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2nd Civil No. B215626
LASC Case No. BP101954

# COURT OF APPEAL, STATE OF CALIFORNIA

# SECOND APPELLATE DISTRICT

ROBERT RAUCHHAUS, as Conservator of the person and estate of MICHELLE HOFFMAN,

Petitioner,

vs.

SUPERIOR COURT OF CALIFORNIA FOR THE COUNTY OF LOS ANGELES,

Respondent.

MICHELLE HOFFMAN,

Real Party in Interest.

LASC Case No.. BP 101954


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From an Order of the Superior Court of
Los Angeles County, Aviva K, Bobb, Judge presiding
[LASC Case No. BP 101954]

## PETITION FOR WRIT OF MANDATE, PROHIBITION AND/OR OTHER APPROPRIATE RELIEF
**[Exhibits Under Separate Cover]**


Marc B. Hankin [Bar No. 096445]
LAW OFFICES OF MARC B. HANKIN
Post Office Box 3668
Beverly Hills, CA 90212
(310) 552-3005
Fax: (310) 552-3009

Attorney for Petitioner Robert Rauchhaus, as Conservator of the Person and Estate of Michelle Hoffman

2nd Civil No. ________________
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| MICHELLE HOFFMAN,<br><br>Real Party in Interest. | |

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Attorney for Petitioner Robert Rauchhaus, as Conservator of the Person and Estate of Michelle Hoffman

TO BE FILED IN THE COURT OF APPEAL

**APP-008**

| COURT OF APPEAL, APPELLATE DISTRICT, DIVISION | Court of Appeal Case Number: |
|---|---|
| ATTORNEY OR PARTY WITHOUT ATTORNEY *(Name, State Bar number, and address):* Marc B. Hankin SBN 096445<br>Law Offices of Marc B. Hankin, Inc.; P.O. Box 3668, Beverly Hills CA 90212<br>433 N. Camden Drive Suite 600, Beverly Hills, CA 90212<br>TELEPHONE NO.: 310-552-3005 FAX NO. *(Optional):* 310-552-3009<br>E-MAIL ADDRESS *(Optional):* nm@marchankin.com<br>ATTORNEY FOR *(Name):* Robert Rauchhaus, Conservator | Superior Court Case Number: BP101954 |
| APPELLANT/PETITIONER: Robert Rauchhaus<br>RESPONDENT/REAL PARTY IN INTEREST: Michelle Hoffman | *FOR COURT USE ONLY* |
| **CERTIFICATE OF INTERESTED ENTITIES OR PERSONS**<br>*(Check one):* ☑ INITIAL CERTIFICATE ☐ SUPPLEMENTAL CERTIFICATE | |

**Notice: Please read rules 8.208 and 8.488 before completing this form. You may use this form for the initial certificate in an appeal when you file your brief or a prebriefing motion, application, or opposition to such a motion or application in the Court of Appeal, and when you file a petition for an extraordinary writ. You may also use this form as a supplemental certificate when you learn of changed or additional information that must be disclosed.**

1. This form is being submitted on behalf of the following party (*name*): Robert Rauchhaus

2. a. ☑ There are no interested entities or persons that must be listed in this certificate under rule 8.208.
   b. ☐ Interested entities or persons required to be listed under rule 8.208 are as follows:

| | Full name of interested entity or person | Nature of interest *(Explain):* |
|---|---|---|
| (1) | | |
| (2) | | |
| (3) | | |
| (4) | | |
| (5) | | |

☐ Continued on attachment 2.

**The undersigned certifies that the above-listed persons or entities (corporations, partnerships, firms, or any other association, but not including government entities or their agencies) have either (1) an ownership interest of 10 percent or more in the party if it is an entity; or (2) a financial or other interest in the outcome of the proceeding that the justices should consider in determining whether to disqualify themselves, as defined in rule 8.208(e)(2).**

Date: April 13, 2009

Marc B. Hankin
(TYPE OR PRINT NAME)

▶ ______________________
(SIGNATURE OF PARTY OR ATTORNEY)

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**TO THE HONORABLE JUSTICES OF THE COURT OF APPEAL, SECOND APPELLATE DISTRICT**:

Petitioner ROBERT RAUCHHAUS, as Conservator of the person and estate of MICHELLE HOFFMAN, respectfully petitions this Court for a Writ of Mandate and/or Prohibition directed to the Respondent SUPERIOR COURT OF LOS ANGELES COUNTY, directing it to rescind its Order denying Petitioner's request for authority to consent to treatment of Conservatee and Real Party in Interest MICHELLE HOFFMAN with psychotropic medication as recommended by a court-appointed medical expert, and by this verified Petition alleges:

## INTRODUCTORY STATEMENT

This petition presents issues vital to the welfare of innumerable mentally disordered conservatees. Can a probate court in a general conservatorship grant the conservator authority pursuant to Probate Code §2355-2357 to consent to involuntary mental treatment for the conservatee, including psychotropic medication, or is such authority restricted to proceedings under the Lanterman-Petris-Short Act (Welfare & Institutions Code §5000 *et seq.*) with its higher procedural and evidentiary barriers? Does equal protection or due process permit the denial of such powers to a general conservator where the treatment is critical to the conservatee's mental well-being but the conservatee does not require LPS commitment and does not meet the narrow statutory definition of "dementia" required for placement powers under Probate Code §2356.5?

The trial court believed that probate courts can order involuntary mental treatment only in a §2356.5 "dementia conservatorship" or under Lanterman-Petris-Short ("LPS") provisions, denying a general conservator any possibility of

providing mental treatment to a patient whose ability to consent or deny consent is illusory, even when the conservatee is likely to suffer serious harm in its absence.

If involuntary mental treatment is allowed only under the onerous conditions imposed by LPS, then thousands of individuals who don't come within its ambit, but require medication to maintain a stable mental condition, will be denied the very medication needed to restore competence, no matter how compelling the medical evidence. This interpretation of the law presents a disastrous dilemma for innumerable mentally disabled and their conservators by imposing irrational, scientifically insupportable and constitutionally suspect preconditions for essential mental treatment.

**PETITION FOR WRIT**

1. Petitioner ROBERT RAUCHHAUS is the duly appointed and qualified Conservator of MICHELLE HOFFMAN in a Conservatorship action now pending before the Respondent SUPERIOR COURT OF LOS ANGELES COUNTY, Conservatorship of Michelle Hoffman, LASC Case No. BP 101954. That proceeding was commenced by *Petition for Appointment of Temporary Conservator* filed by Denise Weinstock on or about December 8, 2006, a true and correct copy of which appears as ***Exhibit 1*** hereto, and *Petition for Appointment of Probate Conservator of the Person* filed on December 8, 2006, a true and correct copy of which appears as ***Exhibit 2*** hereto.

2. MICHELLE HOFFMAN is the Conservatee in that proceeding and is named in this Petition as Real Party in Interest. She suffers, among other things, from paranoid schizophrenia and mood disorders, has attempted suicide several times, and has a history of psychiatric hospitalization.

3. On December 12, 2006, *Letters of Temporary Guardianship* issued to Denise Weinstock, a true and correct copy of which appears as ***Exhibit 3*** hereto

4. On December 12, 2006, the Respondent SUPERIOR COURT, Judge Aviva K. Bobb presiding, appointed David Trader, M.D. under Evidence Code §730 to perform an independent medical evaluation of Real Party, to report on her physical and mental condition and capacity to make medical and other decisions, and to recommend appropriate treatment.

5. On December 12, 2006, Court-appointed Probate Volunteer Panel Attorney Jackson Chen filed a *Preliminary Report*, a true and correct copy of which appears as ***Exhibit 4*** hereto. He reported that Real Party had been living on the streets intermittently and had a history of mental illness and schizophrenia over some 27 years; that she had attempted suicide and had a long history of failing to take medications prescribed by her mental health providers following release from hospitalization. On or about December 20, 2006, the Court also appointed attorney Alex Borden to advocate on behalf of Real Party against treatment through trial

6. On or about January 8, 2007, Denise Weinstock filed a *Petition for Exclusive Authority to Give Consent for Medical Treatment Pursuant to Probate Code §§2355 and 2357*, a true and correct copy of which appears as ***Exhibit 5*** hereto. Weinstock sought authority to consent to administration of psychotropic medication pursuant to the recommendation of Dr. Trader for the purpose of controlling Real Party's schizophrenia, based upon findings of Dr. Trader and Dr. Robert Neshkes that Real Party lacked capacity to give informed consent to medical treatment The medical declarations and evidence in support of the Petition attested that Real Party was a paranoid schizophrenic, that she suffered

from delusional thinking and multiple deficits in her mental functioning, that she lacked the capacity to make medical or financial decisions due to those multiple deficits, and was unlikely to take daily oral medication necessary to control her schizophrenia (the preferred method) and therefore required longer-acting injections of psychotropic medication.

7. On or about January 8, 2007, PVP attorney Jackson Chen filed a *Report re Ex Parte Petition* (a true and correct copy of which appears as ***Exhibit 6*** hereto) asserting that Real Party was opposed to any medical treatment, including that proposed in Weinstock's *Petition for Authority*.

8. The *Petition for Exclusive Authority* came before the Respondent SUPERIOR COURT, the Honorable Aviva K. Bobb presiding, on January 8, 2007. A true and correct copy of the reporter's transcript thereof appears as ***Exhibit*** *7* hereto. Judge Bobb indicated that she thought the Court lacked jurisdiction to order involuntary mental treatment.

9. The *Petition for Exclusive Authority* again came before the Respondent SUPERIOR COURT, Judge Bobb presiding, on January 23 and February 13, 2007. True and correct copies of the reporter's transcripts of those hearings appear as ***Exhibits 8*** and ***9*** hereto.

10. On February 13, 2007, following testimony from Drs. Trader and Neshkes, the Respondent COURT granted the *Petition for Conservatorship* and found lack of capacity to give informed consent to medical treatment, but made no findings with respect to dementia, restricted placement or powers for involuntary medication. (***Exhibit 9***, 60, 67:12-22; 68:11-13) A true and correct copy of the minute order appears as ***Exhibit 10*** hereto.

11. On December 11, 2007 Denise Weinstock filed a motion to vacate the February 13, 2007 order, in part because of the Court's denial of authority to authorize involuntary civil mental health treatment. A true and correct copy of that motion appears as ***Exhibit 11*** hereto. By Order of February 7, 2008, the Respondent Court vacated its Order appointing Denise Weinstock as conservator. A true and correct copy of the order of February 13 appears as ***Exhibit 12*** hereto.

12. On February 11, 2008, Petitioner ROBERT RAUCHHAUS filed his *Petition for Appointment of Successor Probate Conservator*, a true and correct copy of which appears as ***Exhibit 13*** hereto. That Petition requested authority in accordance with Probate Code §2357 to consent to medical treatment including psychotropic medication and other involuntary psychiatric treatment, including temporary confinement in a secure treatment facility (but not authority for involuntary placement in a mental health treatment facility within the meaning of Probate Code §2356), and authority to consent to and compel the Real Party's inpatient hospitalization for emergency short-term treatment, and short-term psychological testing, psychotropic medication, monitoring and treatment. Petitioner is a friend of the Hoffman family and trustee of a needs trust established by Michelle's father.

13. On or about June 23, 2008, PVP attorney Jackson Chen filed a *Report*, a true and correct copy of which appears as ***Exhibit 14*** hereto, advising that Real Party consented to the appointment of Petitioner as Conservator but objecting to the request for power under Probate Code §2357 to consent to mental health treatment and administration of psychotropic medications.

14. On June 24, 2008, the Respondent Court appointed Petitioner as the permanent Conservator of Real Party. The Court found that Real Party could

complete the affidavit of voter registration but made no orders with respect to dementia or restricted placement. A true and correct copy of the reporter's transcripts of that hearing appears as ***Exhibit 15*** hereto. Petitioner's request for powers under Probate Code §2357 was continued for neuropsychological examination, though the Court stated that it would not treat the matter as the equivalent of an LPS conservatorship for purposes of psychotropic medication.

15. On August 5, 2008, and again on November 18, 2008, the matter was continued for completion of neuropsychological examination bearing on whether the conservatee was suffering from dementia. True and correct copies of the reporter's transcripts of those hearings appear as ***Exhibits 16*** and ***17***, respectively.

16. On August 26, 2008, *Letters of Conservatorship* (a true and correct copy of which appears as ***Exhibit 18*** hereto) issued to Petitioner, granting him exclusive authority under Probate Code §2355 to give consent for and to require the conservatee to receive medical treatment that he in good faith and based on medical advice determines to be necessary, "subject to the limitations stated in Probate Code section 2356."

17. On January 13, 2009, Petitioner filed *Declarations of UCLA Prof. Lori Holt, Ph.D. and Marc B. Hankin To Clear Calendar Notes for Hearing on January 13, 2009*, a true and correct copy of which appears as ***Exhibit 19*** hereto, reporting that Dr. Trader had referred Real Party to UCLA Professor Lori Holt for a clinical and neuropsychological evaluation to determine whether her condition satisfies DSM criteria for a diagnosis of dementia. Dr. Holt's report concluded that Hoffman lacked the capacity to provide informed consent to medical treatment, but that she "cannot currently be diagnosed with dementia based upon DSM-IV-TR criteria, due to the artificial dichotomy between psychiatric and

neurological/medical disorders within current DSM nosology, despite the fact that the nature and significance of her impairment is consistent with current diagnostic requirements for dementia."

18. On or about January 26, 2009, Petitioner filed his *Supplemental Points and Authorities and Exhibits Re: Legislative History*, a true and correct copy of which appears as ***Exhibit 20*** hereto.

19. On January 27, 2009, the Superior Court heard the matter of the remaining powers requested by Petitioner under Probate Code §2357. A true and correct copy of the reporter's transcript appears as ***Exhibit 21*** hereto. The parties advised the Court that neuropsychological examination had disclosed that the Conservatee did not suffer from dementia as defined by DSM-IV, which would have given the Conservator psychotropic medication powers under Probate Code §2356.5. (***Exhibit 21***, 1:18-27) The Court again construed §2357 as precluding a grant of psychotropic medication powers and denied the request for authority for involuntary medication. (***Exhibit 21***, 2:2-11)

20. A true and correct copy of the order of January 27, 2009 appears as ***Exhibit 22*** hereto.

21. The action of the Respondent Superior Court in denying Petitioner authority to consent to involuntary mental health treatment, including psychotropic medication, was contrary to law, unreasonable, arbitrary, erroneous, an abuse of discretion, and a violation of the conservatee's rights to due process and equal protection under Amendments 4 and 14 of the United States Constitution and Article I, Section 7 of the California Constitution, and right to enjoy and defend life and liberty, safety and happiness under Article I, Section 1

of the California Constitution, in that it denied treatment and medication necessary to preservation of the mental and physical health and well-being of Real Party.

22. Petitioner has no plain, speedy or adequate remedy at law other than the relief sought by this Petition. The Order denying authority to consent to involuntary mental health treatment is not appealable and does not constitute a final, appealable order under Probate Code §§1300 and 1301 or C.C.P. §901.4, and during the time necessary for appeal Real Party will likely suffer serious mental and/or physical deterioration and injury if left untreated, which injury could not be remedied by reversal after appeal.

23. Petitioner is a person interested in the issuance of a writ herein as the Conservator of the person and estate of Real Party and thus the person with responsibility to secure appropriate treatment and care for Real Party. Unless this Court issues a writ of certiorari, mandate or prohibition, Petitioner will be deprived of the ability to secure necessary and appropriate care for Real Party with consequent permanent and irreparable injury to her.

**WHEREFORE**, Petitioner prays that the Court:

1. Issue a Peremptory Writ of Mandate and/or Prohibition directing the Respondent SUPERIOR COURT to rescind its Order of January 27, 2007 denying Petitioner's request for authority to consent to involuntary mental health treatment and psychotropic medication; or

2. Issue an Alternative Writ of Mandate and/or Prohibition commanding the Respondent SUPERIOR COURT to show cause at a time and place to be

specified by this Court why a Peremptory Writ should not issue compelling the Respondent (a) to rescind its Order of January 27, 2007 denying Petitioner's request for authority to consent to involuntary mental health treatment and psychotropic medication; and

3. Award Petitioner costs of this proceeding; and

4. Grant Petitioner such other and further relief as the Court may deem just and proper.

Respectfully Submitted,

Dated: April ___, 2009

Law Offices of Marc B. Hankin

By: ________________________

Marc B. Hankin
Attorney for Petitioner Robert Rauchhaus,
as Conservator of the person and estate of
Michelle Hoffman

## VERIFICATION OF COUNSEL

I, Marc B. Hankin, declare:

I am an attorney at law licensed to practice in the State of California, and I am counsel for Petitioner Robert Rauchhaus.

I make this verification as attorney for Petitioner because I am more familiar with the proceedings in this action and the facts alleged herein than is Petitioner. The facts set forth herein are within my personal knowledge.

I have read the foregoing Petition for Writ of Certiorari, Mandate and/or Prohibition and know the contents thereof. The allegations thereof are true and correct to my knowledge.

I declare under penalty of perjury that the foregoing is true and correct and that this Verification was executed on this **___th** day of **April 2009** at Beverly Hills, California.

____________________________________

Marc B. Hankin

## MEMORANDUM OF POINTS AND AUTHORITIES

1.

## INTRODUCTION

This Petition presents an opportunity to address as a matter of first impression an issue of significance for thousands of mentally ill conservatees who desperately need mental health treatment, are incompetent to consent thereto, but whose conservators are barred from seeking authority to consent to such treatment no matter how compelling the medical evidence.

In reaction to indiscriminate "warehousing" of the mentally ill and disadvantaged, the California Legislature enacted remedial legislation in the 1960s, including the Lanterman-Petris-Short Act ("LPS") to limit institutionalization and impose higher substantive and evidentiary barriers to placement in mental facilities and involuntary mental treatment. By 1990, it was recognized that many conservatees who did not need institutionalization did require some degree of mental care, though in many cases it would be involuntary since the very mental disability at issue prevented informed consent or made the conservatee resistant to treatment.

The result was the 1990 amendment of Probate Code provisions for general conservatorships with the explicit aim of permitting courts to empower the probate conservator to consent to involuntary mental *treatment* without the more restrictive LPS conditions for *placement* in a mental facility.

The unfortunate reality, however, is that most probate judges and practitioners continue to believe that LPS commitment is the only way that a schizophrenic, for

example, can be compelled to submit to mental treatment essential to their continued well-being, even if placement in a mental health facility is otherwise unnecessary and the conservatee does not meet exacting LPS proof requirements. Hence, conservatees lacking capacity to consent to medical treatment are denied essential mental health care only because their particular diagnosis, while clearly negating their ability to make a reasoned decision about such care, does not fit either the criteria for LPS commitment or the narrow DSM criteria for "dementia" allowing involuntary medication under Probate Code §2356.5.

The trial court herein, while persuaded that the conservatee was delusional, schizophrenic and incompetent, concluded that there was no lawful way for a Court to authorize involuntary psychotropic treatment except in an LPS Conservatorship or in a Probate Conservatorship involving dementia. As demonstrated below, this denial of medically indicated mental health treatment was in violation of both statutory and constitutional law.

## 2.
## STATEMENT OF THE CASE

Michelle Hoffman is a homeless woman suffering from paranoid schizophrenia and mood disorders. She has attempted suicide several times, obeying "voices" no one else can hear, gets most of her food from trash cans, and believes that God will provide for her nutritional and medical needs.

Michelle rarely acknowledges her schizophrenia or mentally illness, and so denies that she needs treatment. Because of her condition, she is unable to understand and appreciate the risks, benefits, probable consequences and reasonable alternatives regarding decisions about food, shelter, hygiene and anti-

psychotic medication. Michelle has responded well in the past to anti-psychotic medication. During previous hospitalizations, when antipsychotic medication was administered over her objections, her thinking became clearer and she expressed appreciation for the intervention. She later denies this occurred, and each time she is released stops taking her medication, having "realized" that she has been "healed" and thus no longer needs medication. The result is a cycle of treatment, refusal to take medications, and relapse.

The Court second report of court-appointed expert David Trader, M.D., recites, *inter alia*:

> The medical records support a long history of mental illness. Michelle Hoffman was first diagnosed as having atypical psychosis, though her primary diagnosis has been schizophrenia. Other diagnoses include: generalized anxiety disorder, depression, schizoaffective disorder and schizotypal personality disorder. She has been hospitalized approximately 12 times at the Psychiatric Health Facility through the Santa Barbara County Mental Health Services. This does not include psychiatric hospitalizations at Westchester Medical Center in New Jersey and a medical hospitalization at Goleta Valley Hospital after swallowing a bottle of liquid dish detergent, as voices told her that she had a dirty soul that must be cleansed. She was also in a 12 month treatment program in New York.
>
> It is clear from the records that Michelle is more organized and functional when she is on psychiatric medications and decompensates without them.
>
> *      *      *
>
> One of the criteria for informed medical consent is the ability to participate in the treatment decision by means of a rational thought process. Michelle Hoffman has command hallucinations which **interfere and prevent that rational thought process. Not only does she have auditory hallucinations, but severe command hallucinations that**

> **could have caused her severe harm. The voices told her to hit a car, which she did. She also overdosed with intent to kill herself, thinking that she would come back. If untreated, who knows what command hallucinations she may have in the future.**
>
> Overall, Michelle Hoffman simply has too many significant mental function deficits that impair her ability to understand and appreciate the consequences of her actions. [***Exhibit 5***, emphasis added.]

In a further report, Dr. Trader found that Michelle had a variety of mental function deficits, including impairment in abstract reasoning, planning, and carrying out actions in her own rational self interest. She had moderate impairment in logical reasoning, mild delusions, was devoid of insight into her symptoms, deficits, or need for medication, and had very poor awareness of safety issues. These mental deficits persisted despite stabilization by antipsychotics (though making her less floridly psychotic) and she continued to manifest impairments similar to dementia, though not meeting DSM-IV diagnostic criteria for dementia. (***Exhibit 19***) Dr. Trader had noted that "it is crucial that Michelle Hoffman remain on antipsychotic medication indefinitely. Without treatment, her condition will definitely worsen," a recommendation consistent with that of psychiatrists throughout Hoffman's 30 year history of schizophrenia and with the scientific and clinical literature on schizophrenia treatment. (***Exhibit* 19**)

A further Neuropsychological Evaluation in January 2009 by Lori Holt, Ph.D. found that "her psychotic symptoms improve considerably when she is medicated and in a structured treatment setting" (***Exhibit 19***), but that Michelle continued to deny that she has schizophrenia or any psychiatric disorder.

Dr. Holt concluded that while Michelle currently had disabling impairments

in learning, memory and executive functioning consistent with DSM-IV criteria for dementia, the DSM did not permit a diagnosis of dementia in a schizophrenic unless an additional neuro-etiological factor superimposed upon schizophrenia was responsible for the cognitive impairment. This constraint was the result of a

> narrowly defined and out-dated (in this respect) diagnostic classification system that makes an artificial dichotomy between "psychiatric" disorders and "neurological" disorders. . . . Nonetheless, given this nosological dichotomy and the diagnostic criteria as currently written, it does not appear possible to diagnose dementia in Ms. Hoffman using DSM-IV-TR criteria, since there is no indication based upon her history, medical records, or the present neuropsychological database of any additional neurological or medical condition, in addition to schizophrenia which would account for her current cognitive deficits, nor does she exhibit deficits that are out of proportion for what is typically seen in chronic schizophrenia (in fact, her cognitive profile is quite consistent with what is seen in this disorder). Despite this, the cognitive deficits that Ms. Hoffman and many other schizophrenics manifest could otherwise meet diagnostic criteria for dementia based solely on the nature and severity of her impairment and there are some researchers in the field who would characterize similar deficits as "dementia" associated with schizophrenia.
> [***Exhibit 19***]

Dr. Holt found that Michelle's deficits, residual psychosis and hallucinations rendered her incapacity to make medical decisions "as provable as a similar disability resulting from a dementia" and "as enduring as those seen in dementia."

> Furthermore, when allowed to make her own medical decisions, she has invariably discontinued her medications (not surprisingly, since she does not believe that there is anything wrong with her) and has consequently relapsed into severe symptoms, at times to the point where she was unresponsive and catatonic, or, even more alarmingly, dangerous to herself and others.
> [***Exhibit 19***]

Dr. Holt found that Hoffman could not consent to medical treatment under Probate Code §813 and that "it is eminently clear that she cannot participate in her treatment decision by means of a rational thought process, given that she is still subject to delusional thinking with respect to her religious preoccupation and its impact upon her medical decision-making. Furthermore, even when at the highest level of functioning that she has enjoyed for most of her life, she continues to manifest a profound lack of insight that leads her to believe that she does not suffer from any disorder whatsoever, much less a severe one, and she fervently denies that she has schizophrenia."

> Unless her conservator is allowed to consent to treatment of her behalf, she will most certainly discontinue her medications and relapse into severe psychosis and the homeless lifestyle which had threatened her health and safety throughout most of her adult life. This has been a vicious cycle that has been repeated numerous times over the nearly 30 year history of her disorder, and there is no evidence to suggest that the same scenario would not take place again (a consideration relevant to her medical decision-making capacity as specified in [Probate Code §]811(c). [***Exhibit 19***]

The difficulty of applying DSM criteria for dementia to a schizophrenic was corroborated by Dr. Robert Neshkes, who testified that the DSM-IV "does not have a place to put dementia secondary to schizophrenia." (***Exhibit 9***, 6:4-5)

> In the DSM-IV, there is no place where a schizophrenic is able to be diagnosed with dementia. Under Schizophrenia, it says that they may have cognitive loss as part of the illness. I think that's true. But there is no diagnosis of dementia secondary to schizophrenia. I believe there should be, that I've seen many people with schizophrenia who have developed dementia over time that I cannot explain on the basis of Alzheimer's disease or strokes. [***Exhibit 9***, 4:23-5:3]

This action began in December 2006 when Denise Weinstock was appointed temporary conservator of Michelle. Weinstock and the PVP Attorney appointed for Michelle agreed that she had been living on the streets intermittently with a 27 year history of mental illness and schizophrenia, had attempted suicide, and had a long history of failing to take medications prescribed by her mental health providers upon release from hospitalization.

Weinstock sought authority under Probate Code §§2355 and 2357 (***Exhibit 5***) to consent to administration of psychotropic medication based on the findings of Dr. Trader, the fact of Michelle's delusional thinking and mental deficits depriving her of the ability to make medical decisions, and the probability that she would cease taking oral medications necessary to control her schizophrenia. Over a series of hearings, the Court indicated that it thought it lacked jurisdiction to order involuntary mental treatment except in an LPS proceeding, viewing *placement* and *treatment* as equivalent under the statutes: "this court has a specific statement in the Code which does not allow it to do the equivalent of any involuntary placement." (***Exhibit** 7*, 10:4-10)

When testing disclosed that Michelle did not meet DSM-IV criteria for "dementia" because her dementia symptoms had no distinct etiology apart from schizophrenia, the Court denied the request for mental health treatment and psychotropic medication powers on the grounds that such authority was only available in an LPS proceeding or a "dementia conservatorship" under Probate Code §2356.5. Yet Michelle was found ***incompetent*** to consent to her own medical care based upon schizophrenia which negated her ability to consent to treatment for that very condition.

3.

## A COURT ADMINISTERING A GENERAL CONSERVATORSHIP MAY AUTHORIZE INVOLUNTARY MENTAL TREATMENT WITHOUT LPS COMMITMENT OR A FINDING OF DEMENTIA

Statutory construction, legislative history and the public policies underlying the system of care for mentally disabled adults all teach that authority to consent to involuntary mental treatment may be granted in a general probate conservatorship.

### A. The Legislature Restored Authority to Consent to Mental Health Treatment in 1990

Present conservatorship law prohibits involuntary ***placement*** of a probate conservatee in a mental health facility except in an LPS proceeding under Welfare & Institutions Code §§5150 and 5350.

> No ward or conservatee ***may be placed*** in a mental health treatment facility under this division against the will of the ward or conservatee. ***Involuntary civil placement of a ward or conservatee in a mental health treatment facility*** may be obtained only pursuant to Chapter 2 (commencing with Section 5150) or Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code. . . . .
> [Probate Code §2356(a), emphasis added]

This bar on involuntary civil ***placement*** was taken by the lower court as a prohibition on involuntary mental health ***treatment***. Statutory history, however, demonstrates that the Legislature intended that while ***placement*** may not be compelled absent LPS proceedings, involuntary ***treatment*** is another matter.

Prior to 1990, §2356(a) expressly precluded ***involuntary civil mental health treatment***:

> (a) No ward or conservatee may be placed in a mental health treatment facility under this division against the will of the ward or conservatee. ***Involuntary civil mental health treatment for a ward or conservatee*** shall be obtained only pursuant to Chapter 2 (commencing with Section 5150) or Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code.. . . [Emphasis added]

See In re Gandolfo (1984) 36 Cal.3d 889, North Bay Regional Center v. Sherry S. (1989) 207 Cal.App.3d 449, and Katz v. Superior Court (1977) 73 Cal.App.3d 952, 971 fn. 12, describing the 1977 statutory scheme under former Probate Code §1851, also prohibiting involuntary treatment.

The 1990 amendment to §2356 (S.B. No. 1775; Ch. 710, Stat. 1990), deleted the prohibition on consent to involuntary mental ***treatment***:

> (a) No ward or conservatee may be placed in a mental health treatment facility under this division against the will of the ward or conservatee. Involuntary civil ***placement*** of a ward or conservatee in a mental health treatment facility may be obtained only pursuant to Chapter 2 (commencing with Section 5150) or Chapter 3 (commencing with Section 5350) of Part 1 of Division 5 of the Welfare and Institutions Code. . . .
> [Emphasis added]

Deletion of the prohibition on involuntary mental *treatmen*t while retaining that on *placement* indicates that it is only involuntary detention that the Legislature deemed to require the rigorous LPS proceedings. The change in terminology would otherwise be meaningless. People v. Mendoza (2000) 23 Cal.4th 896.

The intent to allow involuntary mental treatment is reflected in a simultaneous amendment of Probate Code §2357(h), adding the language underlined below:

> (h) The court may make an order authorizing the recommended course of medical treatment of the ward or conservatee and authorizing the guardian or conservator to consent on behalf of the ward or conservatee to the recommended course of medical treatment for the ward or conservatee if the court determines from the evidence all of the following:
>
> (1) The existing or continuing medical condition of the ward or conservatee requires the recommended course of medical treatment.
>
> (2) If untreated, there is a probability that the condition will become life-endangering or result in a serious threat to the physical **or mental** health of the ward or conservatee.
>
> (3) The ward or conservatee is unable to give an informed consent to the recommended course of treatment.

The 1990 amendments were precipitated by a December 1989 Law Revision Commission (LRC) proposal, available on the LRC website as "Publication 164," which derived from LRC Memorandum 1989-097. LRC materials which have been placed before the Legislature are declarative of legislative intent (People v. Williams (1976) 16 Cal.3d 663, 667-668) and as legislative history are entitled to great weight in statutory construction. Hale v. Southern Cal. IPA Med. Group, Inc. (2001) 86 Cal.App.4th 919, 927; Schmidt v. Southern Cal. Rapid Transit Dist. (1993) 14 Cal.App.4th 23, 30 fn. 10. LRC materials are a key interpretive aid and may be judicially noticed. Kaufman & Broad Communities, Inc. v. Performance Plastering, Inc. (2005) 133 Cal.App.4th 26; Barkley v. City of Blue Lake (1993) 18 Cal.App.4th 1745, 1751 fn.3.

That theses changes were intended to restore to general conservatorships the option of involuntary mental treatment is explicit in the LRC Comments:

> Section 2356 (enacted as a part of the new Probate Code by 1990 Cal.Stat. ch. 79 §14) was amended by 1990 Cal.Stat. ch. 710 §8. The 1990 amendment revised subdivision (a) to resolve an inconsistency in language between the first and second sentences. This amendment recognizes that the provisions of the Welfare and Institutions Code (part of the Lanterman-Petris- Short Act) cited in the second sentence govern situations where a person may be involuntarily placed (*e.g.*, Welf. & Inst. Code §§5150, 5350.1), detained (*e.g.*, Welf. & Inst. Code §5151), confined (*e.g.*, Welf. & Inst. Code §5260), or committed (e.g., Welf. & Inst. Code §5300). The language as revised is also consistent with Section 3211(a). ***The 1990 amendment also recognizes the court's power under Section 2357 to authorize treatment in the case of a serious threat to the mental health of the ward or conservatee.*** See Section 2357. [Comment to 1990 amendment, emphasis added.]

LRC Memorandum 1989-097 is unambiguous about the intent to delete overbroad restrictions in Probate Code §2356 barring a probate conservator from consenting to any "involuntary civil mental health treatment."

> The Commission's Tentative Recommendation Relating to Miscellaneous Probate Code Revisions includes a proposal to expand the power of the court to authorize medical treatment of a threat to a person's mental health. We have prepared this proposal in the form of a separate recommendation which is attached.
>
> *　　*　　*
>
> Ms. Tam [Deputy County Counsel, Alameda County] suggests that the meaning of "involuntary civil mental health treatment" in Section 2356(a) should be clarified. Note that the first sentence of Section 2356(a) refers to involuntary "placement" whereas the second refers to involuntary civil mental health "treatment." Ms. Tam writes that the reference to treatment is interpreted by some to mean any involuntary mental health treatment, and by others to mean placement in a mental health facility for

> treatment. **If the restriction on the application of the procedure in Section 2357 is read to apply to all involuntary mental health treatment, Ms. Tam points out that an anomaly results whereby wards and conservatees who do not meet the stringent LPS standards would not be treatable.**
>
> The staff agrees with Ms. Tam and proposes to revise Section 2356(a) **to make clear that LPS does not apply where there is not . . . involuntary placement.**
>
> In her letter, Ms. Tam also refers to the Riese case, a class action in which it was held that involuntarily committed mental patients have the right to refuse treatment absent a judicial determination of incompetence. See Riese v. St. Mary's Hospital & Medical Center, 209 Cal.App.3d 1303 (1987). This case supports the position that the type of conservatorship (whether LPS or Probate Code) is irrelevant to the issue of capacity to consent. Thus the issue of capacity to give informed consent will be present in both types of proceedings and the person is protected to the same degree. . . .
> [LRC Memorandum 1989-097, Emphasis added.]

The Commentary in Publication 164 recognized that the health of many conservatees was compromised by the absence of such authority, and that procedural safeguards post-dating the LPS Act resolved many concerns.

> [The previous] standard [was] unduly narrow in its restriction of medical treatment of problems that are a threat to the person's physical health as distinct from the person's mental health. The court's power to authorize medical treatment . . . should be expanded to cover serious threats to the person's mental health. There are numerous protections against abuse built into the [new Probate Code] statutes [adopted after the enactment of the LPS Act], including (1) appointment of an attorney to consult with and represent the person; (2) giving notice to interested persons, including the spouse and relatives . . . , (3) judicial determination that the proposed medical treatment is

> necessary: and (4) limitations on the type of treatment that can be given.
> [*Recommendation Relating to Court Authorized Medical Treatment*, 20 Cal. L. Revision Comm'n Reports 537, 541 (1990)]

The transmission letter to the Legislature and Governor from the Law Revision Commission states:

> Existing law permits a court to authorize medical treatment for a person unable to give informed consent. The court can authorize the treatment on a determination that the persons medical condition requires the treatment and, if untreated, the condition will become life-endangering or "result in a serious threat to the physical health" of the person. **This recommendation proposes to expand this standard to include a serious threat to the person's mental health.**
> [Publication 164, pg. 564, emphasis added.]

As Publication 164 states at page 542, by granting authority for involuntary mental treatment of probate conservatees, this change clarifies the relationship between LPS and probate conservatorships and "resolves an anomaly in the law that would result where a ward or conservatee needs treatment but does not meet the standards applicable under LPS."

### B. The Statutory Scheme Recognizes that Courts May Authorize Consent to Involuntary Mental Treatment

Following cannons of construction which require that the statutory scheme be construed as a whole (Kavenaugh v. West Sonoma County Union High School District (2003) 29 Cal.4th 811), it is evident that the "health care" which the court is authorized to order under Probate Code §2355 includes mental health treatment.

First, A.B. 891 (Stats.1999, c. 658) added a new sentence to Probate Code §2355(a), defining the term "health care."

> (a) If the conservatee has been adjudicated to lack the capacity to make health care decisions, the conservator has the exclusive authority to make health care decisions for the conservatee that the conservator in good faith based on medical advice determines to be necessary. . . . The conservator may require the conservatee to receive the health care, whether or not the conservatee objects. In this case, the health care decision of the conservator alone is sufficient and no person is liable because the health care is administered to the conservatee without the conservatee's consent. For the purposes of this subdivision, **"health care" and "health care decision" have the meanings provided in Sections 4615 and 4617, respectively**. [Emphasis added]

Mental health treatment is included in the definition of "health care" found in Probate Code §4615:

> "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a patient's physical **or mental** condition.
> [Probate Code §4615, emphasis added]

The 1990 reenactment of Probate Code §2357, which provides a procedure by which the conservator or other persons can seek authorization where the conservatee "is unable to give an informed consent," added subsection (h)(2) which allows the court to empower the conservator to consent to treatment in the absence of which the condition would probably "become life-endangering or result in serious threat to the physical **or mental health** of the ward of the conservatee." The 1990 Law Revision Commission Comment to §2357 notes that this was added to address the need for preventive mental health care. And §2357 explicitly

concerns treatment to which a conservatee is incapable of consenting.

The statutory scheme provides for involuntary hospitalization for conservatees suffering from dementia "as defined in the last published edition of the 'Diagnostic and Statistical Manual of Mental Disorders'" (Probate Code §2356.5(b)(1)), a provision intended to serve the unique needs of dementing adults "by adding powers to the probate conservatorship." (§2356.5(a)(2)) Subsection (c) of §2356.5 provides that a conservator may authorize the administration of medications "appropriate for the care and treatment of dementia, upon a court's finding, by clear and convincing evidence," that the conservatee (1) has dementia, as defined in the DSM, (2) lacks the capacity to give informed consent "to the administration of medications appropriate to the care of dementia" and has at least one mental function deficit significantly impairing the person's ability to understand and appreciate the consequences of his or her actions pursuant to Probate Code §811(b), and (3) the conservatee needs or would benefit from appropriate medication as demonstrated by evidence from a physician or psychologist.

Section 2356.5 recognizes both the propriety of psychotropic medication and placement in a secure facility, provided that there is close judicial scrutiny and special protections to prevent abuse. Probate Code §2356.5(b), (c), (f). But §2356.5 relief is available only to persons whose dementia condition fits the narrow definition of the current DSM, and hence addresses only psychotropic medication and secure perimeter placement *appropriate to that condition.*

Moreover, §2356.5 contains the specific injunction that "[n]othing in this section shall affect current law regarding the power of a probate court to fix the residence of a conservatee *or to authorize medical treatment for any conservatee who has not been determined to have dementia*." Probate Code §2356.5(k)

(emphasis added). That section was enacted in 1996 against the background of the 1990 amendments and thus presupposes the power of the court to authorize involuntary mental treatment for conditions other than dementia.

This special treatment afforded dementia patients thus acknowledges the general statutory scheme for consent to medical care – including mental health treatment – turns on the conservatee's incapacity to give or withhold informed consent, and that involuntary mental health care appropriate to the needs of the conservatee may be authorized. With the exception of dementia patients falling under §2356.5, it is only *placement* in a mental health treatment facility against the conservatee's will that requires an LPS proceeding. See People v. Karriker (2007) 149 Cal.App.4th 763, 780, quoting 1 Cal. Conservatorships & Guardianships (CEB 2004) §1.11 at pp. 14-15: "The primary difference between a Probate Code conservator and an LPS conservator is the LPS conservator's power to place the conservatee in a locked facility, an action that a Probate Code conservator cannot take."

Among all the Probate Code statutes governing medical care or treatment of conservatees, only §2356 makes the conservatee's "will" or consent a condition of action by the conservator, and that only with respect to ***placement*** in a mental health treatment facility. The inference is that the conservatee's dissent from any type of *non-custodial* treatment is no barrier if the conservator has made a good-faith decision based on medical advice, and that such treatment may be ordered even if contrary to the conservatee's expressed desire.

Finally, §2356 contains its own limitations on medical treatment to which a conservator can consent. Experimental drugs and convulsive therapy are precluded except under specified conditions. Convulsive therapy is solely for

treatment of mental conditions such as depression, and its exclusion would have been superfluous, had there been no general authorization for mental care.

### C. The Convergence of Procedural Protections and Standards for Probate and LPS Conservatorships Justifies Similar Authority for Mental Health Treatment

As the Law Review Commission observed, general probate conservatorships have increasingly been subjected to the more rigorous standards of proof and procedural protections of the LPS Act, giving the probate conservatorship a complementary role in caring for the mentally ill.

Prior to the enactment of LPS, a person "committed" to a mental health treatment facility did not enjoy many due process safeguards which are recognized today as basic rights, and which Publication 164 cites as justifying the 1990 proposal to add mental health care authority to probate conservatorships. Among the concerns underlying the LPS Act were:

> **Money**: The state's mental health ***in***-patient treatment system was perceived as so costly and wasteful that many people were denied treatment, and as inconsistent with Governor Reagan's campaign to cut state spending;

> **Interminable Commitments**: *Indefinite* and *inappropriate* commitments of mentally disordered persons had become a public issue. LPS anticipated that mental health treatment would primarily be provided on an out-patient basis, with the stated aim of "preventing, inappropriate, indefinite commitments of [persons gravely disabled due to a mental disorder]." Ford v. Norton (2001) 89 Cal.App.4th 974, 979.

**Kafkaesque Neo-Freudian Standards**: The standards in 1968 for ascertaining or identifying mental illness were unacceptably vague. This prompted a movement to raise the burden of proof to "beyond a reasonable doubt" and to shift the focus from diagnosis to proof of specific functional disabilities, *e.g.*, the ability to provide for ones food, clothing, shelter, etc. Conservatorship of Roulet (1979) 23 Cal.3d 219, 230-232; Ford v. Norton, *supra,* 89 Cal.App.4th 974; Probate Code §§810(c), 811(b).

**Miscarriages of Justice**: Because of a lack of due process safeguards, many people - particularly the elderly - were being "committed" (*i.e.* warehoused) to psychiatric facilities though not suffering from any mental illness.

**Iatrogenic Harm**: Mental health treatment was perceived as itself causing so much harm to the disabled that many believed the treatment system was delivering more injury than benefit.[1]

**Limited Standing**: Only the Public Guardian could be trusted to initiate proceedings for "commitment"/confinement in a mental health treatment facility, lest proceedings be misused through the complicity of relatives, lawyers, doctors and judges. Kaplan v. Superior Court (1989) 216 Cal.App.3d 1354; People v. Karriker, supra, 149 Cal.App.4th 763, 777; Probate Code §§5351 et seq. *Cf.* Probate Code §1820(a).

The LPS Act was effective in reducing the financial hemorrhaging, putting a stop to unjustifiable and interminable commitments, and replacing the previous

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[1] Conservatorship of Roulet, *supra*, 230-234. "*Iatrogenic*" means harm induced in a patient by a physician's activity, manner, or therapy; *e.g.*, an infection or other complication of treatment.

vague definitions of mental illness with a focus on objective abilities. It prevented many of the previous abusive commitments by requiring the appointment of counsel, thereby reducing the frequency of iatrogenic harm.

Unfortunately, the 1968 LPS Act gave the Public Guardian exclusive standing to initiate a conservatorship for placement in a mental health treatment facility and the requisite funding for Public Guardian staffing never came through. In the first year after the LPS Act was enacted, mental health conservatorships declined by about 90%, psychiatric hospitals began to be emptied, and the State mental health budget was reduced to a fraction of the previous burden. As a recent Hastings Law Journal article asserts that we now have armies of homeless people who die of neglect in the gutter "*with their rights on*."[2] Instead of getting prompt and brief treatment, delivery of treatment became sporadic, delayed and usually unavailable For people whose mental functioning is so impaired that they cannot understand or appreciate the consequences of their decisions, the goal of preserving their "civil liberties" has little meaning.

In response to the unavailability of the grotesquely underfunded Public Guardian, people turned to probate conservatorships for many of the remedies the LPS System had been intended to provide to the mentally ill, and with this greater attention probate conservatorship laws were frequently improved.

For example, LPS due process procedures such as verifiable standards focusing on abilities (food, clothing, shelter, etc.), right to counsel, probate investigator visits, frequent right to review of commitment – were engrafted into probate conservatorships. Probate conservatorships incorporated some features

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2. Karasch, *Where Involuntary Commitment, Civil Liberties, and the Right to Mental Health Care Collide: an Overview of California's Mental Illness System*, 54 Hastings L.J. 493, 503 (2003)

not yet applied in LPS, such as stricter standards for ascertainment of mental deficits (*e.g.,* the *Due Process in Competence Determinations Act*, Probate Code §810 *et seq.*, which requires proof of a linkage between the deficit and the claimed incapacity.) These scientifically objective standards were possible and useful because of post-LPS developments in neuro-behavior and assessment, and simultaneous strides in psychopharmacology which used those assessment tools to determine medications and dosages.

Thus it was that the 1990 amendments to Probate Code §2356 and §2357 allowed mental health treatment in probate conservatorships. After all, probate conservators had long been consenting to anti-psychotic medication (for dementia patients as well as other mentally ill conservatees) and authorizing restraints in and out of nursing homes.

While the probate conservatorship has increasingly come to look like LPS in terms of civil rights protections, it remains the primary system to which friends and family turn for help with the mentally disordered, an essential aspect of which is consent to involuntary mental health care (except "placement" in a mental health treatment facility.) Probate Code §§2355-2357. Patients benefitting from brief periods of care can dissemble or hide the severity of their mental illness, or (like Michelle Hoffman) are incapable of recognizing the need for continued treatment after a period of remission and thus relapse into severe illness. LPS conservatees learn to defeat the stringent annual requirement of proof "beyond a reasonable doubt" of (i) grave disability and (ii) "imminent danger." By contrast, probate conservatorships remain in effect until there is proof by a preponderance of the evidence that the conservatee can be discharged safely from the fiduciary's management.

D. **The Respondent Court's Construction Undermines the Statutory Objective**

The Superior Court effectively read into Probate Code §2355-2357 an exclusion for involuntary mental health *treatment* as well as mental health *placement*, injecting into the statute exceptions which imposed obstacles to the achievement of its purpose. Los Angeles County Employees Assn. SEIU v. Superior Court (2000) 81 Cal.App.4th 164, 175.

Section 2356 is for the protection of the conservatee and his or her estate, and should be liberally construed to that end. Vasquez v. Superior Court (1971) 4 Cal.4th 800, 823. The statute should be read to effect its purposes (Viles v. State (1962) 66 Cal.2d 24) and to afford intended relief to all persons within its purview unless clearly forbidden by its terms. Booth v. Robinson (1983) 147 Cal.App.3d 371, 378. Yet the Court construed the statute so that involuntary mental health treatment is disfavored for the very persons who are incapable of intelligently assessing their need and consenting to such treatment.

It is a genuine Catch 22: the patient so mentally unbalanced as to refuse such medication – to think, like Michelle Hoffman, that they are well and require no medications – cannot be treated under court authorization no matter how grave the need, whereas the conservatee well enough to recognize the need for treatment will require no court authorization at all.

4.

## A CONSTRUCTION OF THE STATUTORY SCHEME WHICH REQUIRES LPS COMMITMENT AS A CONDITION OF INVOLUNTARY MENTAL HEALTH TREATMENT IS CONSTITUTIONALLY SUSPECT

Construing the statutory scheme to permit involuntary treatment of a schizophrenic only when the individual is committed involuntarily under LPS or suffers from DSM-defined "dementia" raises serious constitutional issues.

> It affords no prospect that a schizophrenic patient who does not require LPS commitment, or who cannot meet the LPS requirement of proving "grave disability" beyond a reasonable doubt (Conservatorship of Roulet, *supra*, 23 Cal.3d at 235), can receive essential mental treatment and medication.

In other words, it requires the most restrictive conditions of treatment – commitment – as a condition of receiving essential treatment which does not itself require institutionalization or commitment.

> Where the conservatee is found to be incompetent – and especially where psychotropic medication is indicated to treat the source of incompetence – the conservator (the patient's surrogate for health care decisions) is denied any ability to consent to such medication, no matter how strong the medical evidence and regardless that the conservatee's opposition to treatment is vitiated by delusions or paranoia which could be cured by such treatment. The conservator is legally barred from even seeking court approval for treatment, an infringement upon the fundamental right to medical care, based upon an illusory "right of refusal" that has no volitional reality given

> undisputed evidence of schizophrenia and legal incapacity to consent.
>
> There is no valid rationale for denying probate conservators the right to seek authority to assent to psychotropic medication for schizophrenics or other patients diagnosed with capacity-crippling mental illness while authorizing such treatment for probate conservatees meeting the DSM criteria for dementia and LPS conservatees. The accuracy of diagnosis for Hoffman's disability is no less than that for a dementia patient (the symptomology is identical), and "dementia" could not be diagnosed in her case only because her existing schizophrenia precludes such diagnosis under DSM-IV since the etiology of the *very same symptoms* as dementia is not found in some source independent of the schizophrenia – a diagnostic limitation of the DSM unconnected with any legislative purpose.
>
> The risk of error by overriding a refusal by the conservatee or by an erroneous medical decision – a factor often cited to distinguish different legal regimens for involuntary mental treatment – is no different under LPS or in a dementia conservatorship once incompetence to consent has been established.

Based upon an illusory exercise of their right to refuse treatment a schizophrenic, who could be functional in the outside community and amenable to out-patient treatment, is thus denied medication needed to make him or her competent under the less restrictive probate regime. Yet a gravely disabled (LPS) or demented probate conservatee whose incompetence and need for medication has been ascertained ***with exactly the same degree of certainty*** will receive such treatment. Such a reading contradicts constitutional requirements for the least restrictive commitment conditions and treatment, as well as the foundation of the probate conservatorship law which, among other things, aims to

> (b) Provide that an assessment of the needs of the person is performed in order to determine the appropriateness and extent of a conservatorship and to set goals for increasing the conservatee's functional abilities to whatever extent possible.
> (c) Provide that the health and psychosocial needs of the proposed conservatee are met.
> (d) Provide that community-based services are used to the greatest extent in order **to allow the conservatee to remain as independent and in the least restrictive setting as possible.**
> . . . .
> (f) Ensure that the conservatee's basic needs for physical health, food, clothing, and shelter are met.
> [Probate Code §1800, emphasis added]

A. **The Constitutional Dilemma**

Involuntary mental treatment may be authorized in either LPS or "dementia conservatorships" (Probate Code §2356.5) but not – under the trial court's reading of the Code – in a general probate conservatorship, no matter how strong the showing of medical necessity or incompetence. Yet the determination of incompetence to consent to medical treatment which allows the conservator to seek such treatment is made with equal degrees of certainty in LPS, dementia and probate conservatorships – by a "clear and convincing" standard.

Under this reading, in the case of a probate conservatee such as Michelle Hoffman, the mere expression of a refusal of treatment will preclude essential treatment even if such refusal is induced by delusions or otherwise devoid of the requisites of meaningful consent – *i.e.*, an ability to comprehend the relevant risks and benefits and make a rational decision. Probate Code §813. Michelle's denial that she suffers from any mental illness is enough to assure that she will not be treated, while the same denial by a patient suffering from dementia as narrowly

defined by DSM-IV, or under LPS commitment, is no bar to treatment though their capacity to make an informed decision is no different from Michelle's. As Conservatorship of Wendland (2001) 26 Cal.4th 519, 547, observed, "[T]he practical ability to make autonomous health care decisions does not survive incompetence."

When the decision is thereby relegated to a patient who, by reason of the very illness at issue, is unable to give or withhold meaningful consent, the inmates are running the asylum. The effect is that Michelle is denied essential medical care – a fundamental right – with no legal means for a conservator to secure such care.

Reluctance to allow forced psychotropic medication rests on a constitutionally protected liberty interest "in avoiding involuntary administration of antipsychotic drugs" – an interest that a determination of medical appropriateness might overcome where treatment is, "considering less intrusive alternatives, essential for the sake of [the patients] own safety or the safety of others. Riggins v. Nevada (1992) 504 U.S. 127, 134-135; Washington v. Harper (1990) 494 U.S. 210, 225-226. While psychotropic medication has sometimes been abused, denial of any ability to authorize medication which is medically recommended because it is "involuntary" begs the question when the will of the patient is so compromised as to render consent or refusal invalid. What "liberty interest" is served, and how can it override a well-founded determination by the patient's legal surrogate that such medication is necessary, thereby depriving the patient of the ability to receive essential care – also a constitutionally protected interest?

Cruzan v. Director, Missouri Dept. of Health (1990) 497 U.S. 261, recognized that a competent person's constitutionally protected liberty interest in refusing unwanted medical treatment cannot be exercised by an incompetent.

> An incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment, or any other right. **Such a 'right' must be exercised for her, if at all, by some sort of surrogate**. Here, Missouri has in effect recognized that under certain circumstances a surrogate may act for the patient in electing to have hydration and nutrition withdrawn in such a way as to cause death, but it has established a procedural safeguard to assure that the action of the surrogate conforms as best it may to the wishes expressed by the patient while competent. Missouri requires that evidence of the incompetent's wishes as to the withdrawal of treatment be proved by clear and convincing evidence. The question, then, is whether the United States Constitution forbids the establishment of this procedural safeguard by the State. We hold that it does not.
> [*Id.* at 280, emphasis added.]

Steinkruger v. Miller (S.D.Sup. 2000) 612 N.W.2d 591, observes that denying treatment based on the right to be free of involuntary medication defies logic and the interests of both the state and the patient when the patient's ability to consent is so far impaired as to require a surrogate decision-maker.

> . . . the right to refuse, though constitutionally based, is not absolute; it must be balanced against state interests. . . . South Dakota holds a strong *parens patriae* interest in caring for mentally ill persons and psychotropics retain a vital place in mental health treatment. "Psychotropic medication is widely accepted within the psychiatric community as an extraordinarily effective treatment for both acute and chronic psychoses, particularly schizophrenia." Harper, 494 U.S. at 226 n. 9, 110 S.Ct. at 1039 (quoting Brief for American Psychiatric Association as amicus curiae). **It would be a cruel forbearance to allow incompetents to reject senselessly the medicine necessary to restore their mental health.** "Indeed, use of these drugs has greatly reduced the number of mentally ill requiring hospitalization, and the frequency and length of hospitalizations." Riese v. St. Mary's Hospital Medical

> Ctr., 209 Cal.App.3d 1303, 271 Cal.Rptr. 199, 203 (1987). **Someone must decide for those incapable of consenting when their minds are so affected by mental illness that they lack the capacity to make competent, voluntary, and knowing decisions concerning medication.** Heller v. Doe, 509 U.S. 312, 332, 113 S.Ct. 2637, 2649 (1993) (citations omitted) (state has legitimate interest under its *parens patriae* powers in providing care to its citizens unable to care for themselves); C.E., 204 Ill.Dec. 121, 641 N.E.2d at 353 . . .
> [Steinkruger, 612 N.W.2d 591 at 598]

Winters v. Miller (2nd Cir. 1971) 446 F.2d 65, observes that

> in mental cases, the public interest in treating and caring for patients is greater than the public interest in cases of physical illness. Most patients who are physically ill will be able to determine that they need treatment and, when informed by their physicians, will be able to make a reasoned decision as to the type of treatment to which they wish to subject themselves. But a mental patient, because of the nature of his illness, may be unable either to seek appropriate treatment or to determine what treatment to allow. . . Where the mental patient is not properly treated, the condition may progressively worsen, and the patient may become a public burden and expense. Badly needed beds in mental hospitals may be occupied by those (few or many) who refuse treatment which competent and expert medical practitioners prescribe. Where the proposed treatment is conducive or necessary for the cure or amelioration of mental illness, the failure to provide it would be a step backward in the history of mental hygiene.
> [446 F.2d at 68-69]

"When a person is no longer competent to exercise his or her own right of self-determination, the right still exists, but the decision must be delegated to a surrogate decisionmaker." Guardianship of Browning (Fla. 1989) 543 So.2d 258, 267. Conservatorship of Wendland, *supra*, 26 Cal.4th at 533, notes that while a

competent person's right to refuse treatment "survives incapacity, in a practical sense, if exercised while competent pursuant to a law giving that act lasting validity,

> decisions made by conservators typically derive their authority from a different basis - the *parens patriae* power of the state to protect incompetent persons. Unlike an agent or a surrogate for health care, who is voluntarily appointed by a competent person, a conservator is appointed by the court because the conservatee "has been adjudicated to lack the capacity to make health care decisions." (§§2355, subd. (a).)

Yet under the statutory scheme as construed by the trial court, *no one* can make this decision or authorize treatment no matter how conclusive the evidence for psychotropic medication or other mental treatment, regardless of any balancing of the risk and benefits of treatment.

B. **Due Process**

The blanket prohibition on the conservator's authority to even seek psychotropic medication is in itself the denial of a fundamental right to medical care inhering in the incompetent conservatee.

Conservatorship of Valerie N. (1985) 40 Cal.3d 143, held unconstitutional former Probate Code §2356(d) barring any use of the conservator's statutory powers to authorize sterilization of wards and conservatees. Valerie N. recognized the legitimate objective of ending eugenic sterilization, but held impermissible the absence of any mechanism by which a conservator could be authorized to give consent to sterilization of an incompetent, and thus to exercise vicariously the conservatees' right to the only realistic means of contraception.

> The sad but irrefragable truth, however, is that Valerie is not now nor will she ever be competent to choose between bearing or not bearing children, or among methods of contraception. The question is whether she has a constitutional right to have these decisions made for her, in this case by her parents as conservators, in order to protect her interests in living the fullest and most rewarding life of which she is capable. At present her conservators may, on Valerie's behalf, elect that she not bear or rear children. . . They are precluded from making, and Valerie from obtaining the advantage of, the one choice that may be best for her, and which is available to all women competent to choose-contraception through sterilization. We conclude that the present legislative scheme, which absolutely precludes the sterilization option, impermissibly deprives developmentally disabled persons of privacy and liberty interests protected by the Fourteenth Amendment to the United States Constitution, and article I, section 1 of the California Constitution.
> [40 Cal.3d at 160-161]

> We realize that election of the method of contraception to be utilized, or indeed whether to choose contraception at all, cannot realistically be deemed a "choice" available to an incompetent since any election must of necessity be made on behalf of the incompetent by others. The interests of the incompetent which mandate recognition of procreative choice as an aspect of the fundamental right to privacy and liberty do not differ from the interests of women able to give voluntary consent to this procedure, however. That these interests include the individual's right to personal growth and development is implicit in decisions of both the United States Supreme Court and this court.
> [*Id* at 161-162]

Hence an absolute prohibition upon a medically advisable choice by the conservator charged with the incompetent's welfare - a choice which may be "necessary to the conservatee's ability to exercise other fundamental rights" – is an

infringement of the right of autonomy of person and to appropriate medical care where personal exercise of the ability to consent "has been taken from her both by nature which has rendered her incapable of making a voluntary choice, and by the state through the powers already conferred upon the conservator." (*Id.* 165)

Conservatorship of Angela D. (1999) 70 Cal.App.4th 1410, found former Probate Code §§1958 and 1959, enacted in response to Valerie N., deficient in prohibiting sterilization to wards or conservatees where it would be available to individuals not suffering from those disabilities. "In a case such as the present one, for example, in which there is unrefuted evidence that a pregnancy would very probably cause severe and possibly fatal reactions in Angela due to her existing epileptic and diabetic conditions, and further evidence that Angela's medications might cause severe damage to her fetus during a pregnancy, a woman with the capacity to consent to sterilization would be able to choose that option if she believed that unlawful sexual conduct by others posed a significant threat. Under section 1959, Angela would lack the right to have that same decision made on her behalf." (*Id.* at 1432)

See also Guardianship of Hayes (1980) 93 Wash.2d 228, 608 P.2d 635, 640-641, and In re Grady (1981) 85 N.J. 235, 426 A.2d 467.[3] The notion of substitute judgment has been widely accepted in recognition of the necessity of giving the incompetent's right of choice some meaningful form. Matter of Moe (1982) 385

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3. "We do not pretend that the choice of her parents, her guardian *ad litem*, or a court is her own choice. But it is a genuine choice nevertheless, one designed to further the same interests she might pursue had she the ability to decide herself. We believe that having the choice made in her behalf produces a more just and compassionate result than leaving Lee Ann with no way of exercising a constitutional right. Our Court should accept the responsibility of providing her with a choice to compensate for her inability to exercise personally an important constitutional right." Grady, *supra*, 85 N.J. at 261.

Mass. 555, 432 N.E.2d 712, 720; Bush v. Schiavo (Fla.Sup. 2004) 885 So.2d 321, 331-332; Woods v. Commonwealth (Ky. 2004) 142 S.W.3d 24, 42[4]; In re Estate of Austwick (1995) 275 Ill.App.3d 769, 656 N.E.2d 779; In re Estate of Longeway (1989) 133 Ill.2d 33, 549 N.E.2d 292; In re Peter (1987) 108 N.J. 365, 529 A.2d 419, 423; Guardianship of Grant (1987) 109 Wash.2d 545, 747 P.2d 445; Rogers v. Commissioner of Dep't of Mental Health (1983) 390 Mass. 489, 458 N.E.2d 308; In re Guardianship of Richard Roe, III (1981) 383 Mass. 415, 421 N.E.2d 40 (non-institutionalized but mentally incompetent person has right under common law of Massachusetts and U.S. Constitution to judicial determination of substituted judgment before anti-psychotic drugs can be administered.)

In re C.E. (1994) 161 Ill.2d 200, 641 N.E.2d 345, collecting case authority, concluded that while the ward possessed a "liberty interest" right to refuse the administration of psychotropic medication, the decisions "have also recognized that the state has a legitimate *parens patriae* interest in furthering the treatment of those who are mentally ill by forcibly administering psychotropic medication when the patient is not capable of making a sound decision in his own behalf." (161 Ill.2d 216-217) C.E. held that where is no clear and convincing evidence tending to show what were the mental health recipient's views toward psychotropic drugs at the time he possessed decisional capacity, the court should be guided by what a reasonable person would want. C.E., 161 Ill.2d at 223-224.

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4. "A corollary to any determination that withdrawal of artificial life-prolonging treatment is in the patient's best interest is that the patient's liberty interest to be free of treatment outweighs any interest the patient may have in maintaining a biological existence. Absent KRS 311.631, there is no way for a person like Woods, who had not made an advance directive, either oral or written, to exercise his constitutional liberty interest [after becoming incompetent.] Thus, the statute, by permitting a third party to authorize the termination of life-sustaining treatment, does not violate Woods's constitutional rights but instead provides a mechanism for balancing two competing rights." Woods v. Commonwealth, 142 S.W.3d at 42.

Riese v. St. Mary's Hospital & Medical Center (1987) 209 Cal.App.3d 1303, upheld the right of an LPS conservatee to refuse psychotropic medication when he had *not* been adjudicated incompetent, but also held that upon a determination that the patient lacked capacity to either consent or refuse medical treatment, the court may authorize a surrogate to consent to such treatment for a patient confined for longer than 14 days. (*Id.* 1323) Riese focused upon whether the patient is (a) aware of his situation; (b) able to understand the benefits, risks and alternative to the proposed medication; and (c) able to understand and knowingly and intelligently evaluate information required for informed consent, and otherwise rationally participate in the treatment decision.

> With respect to this last consideration, it has with reason been urged that "the appropriate test is a negative one: in the absence of a clear link between an individual's delusional or hallucinatory perceptions and his ultimate decision," it should be assumed "that he is utilizing rational modes of thought."
> [Riese, at 1323, quoting Gutheil & Appelbaum, Clinical Handbook of Psychiatry and the Law, at 219]

This delusional linkage between the illness and the refusal of consent – critical in an LPS decision to involuntarily medicate with psychotropics – is legally irrelevant in the instant case where that linkage exists without dispute but there is no legal path to authorization of treatment.

These cases recognize that an incompetent's right to consent and to a medically informed decision is lost – not protected – if it cannot be exercised by a surrogate where the patient's "refusal" is delusional or irrational, and that the right to an informed decision – especially for the mentally ill – is fundamental. Youngberg v. Romeo (1982) 457 U.S. 307, 321-322 (mentally retarded detainee is entitled to "the exercise of professional judgment" as to medical needs.)

Due process will not permit the imposition of an unwarranted barrier to treatment of an incompetent. Addington v. Texas (1979) 441 U.S. 419, held that in an indefinite commitment case, a standard of proof "beyond a reasonable doubt" was inappropriate where it was found that the defendant was mentally ill and required hospitalization for his own welfare and the protection of others. While the Court found a "clear and convincing" standard appropriate for commitment, it also observed that institutional standards could not erect an unreasonable barrier to needed medical treatment. While a lower standard of proof poses a risk of erroneous committal, the risk of erroneous *denial* of essential medical treatment precludes the imposition of too-high evidentiary standard.

> [There are] many situations [where], despite the risks of harmful side effects, the administration of drugs to an individual is clearly in his best interests because of the beneficial effects that the drugs can have, including the amelioration of the patient's illness. In such situations, the failure to medicate an incompetent patient could have side effects – *e.g.,* the unnecessary and possibly irreversible continuation of his illness-far more harmful, and probable, than any that might result from the drugs themselves.
>
> Thus, any treatment decision, including the decision not to treat, brings with it the potential for serious harm to the patient. [Rogers v. Okin (1st Cir. 1980) 634 F.2d 650, 660]

The irony of the situation is reflected in decisions which allow the state to compel involuntary psychotropic medication for the purpose of rendering a criminal defendant competent to stand trial – so they can be sent to prison. Sell v. United States (2003) 539 U.S. 166, 179. A patient can be treated so that he can be incarcerated, but not so he can be released to live safely in the community!!

Because this barrier to the exercise of an informed medical decision by the

surrogate burdens fundamental personal rights, it must be evaluated under the "compelling interest" standard: the state must demonstrate "a 'compelling' state interest which justifies the [intrusion] and which cannot be served by alternative means less intrusive on fundamental rights." Valerie N., *supra*, 40 Cal.3d 143, 164; American Academy of Pediatrics v. Lungren (1997) 16 Cal.4th 307, 340-341.

The usual rationale for stringent criteria concerning incarceration or involuntary treatment is the "risk of error" faced by the subject of the proceedings. Addington v. Texas, *supra*, at 423; Heller v. Doe (1993) 509 U.S. 312, 321. Hence, facts triggering confinement must generally be proved to a unanimous jury beyond a reasonable doubt. Conservatorship of Roulet, *supra*, 23 Cal.3d 219, 229-233. When the conservatee has already been adjudicated incompetent to made medical decisions by clear and convincing evidence (and especially when that incompetence derives in part from the delusional or hallucinatory perceptions which specifically undermine the ability to make a decision for the mental condition at issue), placing a high evidentiary barrier or a blanket statutory prohibition on "involuntary" treatment increases the probability of erroneous and harmful denial of treatment exponentially. Cooper v. Oklahoma (1996) 517 U.S. 348 (state cannot impose "clear an convincing" standard for proof of criminal incompetence since it creates a probability of erroneous determination and thus of due process violation.) The risk of an erroneous decision is always present, but placing the decision in the hands of the schizophrenic who denies her illness and whose voices are "advising" on her medical care drastically increase the risk of a harmful decision.[5]

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5. This reality underlies the LPS procedures approved in Riese, under which "the court is not to decide such medical questions as whether the proposed therapy is definitely needed or is the least drastic alternative available, but may consider such issues only as pertinent to assessment of the patient's ability to consent to the treatment." (Riese, *supra*, 209 Cal.App.3d at 322)

## C. **Equal Protection**

As noted above, surrogates for both LPS and "dementia" conservatees have the option of seeking authority for involuntary mental treatment of their incompetent charges, while the probate conservator is denied such opportunity even though incompetence has been adjudicated by the same "clear and convincing" standard and the probate conservatee suffers from a delusional condition – diagnosed with the same certainty as in a case of dementia – that destroys the ability to rationally make the decision to treat that same delusional condition.

This differential treatment in access to mental health care would be bad enough. But the disparity is even greater for a schizophrenic in Hoffman's condition who is sufficiently functional in the community to evade an LPS conservatorship. There is no plausible legal mechanism available for a probate conservator to seek involuntary treatment. LPS is available only if the public guardian seeks a determination that the conservatee is "gravely disabled." A person who is unable to provide for basic personal needs (Welfare & Institutions Code §5008(h)(1)(A)) is not "gravely disabled" if he "can survive safely without involuntary detention with the help of responsible family, friends, or others who are both willing and able to help provide for the person's basic personal needs for food, clothing, and shelter" and who so specifically state in writing. Welfare & Institutions Code §§5350(e)(1)-(3); Conservatorship of Johnson (1991) 235 Cal.App.3d 693, 697. But the inability must be unremitting. Even one whose likelihood of relapse is high, but who is not presently "gravely disabled" does not meet the statutory definition. Conservatorship of Murphy (1982) 134 Cal.App.3d 15, 18-19; Conservatorship of Benvenuto (1986) 180 Cal.App.3d 1030, 1034.

Thus, a schizophrenic like Michelle who is proven incapable of properly providing for her needs (Probate Code §1801(a)), but who can erratically provide for her physical needs (by eating out of the garbage - when not ingesting soap or swimming out to sea), would be exempt from LPS incarceration and incapable of receiving involuntary mental care no matter how persuasive the evidence for the need for such care. A conservatee who is in fact delusional with respect to the factors required for informed consent but has the capacity to provide erratically in some basic fashion for his or her personal needs (like Michelle) will not be treatable under LPS *or* under a probate conservatorship.

This presents both a public policy and a constitutional dilemma. The state has a recognized *parens patrie* interest "in providing care to its citizens who are unable . . . to care for themselves." In re Qawi (2004) 32 Cal.4th 1, 15-16, citing Addington v. Texas, *supra*, 441 U.S. 418, 426. "In California, *parens patrie* may be used only to impose unwanted medical treatment on an adult when that adult has been adjudged incompetent." In re Qawi, 32 Cal.4th 15-16; Conservatorship of Wendland, *supra*, 26 Cal.4th 519, 535. Yet the LPS scheme may not permit an adjudication of incompetency when the mental deficits pertinent to capacity to give informed consent *do not* gravely impair the mental attributes necessary for immediate or short-term physical survival.

Treatment is also disparate as compared with dementia patients, for whom there is authorization for involuntary treatment in Probate Code §2356.5. As the record shows, the DSM-IV dementia diagnosis (which is a predicate to treatment under §2356.5) is precluded by the diagnosis of schizophrenia because DSM-IV requires that the etiology of dementia symptoms be found in some source independent of schizophrenia – a diagnostic limitation of the DSM which reflects no distinction in the certainty of incompetence or need for mental treatment. The

accuracy of diagnosis for Michelle is no less than that for a dementia patient, and there is no dispute as to the existence of schizophrenia, nor its affect on her ability to consent to treatment for that very condition. Yet the surrogate for a demented conservatee with a *less severe* delusional condition or less disabling collection of other mental deficits can secure powers to consent to treatment, while Michelle's conservator cannot.

If clear and convincing evidence indicates that the welfare of the individual requires mental treatment, then why should that care be denied to a probate conservatee but not to an LPS conservatee simply because of an illusory "refusal" by a probate patient having no more competence than the LPS conservatee? And what basis is there for discriminating, to Michelle's detriment, between Michelle and demented conservatees with the same dementia symptomology diagnosed to the same degree of certainty?

"The threshold inquiry in evaluating an equal protection claim is . . . 'to determine whether a person is similarly situated to those persons who allegedly received favorable treatment.'" Women Prisoners of District of Columbia v. District of Columbia (D.C.Cir. 1996) 93 F.3d 910, 924. Plaintiff must show that the requisite relationship between the disparate treatment and the government interest does not exist. To make this determination, the court determines whether the disparate treatment is based on a suspect classification or affects a fundamental right; if so, the court must apply a strict scrutiny test, which requires that the law or policy be narrowly tailored to achieve a compelling government interest. City of Cleburne, Tex. v. Cleburne Living Center (1985) 473 U.S. 432, 440. If the disparate treatment is not based on a suspect classification and does not affect a fundamental right, the court merely requires a rational relationship between the differential treatment and the government's legitimate purpose.

While the denial of mental health treatment to a probate conservatee fails under either strict scrutiny or rational relationship standards, it should be subject to strict scrutiny since it affects a deprivation of essential medical care.

If the statute is construed so that an incompetent cannot be given non-institutionalized care because their mental condition precludes consent for the very condition that renders them incompetent, then it poses an irrational statutory classification, for it is a scheme that defeats its very purpose.

The Fourteenth Amendment to the United States Constitution and article I, section 7, of the California Constitution guarantee all persons equal protection of the law, which "require[s] that, at a minimum, 'persons similarly situated with respect to the legitimate purpose of the law receive like treatment'." Brown v. Merlo (1973) 8 Cal.3d 855, 861. A legislative classification "must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to the object of the legislation, so that all persons similarly circumstanced shall be treated alike." (*Ibid.*) The classification "must involve something more than mere characteristics which will serve to divide or identify the class. There must be inherent differences in situation related to the subject-matter of the legislation. . ." Young v. Haines (1986) 41 Cal.3d 883, 900.

North Bay Regional Center v. Sherry S. (1989) 207 Cal.App.3d 449, held that a construction of the Lanterman Developmental Disabilities Services Act, which precluded a profoundly retarded but non-dangerous adult who could not consent to admission but was not represented by a parent, guardian, or conservator from receiving necessary care, would violate equal protection where such care was afforded to persons who were dangerous because of mental retardation or a "mental disorder," or "gravely disabled" as a result of a "mental disorder," or a

developmentally disabled adult represented by a parent. In re Hop (1981) 29 Cal.3d 82, 92-93, found an equal protection violation where developmentally disabled incompetents were denied the right to a hearing on the appropriateness of placement when other incompetents were afforded such a hearing. See also In re Calhoun (2004) 121 Cal.App.4th 1315, 1350-1354, finding no justification under equal protection for applying different standards for involuntary administration of anti-psychotic drugs to sexually violent predators and mentally disordered offenders.

The instant discrimination is equally unjustifiable. A statute that denies treatment to incompetents who need it (even if involuntarily) because they are not so gravely disabled as to require incarceration in a mental health facility and do not meet the other stringent criteria of LPS, or because their dementia is *in addition to* and arises out of schizophrenia, is irrational: there is no reason to deny treatment where the mental illness exists with the same certainty and the risk of erroneous non-treatment is identical to that of an incarcerated LPS patient, and the symptoms would be diagnosed as dementia except for the additional complicating factor of schizophrenia.

## 5.
## THE RESPONDENT COURT ABUSED ITS DISCRETION

As discussed above, the Respondent Court construed the statutory scheme to prohibit any involuntary mental treatment of a general probate conservatee despite legislative history demonstrating the grant of such powers and the due process and equal protection violations inherent in such an interpretation.

An order based upon a misunderstanding of law or fact, or a failure to

consider the appropriate factors or legal principles relevant to a decision, is an abuse of discretion. Dockery v. Hyatt (1985) 169 Cal.App.3d 830 (trial court failed to consider all factors outlines in court rules in dismissing case); Neal v. Montgomery Elevator Co. (1992) 7 Cal.App.4th 1194; Richards, Watson & Gershon v. King (1995) 39 Cal.App.4th 1176, 1180 (court's failure to exercise discretion is itself an abuse of discretion); Contractors Labor Pool v. Westway Construction (1997) 53 Cal.App.4th 152, 168.

In effect, the Court refused to exercise jurisdiction based on the erroneous belief it had no authority to order such treatment. The remedy of a party aggrieved by an erroneous refusal to exercise jurisdiction is a writ of mandamus. Toy v. Haskell (1900) 128 Cal. 558, 560; Robinson v. Superior Court (1950) 35 Cal.2d 379, 383; 2 Witkin, Cal. Procedure 4th, *Jurisdiction*, §§303, 345, 353.

6.

**REVIEW BY MANDAMUS IS THE ONLY PRACTICABLE METHOD OF SECURING RELIEF**

Interlocutory review is the only viable method for seeking relief from an erroneous denial of a petition seeking medical care for a seriously disabled conservatee. The order is not appealable, and the conservatee would suffer grave an irremediable injury from lack of medication during the time required for an appeal even were that method of review available.

Interlocutory review is appropriate where the case raises an issue of first impression which is likely to produce general guidelines for other cases or a pronouncement likely to facilitate decisions in the lower courts. Carter v. Superior Court (1990) 218 Cal.App.3d 994; Oceanside Union School District v. Superior

Court (1962) 58 Cal.2d 180, 186 (prerogative writ may be used to review questions of first impression that are of general importance to the trial courts and to the profession, and where general guidelines can be laid down for future cases.)

## 7.
## CONCLUSION

Washington v. Harper, *supra*, 494 U.S. at 233, notes that "a State's attempt to set a high standard for determining when involuntary medication with antipsychotic drugs is permitted cannot withstand challenge if there are no procedural safeguards to ensure the prisoner's interests are taken into account." The admonition applies with equal force to denial of necessary psychotropic medication and of a surrogate's right to make medically informed decisions for the patient as to such treatment. Here, according to the trial court's reading, there is no procedure to assess an incompetent probate conservatee's interest in mental treatment, and hence no mechanism to protect a fundamental right.

For the foregoing reasons, Petitioner submits that this Court should issue an alternative or peremptory writ directing the Respondent Court to rescind its Order denying the Petitioner authority to consent to medical care under Probate Code §2357, and further direct the Court to grant that request.

Respectfully Submitted,

Dated: April __, 2009 Law Offices of Marc B. Hankin

By: ___________________________
Marc B. Hankin
Attorney for Petitioner Robert Rauchhaus,
as Conservator of the person and estate of
Michelle Hoffman

## CERTIFICATE OF COMPLIANCE

Counsel hereby certifies that pursuant to Rule 14(c)(1) of the California Rules of Court, the enclosed Petition for Writ is produced using 13 point Roman type and contains approximately 13,931 words, which is less than the 14,000 words permitted by the Rule. Counsel relies on the word count of the program used to prepare this Petition.

Dated: April __, 2009 ________________________

Marc B. Hankin