
IS CALIFORNIA COMMITTED?: WHY CALIFORNIA SHOULD TAKE ACTION TO ADDRESS THE SHORTCOMINGS OF ITS ASSISTED OUTPATIENT COMMITMENT STATUTE

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I. INTRODUCTION

The history of the treatment of mental illness in the United States is anything but simple. While both social and scientific understanding of mental illness have developed tremendously in recent decades,¹ there remain significant barriers to implementing effective treatment and rehabilitation programs for people with mental illness. Inherent in this intersection of law and mental health is the delicate balance between preserving liberty and autonomy interests on the one hand, and providing for individual and societal safety on the other.² This balance is not easily achieved and remains the core debate surrounding much of today's mental health legislation.

One particularly topical area in which this issue arises is civil commitment. Civil commitment, as it is understood and implemented today, represents a hallmark legal and social development regarding the

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1. CHRISTOPHER SLOBOGIN ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 3 (5th ed. 2009).

2. See Jeffrey L. Geller, *The Evolution of Outpatient Commitment in the USA: From Conundrum to Quagmire*, 29 INT'L J.L. & PSYCHIATRY 234, 236 (2006) (describing this tension with respect to outpatient commitment statutes).

treatment and understanding of mental illness.³ Its evolution took place largely during the 1960s and 1970s⁴ in the context of the civil rights movement and in the face of increasing public awareness of “poor hospital conditions and commitment abuses.”⁵ This political era sparked a process called “deinstitutionalization.”⁶ Based on a more libertarian ideology, many states restricted their involuntary commitment criteria and created more procedural protections to reduce the rate of involuntary hospitalization.⁷ The seminal example of this legal reform is California’s Lanterman-Petris-Short Act of 1969 (“LPS”).⁸

The LPS codified “danger to others or [self]” or “gravely disabled” as the standards for involuntary civil commitment.⁹ These new standards were motivated by a desire to preserve the civil rights and liberties of persons with mental illness as well as to improve treatment options.¹⁰ Around the same time, U.S. Congress passed the Community Mental Health Centers Act (“CMHC”)¹¹ in 1963.¹² The CMHC provided federal funding to states for the establishment of community-based mental health treatment centers and reflected an effort to provide deinstitutionalized treatment for mental illness.¹³ The advent of federal benefits such as Medicare, Medicaid, Supplemental Security Income, Social Security Disability Insurance, and food stamps further enabled the deinstitutionalization movement.¹⁴ These

3. See SLOBOGIN ET AL., *supra* note 1, at 701–04 (outlining the evolution of and history behind modern civil commitment statutes).

4. See *id.* at 703 (by the 1970s, thirty-one states allowed involuntary inpatient commitment based solely on a physician’s certification that an individual had a mental illness and needed treatment).

5. *Id.*

6. *Id.* at 705 (internal quotation marks omitted).

7. *Id.* at 705–06.

8. CAL. WELF. & INST. CODE §§ 5000–587 (West 2010 & Supp. 2014). See also SLOBOGIN ET AL., *supra* note 1, at 703–04 (stating that the LPS in California was the “leading statutory indication” that a shift in mental health law was occurring).

9. CAL. WELF. & INST. CODE § 5150 (West 2010 & Supp. 2014).

10. See Ralph Slovenko, *The Transinstitutionalization of the Mentally Ill*, 29 OHIO N.U. L. REV. 641, 649 (2003) (“[The LPS] was designed to protect the civil liberties of persons alleged to be mentally ill and to accelerate the trend toward ‘community’ treatment of the mentally ill as an alternative to hospitalization in remote state institutions.”).

11. Community Health Centers Act, Pub. L. No. 88-164, 77 Stat. 282 (1963) (codified as amended at 42 U.S.C. §§ 2661–698b (2014)).

12. SLOBOGIN ET AL., *supra* note 1, at 706.

13. *Id.*

14. Rachel A. Scherer, Note, *Toward a Twenty-First Century Civil Commitment Statute: A Legal, Medical, and Policy Analysis of Preventative Outpatient Treatment*, 4 IND. HEALTH L. REV. 361, 365 n.12 (2007). See also Slovenko, *supra* note 10, at 650–51 (detailing the “liberalization of rules” under deinstitutionalization that increased federal benefit coverage for the mentally ill).

changes at the state and federal levels, combined with the political atmosphere of the 1960s and 1970s, allowed for the “largescale release” of patients with chronic mental illness into the community.¹⁵ And while this new outlook on the treatment and commitment of persons with mental illness was progressive, deinstitutionalization has had significant “tangential and unintended effects on the administration [of] mental health treatment” throughout the nation.¹⁶ Simply put, while the legislative and social structures were put into place to enable persons with mental illness to integrate into the community, the community-based treatment centers at which they were to receive alternative treatment did not follow.¹⁷

This has resulted in a process that many call “transinstitutionalization,” which refers to the fact that people with mental illness have instead been transferred from mental hospitals to other types of institutions, such as prisons.¹⁸ Because many persons with chronic mental illness do not have sufficient access to treatment, many are incarcerated, arrested, and even homeless.¹⁹ This has created a population of so-called “revolving-door” patients, who are stable when medicated and receiving structured treatment, but become noncompliant with treatment upon release into the community.²⁰ Thus, they are rehospitalized or incarcerated until they are stable again, creating a repeating cycle of institutionalization and

15. SLOBOGIN ET AL., *supra* note 1, at 707.

16. Scherer, *supra* note 14.

17. See S. JUDICIARY COMM., BILL ANALYSIS OF A.B. 1421 (Thomson), 2001–2002 Leg., Reg. Sess., at 1 (Cal. 2002) [hereinafter A.B. 1421 BILL ANALYSIS], available at <http://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml>. (“[M]uch of the community care envisioned by the LPS Act never took place.”); Slovenko, *supra* note 10, at 651 (“[T]he tax dollars not spent on hospitalization [and other forms of institutional treatment] did not follow the patient into the community.”).

18. See Slovenko, *supra* note 10, at 641 (“In a process called transinstitutionalization, the mentally ill are alternately and repeatedly routed between the mental health and criminal justice systems.”); Christina Canales, Note, *Prisons: The New Mental Health System*, 44 CONN. L. REV. 1725, 1727 (2012) (“With new developments on the horizon . . . deinstitutionalization, or the movement of the mentally ill from hospitals to community-based treatment programs, became a real possibility. That movement, however, . . . limited the *treatment* available to these individuals and created a gap that prisons would soon come to fill.”); Wayne Drash, ‘My Son is Mentally Ill,’ *So Listen Up*, CNN, <http://www.cnn.com/interactive/2013/12/health/mentally-ill-son/> (last visited April 19, 2015) (reporting that one in every five people held in America’s prisons and jails has a recent history of mental illness).

19. See 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, 493–94 (2003) (detailing how the current situation leads to miserable consequences for the mentally ill).

20. See Scherer, *supra* note 14, at 415 (“This revolving-door refers to the cycling of persons with mental illness through jail, homelessness, and hospitalization due to inadequate mental health care systems.”).

community reintegration.²¹ Many live on the streets or move in and out of homeless shelters, failing to receive necessary treatment while their physical and mental conditions continue to deteriorate.²² Countless others do not come to the attention of law enforcement or medical authorities, but rather, are the burden of their families and loved ones.²³ These types of persons with mental illness often do not receive treatment until they deteriorate to a level that necessitates inpatient commitment or results in incarceration.²⁴

While all states have civil commitment statutes,²⁵ the advent of “preventative outpatient commitment” has taken the concept of civil commitment to a new level.²⁶ Some states utilize “assisted outpatient treatment” (“AOT”) statutes that order persons with mental illness to seek treatment in the community as a condition of release from involuntary hospitalization.²⁷ “Preventative AOT” (“PAOT”) statutes, however, provide community-based treatment through a court-ordered treatment plan before [individuals with severe mental illness] deteriorate to a “gravely disabled” or dangerous condition that would necessitate inpatient commitment.²⁸ Naturally, PAOT statutes are controversial, and opponents often argue that they are constitutionally overbroad and infringe on

21. A.B. 1421 BILL ANALYSIS, *supra* note 17, at 10.

22. *Id.* at 2.

23. See, e.g., Katherine B. Cook, Note, *Revising Assisted Outpatient Treatment Statutes in Indiana: Providing Mental Health Treatment for Those in Need*, 9 IND. HEALTH L. REV. 661, 691 (2012) (with regard to untreated people with mental illness, the “largest intangible cost . . . is the effect on the family” (quoting *Consequences of Non-Treatment*, TREATMENT ADVOCACY CTR., http://www.treatmentadvocacycenter.org/index.php?option=com_content&task=view&id=1384&Itemid=221 (last visited April 19, 2015))); Karasch, *supra* note 19, at 503 (describing this as a “die with their rights on” approach to limiting involuntary treatment of mental illness); Dave Davies, *Author Wades Through ‘Mental Health Madness,’* NPR (Apr. 17, 2006), <http://www.npr.org/templates/story/story.php?storyId=5346062> [hereinafter *Davies*] (encompassing the common experience that many worried family members and friends experience when a loved one is severely mentally ill and refuses treatment); Drash, *supra* note 18 (quoting the executive director of the National Alliance on Mental Illness, who stated that aside from the media attention given to huge national tragedies, “There are smaller tragedies that happen every day in this country because people are untreated for mental illness”). A reported seventy-five million American families are affected by mental illness, and “[t]hose small, quiet tragedies don’t usually make headlines.” Drash, *supra* note 18.

24. See Karasch, *supra* note 19, at 503 (“A substantial number of mentally ill people will go untreated unless there is involuntary commitment.”).

25. SLOBOGIN ET AL., *supra* note 1, at 705.

26. See Geller, *supra* note 2, at 234–35 (discussing the debate surrounding outpatient commitment in the United States).

27. Scherer, *supra* note 14, at 369.

28. *Id.* at 367–69; Geller, *supra* note 2, at 235.

individuals' liberty interests.²⁹ Conversely, proponents emphasize that they reduce the amount of persons with mental illness resigned to homelessness, incarceration, and revolving-door hospitalizations, and that they are an effective mechanism to drastically reduce costs associated with treatment or other institutional placement of people with mental illness.³⁰

This Note will focus on California's PAOT statute, commonly called "Laura's Law."³¹ Inspired by "Kendra's Law" in New York,³² Laura's Law permits courts to order AOT services to persons with severe mental illness.³³ To receive AOT services under Laura's Law, it must be shown by clear and convincing evidence that individuals meet nine eligibility criteria.³⁴ These criteria were designed to protect individual liberty interests and to ensure the law's applicability to a narrow portion of the population with mental illnesses.³⁵ However, this Note will argue that the fourth criterion, defining a "history of lack of compliance with treatment" for mental illness,³⁶ is too narrowly written to achieve the law's overall goal, and therefore renders the law self-defeating. A critique of this fourth criterion is the focal point of this Note and will be discussed at length in Part III.

Part II of this Note provides an explanation of Laura's Law, including its legislative history, a discussion of the current eligibility criteria, and its procedural basics. Part III then dissects the fourth eligibility criterion, providing an in-depth analysis and critique as to why its limited definition of "lack of compliance with treatment," which focuses on evidence of prior

29. See Geller, *supra* note 2, at 236 (summarizing that those who oppose preventative AOT statutes emphasize that they are too intrusive on individual liberty interests and create a system in which "coercion overtakes treatments").

30. See *id.* (echoing the fact that preventative AOT statutes are cost-effective because they "reduce[] inpatient recidivism," "decrease[] involvement with the criminal justice system," and aim to allow persons with severe mental illness to "sustain[] themselves in the workforce"); Cook, *supra* note 23, at 690–91 ("It is a mistake to think that money is saved overall" by leaving the severely mentally ill untreated because of the high costs associated with homelessness, incarceration, and unemployment (quoting *Consequences of Non-Treatment*, TREATMENT ADVOCACY CTR., http://www.treatmentadvocacycenter.org/index.php?option=com_content&task=view&id=1384&Itemid=221 (last visited April 19, 2015))).

31. CAL. WELF. & INST. CODE §§ 5345–349.5 (West 2010 & Supp. 2014).

32. N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2011).

33. See CAL. WELF. & INST. CODE § 5346(a)(2) (stating that the law applies to individuals suffering from mental illness as defined in section 5600.3(b)(2)–(3), which include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, major affective disorders, "or other severely disabling mental disorders").

34. *Id.* § 5346(a).

35. See A.B. 1421 BILL ANALYSIS, *supra* note 17, at 18–19 (describing the population that Laura's Law was intended to serve).

36. CAL. WELF. & INST. CODE § 5346(a)(4).

incarcerations, hospitalizations, or dangerous behavior, creates too narrow a standard for the receipt of AOT services. In Part IV, this Note proposes a possible solution to the problems addressed in Part III by suggesting new language for the fourth criterion. Part IV also addresses potential arguments opposing such a revision, and why there may be legislative resistance to changing the current language. However, Part IV ultimately refutes this potential opposition with policy justifications for such a revision if California is truly attempting to reform its mental health system through an effective, preventative treatment model.

II. LAURA'S LAW IN CALIFORNIA: BACKGROUND AND BASICS

On January 10, 2001, in Nevada City, California, nineteen-year-old Laura Wilcox was shot and killed by Scott Harlan Thorpe in a public mental health clinic.³⁷ Thorpe was a forty-year-old man who suffered from paranoia and depression.³⁸ His neighbor stated that he had been attending monthly counseling sessions to address his reclusion and fear of being in public places.³⁹ However, about a year before the shooting occurred, Thorpe stopped seeking treatment and secluded himself.⁴⁰ His family tried to convince him to seek appropriate treatment and medication, but to no avail.⁴¹

A. LEGISLATIVE HISTORY AND INTENT BEHIND LAURA'S LAW

In response to the public outcry and confusion over the tragic event, Laura's parents pushed for the implementation of a PAOT statute similar to Kendra's Law⁴² in New York.⁴³ Kendra's Law allows state courts to order

37. Amy Yannello, *Losing Laura*, NEWSREVIEW.COM (Jan. 5, 2006), <http://www.newsreview.com/sacramento/losing-laura/content?oid=45814>.

38. Amy Higuera, *Chapter 1017: Providing a New System for Treating the Mentally Ill*, 34 MCGEORGE L. REV. 485, 485 (2003); Kevin Fagan & Jim Herron Zamora, *Nevada City Mourns/Gunman's Motive Unclear After Fatal Rampage*, S.F. GATE (Jan. 12, 2001), <http://www.sfgate.com/crime/article/Nevada-City-Mourns-Gunman-s-motive-unclear-2965803.php#>.

39. Fagan & Zamora, *supra* note 38.

40. *Id.*

41. Higuera, *supra* note 38.

42. Kendra's Law is codified in N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2011). It was passed in 1999 in response to a similar tragedy, in which a young woman named Kendra Webdale was killed after she was pushed onto the New York City subway tracks by a young man who suffered from untreated schizophrenia and had a history of violent behavior. Pam Belluck, *Program Compelling Outpatient Treatment for Mental Illness is Working, Study Says*, N.Y. TIMES, July 30, 2013, at A13, available at <http://www.nytimes.com/2013/07/30/us/program-compelling-outpatient-treatment-for-mental-illness-is-working-study-says.html>; Maggie Haberman, *Woman, 32, Is Pushed to Her Death in Subway Horror*, N.Y. POST (Jan. 4, 1999), <http://nypost.com/1999/01/04/woman-32-is-pushed-to-her->

AOT to individuals with severe mental illness that meet seven specific criteria.⁴⁴ New York's AOT includes community-based treatment and case management services to help individuals treat their mental illness, to "liv[e] and function[] in the community," and "to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization."⁴⁵ In a statement to the press, Laura's father commented that "Scott Thorpe's family could have gotten him the help he so desperately needed" had such an AOT statute been available.⁴⁶

Thus, Laura's Law⁴⁷ was enacted by the California State Legislature on January 1, 2003 and allows courts to order community-based mental health treatment to persons with mental illness who meet nine narrowly defined statutory criteria.⁴⁸ The current eligibility criteria for AOT services under Laura's Law, however, are the result of an interesting and noteworthy legislative compromise. Laura's Law was intended "to act as a bridge between involuntary detentions and the unassisted street life experienced by persons with mental illness who do not accept voluntary services."⁴⁹ The authors of the bill were interested in a law that would target "the relatively small core of [people with severe mental illness] who [were] unserved by the current system, unable to help themselves, and uncooperative with less directive efforts to persuade them to accept outpatient services."⁵⁰

Specifically, the authors intended to serve persons with mental illness who may not currently meet inpatient commitment standards, but whose conditions go untreated and worsen in time.⁵¹ Consequently, the original version of Laura's Law allowed court-ordered outpatient treatment for individuals with mental illness under two circumstances: (1) when a person suffering from a psychotic disorder had previously responded to treatment but had failed to continue accepting treatment, causing the condition to deteriorate; and (2) when a person's severe mental illness was deteriorating

death-in-subway-horror.

43. Yannello, *supra* note 37.

44. See N.Y. MENTAL HYG. LAW § 9.60(c) (enumerating the eligibility criteria for Kendra's Law); *An Explanation of Kendra's Law*, N.Y. STATE OFFICE OF MENTAL HEALTH (last updated May 2006), http://www.omh.ny.gov/omhweb/Kendra_web/Ksummary.htm (summarizing the substantive and procedural requirements of the law).

45. N.Y. MENTAL HYG. LAW § 9.60(a)(1).

46. Yannello, *supra* note 37 (internal quotation marks omitted).

47. CAL. WELF. & INST. CODE §§ 5345–349.5 (West 2010 & Supp. 2014).

48. *Id.* § 5346(a). See also discussion *infra* Part II.B.

49. A.B. 1421 BILL ANALYSIS, *supra* note 17, at 2.

50. *Id.* at 9.

51. *Id.* at 15.

after “at least two recent hospitalizations” and failure to accept treatment voluntarily.⁵² In proposing such eligibility criteria, the intent was not to substitute AOT services for voluntary treatment; rather, the goal was to establish “initial compliance, and the stabilization and improvements achieved through outpatient treatment” that would hopefully lend itself to long-term, voluntary compliance.⁵³

However, various interest groups and legislators opposed these eligibility criteria, arguing that they were “unconstitutionally overbroad.”⁵⁴ These opponents wanted to amend the eligibility criteria to “dangerous to self or others” or “gravely disabled”—the very same criteria for inpatient commitment under the LPS.⁵⁵ However, the authors rejected such a drastic revision of the law, as it would have completely altered the law’s intended objective and targeted population. The authors also opposed this change because the LPS itself is so broad that courts have applied it only in the narrowest of circumstances, thus making the burden of proof for treatment under the LPS an ever-difficult standard.⁵⁶

As a compromise between the original eligibility standards and the narrow standards for inpatient commitment under the LPS, the law was revised to its current form,⁵⁷ which uses essentially the same criteria as Kendra’s Law in New York.⁵⁸ Before the Bill was finalized, however, the legislature received many letters from the public urging that the broader criteria of the original Bill be restored.⁵⁹ One letter in particular argued that because the AOT criteria under Laura’s Law were only a slight expansion of the LPS criteria, the two laws were practically the same.⁶⁰ Nevertheless,

52. *Id.* at 14–15.

53. *Id.* at 9.

54. *Id.* at 15.

55. *Id.*

56. *See id.* at 17 (“[S]everely mentally ill people can be living under freeways, eating out of dumpsters, dressed in filthy rags, and be plainly delusional, and still be considered insufficiently troubled to qualify for an LPS hold.”); Karasch, *supra* note 19, at 494 (arguing that the LPS “does not adequately provide for the mentally ill” because it makes treatment too difficult to obtain).

57. CAL. WELF. & INST. CODE § 5346(a)(4) (West 2010 & Supp. 2014).

58. *See* A.B. 1421 BILL ANALYSIS, *supra* note 17, at 2 (“In an attempt to provide AOT criteria that are more stringent than those [originally provided], but still somewhat broader than LPS involuntary hospitalization standards, the author has amended the bill to adopt the criteria set forth in ‘Kendra’s Law,’ New York’s AOT statute, with some modifications.”). For the full eligibility criteria under Kendra’s Law, see N.Y. MENTAL HYG. LAW § 9.60(c) (McKinney 2011).

59. *See* A.B. 1421 BILL ANALYSIS, *supra* note 17, at 17 (“Many . . . letters have been submitted urging a return to the broader criteria of the original bill.”).

60. *See id.* at 18 (quoting a Los Angeles Times article that noted that “the criteria are such a slight expansion on the LPS Act’s ‘5150’ commitment standards as to be dubbed ‘5149 and a half’”).

such amendments were necessary to pass the bill, and this legislative history reveals that controversy over the eligibility criteria for AOT services under Laura's Law has existed since the law's inception.

B. ELIGIBILITY CRITERIA AND OTHER BASICS

To receive court-ordered AOT under Laura's Law, an individual must meet nine narrowly defined criteria.⁶¹ The individual must be eighteen years or older,⁶² suffering from a mental illness,⁶³ and clinically determined to be "unlikely to survive safely in the community without supervision."⁶⁴ The fourth criterion, and the focus of this Note, states that the individual must have a "history of lack of compliance with treatment for his or her mental illness."⁶⁵ Lack of compliance can be demonstrated in one of two ways: (1) the mental illness was a "substantial factor in necessitating" at least two hospitalizations or incarcerations in the last thirty-six months, or (2) the mental illness resulted in one or more threats, attempts, or acts of violence or serious physical harm to one's self or others in the last forty-eight months.⁶⁶ The fifth criterion requires that the individual must have failed to voluntarily participate in the proposed treatment plan after having been offered an opportunity to do so.⁶⁷ The final four criteria are enumerated in section 5346(a)(6)–(9): they respectively state that (6) the individual's condition must be "substantially deteriorating,"⁶⁸ (7) the AOT program must be the "least restrictive" alternative to facilitate the individual's "recovery and stability,"⁶⁹ (8) the individual needs AOT "to prevent a relapse or deterioration" that would result in "grave disability or serious harm" to one's self or others,⁷⁰ and (9) the person is likely to benefit from AOT.⁷¹

Proceedings under Laura's Law begin when a county mental health

61. CAL. WELF. & INST. CODE § 5346(a).

62. *Id.* § 5346(a)(1).

63. *See id.* § 5346(a)(2) (referring to CAL. WELF. & INST. CODE § 5600.3(b)(2)–(3), which defines "serious mental disorder" and lists schizophrenia, bipolar disorder, post-traumatic stress disorder, major affective disorders, and "other severely disabling mental disorders" as some potential diagnoses for which the statute would apply).

64. *Id.* § 5346(a)(3).

65. *Id.* § 5346(a)(4).

66. *Id.* § 5346(a)(4)(A)–(B).

67. *Id.* § 5346(a)(5).

68. *Id.* § 5346(a)(6).

69. *Id.* § 5346(a)(7).

70. *See id.* § 5346(a)(8) (referring to CAL. WELF. & INST. CODE § 5150, which prescribes the LPS standard for involuntary inpatient commitment).

71. *Id.* § 5346(a)(9).

director or designee files an in-court petition on behalf of an individual with mental illness.⁷² The petition must describe how the individual meets the nine eligibility criteria and must be accompanied by a physician's affidavit of support.⁷³ The law preserves the most important procedural due process rights of the individual upon whose behalf the petition was made: the right to counsel at all stages of the petition process, the right to notice of the petition, and the right to a hearing on the petition.⁷⁴ The individual may also present evidence, call witnesses on his or her behalf, cross-examine witnesses, and appeal decisions.⁷⁵ The court may order AOT for a period no longer than six months if it finds, by clear and convincing evidence,⁷⁶ that all statutory criteria are met and "there is no appropriate and feasible less restrictive alternative."⁷⁷ Such court-ordered AOT is subject to a written treatment plan that is in accordance with the services enumerated under section 5348.⁷⁸ Failure to comply with the court order alone cannot be grounds to civilly commit an individual or to find that he or she is in contempt of court.⁷⁹ The only repercussion for failure to comply is a civil commitment for no longer than seventy-two hours, but only when such involuntary commitment is necessary and permitted under section 5150.⁸⁰

However, unlike Kendra's Law, under which the provision of AOT services is widespread,⁸¹ the application of Laura's Law is limited only to

72. *Id.* § 5346(b)(1). *See also id.* § 5346(b)(2) (listing family members, spouses, and siblings as among those who may request that the AOT petition be filed); *id.* § 5346(b)(3) ("Upon receiving a request pursuant to paragraph (2), the county mental health director shall conduct an investigation into the appropriateness of the filing of the petition. The director shall file the petition only if he or she determines that there is a reasonable likelihood that all the necessary elements to sustain the petition can be proven in a court of law by clear and convincing evidence.").

73. *Id.* § 5346(b)(4)–(5).

74. *Id.* § 5346(c), (d)(4).

75. *Id.* § 5346(d)(4)(F)–(I).

76. *Id.* § 5346(a).

77. *Id.* § 5346(d)(5).

78. *Id.* § 5346(e). *See also id.* § 5348 (listing access to medications, psychiatric and psychological services, substance abuse services, supportive housing, vocational rehabilitation, and veterans' services as among the many AOT services available under Laura's Law).

79. *Id.* § 5346(f).

80. *Id.*

81. Kendra's Law was passed along with a \$52 million budget to finance the law. Mark Fritz, *A Doctor's Fight: More Forced Care for the Mentally Ill*, WALL ST. J. (Feb. 1, 2006), <http://online.wsj.com/news/articles/SB113876185080261746>. Additionally, New York spends \$32 million each year to provide AOT services under the law. Belluck, *supra* note 42. Thus, the effects of Kendra's Law are widespread. For a full discussion on the statistics and results of Kendra's law, see N.Y. OFFICE OF MENTAL HEALTH, KENDRA'S LAW: FINAL REPORT ON THE STATUS OF ASSISTED

counties that have voluntarily authorized the law and that have also determined that the cost of providing AOT services will in no way hinder the provision of voluntary mental health programs.⁸² Because AOT programs require front-loaded spending,⁸³ without the guarantee of long-term economic returns, many believe that providing funds to AOT is no more economically efficient than what is already available.⁸⁴ Thus, a major shortcoming of the law is that many counties have failed to implement it.⁸⁵ To date, Nevada County, Yolo County, Orange County, San Francisco County, and Los Angeles County are the only counties in the state that have fully implemented Laura's Law.⁸⁶ These implementations may be attributable to the promising results of Nevada County's early efforts, as well as those of Los Angeles County's pilot program. When Laura's Law was first implemented in Nevada County, hospitalization rates of persons with severe mental illness reduced by 46.7 percent, incarceration rates reduced by 65.1 percent, homelessness rates reduced by 61.9 percent, and the number of emergency contacts reduced by 44.1 percent.⁸⁷ Nevada County also reported that it spent \$213,300 less on hospitalizing and \$75,600 less on incarcerating people with severe mental illness after

OUTPATIENT TREATMENT 13–18 (2005), *available at* https://www.omh.ny.gov/omhweb/kendra_web/finalreport/AOTFinal2005.pdf.

82. See CAL. WELF. & INST. CODE § 5349 (Laura's Law is operative in counties "in which the county board of supervisors, by resolution, authorizes its application and makes a finding that no voluntary mental health program serving adults, and no children's mental health program, may be reduced as a result of implementation" of Laura's Law). *But see* Assemb. B. 59, 2015-16 Reg. Sess. (Cal. 2014) (proposing to make Laura's Law mandatory throughout the state rather than leaving individual counties to decide).

83. See *supra* note 81 and accompanying text.

84. Cf. Margo Flug, Note, *No Commitment: Kendra's Law Makes No Promise of Adequate Mental Health Treatment*, 10 GEO. J. ON POVERTY L. & POL'Y 105, 123–24 (2003) (arguing that the costs of oversight and other administrative expenses relating to widespread implementation of AOT services "are especially frustrating given that court oversight may add nothing" to the existing system).

85. Such failure to implement the law may be due to the requirements counties must fulfill in order to comply with its implementation. See CAL. WELF. & INST. CODE §§ 5348(d), 5349.1 (describing what counties must do in order to comply with the law).

86. Maura Dolan, *S.F. Approves Laura's Law to Ensure Mentally Ill Receive Treatment*, L.A. TIMES, July 8, 2014, <http://www.latimes.com/local/lanow/la-me-ln-lauras-law-20140708-story.html>; Abby Sewell, *Los Angeles County Supervisors Vote to Implement Laura's Law*, L.A. TIMES, July 15, 2014, <http://www.latimes.com/local/lanow/la-me-ln-los-angeles-county-lauras-law-20140715-story.html>.

87. *Laura's Law Results in Nevada and Los Angeles Counties*, MENTAL ILLNESS POL'Y ORG., <http://lauras-law.org/states/california/llresultsin2counties.html> (last visited April 19, 2015) [hereinafter *Laura's Law Results*]. See also Michael Heggarty et al., Treatment Advocacy Ctr., Assisted Outpatient Treatment (W&I Code 5345) (AB 1421) "Laura's Law": The Nevada County Experience PowerPoint 13 (Nov. 15, 2011), *available at* http://treatmentadvocacycenter.org/storage/documents/AOT_Lauras_Law_Presentation_Nevada_County_CA.pdf (also describing these results from the county's implementation of the law).

implementing Laura's Law.⁸⁸ Overall, Nevada County reported that it saved \$1.81–\$2.52 for every dollar spent on providing AOT under Laura's Law.⁸⁹ While Los Angeles County's data is based on a more limited sample, it reported a 78 percent reduction in incarceration and an 86 percent reduction in hospitalization among participants in its pilot program.⁹⁰

III. ANALYSIS AND CRITIQUE OF THE FOURTH ELIGIBILITY CRITERION

As evidenced from the discussion above, the eligibility criteria as a whole are mindful of the fact that the state is involuntarily treating individuals and are written not only to target a narrow population of people with mental illness, but also to preserve the rights of this population. However, because the fourth criterion's definition of "history of lack of compliance with treatment" is so narrow, the law does not extend to a large portion of the population with mental illness for whom it was designed. Thus, the current language that defines "lack of compliance" renders the statute stigmatizing and self-defeating. This is because the fourth criterion implicitly makes hospitalization, incarceration, and acts, threats, or attempts of violence prerequisites to receiving services. Therefore, the statute itself perpetuates legal and social stigma toward mental illness and is not truly preventative.

A. CRITICISM OF SECTION 5346(A)(4)(A)

Individuals will satisfy the "lack of compliance" requirement under section 5346(a)(4) ("Prong A") only when they have been hospitalized or incarcerated twice in the last thirty-six months.⁹¹ Therefore, those who have only been arrested or who have been under a treatment plan in an outpatient or other community setting will not qualify because of a lack of involuntary institutionalization, either as an inpatient or as an inmate.⁹² The

88. *Laura's Law Results*, *supra* note 87.

89. *Id.*

90. *Id.* See also CNTY. OF L.A. DEP'T OF MENTAL HEALTH, ASSISTED OUTPATIENT TREATMENT PROGRAM OUTCOMES REPORT 2 (2011), <http://lauras-law.org/states/california/lalauraslawstudy.pdf> (summarizing the outcomes of Los Angeles County's pilot program).

91. CAL. WELF. & INST. CODE § 5346(a)(4) (West 2010 & Supp. 2014).

92. See Scherer, *supra* note 14, at 388 (stating that such a requirement, which was adopted from Kendra's Law in New York, is a great weakness of Kendra's Law because "it fails to protect a larger population of severely mentally ill individuals who may not have received medication in an inpatient facility (quite possibly due to the lack of availability of a bed in a hospital or the public policy of

problem with Prong A, and what this Note argues, is that the current laws pertaining to the treatment of severe mental illness seem to require “dire circumstances” before any type of effective treatment can be provided.⁹³ This may eliminate a large population of otherwise qualified AOT recipients in California because many individuals with mental illness do not come to the attention of public officials, either due to involuntary hospitalization or incarceration, but are nonetheless revolving-door patients in that they live safely within the community only when adhering to a treatment plan.⁹⁴

1. Incarceration

While Laura’s Law does not explicitly use the term “incarceration,” it states that a person’s mental illness must have been a “substantial factor” in necessitating the “receipt of services in a forensic or other mental health unit” of a correctional facility.⁹⁵ Evidence of prior incarcerations establishes “a high evidentiary standard,”⁹⁶ and requiring proof of past incarcerations likely demonstrates legislative cautiousness in that the law only targets those whose mental illnesses have brought about an objective, socially undesirable event. Thus, the targeted individuals are severely ill enough to justify court-ordered treatment.⁹⁷ And while it is important to exercise caution when it comes to intervention in an individual’s freedom within the community, PAOT statutes intervene earlier and less intrusively precisely to avoid the more extreme infringements on civil liberties that society so dislikes.⁹⁸

For instance, the LPS standards of dangerousness to self or others or grave disability are in place because the state actually takes a person into custody and physically confines them in an institution.⁹⁹ Likewise, the

pursuing outpatient over inpatient treatment) or while incarcerated”).

93. *Davies, supra* note 23. *See also* Drash, *supra* note 18 (“The only time mental illness dominates the national conversation is when something goes tragically wrong.”).

94. Scherer, *supra* note 14, at 389, 415.

95. CAL. WELF. & INST. CODE § 5346(a)(4)(A).

96. Scherer, *supra* note 14, at 390.

97. *See* Geller, *supra* note 2, at 242 (stating that some proponents of this criterion claim that it limits AOT only to “appropriate candidates” thereby making the state’s goals “compelling enough to justify restrictions on individuals’ liberties” (quoting Ilissa Watnik, Comment, *A Constitutional Analysis of Kendra’s Law: New York’s Solution for Treatment of the Chronically Mentally Ill*, 149 U. PA. L. REV. 1181, 1207 (2001))).

98. *See* Scherer, *supra* note 14, at 362 (asserting that AOT statutes in New York and California have “led to increased attention to [PAOT] statutes since the turn of the twenty-first century”).

99. *See* SLOBOGIN ET AL., *supra* note 1, at 703–05 (outlining why “dangerousness to self or others” and “grave disability” became inherently linked to the preservation of liberty interests, and noting that even when individuals meet the criteria for involuntary civil commitment, “virtually all

criminal justice system imposes a higher burden of proof for alleged criminal acts because of the drastic effect incarceration will have on a person's liberty and autonomy.¹⁰⁰ AOT, on the other hand, theoretically aims to prevent mental illness from resulting in these outcomes, and does so by preemptively mandating treatment within the community.¹⁰¹ By focusing only on people with mental illness who have been previously incarcerated, Prong A excludes those who may satisfy the eight other eligibility criteria under Laura's Law and who may deteriorate to a state that necessitates incarceration in the future.¹⁰² However, if such an individual fails to show a history of lack of compliance with treatment under the narrow criteria of Prong A, preservation of civil liberties (by denying eligibility for AOT during the petition process) may, in some instances, ironically lead to that person being subjected to a much harsher restriction of autonomy and individual liberty in the future.¹⁰³ While this seems counterintuitive and wasteful,¹⁰⁴ such is the current logic underlying Laura's Law.

Because arrests without incarceration do not count under the current version of Prong A, some individuals may not qualify to receive AOT until

statutes prohibit institutionalization if there is a less restrictive alternative available in the community").

100. See MODEL PENAL CODE § 1.12 (1962) (describing the standard of proof beyond a reasonable doubt for criminal offenses).

101. See, e.g., Geller, *supra* note 2, at 234 (highlighting that "community-based" treatment is the hallmark of AOT statutes becoming more and more popular in the United States).

102. See Scherer, *supra* note 14, at 390 (suggesting that "high incidence of arrest" or "misdemeanor crimes that result in a fine or ticket" may be equally as probative of an individual's likelihood of deterioration, although such a history would not suffice under the current language of the law).

103. See *id.* at 367 (arguing that waiting for "moments of extreme deterioration to occur before permitting involuntary treatment" may render it "too late to effectively rehabilitate the individual").

104. See Kathleen Winchell, *The Need to Close Kentucky's Revolving Door: Proposal for a Movement Towards a Socially Responsible Approach to Treatment and Commitment of the Mentally Ill*, 29 N. KY. L. REV. 189, 189 (2002) (implying that this approach wastes time because "[p]rotection [of liberty interests] in the form of denial of necessary treatment of the mentally ill . . . does not seem to be helping anyone"). With regard to financial waste, the Legislative Analyst's Office of California reported that it costs the state an average of \$47,000 a year to incarcerate one inmate. See *California's Annual Costs to Incarcerate an Inmate in Prison*, LEGISLATIVE ANALYST'S OFFICE (2009), http://www.lao.ca.gov/PolicyAreas/CJ/6_cj_inmatecost. On its face, this figure reveals the staggering expense of having persons with mental illness enter the criminal justice system rather than the mental health system. However, these expenses seem even more wasteful when one also considers the fact that, nationwide, nearly half of the mentally ill inmates are incarcerated for committing nonviolent crimes, including "trespassing, loitering, disorderly conduct and other symptoms of untreated mental illness." Canales, *supra* note 18, at 1739 n.103 (quoting NAT'L ASS'N OF MENTAL HEALTH PLANNING & ADVISORY COUNCILS, JAIL DIVERSION: STRATEGIES FOR PERSONS WITH SERIOUS MENTAL ILLNESS 4 (2006), available at <http://www.namhpac.org/PDFs/01/jaildiversion.pdf>).

they are literally criminalized.¹⁰⁵ This has been a major criticism of the mental health system in general, and many have argued that the deinstitutionalization movement, along with the subsequent transinstitutionalization of individuals with mental illness, has reversed much of the progress made toward the treatment of mental illness because “penal custody[] . . . has often become the treatment of choice.”¹⁰⁶ In fact, law enforcement officers are often the first to respond to psychiatric emergencies.¹⁰⁷ As a result, they have become gatekeepers of the treatment of mental illness because they often determine whether the mental health system, the criminal justice system, or release into the community is an appropriate path for someone.¹⁰⁸ Furthermore, because access to treatment both in hospitals and in the community can be very difficult to obtain, family members frequently resort to law enforcement in order to get their loved ones treated and safely off of the streets.¹⁰⁹ These realities of the current state of treatment options for mental illness demonstrate the necessity for preventative treatment statutes. However, the fact that some persons with mental illness may in fact need to be incarcerated before they are eligible for “preventative” treatment reveals the paradoxical and self-defeating nature of PAOT under Laura’s Law.

Furthermore, including prior incarceration as one of two ways to satisfy Prong A perpetuates social and legal stigma toward mental illness.¹¹⁰ Social stigma occurs through a combination of stereotypes, prejudice, and discrimination.¹¹¹ Statutory language so closely associating incarceration with mental illness perpetuates stigmatizing views of individuals with mental illness. Likewise, stigma is also fueled by public perceptions that mental illness is associated with violence and violent

105. Scherer, *supra* note 14, at 389–90.

106. Slovenko, *supra* note 10, at 655. *See also* Laura Sullivan, *Mentally Ill Are Often Locked Up in Jails That Can’t Help*, S. CAL. PUB. RADIO (Jan. 21, 2014), <http://www.scpr.org/news/2014/01/21/41707/mentally-ill-are-often-locked-up-in-jails-that-can> (describing how the Cook County, Illinois sheriff, a former prosecutor, “had no idea when he took the job of sheriff that he would also become the state’s mental health provider”).

107. Slovenko, *supra* note 10, at 655.

108. *Id.*

109. *Id.* at 655–56. *See also* Canales, *supra* note 18, at 1739 (implying that mentally ill people are also aware that the criminal justice system is an avenue to obtain treatment, and that “many mentally ill homeless people commit misdemeanor crimes in search of [a] warm place to stay”).

110. *See* E. Fuller Torrey, *Stigma and Violence: Isn’t It Time to Connect the Dots?*, 37 SCHIZOPHRENIA BULL. 892, 892 (2011), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160234/pdf/sbr057.pdf> (outlining reasons why stigma toward mental illness exists).

111. Patrick Corrigan et al., *An Attribution Model of Public Discrimination Towards Persons with Mental Illness*, 44 J. HEALTH & SOC. BEHAV. 162, 163 (2003).

behavior.¹¹² Requiring that a history of lack of treatment compliance be established through prior incarcerations only furthers a public perception of mental illness as being synonymous with violence and other criminal behavior. Furthermore, it inherently promotes institutionalization when the law allegedly aims for prevention via community-based and deinstitutionalized care.

This statutory paradox is further demonstrated by the legislative intent and history behind Laura's Law.¹¹³ The original version of the law mentioned nothing about incarceration as evidence of mental illness or proof of psychiatric history.¹¹⁴ The broad criteria of the original law illustrate an attempt to avoid this stigmatized and narrow view of mental illness.¹¹⁵ Similarly, the Bill's authors claimed that "leaving very ill persons homeless or incarcerated under a misbegotten policy of 'free will' is shortsighted and dangerous."¹¹⁶ And while many persons with mental illness who meet the eligibility requirements under Laura's Law may have a history of incarcerations or hospitalizations, this should be a sufficient rather than necessary element of proof of eligibility. Interestingly, redrafting Prong A to allow for broader means of demonstrating a history of lack of compliance would be more consistent with the statutory intent, as well as with the views of those who favor the law's current, narrow language. This is because early intervention with more flexible eligibility criteria would allow for the state and the individual to seek the "least restrictive" alternative to treatment of mental illness not only immediately,¹¹⁷ but also in the long run.¹¹⁸

112. Torrey, *supra* note 110, at 893.

113. *See supra* Part II.A.

114. *See supra* text accompanying note 52.

115. *See supra* Part II.A.

116. A.B. 1421 BILL ANALYSIS, *supra* note 17, at 10. As one proponent of the originally-drafted law stated, "There are many safeguards in the bill to protect a mentally ill person's rights. They should finally be given the right to have a mind that can allow them to make informed decisions—not delusional ones!" *Id.*

117. Prong A cannot be analyzed in isolation. Even if prior hospitalization and incarceration could be demonstrated, a court would not order outpatient treatment if it did not find by clear and convincing evidence that it would be the "least restrictive" alternative available to that person. *See CAL. WELF. & INST. CODE* § 5346(a)(7) (West 2010 & Supp. 2014) (requiring that AOT services be ordered only when there is no lesser restrictive alternative available).

118. *See* Teresa L. Scheid-Cook, *Outpatient Commitment as Both Social Control and Least Restrictive Alternative*, 32 SOC. Q. 43, 46 (1991) (implying that AOT is the least restrictive alternative in the long run because prompting compliance with treatment for mental illness increases the likelihood of individual autonomy and reduces the likelihood of future institutionalized care).

2. Hospitalization

The alternative to meeting the “lack of compliance” requirement under Prong A is showing that mental illness was a “substantial factor in necessitating” at least two hospitalizations in the last thirty-six months.¹¹⁹ Because there is a more logical connection between “prior hospitalization” and a history of “lack of compliance,” this method of satisfying the eligibility criteria may appear less controversial than the incarceration issues discussed above. However, demonstrating two hospitalizations within the specified time period may actually be a difficult standard for many to meet.¹²⁰ Obtaining treatment for mental illness in a hospital setting is increasingly difficult—even for those who clearly need it.¹²¹ Contributing to hospitals’ hesitations in admitting people for inpatient treatment are the generalized antipaternalistic and civil libertarian views that fueled the deinstitutionalization movement.¹²² As this Note has discussed, there is now a prevailing view that voluntary treatment is preferred over involuntary treatment, and community-based treatment is preferred over inpatient treatment.¹²³ While this rationale for reducing involuntary treatment is persuasive given the historical context in which it developed,¹²⁴ it also reveals the circular reasoning behind Prong A of Laura’s Law. Laura’s Law aims for deinstitutionalized care. However, requiring a person to demonstrate prior hospitalizations in a system that is so adverse to hospitalizing makes the prospect of community-based treatment paradoxical.

Focusing on prior hospitalizations is also problematic given the financial realities that govern hospitals today.¹²⁵ Economic hardships and cuts in hospital budgets have led to decreased funding for the treatment of

119. CAL. WELF. & INST. CODE § 5346(a)(4)(A).

120. See Scherer, *supra* note 14, at 390 (arguing that requiring prior hospitalization is a “nearly impossible threshold . . . since most danger-or-grave-disability statutes require actual, imminent, or substantial risk of harm or extreme grave disability”).

121. See *Davies*, *supra* note 23 (relating that despite his son’s multiple psychotic episodes, a deteriorating condition, and suicidal thoughts, Pete Earley’s son could not be hospitalized because medical officials did not consider him an imminent danger to himself or others).

122. See Ken Kress, *An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa*, 85 IOWA L. REV. 1269, 1321 (2000) (explaining the criticisms of such paternalistic principles in the context of involuntary treatment).

123. See Geller, *supra* note 2, at 235 (noting that the United States has an ambivalence surrounding AOT and involuntary treatment in general); Scheid-Cook, *supra* note 118, at 45 (stating that there is a “general social preference” for deinstitutionalized care of mental illness).

124. See *supra* text accompanying notes 3–15.

125. See Anna Gorman, *ERs Are Becoming Costly Destinations for Mentally Disturbed Patients*, L.A. TIMES (Sept. 5, 2011), <http://articles.latimes.com/2011/sep/05/local/la-me-mentally-ill-20110906>.

mental illness.¹²⁶ Between 2009 and 2011 alone, funding for mental health services was cut by 16 percent, a reduction of \$587 million.¹²⁷ In fact, California now has 4 percent of the psychiatric beds that were available fifty years ago.¹²⁸ Consequently, some doctors and hospital officials may preserve beds only for those who pose a serious risk of danger to self or others, or who are very gravely disabled; this may render involuntary hospitalization an impossible route for other persons with severe mental illness, even when they obviously need some sort of treatment.¹²⁹ Because actual inpatient commitment or admittance to a hospital may in fact be a financial impossibility, emergency rooms (“ERs”) have increasingly “become costly and ineffective baby-sitting services for mentally disturbed patients in crisis.”¹³⁰ Under the plain language of Laura’s Law,¹³¹ it is unclear if ER visits would suffice as evidence of previous hospitalizations, even though they clearly illustrate a psychiatric history and may lead to evidence of lack of compliance with treatment.¹³²

Because inpatient treatment for mental illness is increasingly rare, many individuals with mental illness receive some type of treatment or medication in an outpatient setting.¹³³ However, a psychiatric history demonstrating only outpatient treatment would be insufficient under Prong A.¹³⁴ Thus, even if all of the other eight criteria under Laura’s Law were satisfied, the lack of actual hospitalization would result in AOT ineligibility.¹³⁵ The reality that psychiatric histories are more likely to reflect ER visits and outpatient treatment rather than hospitalizations

126. *Id.*

127. *Id.*

128. E. Fuller Torrey, Presentation at San Francisco General Hospital, Carr Auditorium: The Future of Psychiatric Services in California if Public Policy Does Not Change (July 24, 2010), available at <http://www.namioc.org/advocacy/video-presentations/131-dr-torrey>. To illustrate, in 1960, there was one psychiatric bed for every four hundred people in California’s population. *Id.* In 2010, that same psychiatric bed was still available, but only for every ten thousand people in the population. *Id.*

129. See Gorman, *supra* note 125 (stating that it is rarely the case that “[p]atients who are a danger to themselves or others, or are gravely disabled” are admitted to the hospital and transferred to proper psychiatric facilities).

130. *Id.*

131. For the language of the law, see CAL. WELF. & INST. CODE § 5346(a)(4)(A) (West 2010 & Supp. 2014).

132. See Scherer, *supra* note 14, at 388 (suggesting that such ER encounters or other outpatient treatment “even under a danger-or-grave disability statute, would not be admissible evidence”).

133. See Slovenko, *supra* note 10, at 653 (“Without the structure and support afforded in the hospital, medication is used more extensively in the outpatient than in the inpatient setting.”).

134. See *supra* note 119 and accompanying text.

135. See *id.*

reveals that, although prior hospitalizations are a less stigmatizing and more relevant way of defining a “history of lack of compliance,” this aspect of Prong A is too narrow and does not foster a truly effective law given the current state of the mental health care system. Furthermore, like the “incarceration” component of Prong A, requiring two prior hospitalizations is not truly preventative and is a self-defeating aspect of the law. Considering the law’s so-called preventative nature and society’s so-called dedication to deinstitutionalization, requiring prior hospitalizations to prevent future hospitalizations is counterproductive.

B. CRITICISM OF SECTION 5346(A)(4)(B)

Section 5346(a)(4)(B) (“Prong B”) establishes that, aside from prior incarcerations or hospitalizations, an individual with mental illness may alternatively show a history of noncompliance with treatment if the mental illness resulted in one or more acts, attempts, or threats of serious violent behavior or physical harm toward him or herself or others within the last forty-eight months.¹³⁶ While Prong B is clearly designed to parallel the “danger to self or others” standard established by the LPS for involuntary inpatient commitment,¹³⁷ the problem with this is that, in the context of a PAOT statute, it does nothing to actually prevent violence from occurring in the first place. By requiring this as a means of showing a history of lack of compliance with treatment, it not only risks that preventable instances of violent behavior will occur, but also perpetuates a stigmatizing understanding of mental illness.

There have been many studies on the correlation between violence and mental illness.¹³⁸ While data shows that “people with certain psychiatric problems do commit violent crimes at a higher rate”¹³⁹ than others, people with mental illness as a whole are not more likely than anyone else in the general population to commit violent acts or display violent behavior.¹⁴⁰ In

136. CAL. WELF. & INST. CODE § 5346(a)(4)(B).

137. See *id.* § 5150 (defining the LPS standard for involuntary inpatient commitment); Scherer, *supra* note 14, at 387 (stating that the “second prong of the fourth criterion is similar to the danger statutes”).

138. See, e.g., Edward P. Mulvey, *Assessing the Likelihood of Future Violence in Individuals with Mental Illness: Current Knowledge and Future Issues*, 13 J.L. & POL’Y 629, 629 (2005) (implying that because of the importance behind the “relationship between mental illness and violence,” there has been much research surrounding the topic).

139. Amina Khan, *Are the Mentally Ill More Violent?*, L.A. TIMES (Jan. 20, 2011), <http://articles.latimes.com/2011/jan/20/health/la-he-mentally-ill-violent-20110116>.

140. See Mulvey *supra* note 138, at 630 (“This relationship between reported indicators of mental illness and violence, however, does not mean that most people with mental illness are violent or that most violent acts are committed by people with mental disorders.”); Khan, *supra* note 139 (“[T]he vast

fact, mental illness accounts only for 4 percent of the variability in predicting violence.¹⁴¹ The irony here is that violent behavior is often a symptom of untreated mental illness.¹⁴² One component of the “revolving-door” concept is that when persons with mental illness are discharged and released back into the community, they may “revert[] to taking illicit drugs, cease[] taking medicinal drugs, and once again exhibit[] the dangerous behaviors that mandated treatment or intervention . . . in the first place.”¹⁴³ Thus, lack of compliance with antipsychotic medication, sometimes combined with substance abuse,¹⁴⁴ is the leading factor in predicting violence among people with mental illness.¹⁴⁵

Because violence is often a symptom of untreated mental illness, and because Laura’s Law aims to provide treatment for untreated mental illnesses, illustrating psychiatric history under Prong B may in fact make sense. However, Prong B also negates the law’s preventative efforts because, given the undesirability of hospitalization or incarceration under Prong A, Prong B’s version of a dangerousness standard may actually promote violence by increasing the opportunities for and severity of it.¹⁴⁶ Furthermore, for those who do have a history of violent tendencies, the unpredictability of mental illness can make them a “tragedy waiting to happen.”¹⁴⁷ In narrowing the eligibility criteria for AOT services, Prong B of Laura’s Law inadvertently requires some variation of violence to occur within society before a person with mental illness can receive necessary treatment.

The Laura’s Law equivalent of a dangerousness standard is certainly different from that of the “dangerousness to self or others” standard for

majority of homicides, arsons and assaults are perpetrated by people who are not considered severely mentally ill.”).

141. Mulvey, *supra* note 138, at 630.

142. See Torrey, *supra* note 110, at 894 (stating that seriously mentally ill individuals become violent when they are not treated).

143. Paul Stavis & Amy Petragnani, *Violent Acts by Persons with Mental Illness: What Are Society’s Options Under the Current Law?*, TREATMENT ADVOCACY CTR. (1995), <http://www.treatmentadvocacycenter.org/legal-resources/legal-articles/363>.

144. See Mulvey, *supra* note 138, at 637 (reporting that in one study about the relationship between violence and mental illness, the “most dramatic finding[]” was the correlation between substance abuse and violence); Canales, *supra* note 18, at 1740 (stating that around 75 percent of mentally ill inmates also meet the criteria for a co-occurring substance abuse or dependence diagnosis).

145. See Torrey, *supra* note 110, at 893 (asserting that most episodes of violence involving mental illness are associated with failure of proper treatment, usually including noncompliance with medication).

146. Kress, *supra* note 122, at 1293.

147. Stavis & Petragnani, *supra* note 143.

inpatient commitment under the LPS.¹⁴⁸ In one way, the language is broader and less concerned with impeding on civil liberties because it can be satisfied by mere “threats” or “attempts” at violence toward self or others.¹⁴⁹ However, Laura’s Law is supposed to be preventative, and whether “dangerousness” or “violence” is demonstrated by threats, attempts, or acts, all three variations represent a form of violence and present risks not only to the individual, but also to the individual’s family, friends, and community. Currently, Prong B does not serve the purposes of a truly preventative statute because it does not seek to hamper such behavior from occurring in the first place; in fact, by requiring proof of past actions, Prong B’s language raises concerns that potentially dangerous or violent persons might be living within the community and may “ensure[] that many otherwise preventable violent acts will occur.”¹⁵⁰ Laura’s Law does not impose the same restrictions on liberty that institutionalization does because AOT recipients are free to be in the community,¹⁵¹ cannot be forced to take medications,¹⁵² and cannot be penalized merely for failing to adhere to a court order.¹⁵³ Therefore, a broader definition for history of lack of compliance may take the focus away from violence and may make treatment more readily available to those who may not be violent, but who nonetheless need treatment.

Another concerning aspect of this narrowly-defined criterion is that, like the incarceration component of Prong A, the language creates a close association between violence and mental illness. This is stigmatizing because the association between violence and mental illness is a common social stereotype.¹⁵⁴ The language in Prong B only perpetuates this stigmatizing misconception because, by inherently requiring some demonstration of violence in order to qualify for AOT services, Laura’s

148. Compare CAL. WELF. & INST. CODE § 5346(a)(4)(B) (West 2010 & Supp. 2014) (permitting acts, threats, or attempts of violence toward self or others as admissible evidence for AOT under Laura’s Law), with *id.* § 5150 (requiring, by probable cause, that a person be dangerous to self or others or gravely disabled to be involuntarily committed).

149. Scherer, *supra* note 14, at 387.

150. Kress, *supra* note 122, at 1327.

151. CAL. WELF. & INST. CODE § 5348(a).

152. *Id.* § 5348(c).

153. *Id.* § 5346(f).

154. See Jo C. Phelan & Bruce G. Link, *Fear of People with Mental Illness: The Role of Personal and Impersonal Contact and Exposure to Threat or Harm*, 45 J. HEALTH & SOC. BEHAV. 68, 68 (2004) (“Among the many negative characteristics the public ascribes to people with mental illness—for example, being dirty, weak, ignorant, bad, and cold . . . perhaps the most prominent and problematic is the idea that people with mental illness are dangerous.” (citations omitted)); Torrey, *supra* note 110, at 893 (“It is clearly established that viewing persons with mental illness as dangerous leads to stigmatization.”).

Law promotes the stereotype of violence among persons with mental illness instead of decreasing the prevalence of violent behavior.¹⁵⁵ Additionally, the original draft of Laura's Law did not reference violence or dangerousness as eligibility requirements for AOT services.¹⁵⁶ Thus, Prong B shows one result of the legislative compromise over Laura's Law.¹⁵⁷ However, this change not only nullifies its function as a PAOT statute, but also prevents the law from realizing its purpose of providing stabilizing mental health care to those who truly need it in order to avoid deterioration to a mental state that would necessitate hospitalization or incarceration.

IV. A POSSIBLE SOLUTION FOR LAURA'S LAW

Many mental health advocates view Laura's Law as a progressive step to reforming the mental health system in California.¹⁵⁸ However, it remains controversial because there is still a disconnect between treatment and the community.¹⁵⁹ The shortcomings posed by section 5346(a)(4) of Laura's Law illuminate such a problem. Although the law was passed to provide a middle ground for persons with mental illness who are not well enough to seek voluntary treatment, but who do not yet satisfy inpatient commitment criteria,¹⁶⁰ the legislative compromises over the eligibility criteria have distanced the application of the law from its stated goal. The California legislature could align the application of the law with its intent, and thereby enable it to provide effective services to its targeted population, by amending section 5346(a)(4) to include a broader standard for courts to evaluate an individual's "history of lack of compliance with treatment"¹⁶¹ for mental illness.

A. PROPOSED REVISION OF SECTION 5346(A)(4)

In light of the discussion in Parts II and III, this Note argues that one effective revision to section 5346(a)(4) may be the following:

155. See Canales, *supra* note 18, at 1742 ("Even those individuals who have not committed a crime are sometimes stigmatized as dangerous and violent because of the horrific actions of a small subsection of the mentally ill population on which the media focuses.").

156. See *supra* text accompanying note 52.

157. See *supra* text accompanying notes 52–57.

158. See, e.g., Scherer, *supra* note 14, at 363 (voicing a widely held opinion that PAOT statutes "offer a promising and much needed update to state civil commitment statutes").

159. See *supra* text accompanying notes 16–24.

160. See *supra* text accompanying note 49.

161. CAL. WELF. & INST. CODE § 5346(a)(4) (West 2010 & Supp. 2014).

“The person has a history of lack of compliance with treatment for his or her mental illness. The following is a non-exhaustive list of factors or sources of information that a court may consider in assessing whether the person has such a history: psychiatric and medical history as compiled by hospitals, outpatient treatment centers, or other institutional care facilities; evidence of past hospitalizations; evidence of potential risk of dangerousness to self or others; evidence of symptoms contributing to the person’s inability to comply with or to recognize his or her need for treatment for mental illness.”

1. Revisions Explained

The proposed revision eliminates the now-existing language in Prongs A and B and replaces it with broader factors to guide a court’s assessment of a person’s history of lack of treatment compliance. The factors proposed more accurately reflect how a person with severe mental illness, for whom Laura’s Law is intended, would likely be able to show such a history given the realities of the current mental health care system.¹⁶² They would permit courts to look at psychiatric and medical records not only from prior hospitalizations, but also from regularly treating physicians, ERs, and outpatient care facilities.¹⁶³ Furthermore, by adding “other institutional care facilities,” the revised language accounts for the fact that many people with mental illness will have been previously arrested or incarcerated, and will allow use of such evidence to prove eligibility under the fourth criterion.¹⁶⁴ By broadening potential sources of evidence of a history of non-compliance, Laura’s Law would be more inclusive and able to better serve individuals intended to qualify for AOT services, rather than exclude many who would qualify but for the restrictive criteria under Prongs A and B.¹⁶⁵ Unlike the current law, it does not explicitly limit proof by referencing incarceration and hospitalizations, and therefore decreases the blatant stigmatization of mental illness.

As a result of the middle-ground approach to the proposal, the revised language includes reference to evidence of past hospitalizations and evidence of potential risk of dangerousness to self or others. Despite the

162. See *supra* Part III.A–B.

163. See *supra* Part III.A.2 (discussing that these sources of care and treatment are more reflective of what a severely mentally ill individual is likely to receive prior to AOT services).

164. See Scherer, *supra* note 14, at 390 (supporting the idea that “state legislatures might consider omitting the actual incarceration . . . requirement” and instead substitute it with “a requirement of high incidence of arrest, possibly even for misdemeanor crimes that result in a fine or ticket.”).

165. See *supra* Part III.A.

criticisms previously mentioned in this Note,¹⁶⁶ such evidence may be relevant in assessing a person's psychiatric history,¹⁶⁷ however, unlike the current language in Prongs A and B, the absence of this evidence is not determinative of one's eligibility for AOT services. The revision merely speaks of "potential risk" of dangerousness, which does not require actual threats, attempts, or acts, but rather, requires a demonstrable "risk" of such behavior. Not only does this revised language ameliorate some concerns addressed in the current version of section 5346(a)(4),¹⁶⁸ but by maintaining some of the essence of the existing language, the revision also preserves an attitude of objectivity in assessing a person's psychiatric history and may help reduce opposition to a broadening of the eligibility criteria.

The final noteworthy aspect of this revised language is the reference to the person's inability to comply with or recognize the need for treatment. As this Note will discuss, such lack of insight is not only a common symptom of severe mental illness, but is sometimes a contributing factor in an individual's failure to comply with treatment.¹⁶⁹ Therefore, evidence regarding this issue will often be relevant and will render the law more applicable to its targeted population of individuals with mental illness.¹⁷⁰

2. Why This Is the Best Current Solution

Some advocacy groups may argue that this Note's proposal could go further, and that the real solution to Laura's Law would be to eliminate the necessity for a history of lack of compliance, and instead, implement a "mentally ill and in need of treatment" standard for AOT eligibility.¹⁷¹

166. See *supra* Part III.A.2–B.

167. See *infra* Part IV.B.

168. See *supra* Part III.

169. See *infra* Part IV.C.2.

170. See *California Law That Aspires to Improve Mental Health Raises Coercion Concerns*, Transcript, PBS NEWSHOUR (Dec. 26, 2012), http://www.pbs.org/newshour/bb/health/july-dec12/lauraslaw_12-26.html [hereinafter *California Law Transcript*] (reporting that the mother of one AOT recipient under Laura's Law considers the law to be a "game-changer" because her son "doesn't recognize—even when he's at his worst . . . that he has an illness").

171. See Robert Hayes et al., *Evidence-Based Mental Health Law: The Case for Legislative Change to Allow Earlier Intervention in Psychotic Illness*, 14 PSYCHIATRY PSYCHOL. & L. 35, 35–36 (2007) (arguing for a broader definition of mental illness in New South Wales, Australia in order to provide legal intervention at the earliest possible phases of severe mental illness); *Better Treatment Standards*, TREATMENT ADVOCACY CTR., <http://www.treatmentadvocacycenter.org/solution/improved-treatment-standards> (last visited April 19, 2015) (defining a "need-for-treatment" standard and how it often permits court intervention when a person is unable to seek psychiatric care, when a person is unable to make informed medical decisions, or when treatment is necessary to prevent further

However, this Note advocates for a middle ground that involves some consideration of a history of lack of compliance with treatment. The above proposal, therefore, provides courts with guidelines to measure psychiatric histories, but does not provide the exclusionary, bright-line rules that currently exist in Prongs A and B. This Note supports the conclusion that such guidelines will enable Laura's Law to actually serve its intended purpose as a preventative treatment statute. And while a "mentally ill and in need of treatment" standard would presumably work to achieve that same purpose, there is a risk that such a liberal standard may confuse the courts by failing to define a "need" for treatment; judicial confusion may result in hesitancy to apply the law, which would render Laura's Law even more counterproductive.¹⁷²

Juxtaposing the young life of Laura's Law and the long evolution of mental health law, it is apparent that California is just scratching the surface of the true potential of PAOT statutes. In these early stages, there is some merit to analyzing an individual's psychiatric history before allowing court-ordered intervention: it preserves the balance between prevention and liberty interests by assessing "verifiable indicators"¹⁷³ of future mental deterioration. Furthermore, the original version of the law advocated eligibility criteria that assessed previous treatment and previous hospitalizations,¹⁷⁴ indicating that the authors intended something narrower than a "mentally ill and in need of treatment" standard. In advocating for this middle ground, this proposed revision of Laura's Law is designed to ensure that the law stays true to its targeted population of revolving-door patients who are not ill enough for institutionalization, but who are too ill to voluntarily prevent likely future deterioration.¹⁷⁵

Viewing this Note's proposed revision and comparing it to a "mentally ill and in need of treatment" standard, the latter is clearly the first choice in terms of a truly preventative model. Consequently, this Note does not discount that this broader standard for PAOT eligibility could be feasible in the future. For example, enabling greater effectiveness and broader implementation of Laura's Law may some day pave the way for the provision of AOT services to the newly, persons with mental illness who are refusing voluntary treatment for the first time—without looking at

deterioration).

172. See *supra* text accompanying notes 57–60.

173. A.B. 1421 BILL ANALYSIS, *supra* note 17, at 15.

174. See *supra* text accompanying note 52.

175. See *supra* Part II.A.

any history of lack of treatment compliance.¹⁷⁶ However, even the proposal set forth above will likely be viewed as a threat to civil liberties, especially by those who oppose PAOT statutes altogether.¹⁷⁷ Therefore, the proposal is designed to facilitate a more peaceful shift in legislative and public acceptance of PAOT statutes, while also implementing criteria that can actually be administrable in practice.¹⁷⁸ This middle-ground proposal is the second-best option given the current state of mental health legislation in society; it is a feasible yet progressive step toward affecting the intent of Laura's Law.

B. OPPOSITION TO AN AMENDMENT OF LAURA'S LAW

Advocates of the law's current version may defend the requirements of prior incarcerations, hospitalizations, or violent behavior because they relate to a "recent, overt act" requirement, somewhat analogous to the *actus reus* requirement in criminal law.¹⁷⁹ The ideological underpinnings are that a person must do something in order to experience any consequences or legal actions that impede on autonomy or other civil liberties.¹⁸⁰ Thus, the criterion establishes "a high evidentiary standard that protects the liberty interests of non-severely mentally ill individuals" who do not need AOT.¹⁸¹ Because section 5346(a)(4) speaks to a person's history of lack of compliance, it goes to a broader illustration of a person's history of mental illness and views prior hospitalizations, incarcerations, and violent tendencies as evidence of severe mental illness. Thus, section 5346(a)(4) likely aims to "distinguish between [persons with severe mental illness] and those persons who suffer from more minor conditions of mental illness."¹⁸² This is consistent with the fact that Laura's Law was drafted to focus on a targeted population, and such language shows the law's intended application only to those who have manifested targeted and objective

176. See Hayes et al., *supra* note 171, at 36 (proposing a new system of legal intervention called "Community Counseling, Assessment and Treatment Order," which would permit involuntary treatment at the earliest stage of severe mental illness, without "requiring that the patient have fairly overt signs of psychosis before they are deemed [eligible] for treatment against their will").

177. See *supra* text accompanying notes 54–55.

178. See discussion *supra* Part IV.A.1.

179. Kress, *supra* note 122, at 1325.

180. See MODEL PENAL CODE § 2.01 (Proposed Official Draft 1962) (explaining in the editors' notes, that in the criminal context, a person cannot be found criminally liable "based upon mere thoughts").

181. Scherer, *supra* note 14, at 390.

182. *Id.* at 389.

behaviors.¹⁸³

As this Note has previously mentioned, the focus on preserving a person's civil liberties is very important.¹⁸⁴ In fact, one major critique of PAOT statutes is their effect on nonviolent persons with mental illness, or those whose conditions are perhaps less severe.¹⁸⁵ Because Laura's Law allows the possibility of hospitalization after AOT proceedings have begun,¹⁸⁶ it has been argued that the potential confinement of individuals with mental illness is an extreme threat to liberty interests, especially for those who have no history of violence.¹⁸⁷ Thus, requiring concrete proof of a person's past incarcerations or dangerous behaviors may demonstrate legislative cautiousness in that the law only targets those whose mental illnesses have resulted in socially undesirable events, and thus are severely ill enough to justify legal intervention.¹⁸⁸ A similar argument could be made for the hospitalization requirement because prior hospitalizations do not do as much by way of stigmatizing mental illness. Rather, a history of hospitalizations may merely indicate that a person is indeed severely mentally ill, is unstable when released into the community, and does in fact revolve in and out of hospital doors.¹⁸⁹ Additionally, this definition of lack of compliance with treatment is more consistent with the legislative intent behind Laura's Law, as prior hospitalizations were among the criteria for demonstrating eligibility for the law as it was originally drafted.¹⁹⁰

183. Some legislators and interest groups might oppose a revision of the fourth criterion because it may enable intervention without concrete evidence to justify a court order. *See, e.g.,* Kristina M. Campbell, *Blurring the Lines of the Danger Zone: The Impact of Kendra's Law on the Rights of the Nonviolent Mentally Ill*, 16 NOTRE DAME J.L. ETHICS & PUB. POL'Y 173, 175 (2002) (suggesting that opponents would argue that such a change would be "overbroad and unconstitutional because it is inconsistent with the state and federal constitutional standards for deprivation of liberty, due process, and the right to refuse treatment").

184. *See supra* text accompanying notes 1–5.

185. *See* Campbell, *supra* note 183, at 174 (arguing that because AOT statutes may apply to mentally ill individuals without a history of violence, they "pose[] a major threat to the liberty interests" of these individuals).

186. *See* CAL. WELF. & INST. CODE § 5346(f) (West 2010 & Supp. 2014) (allowing for an individual to be civilly committed only if a licensed mental health treatment provider determines that it is necessary at any point during which the individual is noncompliant with AOT services).

187. Campbell, *supra* note 183, at 174. For an even more extreme analysis of this concern, which argues against AOT statutes as well as the "gravely disabled" standards for civil commitment, see Donald H. Stone, *Confine Is Fine: Have the Non-Dangerous Mentally Ill Lost Their Right to Liberty? An Empirical Study to Unravel the Psychiatrist's Crystal Ball*, 20 VA. J. SOC. POL'Y & L. 323 (2012).

188. *See supra* text accompanying notes 182–83.

189. *See* Scherer, *supra* note 14, at 387–88 (stating that while the hospitalization requirement is "a broad expansion away from the danger-or-grave-disability statutes," the fact that it must be shown through a narrow definition may also ensure that AOT is limited only to "a narrow population of mentally ill individuals").

190. *See supra* text accompanying note 52.

Thus, potential opposition to this Note's proposed revision is multifaceted. On one extreme, some believe that because AOT can be construed as a species of civil commitment, its legal standard should be as stringent as that of inpatient commitment.¹⁹¹ Similarly, supporters of the current version of Laura's Law may object to criticisms that the existing law is not truly preventative or effective at reaching its potential beneficiaries. They may argue that, because Laura's Law is relatively new and has yielded limited results,¹⁹² there is no need to change it until concrete statistics show the necessity of a revision. Along this line of reasoning, the current version of the law is satisfactory because its results illustrate that it is somewhat preventative and somewhat effective in practice.¹⁹³ On another extreme, some may be impartial to Laura's Law in its entirety because, whether or not it is amended, the lack of enforcement mechanisms to ensure that individuals engage in AOT services renders the law somewhat toothless.¹⁹⁴

Furthermore, some may argue that the expansion of the fourth criterion moves Laura's Law away from its purpose of providing involuntary services and merely aims to make services more available. Along this line of reasoning, California's efforts should be focused not on involuntary court intervention, but on making voluntary treatment more available.¹⁹⁵ This is desirable for many who oppose even the current Laura's Law criteria, arguing that PAOT statutes are not more economically efficient¹⁹⁶ and that they intervene in the lives of individuals

191. See *supra* text accompanying notes 54–55.

192. See *supra* text accompanying notes 87–91.

193. See *supra* text accompanying notes 87–91.

194. See Christian E. Piccolo, *Falling Through the Cracks: The Need for Enhanced Supervision in the Involuntary Outpatient Civil Commitment Setting*, 54 VILL. L. REV. 309, 313 (2009) (arguing a problem with such statutes is that they result in inadequate enforcement); Susan Stefan, *Preventive Commitment: The Concept and its Pitfalls*, 11 MENTAL & PHYSICAL DISABILITY L. REP. 288, 290 (1987) (criticizing inadequate enforcement of statutes like Laura's Law).

195. See A.B. 1421 BILL ANALYSIS, *supra* note 17, at 11 (describing how the opponents of Laura's Law disagreed with the Bill's authors' "contention that a core group of mentally ill [were] too resistant to accept voluntary treatment, by arguing that the real problem is a lack of sufficient voluntary outpatient services"); *Outpatient and Civil Commitment*, JUDGE DAVID L. BAZELON CTR. MENTAL HEALTH LAW, <http://www.bazelon.org/Where-We-Stand/Self-Determination/Forced-Treatment/Outpatient-and-Civil-Commitment.aspx> (last visited April 19, 2015) ("When safety is not an issue, treatment should be voluntary, because this approach holds the best promise for long-term engagement in treatment.").

196. See Geller, *supra* note 2, at 236 (stating that AOT opponents claim it "becomes too expensive and too intrusive much too quickly"); Flug, *supra* note 84, at 123–24 (arguing that the costs associated with PAOT statutes are not justified).

“who would eventually have sought treatment or hospitalization.”¹⁹⁷ Thus, the argument is that PAOT statutes are “antitherapeutic” because individuals who voluntarily seek treatment are more motivated to get well and are more likely to benefit from such treatment than those “who are treated in consequence of government intervention.”¹⁹⁸ For this reason, broadening the criteria for involuntary treatment would be a waste of time and resources when energy could be focused on an anti-coercion approach that may be more effective¹⁹⁹ and may also reduce current concerns surrounding enforcement.²⁰⁰

C. JUSTIFICATIONS FOR AN AMENDMENT OUTWEIGH OPPOSITION’S CONCERNS

The disconnect between the purpose and goal of Laura’s Law, and the practical effect of its criteria, has been set forth in Parts II and III of this Note. In light of this discussion, this Note argues that there are some very basic policy justifications as to why a change to Laura’s Law is sufficiently necessary, and why such a change outweighs any arguments to the contrary. These policy-based reasons in favor of an amendment emphasize the fact that a change to Laura’s Law would be consistent with its intent, would enable the law to achieve its desired result, and would effectively preserve liberty interests in the least restrictive treatment alternative for mentally ill individuals with severe mental illness.

1. Consistency with Intent

The eligibility criteria for receiving AOT services under the law are, as a whole, very mindful of preserving liberty interests and are clearly drafted so as to apply only to a limited population of persons with severe mental illness. When weighing the fourth criterion against the other eight criteria, however, the fourth criterion elevates the burden of proof for eligibility to almost as high as that of involuntary inpatient commitment.²⁰¹

197. Kress, *supra* note 122, at 1316.

198. *Id.*

199. See Bruce J. Winick, *A Therapeutic Jurisprudence Approach to Dealing with Coercion in the Mental Health System*, 15 PSYCHIATRY PSYCHOL. & L. 25, 27 (2008) (“[F]eelings of coercion may undermine the effectiveness of hospitalization and treatment, whereas feelings of voluntariness may increase their efficacy.”). Because people generally “function more effectively when they make decisions for themselves than when they are subjected to coercion,” focusing on a voluntary approach to mental health treatment may eliminate concerns about enforcing court-ordered treatment. *Id.*

200. See *supra* text accompanying note 194.

201. See Karasch, *supra* note 19, at 494 (arguing that even the LPS is ineffective at providing for people with mental illness “because it entails a cumbersome process that strikes a balance too far toward preserving due process rights”).

Laura's Law could achieve the same preservation of liberty interests and simultaneously extend its applicability to those truly in need, by balancing eight narrow criteria with one broader criterion—the demonstration of a history of lack of treatment compliance.

Given the legislative debate over eligibility criteria that took place before Laura's Law was enacted,²⁰² opposition to the broadening of this criterion is likely. And while the current language is the result of a compromise to make the AOT standard less stringent than the burden of proof required under the LPS for inpatient commitment, the language effectively amounts to having the same effect.²⁰³ A revision to section 5346(a)(4) would salvage the applicability and intent of the law because of the simple fact that it would be applied in the context of the eight other eligibility criteria. These other eight criteria are narrow and focus on, among other things, whether an individual's condition is substantially deteriorating, whether AOT would be the least restrictive alternative for the individual, and whether AOT is necessary to prevent deterioration to a state of grave disability or danger to self or others.²⁰⁴ In light of these narrow criteria, which are focused on a person's likely future disposition, finding a history of lack of treatment compliance through such narrow instances of past behavior makes less sense. Viewing the eligibility criteria as a whole, a revision to the fourth criterion may provide a more appropriate balance of narrowly and broadly construed criteria to assess the appropriateness of AOT given a person's past and likely future prognosis. Not only that, but combined with the other statutory mandates regarding an individual's procedural due process rights,²⁰⁵ Laura's Law will be able to balance concerns for public safety, social control, and least restrictive alternatives for persons with severe mental illness—but not at the expense of implementing the type of preventative framework necessary to reform the mental health system.

2. Desired End Results Will Remain the Same

While opponents may believe that the proposed revision would change the focus of the law from providing involuntary treatment to making services more available,²⁰⁶ this argument fails to account for what a broader

202. *See supra* Part II.A.

203. *See supra* note 60 and accompanying text.

204. CAL. WELF. & INST. CODE § 5346(a)(6)–(8) (West 2010 & Supp. 2014).

205. *Id.* § 5346(c), (d)(4).

206. *See supra* text accompanying notes 195–200.

application of Laura's Law is capable of achieving in terms of preventative care and mental health reform. This revision does not attempt to replace involuntary AOT as the first option for treating severe mental illness. Rather, such a revision will further the goal of providing involuntary outpatient treatment and merely drafts the eligibility criterion in a way that enables a more feasible application of the law necessary to reflect the reality of today's mental health system. And while voluntary treatment is ideal, without laws that allow resistant groups of persons with mental illness to be treated, even the best voluntary options may be useless.²⁰⁷

Contrary to the opposition's belief, the revision proposed in this Note shows that an involuntary treatment model can be both a prevention mechanism as well as a segue into long-term, voluntary compliance. Because persons with severe mental illness sometimes lack insight into the very fact that they are ill, they may be the least likely to seek treatment for their mental illnesses on a voluntary basis.²⁰⁸ This reality, reflected in the last listed factor of the proposed revision of Laura's Law,²⁰⁹ can sometimes prevent people from recognizing their own need for treatment or from treatment compliance.²¹⁰ This can contribute to an individual's status as a revolving-door patient, as a lack of insight into the illness fuels failure to adhere to a treatment plan, which in turn perpetuates the cyclical nature of the illness by increasing the chances of rehospitalization, incarceration, homelessness, victimization, or violence.²¹¹

Thus, the very nature of severe mental illness renders the preference for voluntary treatment somewhat paradoxical. Furthermore, statistics show that Laura's Law has been successful,²¹² regardless of whether or not it is labeled as "coercive." The law's success could be due to the mere presence of a court order.²¹³ However, it may also relate to the fact that the

207. See *E. Fuller Torrey on Mental Illness*, NPR (Apr. 17, 2006), <http://www.npr.org/templates/story/story.php?storyId=5346065> [hereinafter *NPR Interview with Torrey*] ("If you don't have laws that allow people to be treated, then it doesn't matter how good [our] services are—it's not going to work.")

208. A.B. 1421 BILL ANALYSIS, *supra* note 17, at 2.

209. See *supra* Part IV.A.

210. Kress, *supra* note 122, at 1274.

211. See *id.* (explaining that this is one of many reasons why preventative AOT statutes might "remedy many of the difficulties suffered by those with serious mental illness" and how such statutes might "address some of the public concerns created by certain behavior exhibited by people with mental illness").

212. See *supra* text accompanying notes 87–90.

213. See A.B. 1421 BILL ANALYSIS, *supra* note 17, at 9 (explaining that respect of the judge and the court order "often [were] the key[s] to cooperation for the recalcitrant mentally ill"); Elyn R. Saks, *Involuntary Outpatient Commitment*, 9 PSYCHOL. PUB. POL'Y & L. 94, 101 (2003) ("[S]ome patients

procedural safeguards built into Laura's Law may make individuals feel involved in the process and that they have a voice in their treatment.²¹⁴ Looking at the limited results of Laura's Law and comparing them to the incoherence of the criminal justice and mental health systems, it is hard to dispute the transformative potential of the law. By broadening the eligibility criteria, Laura's Law could be implemented more frequently, and thus would enable the legal and mental health systems to effectively offset the "coercive" nature of the court order with the therapeutic effects of due process, choices regarding treatment options, and patient participation throughout the treatment process.²¹⁵ This use of short-term court orders as means for long-term stabilization is the spirit of Laura's Law,²¹⁶ and in practice, the transformation from involuntary to voluntary treatment has proven to be quite common.²¹⁷ Because people enjoy a higher quality of life when they are not homeless, victimized, arrested, or in prison, involuntary stabilization via a court order often leads to voluntary adherence to treatment.²¹⁸ Moving forward, California may be able to transform the image of involuntary mental health treatment and thereby reduce concerns surrounding its enforcement.²¹⁹

Similarly, arguing that the current version of Laura's Law is satisfactory because it has proven to be somewhat effective and somewhat preventative²²⁰ is logically inconsistent. Involuntary treatment or medication is not ideal for anyone, regardless of the ailment. However, in medical emergencies, hospitals and doctors do everything in their power to treat and save the lives of people in need—even if this occurs involuntarily. Just as with any other laws regarding any other health issues, advocates

probably comply because they think they have to," calling this a permissible matter of "respecting a court order . . .").

214. See Winick, *supra* note 199 at 32 ("Patient choice in matters of treatment may bring a degree of commitment, which mobilizes the self-evaluative and self-reinforcing mechanisms that facilitate goal achievement." (citations omitted)).

215. See *id.* at 28 (emphasizing that an individual's perception of the legal action is important).

216. A.B. 1421 BILL ANALYSIS, *supra* note 17, at 9.

217. See Scheid-Cook, *supra* note 118, at 55 (citing early findings about the effectiveness of PAOT statutes and illustrating this transformative potential); *NPR Interview with Torrey*, *supra* note 207 (describing this phenomenon).

218. *NPR Interview with Torrey*, *supra* note 207.

219. See Winick, *supra* note 199, at 33 ("Even if coercion is necessary for a patient suffering acute symptoms, whose mental illness might prevent rational decision-making about hospitalization and treatment and who otherwise would refuse them, once the patient can participate in decision-making and experience the psychological value of making [such] choices, the justifications for coercion will cease.").

220. See *supra* Part IV.B.

should strive to make Laura's Law realize its true potential as a preventative treatment statute rather than embrace an attitude of complacency. Thus, the proposed revision to Laura's Law exposes mental illness's inferior footing in the health care hierarchy, but also shows that a correction of this discrepancy is possible with a more effective preventative treatment model.

3. Effective Preservation of Individual Liberty Interests in the "Least Restrictive Alternative"

While concerns about patient rights and autonomy are certainly valid, the reality is that strict adherence to an antipaternalistic approach to the treatment of mental illness, coupled with the civil libertarian concerns that fueled the deinstitutionalization movement, is counterproductive given the current state of California's mental health system. Movement toward the more constitutional standards of "dangerous to self and others" and "grave disability" was necessary in the past.²²¹ However, continuation of this movement has now transformed into an aversion to virtually all involuntary treatment models. This generalized aversion, however, ignores the greatly improved treatment methods and understandings of mental illness that the medical, psychological, and psychiatric fields have developed.²²² PAOT statutes, if they are to be at all effective, require confidence in the community-based model without the outdated, antipaternalistic fears surrounding their involuntary nature.²²³ This shift in thinking may allow opponents to realize that Laura's Law imposes few restrictions on liberty because AOT recipients are free to be in the community,²²⁴ cannot be forced to take medications,²²⁵ and cannot be penalized merely for failing to adhere to the court order.²²⁶ Therefore, a broader definition for history of lack of compliance is consistent with the idea of the "least restrictive alternative" and providing broader grounds for legal intervention may lead to "greater stability and higher quality of life for [individuals with mental illness], as well as their friends and loved ones."²²⁷

The controversy in PAOT statutes often shines through in the

221. SLOBOGIN ET AL., *supra* note 1, at 705; Kress, *supra* note 122, at 1321.

222. Kress, *supra* note 122, at 1321.

223. *See id.* (arguing that "recent improvements in the treatment of persons with mental illness undercut the motivation—if not the best available justification" for strict adherence to underlying antipaternalistic principles).

224. CAL. WELF. & INST. CODE § 5348(a) (West 2010 & Supp. 2014).

225. *Id.* § 5348(c).

226. *Id.* § 5346(f).

227. Kress, *supra* note 122, at 1316.

perceived dichotomy that such statutes can either serve as “a transitional step toward a person’s independent and fully integrated community functioning”²²⁸ or as means of “social control.”²²⁹ However, these two somewhat contradictory understandings of PAOT statutes do not have to be mutually exclusive.²³⁰ For example, a broader definition of “history of lack of compliance with treatment” under Laura’s Law may make the law applicable to more persons with severe mental illness who cannot show such lack of compliance under the current requirements. By increasing the law’s accessibility, the State removes the need for people to demonstrate prior hospitalizations, incarcerations, or violent behavior in order to qualify for AOT services, and this in turn enhances independent and autonomous community functioning. Similarly, by enabling preemptive treatment, the State reduces the risk that individuals with mental illness will deteriorate to a dangerous, gravely disabled, or violent state, thereby promoting public safety and least restrictive alternatives in both the long- and short-term.

V. CONCLUSION

The analysis set forth in this Note demonstrates that California needs to evaluate its priorities when it comes to treatment of severe mental illness. This evaluation can be summarized in one important question: Does the State want Laura’s Law to be an effective, preventative law, or does it want Laura’s Law to be a mere symbol of progression and reform of the mental health system? The query is not an attempt to downplay the significance of civil liberties or autonomy. Rather, this Note has argued that given the state of the current mental health system and the treatment options that are available, the California State Legislature must stop talking about the abstract concepts of “autonomy” and “liberty” and weigh the tangible outcomes of allowing severe mental illness to go untreated.²³¹

Involuntary treatment under an AOT model should be prioritized when “the benefits achieved by involuntary treatment . . . would be sufficient to outweigh the harms caused by involuntary treatment, including the involuntary nature of the treatment.”²³² The arguments set forth in this

228. Henry A. Dlugacz, *Involuntary Outpatient Commitment: Some Thoughts on Promoting a Meaningful Dialogue Between Mental Health Advocates and Lawmakers*, 53 N.Y.L. SCH. L. REV. 79, 87 (2008).

229. *Id.* at 82.

230. *Id.*

231. Dora W. Klein, *Involuntary Treatment of the Mentally Ill: Autonomy Is Asking the Wrong Question*, 27 VT. L. REV. 649, 652 (2003).

232. *Id.* at 653.

Note support the conclusion that greater utilization of Laura's Law would achieve significant treatment benefits and sufficiently outweigh the current harms posed by the limited treatment options for mental illness. As has been stated, much of the struggle with mental illness occurs in the gap between institutionalization (in hospitals or prisons) and inadequate community support, often leading to homelessness, family strife and concern, and a revolving-door pattern.

True reform of the mental health system can be achieved through wider implementation of preventative treatment statutes, such as Laura's Law. However, wider implementation by the courts is possible only if the legislature has provided the means for doing so. This Note proposes a modest legislative change that, if implemented, would allow for increased use of AOT and access to treatment for severe mental illness, higher quality of life for individuals with severe mental illness, and greater overall public wellbeing. While it may be an uncomfortable legislative action, reform must begin in California's highest governing body if both society and the law are to truly "maximize the overall well-being" of persons with mental illness rather than "maximize only their [short-term] autonomy."²³³ Approaching Laura's Law from this holistic perspective, rather than a merely coercive perspective, could potentially change the image of PAOT statutes as a whole.²³⁴ Reframing the AOT process may help restructure the tone and label associated with it; this in turn may not only reduce concerns surrounding coercion and enforcement in Laura's Law, but may also reduce stigma surrounding mental illness in general. Where the legal resources are available to enable short-term intervention for purposes of long-term health and self-sufficiency, mental health advocates can only hope that California capitalizes on such an opportunity for reform and progression.

233. *Id.*

234. Steven S. Sharfstein, *Individual Rights Must Be Balanced with 'Caring Coercion,'* PSYCHIATRIC NEWS (Oct. 10, 2014), <http://psychnews.psychiatryonline.org/doi/full/10.1176%2Fpn.40.17.00400003>.

