—often converted nursing homes—were created by private entrepreneurs to fill the gaps left by the downsizing of state-run psychiatric hospitals in the second half of the 20th century. Alec recalls one that was like a "really bad prison," with "no TV and no smoking." He paused before adding, wryly, "You weren't slipping on human waste on the floors. If I had to say something good about [the facility], it's that maybe they cleaned the floors."

Despite costing upward of $300 per person per day, these rehab centers provide almost no one-on-one psychotherapy. Alec only saw his psychiatrist for 15 minutes once a month. He realized the doctor was "disciplining" him in the most superficial way. So "I'd just go in and think about the image they wanted to see, [tell them] that whatever their strategy is was working, that I can identify my symptoms [delusions]." Eventually, the facility would declare he was stabilized and let him leave to go live in an unlocked boarding home in the community.

Each time he was discharged, Alec said, he'd "go along" with his program of outpatient care for a few months. But inevitably, he'd "get the spirit back and run away," often to the rural north of the state. If his guardian couldn't find him in time for the yearly hearing in front of the judge, they'd drop the conservatorship. Then he'd drift between homeless shelters until his psychosis caught up to him—at which time he'd be hospitalized again.

California state government provides no guidance as to who should be conserved or what the objectives of conservatorship are. No agency collects data on the care conservatees receive or where they end up. Anthony Hatch describes this "willful ignorance" as part of how the state avoids public scrutiny for the kinds of coercive practices to which conservatees are subject. This "nonknowledge" covers up not just abuse, but embarrassment. Many private mental health providers aren't just failing to deliver transformative care; they're failing the more basic task of keeping conservatees safe and off the streets.

forcing meds in a fragmented system

Conservatees cycling through dead-end private facilities are ensnared in a system of what disability scholars Beatrice Adler-Bolton and Artie Vierkant call "extractive abandonment." In this scheme, private institutions harvest the government benefits of the otherwise-forgotten people they intern. But some conservatees are on the caseloads of *multiple* government medical, welfare, and judicial agencies. Their cases reveal how uncoordinated the many hands of the state, which are supposed to be "disciplining" or "regulating" conservatees, actually are.

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I spent time in one northern California county trying to strike a new balance between care, coercion, and control. Under its "Community Conservatorship" pilot, participants lived outside locked facilities, albeit in a location approved by their guardian. This gave them autonomy when it came to things like how to spend their social security check and where to spend their days. Julie, a social worker from the county's Public Guardian office—the local agency that serves as conservator for people whose families can't—highlighted their unique approach to conservatorship: "We're person-centered, strengths-based. It's easy to say, 'we make all the decisions for you,' but that doesn't resonate for me. If you don't need to take away someone's rights, why would you?" Still, to participate in the program, clients (nearly all of whom have psychiatric disabilities like schizophrenia or bipolar disorder) have to agree to one very important condition: they'll accept a monthly anti-psychotic injection.

The morning we spoke, the Public Guardian's office had six clients overdue for their injections. The social worker, Julie, explained that in these situations, "We don't just default to 'we have the authority' [to force medication] and start rubber-stamping…. We dig in quick and dive into the situation." Perhaps the person lost their medication in one of the precarious, chaotic single-room occupancy hotels where many live. Or maybe the medication's side effects proved intolerable and it was time for the psychiatrist to tweak the dosage.

At the end of the day, though, the program rests on the assumption that, if negotiations and enticements fail, the Public Guardian can twist a conservatee's arm hard enough to get a shot into it. The first move, Julie said, was to organize a "show of support" at a conservatee's home involving the conservator, fire department paramedics, and police. Sergeant Baer, from the Police Department, recounted, "I'd hide my gun, but I'd have my badge, and say, 'You're going to need to do this, there's a court order, the judge says this needs to happen.' Nine times out of ten, they'll roll up their sleeve." But if they didn't, the officer and the paramedic would go "hands on," putting the person into an ambulance and bringing them to an ER for their shot.

When I visited in 2022, though, the conservator's office had a problem: the police weren't willing to touch their clients anymore. "Police officers are not liked right now, people are out to fire us," Sergeant Baer told me, her frustration with the 2020 racial justice movement's calls to defund the police shining through. She explained that she didn't think it was "fair to ask officers to risk their livelihood" just to force a mentally ill person onto a gurney. She admitted that the result was that "there's a void right now," with officers' now hands-off approach sapping conservatorships' coercive power.

Multiple informants offered their own takes on how that void played out in a recent case. One young man, Connor, left a locked facility on a community conservatorship, but his outpatient psychiatrist made an inexplicable medication switch. By the time Julie's office found out, Connor was on his way to the airport as part of a delusion-fueled voyage. The Public Guardian reached security in time to prevent him from boarding a flight. Then Connor fled to his grandmother's house, where she—facing the wrenching dilemmas confronting any family trying to get emergency help for a loved one with mental illness—called 911.

When Julie arrived, the police, fire department, and county mobile crisis team (clinicians specialized in emergency psychiatric evaluations) were already feuding. The police wanted to know if they should arrest Connor; when Julie said no, they declared they didn't want to go inside and risk a use-of-force incident. But the mobile crisis team, Julie said, "didn't feel safe" entering without police backup. Eventually, Connor's grandma—who the police had hustled out of the house—went back in. She returned to report that her grandson had shot some heroin and passed out. Julie called Matt, an experienced fire department paramedic, who headed upstairs, roused Connor, and marched him downstairs to an ambulance. "It took me all of five minutes," Matt recalled with a half-smile.

> One public guardian has a message for policymakers seeking to expand coercive control: conservatorship is not a "magic wand."

But the saga continued. Julie, the county conservator, now ordered Matt and the county fire department to take Connor to the county hospital. When they arrived, nurses wheeled Connor to an evaluation room. Matt tried to follow, hoping to explain the situation to the treating psychiatrist and make sure Connor was held overnight. Instead, a nurse stood in the doorway, blocking Matt's entrance. Julie got a call from the hospital a few minutes

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later, announcing that Connor would be discharged. "After the exhaustion and the intensity of getting a conservatee back into safety, back into care… I was absolutely shocked that they were going to release him. *To where?*" she fumed.

I could better empathize with the hospital's reticence to admit this very sick client once I visited the facility a few weeks later. In the vastly over-capacity psychiatric ER, deeply distressed and profoundly psychotic patients were spilling into the hallway. During the Great Recession, the county cut in half the number of psychiatric beds upstairs, so there were fewer places than ever for admitting those patients. "What goes in must go out," Dr. Sung, the head of the inpatient unit, explained. One reason for the crunch on bed space, she elaborated, was that three-quarters of her unit was occupied by people on a conservatorship who were cleared for discharge, but for whom the Public Guardian's Office had been unable to line up a step-down placement.

In Connor's case, Julie roped in yet another public agency, the County Attorney. They leaned on hospital administration, arguing that the county could be liable if Connor committed a crime or was harmed while on conservatorship. Connor eventually made it up to the inpatient unit, which restarted his medication. "It was a situation ripe with systems issues," Julie demurred with her talent for understatement.

While many people with disabilities are profoundly neglected by the state, some conservatees face interventions from a plethora of government agencies. "We have people with seven social workers," Julie once exclaimed, "but they're still homeless!" As she recognized, because each government institution has little authority over the others, it is nearly impossible to offer a coordinated response. People like Connor are not really "abandoned" but instead subjected to repeated and ineffectual involuntary interventions.

no magic wand

Despite the ongoing failures of the conservatorship system to serve the people already under its auspices, politicians have been trying to push more people into it. In 2020, Governor Gavin Newsom declared that California's "thresholds for conservatorship [were] too high" and were contributing to the state's intertwined crises of homelessness, overdoses, and urban disorder. In response, California's legislature widened the pathway into conservatorship by allowing conservatorships for people with a substance use disorder and by creating new mechanisms to divert people from prosecution into forced mental health care.

These reforms seem to be widening the net of what Ben-Moshe and other scholars of disability refer to as a "carceral matrix" of coercion and control. Yet the examples of conservatees like Alec, Jacob, and Connor point to just how frayed this net of control, woven from underregulated private facilities and fragmented public agencies, actually is. One public guardian I interviewed had a message for policymakers seeking to expand coercive control: conservatorship was "not a magic wand." She couldn't stop a conservatee from using drugs if a facility wasn't staffed well enough to monitor them, for example, nor keep people off the streets if a private hospital wouldn't take them in.

Indeed, when I asked guardians about contexts which

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conservatorship was effective, they usually downplayed their coercive powers and emphasized their roles as advocates for conservatees. Madeline, a public guardian in a rural county, remembered a client who was discharged from a locked facility, left conservatorship, and went to live in a trailer with her boyfriend. The boyfriend eventually refused entry to the woman's outpatient treatment team. The client then stopped her medication and ceased caring for her diabetes. Madeline, whose county was small enough that she could keep tabs on people who had "graduated" from conservatorship, got wind that the client's health was declining—she was at risk of going blind. So Madeline filed for a new conservatorship and, armed with a court order, scared the boyfriend into letting the woman leave for her medical appointments. Madeline got her into a hospital and then into an unlocked group home. Since then, Madeline "hasn't heard a peep": "She's not in a hospital and not being referred to conservatorship again." This suggested the client had earned a measure of independence in the community.

Debby, another public guardian, offered her own story of effectively using the authority of a conservatorship to mobilize the system to provide what people need, rather than force them to accept something they didn't want. She remembered spending years chasing after a homeless conservatee suffering from meth-use disorder who always seemed to have been discharged from an ER or released from jail just a few hours before she arrived. Debby—like Jacob's dad, Phil—concluded that the drug Clozaril offered the conservatee the best chance at stability. But while the client was open to it, few private providers would take the risk of giving a drug that requires intensive monitoring to someone they couldn't even consistently locate. Debby shopped around until she found a psychiatrist willing to take what was, admittedly, a serious risk. The client has now been living in a group home for years, spending her golden years writing poetry. Her case manager bound some of the poems together into a book. On the first page, Debby said, the woman wrote, "This is for my conservator who helped me find out that I could be me, in a good way."

These anecdotes would hardly be success stories from a perspective that sees conservatorship as a "carceral" measure that should be abolished and replaced with a robust system of voluntary supports. My research, however, has convinced me that while we are waiting for that system to be built, the legal power of conservatorship may be necessary to pull together life-saving services and people who may be reluctant (often understandably, given a history of harmful interactions with the mental health system) to accept them.

Even so, any attempts to expand the reach of conservatorship should come with a new approach that focuses on making guardians into advocates, not overseers. While most professional guardians in California are social workers, peers with lived experience of psychiatric treatment might actually do a better job in this role—empathizing with conservatees, understanding their reticence toward treatment, and demanding quality care from mental health providers. Both conservatees and people at risk of conservatorship should have the opportunity to fill out a Psychiatric Advanced Directives. These documents allow individuals to specify their preferences for treatment when they can no longer advocate for themselves, and they provide legally-binding instructions for clinicians and first responders in moments of crisis. We should recognize that the most important control conservatorship can exert is not over conservatees resistant to care, but over a heavily privatized, fragmented system reluctant to provide it.

recommended resources

Beatrice Adler-Bolton and Artie Vierkant. 2022. *Health Communism*. Verso. Adler-Bolton and Vierkant expose how disabled people are exploited for profit in our medical system, and they envision an alternative system committed to meeting everyone's needs.

Liat Ben-Moshe. 2020. *Decarcerating Disability: Deinstitutionalization and Prison Abolition.* University of Minnesota Press. Ben-Moshe analyzes how, despite the closure of large, state-run psychiatric hospitals in the mid-20th century, people with psychiatric and developmental disabilities continue to be controlled within a "carceral matrix" in the community.

Anthony Ryan Hatch. 2019. *Silent Cells: The Secret Drugging of Captive America.* University of Minnesota Press. Hatch argues that psychiatric medications have been essential to ensuring control in overcrowded prisons but that state governments have deliberately disappeared the data necessary to monitor the medications' use.

Neil Gong. 2024. *Sons, Daughters, and Sidewalk Psychotics.* University of Chicago Press. Gong shows the disparity in mental health services for the rich and poor in Los Angeles, with the former getting intensive interventions geared toward recovering a meaningful life, and the latter tolerant neglect intended only to keep them out of sight.

Owen Whooley. 2023. "How Long Does Madness Take? Time and the Construction of Mental Illness in Community Mental Health Work," *Social Problems* 71(4). The United States, Whooley contends, doesn't have a mental health "system" so much as a "mess" in which professionals scramble to offer minimal care to some of society's most vulnerable individuals.

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