

LAURA'S LAW:

Concerns, Effectiveness, and Implementation

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As a litany of stories attest, there is an ongoing mental health crisis in America, and the current mental health care “systems” are not adequately addressing it. The latest surveys indicate that nearly 40 percent of adults with severe mental illnesses¹ such as schizophrenia and bipolar disorder receive no treatment, and that 60 percent of all adults with a mental

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¹ “Serious” or “severe” mental illnesses are principally those designated by the DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS as psychotic disorders, with schizophrenia and bipolar disorder the most common. See KENDRA’S LAW: FINAL REPORT ON THE STATUS OF ASSISTED OUTPATIENT TREATMENT, New York State Office of Mental Health, March 2005 [hereinafter “Final Report”] (84% of Kendra’s Law AOT individuals had a diagnosis of either schizophrenia or bipolar disorder).

illness receive no treatment.² Current state mental health laws and policies are roundly criticized as not being anywhere near sufficient in addressing the challenges posed by severe mental illness.³ The challenges of dealing with severe mental illness continue to loom over communities.⁴ One type of program that has been proposed to help meet this challenge is assisted outpatient treatment (AOT),⁵ known in California as Laura's Law.⁶

HOW LAURA'S LAW HELPS

Specifically, Laura's Law targets a subset of the population of people with mental illness who are falling through the cracks. There is a portion of that population who do not accept treatment voluntarily because of "anosognosia," the medical term for a lack of awareness of their illness.⁷ As a result, they do not avail themselves of treatment services.⁸ This makes intuitive

² Liz Szabo, *Cost of not caring: Nowhere to go*, USA TODAY, <http://www.usatoday.com/longform/news/nation/2014/05/12/mental-health-system-crisis/7746535/>.

³ There are various ways of expanding access to treatment, including involuntary treatment. For example, several states have civil commitment standards that are broader than California's. See, e.g., Wis. Stat. § 51.20(1)(a)(2) (Wisconsin state civil commitment statute with a broad definition of "dangerous" and "grave disability" that recognizes potential for deterioration). Many of these proposals have merit. However, they are outside the scope of this paper.

⁴ Alex Emslie & Rachael Bale, *More Than Half of Those Killed by San Francisco Police are Mentally Ill*, KQED NEWS, Sept. 30, 2014, available at <http://ww2.kqed.org/news/2014/09/30/half-of-those-killed-by-san-francisco-police-are-mentally-ill>.

⁵ Here as in other controversial areas, proponents and opponents use different terms to describe the legal procedure in question. Opponents often will describe it as "involuntary outpatient commitment." Proponents often use the terms "assisted" or "assertive outpatient treatment," as does the California Welfare and Institutions Code. Other terms include preventive assistive community treatment, community outpatient treatment, and preventive outpatient treatment, among others. See Rachel A. Scherer, Note, *Toward A Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventive Outpatient Treatment*, 4 IND. HEALTH L. REV. 361, 369-70 (2007). This paper will generally use assisted outpatient treatment or "AOT."

⁶ Cal. Welf. Inst. Code § 5345.

⁷ This is an issue contested by opponents of Laura's Law. See *infra* Part "Opponents' Arguments." This paper adopts the view of the proponents, supported by medical studies, that anosognosia is a real neurological medical condition. See *infra* Part "Proponents' Arguments."

⁸ Sometimes individuals do not seek or continue treatment because of the undesirable side effects of medications. Reducing or eliminating undesirable side effects often

sense: if someone subjectively doesn't think they are ill, they will not seek out "unnecessary" treatment. That "lack of necessity" leaves this population unengaged with treatment options until they are brought in through the involuntary system of care. In California, as in other states, the current standards for involuntary hospitalization require the person to be a danger to self or others, or be gravely disabled.⁹ Section 5150 of California's Welfare and Institutions code allows someone to be held up to 72 hours. However, if someone no longer meets the criteria — as may often happen when someone comes in as a danger to herself or others and has the opportunity to "calm down," or start to receive some of the effects of medication for her illness — she has to be released.¹⁰ This process of admission, stabilization, discharge,

requires finding the right type of medication or the right dosage, as individuals respond to medications differently. This can only be done with continued engagement and supervision with a competent prescribing physician and competent treatment team, which is Laura's Law's goal. Sometimes individuals do not seek or continue treatment if they find the treatment is limited and does not meet their needs. Laura's Law provides for a "whatever it takes" model, providing appropriate services to meet the client's needs.

⁹ Cal. Welf. Inst. Code § 5150; see also Megan Testa & Sara G. West, *Civil Commitment in the United States*, 7 PSYCHIATRY (Edgmont) 10, 30–40 (2010), at *Shift to Dangerousness Criteria as the Standard for Civil Commitment*. On October 7, 2015 California enacted AB 1194, which clarifies that "the individual making that determination [for involuntary hospitalization] shall consider available relevant information about the historical course of the person's mental disorder if the individual concludes that the information has a reasonable bearing on the determination, and that the individual shall not be limited to consideration of the danger of imminent harm." AB 1194, 2015-2016 (Cal. 2015), available at http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB1194. Many counties had been construing § 5150 to require imminent danger, which resulted in uneven and decreased application of § 5150 in many appropriate cases. Opponents argued that the bill is "unnecessary" and "suggests that consideration of historical course alone can lead to a finding of present danger." Letter from Margaret Johnson, Advocacy Dir., Disability Rights California, to Assemblyman Rob Bonta (Apr. 6, 2015), available at <http://www.disabilityrightsca.org/legislature/Legislation/2015/Letters/AB1194EggmanOpposeApril62015.pdf>.

¹⁰ See e.g., Demian Bulwa, *Killing Reveals Mental Health Care Fight*, SF CHRONICLE, Oct. 16, 2014, available at <http://www.sfgate.com/crime/article/Killing-reveals-mental-health-care-fight-3781958.php> ("What they really want to know is: Did he hit you? Did he damage something? They'll keep him as long as he's exhibiting that behavior in the hospital. If he's not, the revolving door continues." Candy Dewitt describing her son Daniel Dewitt's nine § 5150 holds.); Meredith Karasch, Note, *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, 493 (2003) [hereinafter

decompensation and re-admission constitutes a “revolving door” in which the individual uses costly emergency services and does not receive long-term stabilization or treatment. The requirement of dangerousness to self or others for involuntary hospitalization does not align with medical treatment needs for an individual.¹¹ Dangerousness is under-inclusive, as both proponents and opponents point out that, broadly speaking, people with mental illness are less or at least no more likely to be violent.¹² Once the danger has passed, hospitals have no legal authority to continue holding the individual. Thus, an individual still in medical need of treatment to prevent relapse and deterioration (and to decrease symptoms and increase quality of life), who often does not have the ability to understand they have an illness because of the neurological deficit of anosognosia, will be released from an involuntary hospitalization and not receive any treatment at all.

Further, the power to remove medical treatment decision-making power from the individual and vest it with someone else can generally only be exercised when the person is gravely disabled.¹³ Grave disability means “a condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic personal needs for food, clothing,

“Collide”] (describing the case of a man caught in the revolving door of hospitalization, jail, and the streets back in 2003, and its commonness even then).

¹¹ See The California Treatment Advocacy Coalition & The Treatment Advocacy Center, *A GUIDE TO LAURA’S LAW: CALIFORNIA’S LAW FOR ASSISTED OUTPATIENT TREATMENT*, Sept. 2009, available at http://www.treatmentadvocacycenter.org/storage/documents/ab_1421_--_final_updated_booklet-sept_2009.pdf (criticizing the Lanterman–Petris–Short Act (LPS), passed in 1967, as “tak[ing] no account of what has since been learned about these illnesses, the vastly different framework of present mental health services, or the diversity of effective medications that are now available”).

¹² See *infra* note 53.

¹³ Cal. Welf. Inst. Code § 5350 et seq. (LPS conservatorship); Treatment Advocacy Center, *Facts About Common Laura’s Law Misconceptions*, <http://www.treatmentadvocacycenter.org/storage/documents/ll-qa-2012.pdf>. There are other limited circumstances where a treatment decision is exercised by someone other than the individual (i.e. the health care provider), such as an emergency situation “when there is a sudden marked change in the patient’s condition so that action is immediately necessary for the preservation of the life or the prevention of serious bodily harm to the patient or others, and it is impracticable to first obtain consent.” Cal. Admin. Code, tit. 9, § 853. As noted before, once the patient’s condition changes so that the emergency no longer exists (as happens when someone calms down after receiving medication, or even exhaustion), the health care provider can no longer force treatment.

or shelter.”¹⁴ Because many people with even severe mental illness who are homeless are still able to find food and clothes from dumpsters, and bridges and doorways to sleep beneath, they do not qualify for conservatorship.¹⁵ Thus, treatment decision-making power is left with someone who lacks the full capacity to make the decision. While Laura’s Law does not impose a true conservator-like substitute decision-maker, it does use the power of the judicial system to persuade, influence, and coerce the individual to engage in necessary treatment when he otherwise would not.

This paper will describe Laura’s Law, various arguments made for and against its adoption, its effectiveness and its constitutionality, and some of the challenges to its implementation. The paper argues for statewide adoption in California of Laura’s Law as part of a comprehensive mental health treatment system, and suggests that other states considering a similar statute also adopt assisted outpatient treatment.

BACKGROUND ON LAURA’S LAW

Laura’s Law is a California statute that allows for court-ordered AOT for people with a serious diagnosed mental illness, “plus a recent history of psychiatric hospitalizations, jailings or acts, threats or attempts of serious violent behavior towards [self] or others,” among other requirements.¹⁶ The law was modeled on New York’s Kendra’s Law, as well as other states’

¹⁴ Cal. Welf. Inst. Code § 5008; *see also* Conservatorship of Guerrero, 69 Cal. App. 4th 442 (1999) (individual cannot be found gravely disabled merely because he will not accept voluntary treatment, or because he may relapse and become gravely disabled in the future).

¹⁵ In California, a judicial finding of grave disability requires proof beyond a reasonable doubt and a unanimous jury. *See* Conservatorship of Roulet, 23 Cal. 3d 219, 235 (1979). This is a very difficult standard to meet, and does not comport with Supreme Court precedent or a large number of other states’ standards. *See* Collide *supra* note 10, Sec. III.

¹⁶ *Laura’s Law*, Wikipedia, http://en.wikipedia.org/wiki/Laura's_Law. *See also*, Gary Tsai, *Assisted Outpatient Treatment: Preventive, Recovery-Based Care for the Most Seriously Mentally Ill*, <http://mentalillnesspolicy.org/states/california/Aotbygary.pdf> (“court-order programs are community-based, recovery-oriented, multidisciplinary services for seriously ill individuals who have a history of poor adherence to voluntary treatment and repeated hospitalizations and/or incarcerations”); Laura’s Law Home Page, Mental Illness Policy Org, <http://mentalillnesspolicy.org/states/lauraslawindex.html> (“allows courts — after extensive due process, to order a small subset of people with serious mental illness who meet very narrowly defined criteria to accept treatment as a condition of living in the community”).

AOT laws.¹⁷ Laura's Law is currently set to expire in 2017, but has been extended twice before, in 2006 and again in 2012.¹⁸ Although it is a state statute, each county was left with the option of implementing the section, or not doing so.¹⁹

IMPLEMENTATION OF LAURA'S LAW BY COUNTY

Counties have been slow to opt in to Laura's Law. Nevada County was the first county to opt in to Laura's Law in 2008.²⁰ As of October 27, 2014, six counties have either implemented Laura's Law, or authorized its implementation.²¹ Many other counties are currently researching the issue and scheduling votes for implementation.²² Assemblymember Marie Waldron

¹⁷ 2002 Cal AB 1421 (stating that the Senate Committee on Rules commissioned a RAND Corporation Report on "involuntary outpatient treatment" in other states); see John Borum et al., *THE EFFECTIVENESS OF INVOLUNTARY OUTPATIENT TREATMENT: EMPIRICAL EVIDENCE AND THE EXPERIENCE OF EIGHT STATES 15*, available at http://www.rand.org/content/dam/rand/pubs/monograph_reports/2007/MR1340.pdf (studying Michigan, New York, North Carolina, Ohio, Oregon, Texas, Washington, and Wisconsin).

¹⁸ Cal. Welf. Inst. Code § 5349.5.

¹⁹ National Alliance on Mental Illness San Francisco, *LAURA'S LAW: A REVIEW AND INVITATION TO DISCUSS 1*, http://www.namif.org/files/news/LaurasLaw_August2012.pdf.

²⁰ Resolution Authorizing Implementation in Nevada County of Laura's Law as of April 22, 2008, available at <http://mentalillnesspolicy.org/states/california/nv-countyaotresolution.pdf>; see also *Nevada County: First in the State — Assisted Outreach Treatment Program*, YOUTUBE (April 25, 2011), https://www.youtube.com/watch?v=_2p6_CvklYg (Nevada County's short description of the history of Laura's Law's implementation in their county).

²¹ Teri Sforza, *OC Approves forced treatment for seriously mentally ill*, ORANGE COUNTY REGISTER, <http://www.ocregister.com/articles/law-613983-laura-treatment.html> (Orange); Marisa Lagos, *Laura's Law passes easily in S.F. supervisors' vote*, SF CHRONICLE, <http://www.sfgate.com/bayarea/article/S-F-supervisors-pass-Laura-s-Law-to-treat-5607612.php> (San Francisco); Sarah Dowling, *Yolo Supervisors vote to fully implement Laura's law*, THE DAILY DEMOCRAT, http://www.dailydemocrat.com/breakingnews/ci_25965055/yolo-supervisors-vote-fully-implement-lauras-law (Yolo); Abby Sewell, *L.A. County to Expand Laura's Law mental-illness treatment program*, LA TIMES, <http://www.latimes.com/local/countygovernment/la-me-lauras-law-20140716-story.html> (Los Angeles); Gus Thomson, *Laura's law now part of Placer County Mental Health Tool Chest*, AUBURN JOURNAL, <http://www.auburnjournal.com/article/8/26/14/laura%E2%80%99s-law-now-part-placer-county-mental-health-tool-chest> (Placer).

²² Vivian Ho, *Laura's Law mental-health debate rages in Bay Area: Alameda County delays mental-health program*, <http://www.sfgate.com/default/article/Laura-s-Law>

recently introduced a proposal in the state assembly to require that all California counties implement Laura's Law, among other provisions.²³

Concerns over funding of Laura's Law have been a barrier to its implementation for some time. The recent deluge of counties moving to opt in to

mental-health-debate-rages-in-Bay-Area-5271446.php (Alameda); *Compare Douglas & Linda Dunn, Supervisors have a chance to fix broken mental health system*, CONTRA COSTA TIMES, available at http://www.contracostatimes.com/opinion/ci_26657331/guest-commentary-supervisors-have-chance-fix-broken-mental, with Amy Yannello, *Contra Costa's outrageous delay on mental health treatment law*, SF CHRONICLE, Oct. 21, 2014, available at <http://www.sfgate.com/opinion/openforum/article/Contra-Costa-s-outrageous-delay-on-mental-5838344.php> (Contra Costa County postponed a vote on implementation, without sufficient explanation.); Lara Cooper, *Santa Barbara County Supervisors Move Forward on Laura's Law*, http://www.noozhawk.com/article/santa_barbara_county_supervisors_move_forward_on_lauras_law (Santa Barbara); Megan Tevrizian & Andie Adams, *County Supervisor Works to Implement Mental Health Law*, <http://www.nbcsandiego.com/news/local/County-Supervisor-Works-to-Implement-Lauras-Law--273127881.html> (San Diego); Kathleen Wilson, *Ventura County panel evaluating Laura's Law*, http://www.vcstar.com/news/local-news/county-news/ventura-county-panel-evaluating-lauras-law_31033592 (Ventura); Adam Randall, *Mendocino County Board of Supervisors to Revisit Laura's law*, UKIAH DAILY JOURNAL, http://www.ukiahdailyjournal.com/news/ci_26895279/mendocino-county-board-supervisors-revisit-lauras-law (Mendocino). As of October 8, 2015, seven more counties have voted to opt in to Laura's Law: Adam Randall, *Laura's law implementation to be delayed in Mendocino County*, UKIAH DAILY JOURNAL, <http://www.ukiahdailyjournal.com/general-news/20150619/lauras-law-implementation-to-be-delayed-in-mendocino-county> (Mendocino, noting that implementation has been delayed until Jan. 2016); Kurtis Alexander, *Contra Costa County adopts mental health care law*, SF CHRONICLE, <http://www.sfgate.com/bayarea/article/Contra-Costa-County-votes-to-embrace-Laura-s-Law-6060304.php> (Contra Costa); Joshua Stewart, *County backs forced care of mentally ill*, SAN DIEGO UNION-TRIBUNE, <http://www.sandiegouniontribune.com/news/2015/apr/21/county-backs-law-for-treatment-of-mentally-ill/> (San Diego); Alexander Nguyen, *County Supes Unanimously Voted to Adopt Laura's Law*, SAN MATEO PATCH, <http://patch.com/california/sanmateo/county-supes-unanimously-voted-adopt-lauras-law> (San Mateo); Kyle Harvey, *Kern County adopts "Laura's Law" for mentally ill*, BAKERSFIELDNOW.COM, <http://www.bakersfieldnow.com/news/local/Aiming-to-increase-treatment-for-mentally-ill-Kern-County-adopts-Lauras-Law-319124681.html> (Kern); *El Dorado County adopts Laura's Law*, LAKE TAHOE NEWS, <http://www.laketahoenews.net/2015/08/el-dorado-county-adopts-lauras-law/> (El Dorado); *LIVE TWEETS: Board of Supervisors to negotiate union contract*, RECORD SEARCHLIGHT, <http://www.redding.com/news/local-news/live-tweets-protest-against-heroin-precedes-supervisors-meeting> (Shasta).

²³ AB 59, Dec. 9, 2014, available at http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_0051-0100/ab_59_bill_20141209_introduced.htm.

Laura's Law directly flows from the recent passage of SB 585, which amended Laura's Law to clarify that various state funding sources, including the Mental Health Services Act (also known as Prop. 63 or "MHSA") would be available as funding sources.²⁴ The California Legislature passed MHSA in 2004 with the purpose of expanding the system of care services to children, adults, and older adults with serious mental illness.²⁵ The recent clarification is in line with the purpose and intent of MHSA. Other prospective sources of funding include the Helping Families in Mental Health Crisis Act (HR 3717), a bill introduced by former psychologist and Congressman Tim Murphy aimed at overhauling many aspects of U.S. mental health systems.²⁶ Although this bill was not brought for a vote in the last Congress, Congress did include the grant program for demonstrations of AOT in the Protecting Access to Medicare Act.²⁷ This pilot program will grant up to \$1 million per county or other eligible entity to start, implement, and measure and report outcomes of an AOT program. These funding sources can alleviate the burden for counties having to invest initially from their own general funds in order to implement Laura's Law.

LAURA'S LAW ELEMENTS AND PROCEDURES

Laura's Law is a robust and narrowly tailored statutory scheme. Under Laura's Law, an adult cohabitant, close relative, director of a facility or hospital

²⁴ Cal. Welf. Inst. Code § 5349.

²⁵ California Mental Health Directors Association, *THE MENTAL HEALTH SERVICES ACT OF 2004 PURPOSE AND INTENT*, <http://www.caHPF.org/GoDocUserFiles/422.MHSA%20purpose%20and%20intent.pdf> (in addition, the purpose and intent of MHSA is to "reduce the long-term adverse impact on individuals, families, and state and local budgets resulting from untreated serious mental illness" and "increase integration of mental health services and outreach to individuals most severely affected by or at risk of serious mental illness, and expand programs that have demonstrated their effectiveness"); *see also*, California Department of Health Care Services, *Purpose of MHSA Initiative*, 1–2, "Background," http://www.dhcs.ca.gov/services/MH/Documents/MayLegReportFormat4_14_08_V8.pdf.

²⁶ H.R. 3717, § 103(f). For more on the bill and Congressman Murphy's efforts as of today, *see* Wayne Drash, *I ask members of Congress to look those Newtown families in the eye*, CNN.com, <http://www.cnn.com/2014/12/11/us/tim-murphy-mental-health-profile/> (last updated Dec. 13, 2014).

²⁷ P.L. 113–93 § 224, *available at* <http://www.gpo.gov/fdsys/pkg/PLAW-113publ93/content-detail.html>.

providing mental health care, mental health provider supervising or treating the person, peace officer, or parole or probation officer supervising the person²⁸ can “petition for an order authorizing assisted outpatient treatment” that “may be filed by the county mental health director, or his or her designee, in the superior court in the county in which the person who is the subject of the petition is present or reasonably believed to be present.”²⁹ The director then conducts an investigation and files only if she determines there is a reasonable likelihood all necessary elements to sustain the petition can be proved by clear and convincing evidence.³⁰ Those necessary elements include that the person be eighteen years of age or older, be diagnosed with a serious mental illness, be unlikely to survive safely in the community without supervision, have a history of a lack of compliance demonstrated by two or more hospitalizations in the last thirty-six months or one or more acts or threats of serious violence within the last forty-eight months, have refused to voluntarily participate in treatment, be substantially deteriorating, be in need of treatment to prevent a relapse or deterioration, and be likely to benefit from treatment, as well as a finding that AOT is the least restrictive placement to ensure recovery.³¹ The person has the right to be represented by counsel at all stages, and upon election the court will appoint a public defender or attorney to represent them.³² Within five court days the court will conduct the hearing (in absentia if the person fails to appear despite “appropriate attempts” to notify that person of the hearing) and may examine the person in or out of the courtroom.³³ The court requires that a mental health treatment provider examine and testify at the hearing.³⁴ The court can request that the person consent to the examination, and if the person refuses and the court finds

²⁸ There had been a proposed amendment to allow discharging staff from a treatment facility to petition for an order. 2013 Bill Text CA A.B. 2266. That bill drew opposition from opponents of Laura’s Law and has stalled in committee.

²⁹ Cal. Welf. Inst. Code § 5346(b)(1), (2).

³⁰ *Id.* at (b)(3). This appears to be a subjective judgment by the mental health director.

³¹ *Id.* at (a). For a discussion of these elements, and a comparison with other states’ AOT statutes, see *generally* Note, *supra* note 5, at 369–70.

³² Cal. Welf. Inst. Code § 5346(c).

³³ *Id.* at (d)(1).

³⁴ *Id.* at (d)(2).

“reasonable cause” to believe the petition is true, the court may then order anyone designated under Section 5150 to take the person to a hospital for examination by a mental health treatment provider.³⁵ The person has many procedural rights at the hearing guaranteed by the statute, including the right to present evidence, call witnesses, cross-examine witnesses, and appeal the court’s decision.³⁶ Upon hearing the relevant evidence, and determining that all elements are met and that there is no less restrictive treatment option, the court shall order AOT for a period not to exceed six months.³⁷ The court is limited to ordering the treatment recommended by the examining mental health treatment provider.³⁸ Any advance directive (Cal. Prob. Code Section 4650–4701) shall be considered in formulating the treatment plan.³⁹

Next, if the person refuses to meet with the treatment team, the court may order the person to do so, and the team “shall attempt to gain the person’s cooperation with treatment ordered by the court.”⁴⁰ If the person refuses, they may be subject to a Section 5150 hold.⁴¹ The statute then grants a licensed mental health provider who has found in their clinical judgment that the person (1) has refused to comply with court-ordered treatment after efforts were made to solicit compliance, and (2) may be in need of involuntary admission to a hospital for evaluation, to then initiate the Section 5150 process that governs any involuntary hospitalization.⁴² This is the “stick” in the court-order process meant to persuade compliance with the court order. Patients generally, understandably, have an aversion to the involuntary Section 5150 process — which is why it can be an effective motivator. The statute explicitly states that failure to comply with a court order for AOT alone is not sufficient for either involuntary civil commitment

³⁵ *Id.* at (d)(3).

³⁶ *Id.* at (d)(4)(A)-(I).

³⁷ *Id.* at (d)(5)(b). It is unclear why the “least restrictive alternative” is included here again, as it is already one of the required elements.

³⁸ *Id.*

³⁹ *Id.* As an aside, the advanced directive statute explicitly prevents the authorization of consent to commitment or placement in a mental health treatment facility. Cal. Prob. Code 4652(a).

⁴⁰ Cal. Welf. Inst. Code § 5346(d)(6).

⁴¹ *Id.*

⁴² *Id.* at (f).

or contempt of court.⁴³ The court does not apply strong legal action except through the Section 5150 process.

Petitions for continued AOT may be made by the director of the treatment team at the end of the order with a determination that further treatment is needed.⁴⁴ Such additional treatment cannot exceed 180 days.⁴⁵ Every 60 days the director of the team must file an affidavit that the person still meets AOT criteria.⁴⁶ The person has a right to a hearing to assess whether she still meets the AOT criteria, with the burden of proof on the director.⁴⁷ And during each 60-day period, the person may file a petition for a writ of habeas corpus.⁴⁸

During the petition process but before a court order requiring AOT, the person may voluntarily agree to treatment under a settlement agreement not to exceed 180 days.⁴⁹ Such an agreement requires a finding by a licensed examining mental health treatment provider that the person can survive safely in the community.⁵⁰ This provision encourages the person to agree to the treatment before the court hearing process begins, using the court hearing itself as a “stick.” Although the statutory structure is complicated, it attempts to use the court hearing process and the judicial officer as tools to encourage engagement and compliance with treatment.⁵¹

OPPONENTS' ARGUMENTS

Laura's Law engenders controversy for what opponents argue is forced medication in violation of an individual's right to refuse treatment, and

⁴³ *Id.* at (f).

⁴⁴ *Id.* at (g).

⁴⁵ *Id.*

⁴⁶ *Id.* at (h).

⁴⁷ *Id.*

⁴⁸ *Id.* at (i).

⁴⁹ Cal. Welf. Inst. Code § 5347.

⁵⁰ *Id.* at (b)(1).

⁵¹ For a description of the functioning of the court administering Laura's Law provided by the presiding judge in Nevada County, Tom Anderson, see *History of Public Psychiatry — Part III: Assisted Outpatient Treatment*, YouTube, Jul. 15, 2014, <https://www.youtube.com/watch?v=Y19oGFK2fw4>.

that the law has the potential for civil rights abuses.⁵² Opponents of Laura's Law often argue that most people with mental illness are non-violent, and only a very small minority of people with mental illness commit violent acts.⁵³ They have also challenged claims of "lack of insight" into illness as "often no more than disagreement with the treating professional."⁵⁴ Opponents also often argue that a full range of voluntary mental health services, as required by law, should be available before resorting to AOT programs such as Laura's Law.⁵⁵ Finally, they argue that empirical studies show that AOT has not been shown effective in reducing hospitalization or other adverse outcomes.⁵⁶

PROponents' ARGUMENTS

Proponents of Laura's Law argue that many of the most serious cases of mental illnesses, such as schizophrenia and bipolar disorder, are not being treated because people suffering from those illnesses often do not realize they are ill and lack insight into their condition ("anosognosia"), and thus

⁵² Kirk Siegler, *The Divide Over Involuntary Mental Health Treatment*, NPR, <http://www.npr.org/blogs/health/2014/05/29/316851872/the-divide-over-involuntary-mental-health-treatment> [hereinafter *Divide*]; see also *Position Statement 22: Involuntary Mental Health Treatment*, Mental Health America, <http://www.mentalhealthamerica.net/positions/involuntary-treatment>.

⁵³ *Divide*, *supra* note 52.

⁵⁴ Bazelon Center, POSITION PAPER ON INVOLUNTARY COMMITMENT, <http://www.bazelon.org/LinkClick.aspx?fileticket=BG1RhO3i3rI%3d&tabid=324>; see also, Ann Menasche & Delphine Brody, *AB 1421: Involuntary Outpatient Commitment*, 17, Disability Rights California and California Network of Mental Health Clients (labeling the claim as a "myth"). This difference in "viewpoint" on the existence of anosognosia underlies much of opponents' opposition to AOT and Laura's Law, and their claims that more voluntary mental health services are a superior policy answer.

⁵⁵ Leslie Napper & Leslie Morrison, *Mentally Ill need full range of voluntary services*, SACRAMENTO BEE, Oct. 11, 2014. *But see*, *Facts About Common Laura's Law Misconceptions*, <http://www.treatmentadvocacycenter.org/storage/documents/11-qa-2012.pdf> ("The availability and completeness of community services are irrelevant for people who are unable to recognize they are ill and/or to seek services voluntarily.").

⁵⁶ Mental Health America, *Position Statement 22: Involuntary Mental Health Treatment*, n.8, <http://www.mentalhealthamerica.net/positions/involuntary-treatment>; see also, Bazelon Center for Mental Health Law, *Outpatient and Civil Commitment*, <http://www.bazelon.org/Where-We-Stand/Self-Determination/Forced-Treatment/Outpatient-and-Civil-Commitment.aspx> ("[T]here is no evidence that it improves public safety.").

actively resist seeking out or “voluntarily” acquiescing to treatment.⁵⁷ Also, proponents argue that treatment early on for psychotic mental illnesses reduces repeated psychotic breaks and thus reduces the brain damage associated with psychotic breaks, which produces better long-term outcomes for the affected people.⁵⁸ Proponents often criticize treatment providers who oppose Laura’s Law as having self-interested motives to select easier patients and cases to handle.⁵⁹ In addition, they argue that existing funds coming from California’s Mental Health Services Act can and should be used for Laura’s Law, consistent with the purpose of Laura’s Law to prevent and treat “severe” mental illness.⁶⁰

Furthermore, proponents argue there is a community-wide financial benefit to adopting Laura’s Law. Nevada County reported a savings of \$1.81 in public expenditures for every \$1 spent on implementation of Laura’s Law.⁶¹ Other counties estimate similar systemic savings.⁶² Another

⁵⁷ Dunn, *supra* note 22 (“In the past 20 years, more than 60 large scientific studies affirm that 50 percent of those with serious mental illness are extremely vulnerable because they do not realize they are seriously mentally ill and actively resist treatment.”); see also, THE ANATOMICAL BASIS OF ANOSOGNOSIA — BACKGROUNDER, available at <http://www.treatmentadvocacycenter.org/about-us/our-reports-and-studies/2143> (summarizing multiple studies correlating brain changes with lack of awareness of illness); National Alliance on Mental Illness, *Involuntary Commitment and Court-Ordered Treatment*, http://www.nami.org/Content/ContentGroups/Policy/Updates/Involuntary_Commitment_And_Court-Ordered_Treatment.htm (“There are certain individuals with brain disorders who at times, due to their illness, lack insight or judgment about their need for medical treatment.”).

⁵⁸ *Id.*; see also, Mental Illness Policy Org, Laura’s Law home page, <http://mentalillnesspolicy.org/states/lauraslawindex.html> (“[T]ime is brain Treatment can prevent the deterioration.”).

⁵⁹ Mental Illness Policy Org, *Analysis of Orange County Health Care Agency Response to Board of Supervisors Request for a Plan to Implement Laura’s Law*, <http://mentalillnesspolicy.org/states/california/analysisicareport.pdf>.

⁶⁰ *Id.* at 4 (“OC has been allocated [a] total of \$556,272 million in MHSA revenue (\$75 million FY 11–12) but gives much of it [to] programs that do not focus on ‘severe mental illness.’”).

⁶¹ Nevada County Grand Jury, LAURA’S LAW IN NEVADA COUNTY: A MODEL FOR ACTION — SAVING MONEY AND LIVES, available at <http://www.nevadacountycourts.com/documents/gjreports/1112-HEV-AB1421LaurasLaw.pdf>.

⁶² See Amy Yannello, *Contra Costa’s outrageous delay on mental health treatment law*, available at <http://www.sfgate.com/opinion/openforum/article/Contra-Costa-s-outrageous-delay-on-mental-5838344.php> (citing financial analysis for board of

financial benefit to counties, proponents argue, is that Laura's Law will stabilize individuals enough to complete the Medi-Cal enrollment process where they otherwise would not. This would bring in more federal funds for treatment and leave more county money for other services generally.⁶³

EVALUATION OF ARGUMENTS

AOT PROGRAMS HAVE BEEN FOUND CONSTITUTIONAL AND DO NOT VIOLATE CIVIL RIGHTS OR UNDULY RESTRICT CIVIL LIBERTIES

The form of AOT in New York known as Kendra's Law has been declared constitutional unanimously by the state's highest court.⁶⁴ In that case, the patient alleged that the statute violated his due process right because there was no requirement of a finding of incapacity (i.e. incompetence) before a court could issue an order under Kendra's Law.⁶⁵ The court found that because there was no forced medication administration, a showing of incapacity was not required under existing state precedent.⁶⁶ Thus the court reasoned that Kendra's Law's process only needed to satisfy due process.⁶⁷ The Court of Appeals explained that, while under existing state precedent a person of adult years and sound mind has a right to control their medical treatment, "these rights are not absolute."⁶⁸ Rather, the right has to be balanced against compelling state interests, including the state's "parens patriae

supervisors that "an initial investment of roughly \$7.6 million could save the county \$12 million to \$16 million if it adopted Laura's Law"; see also Facts About Common Laura's Law Misconceptions, *supra* note 13 ("[M]ost people who qualify for Laura's Law will also qualify for medi-cal and federal support such as SSI as well as realignment mental health services.").

⁶³ *Id.*

⁶⁴ *In re K.L.*, 1 N.Y. 3d 362 (N.Y. Ct. App. 2004); see also Final Report Appendix 2 ("[I]t is now well settled that Kendra's Law is in all respects a constitutional exercise of the State's police power, and its parens patriae power.").

⁶⁵ *In re K.L.*, 1 N.Y. 3d at 368–69.

⁶⁶ *Id.* at 369–70.

⁶⁷ *Id.* at 370. ("If the statute's existing criteria satisfy due process — as in this case we conclude they do — then even psychiatric patients capable of making decisions about their treatment may be constitutionally subject to its mandate.").

⁶⁸ *Id.*, citing *Rivers v Katz*, 67 N.Y. 2d 485 (N.Y. Ct. App. 1986).

power to provide care to its citizens who are unable to care for themselves,”⁶⁹ and “authority under the police power to protect the community from the dangerous tendencies of some who are mentally ill,” recognized by the Supreme Court.⁷⁰ In balancing, the court found that Kendra’s Law’s impingement on liberty was light, and the state interests weighty. The court found that “the restriction on a patient’s freedom effected by a court order authorizing assisted outpatient treatment is minimal, inasmuch as the coercive force of the order lies solely in the compulsion generally felt by law-abiding citizens to comply with court directives.”⁷¹ The court then also found that, in any event, the patient’s right to refuse treatment generally is outweighed here “by the state’s compelling interest in both its police and *parens patriae* powers.”⁷² It emphasized that the statutory requirement of finding by clear and convincing evidence that the patient would either become a danger to themselves or others, or deteriorate, “properly invoked” the state’s interests in its police and *parens patriae* powers.⁷³

The patient also alleged an equal protection violation because of the lack of a finding of incapacity for him to be subject to court order under Kendra’s Law. He claimed that the law treated those subject to court orders under Kendra’s Law differently from those subject to guardianship proceedings or involuntary commitment statutes who still needed to be found incompetent

⁶⁹ *In re K.L.*, 1 N.Y. 3d at 370.

⁷⁰ *Id.*, citing *Addington v. Texas*, 441 U.S. 418, 426 (1979).

⁷¹ *In re K.L.*, 1 N.Y. 3d at 370.

⁷² *Id.* What is interesting is that patients subject to AOT still have the right to refuse treatment. There is no forcible medication authorized as part of the court order, and the penalty for non-compliance with the court order is merely transportation to an appropriate facility for an evaluation for an involuntary civil commitment.

⁷³ *Id.* at 371–72. Specifically, the court listed several required elements for treatment under Kendra’s Law:

the patient is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to self or others . . . the patient is unlikely to survive safely in the community without supervision; the patient has a history of lack of compliance with treatment that has either necessitated hospitalization or resulted in acts of serious violent behavior or threats of, or attempts at, serious physical harm; the patient is unlikely to voluntarily participate in the recommended treatment plan; the patient is in need of assisted outpatient treatment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others; and it is likely that the patient will benefit from assisted outpatient treatment.

to receive forced medication.⁷⁴ The court again emphasized that a court-ordered assisted outpatient treatment plan “simply does not authorize forcible medical treatment.”⁷⁵ Thus Kendra’s Law did not treat its assisted outpatients differently from those in guardianship proceedings or involuntary commitment. They were treated equally with regard to forced medication.

Next, the Court of Appeal analyzed the patient’s claim that Kendra’s Law’s failure, post court order, to “provide for notice and a hearing prior to the temporary removal of a noncompliant patient to a hospital violates due process.”⁷⁶ Here the court undertook a straightforward application of the *Mathews* balancing test and “conclude[d] that the patient’s significant liberty interest is outweighed by the other *Mathews* factors.”⁷⁷ The risk of erroneous deprivation of liberty is minimal because of judicial findings by the clear and convincing evidence standard prior to the court order.⁷⁸ And since the court is “not . . . better situated than a physician to determine whether the grounds for detention . . . have been met[, a] preremoval hearing would not reduce the risk of erroneous deprivation.”⁷⁹ The court then found that the third part of *Mathews* balancing also weighed for the state because of the state’s strong interests in both “removing from the streets noncompliant patients previously found to be, as a result of their non-compliance, at risk of a relapse or deterioration likely to result in serious harm to themselves or others,” and “warding off long periods of hospitalization” that “tend to accompany relapse or deterioration.”⁸⁰ Requiring another hearing would unnecessarily delay treatment and thus would be detrimental to the patient. And, as a matter of statutory functionality, the removal provision was critical as the “mechanism by which to force a noncompliant patient to attend a judicial hearing in the first place.”⁸¹ Thus, the Court of Appeal found that the removal provision met due process requirements.

Finally, the patient alleged a violation of the Fourth Amendment prohibition against unreasonable searches and seizures because of the “lack of

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ *Id.* at 373.

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Id.* at 374.

requirement that [a] physician have probable cause or reasonable grounds to believe a noncompliant assisted outpatient is in need of involuntary hospitalization” before removal.⁸² But the court pointed out that the requirement that the determination be made in the “clinical judgment” of a physician already “necessarily contemplates that the determination will be made on the physician’s reasonable belief.”⁸³ Thus, the Court of Appeals found no constitutional violation there, or anywhere else in the statute.

Because Laura’s Law is almost entirely modeled on Kendra’s Law, and retains the same elements relied upon by the Court of Appeals in *In re K.L.*, there is no reason to believe it would not successfully withstand a federal constitutional challenge in California.⁸⁴ While it is true that the California Constitution’s right to privacy has been interpreted by the California Court of Appeal to confer upon the “individual the freedom to choose to reject, or refuse to consent to, intrusions of his bodily integrity,”⁸⁵ the reasoning from the New York Court of Appeals is relevant just the same.⁸⁶ There is no forced medication under either Kendra’s Law or Laura’s Law,

⁸² *Id.*

⁸³ *Id.*

⁸⁴ See also, John K. Cornwell & Raymond Deeney, *Preventive Outpatient Treatment For Persons With Serious Mental Illness: Exposing the Myths Surrounding Preventive Outpatient Commitment for Individuals with Chronic Mental Illness*, 9 PSYCHOL. PUB. POL’Y & L. 209, 219–25 (2003) (discussing arguments that AOT statutes satisfy Equal Protection, Substantive Due Process, and Procedural Due Process constitutional concerns.).

⁸⁵ *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1137 (1986). The California Supreme Court has not yet taken up the precise question. In *Bouvia*, the Second District Court of Appeal found that the right to refuse treatment for a competent adult allowed plaintiff *Bouvia* to remove a nasogastric feeding tube that was providing life-sustaining treatment. Scholars view *Bouvia* principally as a “right to die” case. However, the court focused on her unbearably painful circumstances in commenting, “we cannot conceive it to be the policy of this state to inflict such an ordeal upon anyone.” *Id.* 1143–44. As this paper has discussed only in brief, people with severe mental illness are subject to incredible rates of revolving involuntary hospitalization, incarceration, and homelessness; alarming increased rates of victimization including violent assault and rape; and the subjective terror of persecutory delusions, hallucinations and psychotic depression driving many to suicide, all while often their very serious illnesses prevent them from recognizing the need for and availability of medical care. This author too cannot conceive it to be the policy of the state to inflict such an ordeal upon anyone.

⁸⁶ California’s case law analogous to New York’s case law recognizing the right of a patient not adjudicated incompetent to refuse psychiatric medication in non-

and thus there is no intrusion of bodily integrity. Quite simply, patients do have the right under Laura's Law to refuse treatment.⁸⁷ Indeed, the patient works with the treatment team in tailoring the treatment plan. Thus the patients are exercising control over the course of treatment. Laura's Law, like Kendra's Law, is facially constitutional.

Supporters also argue that AOT enhances civil liberty. They argue that AOT prevents "trans-institutionalization" of people with mental illness to prisons and further loss of liberties by preventing deterioration — avoiding locks, restraints, seclusion, or actual forced medication. A successful Laura's Law intervention avoids the further impingement on individual freedom and autonomy inherent in incarceration. It also avoids the increased likelihood of victimization in prison.⁸⁸ In addition, the threshold for forcible administration of medication is actually lower for an individual in prison, given that the state has a compelling interest in meeting its affirmative duty to treat its prisoners and maintain a safe prison environment.⁸⁹ In prison, the requirements are that the inmate be a danger to himself or others, and that treatment is in the inmate's medical interests.⁹⁰ There is no need for either a finding of incompetence or an emergency situation, as is required during a civil commitment.⁹¹ To the extent that AOT seeks, as

emergency situations, *Riese v. St. Mary's Hospital & Medical Center*, relies heavily on that New York case, *Rivers*.

⁸⁷ Furthermore, *Addington* still requires a balancing of the patient's right to refuse treatment against compelling state interests. See *supra* note 70.

⁸⁸ See Cynthia L. Blitz, et al., *Physical Victimization in Prison: The Role of Mental Illness*, 31 INT'L J.L. & PSYCHIATRY 385, 385 (2008); see also David Mills et al., *When did prisons become acceptable mental health care facilities?*, Stanford Law School Three Strikes Project, https://www.law.stanford.edu/sites/default/files/child-page/632655/doc/slspublic/Report_v12.pdf ("[F]or example, they are much more likely to be sexually assaulted than other prisoners. Some prisoners react to the extreme psychic stresses of imprisonment by taking their own lives. Tragically, rates of suicide inside prisons and jails are much higher among the mentally ill."). There is also evidence that people who are more symptomatic and sicker generally are victimized at greater rates. See E. Fuller Torrey, *THE INSANITY OFFENSE: HOW AMERICA'S FAILURE TO TREAT THE SERIOUSLY MENTALLY ILL ENDANGERS ITS CITIZENS* 138 (2008). "The corollary to this fact is that if you treat them and reduce their symptoms, you reduce their chances of being victimized." *Id.*

⁸⁹ See *Washington v. Harper*, 494 U.S. 210 (1990).

⁹⁰ *Id.* at 227.

⁹¹ See *Riese v. St. Mary's Hospital & Medical Center*, 209 Cal. App. 3d 1303 (Cal. App. 1st Dist. 1987).

a matter of public policy, to prevent people with severe mental illness from landing in jails and prisons, it seeks to prevent more severe curtailment of an individual's civil liberties and thus protects them.⁹²

LAURA'S LAW DOES NOT TARGET PEOPLE BASED ON MENTAL ILLNESS ALONE

While "data shows it is simplistic as well as inaccurate to say the cause of violence among mentally ill individuals is the mental illness itself," mental illness "is clearly relevant to violence risk," but "its causal roles are complex, indirect, and embedded in a web of other arguably more important individual and situational cofactors to consider."⁹³ A recent study found that future violence was more closely associated with other particular factors such as past violent acts, substance abuse, and environmental factors.⁹⁴ In analyzing the MacArthur Study from 1999 in light of continued research and literature, the authors state, "the relationship between diagnosis and violence, we believe, is still an open question . . ."⁹⁵ Those authors did find that the predictors of violence for people with mental illness "are more similar than different" to the predictions of violence in the population as a whole.⁹⁶ Those predictors also included alcohol and substance abuse.

It should be noted that there are studies which still show an indication that violence is more prevalent within certain diagnoses and symptoms of mental illness. A national study of patients with schizophrenia found that patients with particular clusters of positive psychotic symptoms, such as persecutory ideations, were more likely to be violent.⁹⁷ A recent Australian study found

⁹² For a more thorough discussion on the concept of autonomy, see Dora W. Klein, *Autonomy and Acute Psychosis: When Choices Collide*, 15 VA. J. SOC. POL'Y & L. 355, 388–89 (author argues that mental illness itself limits autonomy more than involuntary treatment).

⁹³ Eric B. Elbogen, Sally C. Johnson, *The Intricate Link Between Violence and Mental Disorder*, 66 ARCH. GEN. PSYCHIATRY 2 (February 2009).

⁹⁴ *Id.*

⁹⁵ E. Fuller Torrey et al., *The MacArthur Violence Risk Assessment Study Revisited: Two Views Ten Years After Its Initial Publication*, 59 PSYCHIATRIC SERVICES 2 (Feb. 2008).

⁹⁶ *Id.* at Conclusion.

⁹⁷ Jeffrey Swanson et al., *A National Study of Violent Behavior in Persons with Schizophrenia*, 63 ARCH. GEN. PSYCH 490 (May 2006). Part of the study's conclusion was that "violence risk management must include a focus on the whole person in the community environment" which is what Laura's Law does.

those diagnosed with schizophrenia, while overwhelmingly not violent, were still more likely to be violent than a control group of people without schizophrenia.⁹⁸ These studies suggest that, while it is erroneous and an oversimplification to say that people with mental illness are violent or at a higher risk of violence, it is equally erroneous to conclude that there are not subsets of the population of people with mental illness who do present an increased risk of violence. Laura's Law, with its requirements of an act of serious violence or involuntary hospitalization (resulting from serious violence) aims to reach such subpopulations and reduce acts of violence, among other negative outcomes.

STUDIES OF AOT DEMONSTRATE ITS EFFECTIVENESS

Multiple studies have shown that AOT is effective in reducing negative outcomes as well as increasing the subjective well-being of the individuals subject to the process. The New York State Office of Mental Health's Final Report on the status of Kendra's Law found that people subject to that AOT program had generally good subjective experiences of the programs. Although about half reported feeling angry or embarrassed by the experience, 62% considered the court-ordered treatment "good for them."⁹⁹ The large majority of people reported that the pressures exerted on them helped them get well and stay well (81%) and gain control over their lives (75%), and the pressures made them more likely to keep appointments and take medication (90%).¹⁰⁰ This report strongly suggests that the informally coercive effect of AOT provides benefits to the person that the person subjectively appreciates. In fact, whether an individual subjectively feels coerced depends more on the participants in the process than on the process itself.¹⁰¹ Specifically, the patient's view depends on her belief that others acted out of concern, treated her respectfully and in good faith, and afforded the patient an opportunity to tell her side of the story.¹⁰² Results

⁹⁸ T. Short et al., *comparing violence in schizophrenia with and without comorbid substance-use abuse disorders to community controls*, ACTA PSYCHIATRICA SCANDINAVICA, 1-1 (2013).

⁹⁹ Final Report 20-21.

¹⁰⁰ *Id.*

¹⁰¹ See generally J. Monahan, *Coercion in the Provision of Mental Health Services: The MacArthur Studies*, 10 RESEARCH IN COMMUNITY & MENTAL HEALTH 13, 26-67 (1999).

¹⁰² *Id.*

from the Final Report showing that the vast majority feel confident in their case manager's ability to help them (87%), and that they both "agree on what's important" (88%),¹⁰³ coupled with the structure of AOT (representative attorney listening and representing the person, judge engaging directly with the person, individualized treatment team working with the person) strongly suggest that a person subject to AOT will subjectively feel less coercion than opponents contend. Another study suggested that multiple stakeholder groups, including individuals with psychoses, were willing to accept the perceived coerciveness of outpatient commitment in order to gain improved outcomes.¹⁰⁴

The Final Report also found an enormous reduction in several negative significant event categories. The report found large reductions in incarceration (87%), arrest (83%), psychiatric hospitalization (77%), and homelessness (74%) for those individuals in AOT compared to those same individuals before AOT.¹⁰⁵ Further, they were less likely to threaten suicide or harm others (47%), physically harm themselves (55%), or threaten to harm others (43%).¹⁰⁶ These numbers suggest strong support for the claim that AOT achieves its goals.

One independent analysis of the effectiveness of Kendra's Law in New York (the Community Outcomes of Assisted Outpatient Treatment, or "COAOT study") found that people under court-ordered AOT experienced improvements compared to a control group in areas of serious violence perpetration, suicide risk, and illness-related social functioning.¹⁰⁷ Specifically, there was a 4.31 times greater likelihood of perpetration of serious violence for those not under AOT. The study also found that the AOT group reported "marginally less stigma and coercion than the control group."¹⁰⁸

¹⁰³ Final Report, 21.

¹⁰⁴ Jeffrey Swanson et al., *Assessment of Four Stakeholder Groups' Preferences Concerning Outpatient Commitment for Persons With Schizophrenia*, 160 AM. J. PSYCHIATRY 1139, 1139 (June 2003).

¹⁰⁵ *Id.* at 17–18.

¹⁰⁶ *Id.* at 16.

¹⁰⁷ Phelan et al., *Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State*, 61 *Psychiatric Services* 2 (2010), <http://www.ncbi.nlm.nih.gov/pubmed/20123818> [hereinafter COAOT].

¹⁰⁸ *Id.*; cf. Bruce Link et al., *Stigma and coercion in the context of outpatient treatment for people with mental illnesses*, 67 *SOCIAL SCIENCE AND MEDICINE*, 3, 408–19

Most studies of outpatient commitment “have been naturalistic or quasi-experimental” and “subject to bias from selection and confounding.”¹⁰⁹ Thus, many of the objective studies designed to offer empirical data on the results of AOT suffer from shortcomings, but those shortcomings generally apply across all studies. Indeed, there are serious ethical problems in creating a true experiment that would randomly assign individuals to either AOT or not when they all meet the criteria of AOT. In the case of the COAOT study, the study designers “used a propensity score analysis to achieve the strongest possible causal inference without a randomized experimental design.”¹¹⁰ The COAOT study should be viewed as a valuable empirical study that supports the adoption of AOT. In addition, a “study of studies” published in 2004 found that “on balance, empirical studies support the view that [AOT] is effective under certain conditions” while acknowledging the fact that controversial views continue to permeate the field.¹¹¹

Studies of Kendra’s Law generally have displayed results indicating its effectiveness.¹¹² In particular, a 2011 quasi-experimental study indicated that outpatient commitment under Kendra’s Law is associated with a reduced risk of arrest for patients under AOT orders compared to patients not under AOT orders, and for patients under AOT orders compared to

(Aug. 2008) (“We found that improvements in symptoms lead to improvements in social functioning. Also consistent with this perspective, assignment to mandated outpatient treatment is associated with better functioning and, at a trend level, to improvements in quality of life. At the same time . . . findings showing that self-reported coercion increases felt stigma (perceived devaluation-discrimination), erodes quality of life and through stigma leads to lower self-esteem.”) The authors recommend that “future policy needs not only to find ways to insure that people who need treatment receive it, but to achieve such an outcome in a manner that minimizes circumstances that induce perceptions of coercion.” *Id.* The importance of the participants’ working with the individual so as to reduce this feeling of coercion appears to be of strong importance.

¹⁰⁹ COAOT, *supra* note 107.

¹¹⁰ *Id.*

¹¹¹ Marvin S. Schwartz & Jeffrey W. Swanson, *Involuntary Outpatient Commitment, Community Treatment Orders, and Assisted Outpatient Treatment: What’s in the Data?*, 49 CAL. J. OF PSYCHIATRY 585–91 (2004), available at <https://ww1.cpa-apc.org/Publications/Archives/CJP/2004/september/swartz.pdf>.

¹¹² *Kendra’s Story: Her Killer Speaks for the First Time*, aired Feb. 1, 2013, <http://archive.wgrz.com/news/article/198510/13/Kendras-Story-Her-Killer-Speaks-For-The-First-Time>.

those same patients before AOT.¹¹³ These studies, while not ideal research, are still valuable and reliable and show data indicating that AOT is associated with better outcomes for patients.

Critics of AOT cite the Oxford Community Treatment Order Evaluation Trial (OCTET) study published in April 2013 as contradicting claims of effectiveness from an AOT program.¹¹⁴ In that study, participating patients leaving psychiatric discharge were either randomized to “community treatment orders” and were subject to clinical monitoring and rapid recall assessment, or they were randomized to “§ 17 leave” and were subject to recall for assessment but received significantly less extensive monitoring and for shorter times.¹¹⁵ The study authors interpreted their results as showing “in well coordinated mental health services, the imposition of compulsory supervision does not reduce the rate of readmission of psychotic patients.”¹¹⁶ Here, proponents of AOT distinguish this study as inapplicable to AOT, because the CTO is a “purely administrative order” issued by a clinician and not a judge.¹¹⁷ As such, it lacks the critical “black robe effect.”

The theory behind the black-robe effect is that a judicial process and a judge's imprimatur increase the likelihood that the patient will take to heart the need to adhere to prescribed treatment. It is not a single factor but a host of related ones that combine to send a potent message: the ritual of being summoned to court and taking part in a hearing, the recognition that a fair-minded third party has listened to both sides and ultimately agreed with clinicians that assisted treatment is warranted, the cultural perception of the

¹¹³ B.G. Link et al., *Arrest outcome associated with outpatient commitment in New York State*, PSYCHIATRIC SERVICES 2011; 62:504–08, <http://ps.psychiatryonline.org/article.aspx?articleid=116189>.

¹¹⁴ T. Burns et al., *Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial*, LANCET 381:1627–33, 2013

¹¹⁵ *Id.* See also Michael Rowe, *Alternatives to Outpatient Treatment*, JOURNAL OF THE AMERICAN ACADEMY OF LAW AND PSYCHIATRY ONLINE, Sept. 2013, <http://www.jaapl.org/content/41/3/332.full>.

¹¹⁶ OCTET *supra* note 114, at Interpretation.

¹¹⁷ Treatment Advocacy Center, *No Relevance to Assisted Outpatient Treatment (AOT) in the OCTET Study of English Compulsory Treatment*, May 2013, <http://treatmentadvocacycenter.org/storage/documents/Research/may2013-octet-study.pdf> [hereinafter No Relevance].

judge as an authority figure, and the inclination of many judges to use their bench as a sort of civic pulpit.¹¹⁸

There are other reasons to discount the validity of the study. The OCTET study compares groups undergoing different forms of mandatory treatment, with neither a court order nor judicial administration. It does not compare court-ordered treatment to voluntary treatment. Additionally, the study included a substantial number of subjects who had not refused treatment.¹¹⁹ However, non-compliance with treatment is a requirement under AOT. Further, patients whose families felt very strongly that their loved one needed treatment were excluded because of an unwillingness to risk her assignment to the non-CTO group, and a substantial number of patients who were eligible for the study refused to participate in the initial interviews.¹²⁰ Both of these groups, which self-selected out of the study, are likely to be among those subject to AOT orders — in the first case because of an indication of the seriousness of the illness, and in the second because of their non-compliance with the study program. Their exclusion casts further doubt on OCTET's applicability to AOT programs that require serious mental illness and non-compliance with treatment. Thus, the study lacks the external validity to compare it to AOT. It offers few or no generalizable results.

LAURA'S LAW'S EFFECTIVENESS

Nevada County, the only county to have fully implemented Laura's Law, currently provides the only Laura's Law test jurisdiction in California for evaluation. The county showed results that indicate the effectiveness of Laura's Law in a California county. Looking at the twelve months pre-treatment versus twelve months post-treatment for patients via AOT/ACT,¹²¹ Nevada

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 3 (sample of 200 patients found 30% had "no history of non-compliance or disengagement from treatment.") (citing J. Williams, *Are community treatment orders being overused?*, THE GUARDIAN, Oct 27, 2010).

¹²⁰ No Relevance, *supra* note 117, at 3 (citing T. Burns et al., *Community treatment orders for patients with psychosis (OCTET): a randomized controlled trial*, THE LANCET, April 2013).

¹²¹ The numbers reflect both those using ACT through AOT and those using it voluntarily. The study found that AOT outcomes are similar to ACT outcomes. Further,

County found decreases in the number of psychiatric hospital days (46.7%), incarceration days (65.1%), homeless days (61.9%), and emergency interventions (44.1%).¹²² Those significant decreases indicate that Laura's Law has a significant effect in preventing adverse outcomes, and the institutionalization and accompanying loss of liberty of those patients.¹²³

IMPLEMENTATION CHALLENGES

THE POLITICS OF MENTAL HEALTH

Just as there were political challenges faced and compromises made to pass Laura's Law in the state legislature,¹²⁴ there are serious political challenges to passing Laura's Law county by county.¹²⁵ Often, opponents or those ambivalent about AOT will cite concerns regarding racial disparities in enforcement or cultural competency of assessment and treatment, and the nature of the hearings provided to individual patients as reasons to deny or delay opting in. While those are serious concerns, the evidence strongly suggests that enforcement of Laura's Law does not unfairly discriminate based on race, employs cultural competency in its implementation, and handles hearings in an appropriate manner for the individuals.

AOT is used to engage those patients who will not engage in ACT voluntarily, which is a separate population. *See supra*, note 57.

¹²² Michael Heggerty, ASSISTED OUTPATIENT TREATMENT (W&I CODE 5345) (AB 1421) "LAURA'S LAW": THE NEVADA COUNTY EXPERIENCE 31, Nov. 15, 2011, available at <http://mentalillnesspolicy.org/states/california/nevada-aot-heggerty-8.pptx.pdf>.

¹²³ Laura's Law 2015 Annual Report indicated a decrease in psychiatric hospital days of 77.6%, in incarceration days of 100%, and in homeless days of 79.5%. A consumer satisfaction survey rated overall satisfaction with the AOT Program at 78.3%. *See* Friday Memo for 4/17/2015, "Laura's Law 2015 Annual Report," MyNevadaCounty.com (Apr. 17, 2015 2:25 PM), <http://www.mynevadacounty.com/nc/ceo/Pages/FridayMemo-20150417.aspx#id-879>.

¹²⁴ *See generally*, Paul Applebaum, *Law & Psychiatry: Ambivalence Codified: California's New Outpatient Commitment Statute*, 54 PSYCH SERVS. 1, 26–28 (Jan. 2003).

¹²⁵ A full discussion of the politics of enacting AOT is outside of the scope of this paper. For more information, *see, e.g.*, Amy Yannello, *The case for Laura's Law: An Open Letter to Citizens and Elected Officials*, <https://www.beaconreader.com/amy-yannello/the-case-for-lauras-law-an-open-letter-to-citizens-and-elected-officials> (describing Contra Costa county's political battle).

LAURA'S LAW DOES NOT RACIALLY DISCRIMINATE

There has been concern that African Americans and other minority groups have been over-represented in the AOT program in New York.¹²⁶ Partly in response, the New York State Office of Mental Health commissioned an independent evaluation of Kendra's Law that found "no evidence that the AOT Program is disproportionately selecting African Americans for court orders, nor [] evidence of a disproportionate effect on other minority populations Our interviews with key stakeholders across the state corroborate these findings."¹²⁷ The study's authors concluded that, at first glance, African Americans appeared to be overrepresented in relation to the total population.¹²⁸ However, when conducting a deeper statistical multivariable analysis, the results showed that "differences are dependent on context," and that when the most relevant populations for AOT are analyzed, there was *no appreciable racial disparity*.¹²⁹ From this the authors infer that the seeming overrepresentation of African Americans compared to the total population "is influenced by a number of 'upstream' social and systemic variables such as poverty that may correlate with race," but saw "no evidence suggesting racial bias in the application of AOT to individuals."¹³⁰

In another publication, the authors of the same independent study noted that to the extent that selection is based on clinical appropriateness and need, and not on "systemic, legal, and regulatory factors that treat minorities differently than their nonminority counterparts; or [] discrimination, bias, stereotyping, and clinical uncertainty within the system," a *difference* should not be considered a negative *disparity*.¹³¹ Given the results of the

¹²⁶ See New York Lawyers for the Public Interest, Inc., *Implementation of 'Kendra's Law' is Severely Biased*, 2–5 (April 7, 2005), available at http://www.prisonpolicy.org/scans/Kendras_Law_04-07-05.pdf.

¹²⁷ John Monahan et al., *NEW YORK STATE ASSISTED OUTPATIENT TREATMENT PROGRAM EVALUATION* vii, Duke University School of Medicine, Durham, NC (June 2009).

¹²⁸ *Id.* at 13.

¹²⁹ *Id.* at 14.

¹³⁰ *Id.* at 14–15.

¹³¹ Jeffrey Swanson et al., *Racial Disparities In Involuntary Outpatient Commitment: Are They Real?*, 28 *HEALTH AFFAIRS* 3, 816–18, Exhibit 1 (2009) [hereinafter "Racial Disparities"] (adopting a 2002 Institute of Medicine report which "argues that 'disparity' should be reserved for that portion of the difference in health care quality that is attributable to (1) systemic, legal, and regulatory factors that treat minorities

program evaluation, it does not appear that those systemic or discriminatory problems are present. The more closely the study analyzed individuals who would actually be subject to AOT, the closer those individuals' proportional representation in AOT matched their ratios relative to the general population.¹³²

In that same publication, the authors of the independent study opined that “whether this overrepresentation under court-ordered outpatient treatment is unfair depends on one’s view: is it access to treatment and a less restrictive alternative to hospitalization, or a coercive deprivation of personal liberty?”¹³³ Thus, to the extent there even is a *disparity* in the ratio of African Americans and other minority groups treated compared to the total population, whether one views that disparity negatively (as discriminatory) depends on whether one views AOT negatively. Opponents of AOT have, not surprisingly, attempted to cast that difference as a negative.¹³⁴ As a corollary, even if proponents of AOT were to believe that there was a disparity in AOT’s application, it is unclear that they would view that as negatively “unfair” for African-Americans with severe mental illness. It is entirely possible to see that from their point of view, that disparity favors a group with the advantage of appropriate AOT treatment. Whether this point continues to be a source of contention in the future may simply be in the eye of the beholder. As the success of AOT programs becomes clearer, the concern that the effect of the programs is negative and unfair will likely dissipate.

A lot of the concern regarding racial disparities in the AOT population in New York’s experience can be attributed to a longstanding distrust of

differently than their nonminority counterparts; or (2) discrimination, bias, stereotyping, and clinical uncertainty within the system.”).

¹³² See *supra* note 126.

¹³³ Racial Disparities, 816.

¹³⁴ See, e.g., Jennifer Friedenbach, *Laura’s Law a looming disaster for mentally ill*, SF EXAMINER, June 8, 2014 (“This law was implemented in New York, and studies found *disturbing disparities* among people of color — African-Americans and Latinos were *forcibly* treated at much higher rates.”) (emphasis added); Jasenn Zaejian, *Current Research on Outpatient Commitment Laws*, MAD IN AMERICA, available at <http://www.madinamerica.com/2014/02/current-research-outpatient-commitment-laws-lauras-law-california%E2%80%8E/> (summarily dismissing the Swanson study’s conclusions and asserting that the data “clearly indicates prima facie racial discrimination”).

law enforcement among minority racial groups generally and legitimate concern that certain elements of law enforcement act prejudicially in their enforcement discretion.¹³⁵ These are certainly important concerns. However, the AOT process is not controlled by law enforcement. Law enforcement officers are only one of a number of categories of reporters who can petition the county mental health director to conduct an investigation and subsequently petition the court for AOT proceedings.¹³⁶ Indeed, police are one of the primary sources of referrals. However, the decision as to whether an individual qualifies for AOT ultimately depends on professional psychiatric health judgments using objective medical standards for diagnosis, and then an independent judge's finding of all of the requisite statutory elements by clear and convincing evidence. The decision to initiate the AOT process and the decision to issue a court order are not made by law enforcement. While that is a key distinction, there can still be legitimate concerns regarding those who are making treatment decisions.¹³⁷

CONCERNS ABOUT CULTURAL COMPETENCY

Cultural competency is key to effective implementation of Laura's Law. Cultural competency is defined by the U.S. Department of Health and Human Services as "a set of values, behaviors, attitudes, and practices within a system that enables people to work effectively across cultures" and "refers to the ability to honor and respect the beliefs, language, interpersonal styles, and

¹³⁵ This is putting it mildly. The recent fatal police officer shooting of Michael Brown and fatal choking of Eric Garner, and subsequent non-indictments have fueled nationwide protests and brought the national spotlight to problems between law enforcement and the African-American community. See Natalie DiBlasio & Yamiche Alcindor, *'Justice for All,' 'Millions March' draw tens of thousands of protestors*, USA TODAY, Dec. 14, 2014; Meagan Clark, *More Protests Planned This Week For Eric Garner, Tamir Rice, Mike Brown*, INTERNATIONAL BUSINESS TIMES, <http://www.ibtimes.com/more-protests-planned-week-eric-garner-tamir-rice-mike-brown-1740395>. As of a recent update to this paper, the in-police-custody death of Freddie Gray has ignited protests in Baltimore. See Sheryl Gay Stolberg & Stephen Babcock, *Scenes of Chaos in Baltimore as Thousands Protest Freddie Gray's Death*, NY TIMES, April 25, 2015, available at http://www.nytimes.com/2015/04/26/us/baltimore-crowd-swells-in-protest-of-freddie-grays-death.html?_r=0.

¹³⁶ Cal. Welf. Inst. Code § 5346(a).

¹³⁷ See generally Jonathan Metzi, *THE PROTEST PSYCHOSIS: HOW SCHIZOPHRENIA BECAME A BLACK DISEASE* (2010).

behaviors of individuals and families receiving services, as well as staff who are providing such services.”¹³⁸ Cultural competency is critical because

[c]ulture counts when it comes to diagnosis and treatment of mental disorders. How people manifest their diseases, how they cope, the type of stresses they experience, and whether they are willing to seek treatment are all impacted by culture. Stigma also is greatly influenced by culture. . . . Professionals also are influenced by culture. Our culture impacts upon how we hear things when we talk to patients. It can interfere with our ability to make accurate diagnoses and can even impact our judgment about treatment. This is a major component of disparities in quality of care.¹³⁹

Indeed, the President’s New Commission on Mental Health in 2003 found that there were many challenges that needed to be addressed for minority groups to gain both better diagnosis and better access to treatment.¹⁴⁰ To address those challenges, there are federal laws that mandate non-discrimination in availability of services for programs receiving federal funds.¹⁴¹ At the state level, the California Department of Health has ordered all county mental health departments to create cultural competency programs.¹⁴²

Laura’s Law itself mandates that counties that opt in must have a service planning and delivery process that considers “cultural, linguistic, gender, age, and special needs of minorities” and must provide “staff with the cultural background and linguistic skills necessary to remove barriers to mental health

¹³⁸ National Alliance on Mental Illness, Multicultural Action Center, http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Cultural_Competence/Cultural_Competence.htm (last visited May 12, 2015).

¹³⁹ David Satcher, *The Connection Between Mental Health and General Health*, in THE PRESIDENT’S NEW FREEDOM COMMISSION ON MENTAL HEALTH: TRANSFORMING THE VISION, 11 (The Carter Ctr. ed., Nov. 5–6, 2003), available at <http://www.carter-center.org/documents/1701.pdf>.

¹⁴⁰ PRESIDENT’S NEW FREEDOM COMMISSION ON MENTAL HEALTH 49 (July 22, 2003), available at <http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf>.

¹⁴¹ California Department of Mental Health, *Cultural Competence Plan Requirements CCPR Modification 27–28*, <http://www.dhcs.ca.gov/services/MH/Documents/CCPR10-17Enclosure1.pdf>.

¹⁴² California Department of Mental Health, *Cultural Competence*, <http://www.dhcs.ca.gov/services/mh/pages/culturalcompetenceplanrequirements.aspx> (last visited May 12, 2015).

services as a result of having limited English-speaking ability and cultural differences.”¹⁴³ They also must provide “services [that] reflect special need[s] of women from diverse cultural backgrounds.”¹⁴⁴ The statute also requires that “individual personal services plans shall ensure . . . age-appropriate, gender-appropriate, and culturally-appropriate services” designed to enable a number of positive psychosocial outcomes for the individual.¹⁴⁵ Thus there are substantial cultural competency requirements for the provision of mental health treatment and associated services built into the mandate of the statute. Their effective implementation presumably will provide necessary cultural competency in the treatment that Laura’s Law aims to provide.

PRIVACY OF LAURA’S LAW HEARINGS

Another possible concern with the implementation of Laura’s Law is the privacy of its hearings. In order to gauge how the court should decide this issue, we should analyze how current conservatorship court hearings under the Lanterman–Petris–Short Act (also known as “LPS,” codified in the California Welfare and Institutions Code) are structured. In the leading case on the privacy of court hearings under LPS, the California Court of Appeal for the Sixth Appellate District granted a writ of mandate in *Sorenson* commanding the Superior Court of Monterey County to vacate and issue a new order denying two newspapers access to the trial records of Christopher Sorenson’s LPS conservatorship jury trials.¹⁴⁶ The newspapers’ interest emerged after Sorenson was charged with killing his mother, her death occurring eight days after the conclusion of his second LPS trial.¹⁴⁷ The appellate court held that Section 5118 of the Welfare and Institutions Code makes LPS jury trials presumptively non-public.¹⁴⁸ This finding constitutes an exception to California Code of Civil Procedure 124, which states that the sittings of every court must be public.¹⁴⁹

¹⁴³ Cal. Welf. Inst. Code § 5348(a)(2)(B).

¹⁴⁴ *Id.* at (a)(2)(I).

¹⁴⁵ *Id.* at (a)(4). Such services are qualified “to the extent feasible.” *Id.*

¹⁴⁶ *Sorenson v. Superior Court*, 219 Cal. App. 4th 409, 415 (2013).

¹⁴⁷ *Id.*

¹⁴⁸ *Id.* at 416 (“[T]hey are not special proceedings for which there is a qualified First Amendment right of public access.”).

¹⁴⁹ Cal. Code Civ. Proc. § 124. There is an exception for family law matters. Cal. Fam. Code § 214.

In *Sorenson*, which applies to LPS court trials,¹⁵⁰ the court reasoned that an LPS jury trial is “not an ordinary civil proceeding,” and so the right of access recognized by the California Supreme Court in ordinary civil proceedings did not apply.¹⁵¹ Further, the court noted, “there is not such a tradition of openness or utility associated with having the proceedings public to support a finding of a constitutional right of access.”¹⁵² The lack of historical right of access, added to the plain language of the statute, the fact that the state mandates that all records be confidential, and the fact that the LPS Act itself specified a right to privacy, suggested to the court that there was no public right of access to LPS trials, and that closed proceedings were favored.¹⁵³ Utility concerns of “enhancing the conduct, accuracy, and truth-finding function of trials” by making them public were found substantially weaker in the situation where the purpose of the proceeding is the mental health of the individual.¹⁵⁴ Likewise, the therapeutic value of open proceedings regarding criminal matters did not apply here for the appellate court.¹⁵⁵ The court reasoned that although openness would serve the purpose of preventing abuse of judicial power, it could theoretically apply to *any* proceeding, and because Section 5118 allowed for any party to demand that the proceeding be public, it had an “escape valve” that would facilitate that goal if needed.¹⁵⁶ The court buttressed its holding by citing a patient’s constitutional right to privacy under the California Constitution, and the protections of the psychotherapist–patient privilege.¹⁵⁷ Finally, and perhaps most strongly, the court noted, “a conclusion that LPS trials are presumptively public proceedings would cause proposed involuntary conservatees to suffer the embarrassment and stigma of public scrutiny to their alleged mental difficulties and to their personal psychiatric records.”¹⁵⁸

All of the court’s analysis in *Sorenson* applies directly for Laura’s Law hearings. Given that AOT proceedings are relatively recent and are

¹⁵⁰ *Sorenson*, 219 Cal. App. 4th at 443.

¹⁵¹ *Id.* at 430–31.

¹⁵² *Id.*

¹⁵³ *Id.* at 433–34.

¹⁵⁴ *Id.* at 434–35.

¹⁵⁵ *Id.* at 436.

¹⁵⁶ *Id.*

¹⁵⁷ *Id.* at 444.

¹⁵⁸ *Id.* at 448.

decidedly different from an “ordinary civil proceeding,” the same analysis should apply here. The fact that Laura’s Law is contained, along with the Lanterman–Petris–Short Act provisions, in the California Welfare and Institutions Code argues more strongly for applying the same reasoning. The legal analysis supports finding that Laura’s Law hearings should be presumptively private. And as the *Sorenson* court pointed out, privacy of proceedings makes sense as a policy matter. Privacy of proceedings protects the individual from public scrutiny and embarrassment during a time when their illness will be highlighted in detail. The focus during the Laura’s Law hearing should be on providing the individual with the needed support and therapeutic coercion to maximize the potential for successful treatment. Outside observers will not add anything toward that goal.

COUNTY SAVINGS FROM IMPLEMENTATION SHOULD BE USED FOR OTHER MENTAL HEALTH SERVICES

One thing on which all sides can agree is that mental health services are currently underfunded. For example, the Behavioral Health Court in San Francisco (a diversionary court that seeks to place people with mental illness who have been arrested for crimes in needed treatment facilities and programs) often faces a lack of currently available space in those programs and facilities. Lack of adequate funding for psychiatric hospital beds, residential treatment facilities, community clinics and other community-based resources is a challenge to both voluntary and involuntary users of such resources.¹⁵⁹ Since 2008, \$4.5 billion has been cut from mental health care

¹⁵⁹ Bernard J. Wolfson, *Psych patients pack emergency rooms*, Orange County Register (Oct. 25, 2014), available at <http://www.ocregister.com/articles/psychiatric-639758-patients-emergency.html> (“A severe shortage of psychiatric hospital beds, tight space at residential facilities and less help at community clinics has turned E.R.s into virtual boarding houses for psych patients.”); see also, E. Fuller Torrey et al., *THE SHORTAGE OF HOSPITAL BEDS FOR MENTALLY ILL PERSONS 2*, http://www.treatmentadvocacycenter.org/storage/documents/the_shortage_of_publichospital_beds.pdf (“The total estimated shortfall of public psychiatric beds needed to achieve a minimum level of psychiatric care is 95,820 beds.”). The California Hospital Association in Sacramento reported, “California’s bed rate is an appalling one bed for every 5,975 people, as of 2011, worse than the rest of the nation’s average of one bed for every 4,758 people.” Joanne Williams, *Feature: Beds of Unbalance*, PACIFIC SUN, available at <http://www.calhospital.org/news-headlines-article/feature-beds-unbalance> (last visited May 12, 2015).

funding.¹⁶⁰ Currently, nearly half of California counties have no psychiatric inpatient beds available.¹⁶¹ Given the potential for Laura's Law to save county funds that can be diverted to providing more resources overall,¹⁶² and its ability to bring treatment of severe mental illness further to the forefront of public discourse, it is an important policy that should continue to be carefully implemented.

Overall, successful implementation of Laura's Law will often depend on a strong and sustained good-faith collaboration among the county mental health director, the judge presiding, the treatment team, and local community groups of interest, such as the National Alliance on Mental Illness. Their effective cooperation and coordination is needed to assure that counties implement Laura's Law in a just, fair, and therapeutic manner.

CONCLUSION — IMPLEMENT LAURA'S LAW/AOT

Assisted outpatient treatment offers more than hope. Multiple studies have provided evidence of its effectiveness. Laura's Law, as a version of assisted outpatient treatment, retains all the necessary elements of AOT. The evidence on Laura's Law in particular directly points toward its success in California. There is every reason to believe that Laura's Law has and will work for the small population of people with severe mental illness it targets for treatment. AOT has passed legal muster, and Laura's Law is constitutional as well. Beyond legal tests, Laura's Law is sound public policy that will help reduce the worst outcomes for people with severe mental illness, and provide support and treatment for those who need it most. It is a policy proposal that offers a desperately needed option for families and communities crushed under the heavy financial weight and profoundly heavier emotional and psychological toll of untreated and poorly treated severe mental illness. There are implementation challenges and concerns, as there are with every piece of legislation. But they should not be and are

¹⁶⁰ 60 Minutes, *Nowhere to Go: Mentally Ill Youth in Crisis*, Jan. 26, 2014, available at <http://www.cbsnews.com/news/mentally-ill-youth-in-crisis/>.

¹⁶¹ California Healthline, *Report: Calif. Hospitals Lack Beds for Those With Mental Illnesses*, <http://www.californiahealthline.org/articles/2014/4/15/report-calif-hospitals-lack-beds--for-those-with-mental-illnesses>.

¹⁶² Jeffrey Swanson et al., *The Cost of Assisted Outpatient Treatment: Can It Save States Money?*, AM. J. PSYCHIATRY, AIA 1–10 (July 2013).

not a barrier to adopting Laura's Law. It is true that Laura's Law is not a silver bullet that will solve all the challenges faced by people with mental illness and our communities, but it is another tool in the toolbox for our communities to use in fixing our broken mental health system.

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