ABSTRACT

LAURA'S LAW: A POLICY ANALYSIS

By

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The purpose of this project was to analyze Assembly Bill 1421, known as Laura's Law, from a social work perspective of recovery-oriented care. Gil's framework was used to assess primary and secondary data from journal articles, government publications, and law reviews. A review of the literature was conducted to understand the historical background of coercive mental health treatment. Coercive treatment has been a pervasive problem generated from public fear and misconceptions about the association between mental illness and danger. Laura's Law was established as a result of the murder of 19 year-old Laura Wilcox by an individual with serious mental illness. The law's primary stated objective was to provide preventative mental health services to those identified as most in need before tragedy struck. Significant shortcomings were discovered within the analysis and alternatives to this policy are suggested as well as the implications for social work policy and practice.

LAURA'S LAW: A POLICY ANALYSIS

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INTRODUCTION

Violence as a result of mental illness has been a long-standing concern for the public. Recent public and school shootings such as the Denver movie theater, Virginia Tech, Sandy Hook, Isla Vista, and University of California, Santa Barbara, brought these concerns to light more than ever before (Price, 2012). Information that is relayed on various news outlets on the profiles of those responsible for these violent acts puts a misguided emphasis on the mental illness as the primary cause of violence among those with mental illness (McGinty, Webster, Jarlenski, & Barry, 2014). This idea perpetuates the assumption that people with mental illness are dangerous and violent, and that steps to implement policy must be taken to cure them and prevent tragedy (Rosenberg, 2014). This rationale has been the catalyst behind many laws being passed worldwide to target this issue (Applebaum, 2003).

Background

Involuntary outpatient treatment (IOT), also known as assisted outpatient treatment (AOT), was the proposed legal solution to violence as a result of mental illness (Swartz et al., 2010). IOT is a legal procedure that allows court-ordered, community-based treatment for individuals who meet specific criteria (Swartz et al., 2010). This legal statute is also an effort to keep individuals with mental illness from falling into the "revolving door" system when they fail to adhere to voluntary outpatient treatment (Stettin, 2014). IOT has been enacted across 45 states and the District of Columbia over the past 15 years (Stettin, 2014). The most publicized implementation of IOT was in the state of New York, titled Kendra's Law (Swartz et al., 2010). Kendra's Law was a result of a young woman named Kendra Webdale being pushed in front of an oncoming subway by a man who was suffering from schizophrenia who had a history of violence and, at that time, was not taking his prescribed medication (Watnik, 2001). This was the foundation for Laura's Law, also titled Assisted Outpatient Treatment Act Project of 2002 or Assembly Bill 1421, which came about after the spree murder of 19 year old Laura Wilcox, and two others, by a man suffering from paranoid delusions (Applebaum, 2003).

For the American public, the passing and enforcement of IOT laws were perceived as important, because (1) they aimed to protect society from violent, mentally ill individuals who were not capable of complying with voluntary outpatient treatment; (2) they aimed to reduce the amount of hospitalizations and arrests; and (3) they were predicted to be cost-effective and save the state money (California Department of Health Care Services [CDHCS], 2011; Elbogen & Johnson, 2009; Nevada County Grand Jury, 2012).

Opponents point out that the concrete problems associated with IOT laws are: (1) difficult to enforce; (2) perpetuate the idea that mentally ill individuals are violent and are to be feared when association between violence and mental illness is moderate; (3) further perpetuate the stigma already associated with mental illness; and (4) do not take into account other variables that could influence violence, such as substance abuse disorders, trauma, childhood maltreatment, neurological differences, and other etiological risk factors (Rosenberg, 2014; Rueve & Welton, 2008; Sabella, 2014; Van Dorn, Volavka, & Johnson, 2012).

Laura's Law is an effort to ensure that individuals with mental illness gain access to treatment they had not otherwise sought in the least restrictive environment (the community), though it would be court-ordered and therefore not of their own accord (CDHCS, 2011). Laura's Law is also an effort to reduce the revolving door effect in terms of hospitalization and the criminal justice system.

In California, 20% of inmates were reported to have mental illness, 38% of inpatient state beds were utilized by the mentally ill offenders, and overall acute psychiatric inpatient stays accounted for 37% of state beds (California Health Care Almanac [CHCA], 2013; LPS Reform Task Force II, 2012). The criteria for Laura's Law, however, is much more narrow than that of Kendra's Law, making it more difficult for individuals to meet the necessary requirements for IOT (Applebaum, 2003). Furthermore, there is no real way to enforce this policy. If an individual is non-compliant with the court order, they may be held in a crisis unit on a 72 hour hold for evaluation. If they do not meet requirements for involuntary inpatient treatment, they must be released (California Hospital Association, n.d.). Noncompliance with an order of IOT is also not grounds for being in contempt of the court (California Hospital Association, n.d.). The lack of ability to enforce IOT contradicts the stated purpose of the policy.

Statement of Purpose

The purpose of this project was to analyze Laura's Law from a social work perspective as well as recovery-oriented care. California has been adopting the recovery paradigm in mental health services, which is a highly individualized process that relies on choice, self-determination, and empowerment to help the individual establish a meaningful role in his or her life (Ragins, 2010). Though the CDHCS (2011) states the implementation of Laura's Law will be aligned with the recovery model, it is unclear how the core values associated with the recovery model will be maintained under the implementation of this policy. The purpose of this project was also to establish whether or not IOT is effective–and what the definition of effective is in relation to IOT as evidenced in the literature.

Definition of Terms

Serious mental illness (SMI): Specific to those 18 and older who have chronic mental illness, including major depression, obsessive compulsive disorder, panic disorders, schizophrenia, post-traumatic stress disorder (PTSD), bipolar disorder, and borderline personality disorder, that affect their ability to perform basic work tasks (Revised medical criteria, 2010).

Recovery model: A person-centered framework promoting hope, empowerment, self-responsibility, and meaningful roles through collaborative treatment to manage symptoms of mental illness and function independently in the community (Walker, 2006).

Mentally ill offender: The term "mentally ill offender" is ambiguous, as there is no agreed upon criteria from state to state, or prison to prison, of what the definition of the term actually entails (California Corrections Standards Authority, n.d.).

Multicultural and Social Work Relevance

Native Americans, those who are multiracial, African American, and Hispanic individuals have the highest rates of serious mental illness in California, ranging from 1%-3% above the state average (CHCA, 2013). Racial and ethnic minorities, particularly Hispanics and African-Americans, experience lower lifetime prevalence of serious mental illness than Caucasians; however, they make up a large percentage of other marginalized groups and experience higher persistence and disability rates as a result of mental illness (Primm et al., 2010). According to Primm et al., racial and ethnic minorities tend to be disproportionately represented in inpatient treatment, and insufficiently represented in outpatient treatment. The literature also suggests racial and ethnic minorities tend to utilize alternative treatments; a direct result of less access to community mental health services due to barriers such as health insurance, language, and accessibility (Primm et al., 2010). It is worth noting that the mass murders that have been used to emphasize the need of IOT laws have been executed by young, White men: the population that has the most access to community mental health services.

While there is no definitive stance from the National Association of Social Workers (NASW), the profession itself has values that seemingly do not align with IOT laws. NASW (2012) has issued a policy statement that a balance be achieved between self-determination, family, and public safety in regards to all forms of mandated treatment. The values, ethics, and policies of self-determination, informed consent, reducing stigma, and choices about service options are in conflict with the coercive implications of mandatory treatment (NASW, 2008, 2012). The NASW Code of Ethics promotes cultural competence that includes disability and is relevant to the issue of IOT as the public is generally misinformed about the prevalence of violence associated with the disability of mental illness (McGinty et al., 2014; NASW, 2008). In educating policy makers and the general public about all etiological risk factors associated with violence and mental illness, those in the field of social work can advocate for and directly address stigma associated with those who have a mental illness (NASW, 2012). Through advocating and efforts to reduce stigma, this may also reduce the implementation of policies that are not aligned with the values and ethics of the field (NASW, 2012).

CHAPTER 2

LITERATURE REVIEW

Historical Overview of Mental Health Treatment

Historically, those with mental illness and intellectual disabilities were seen as incapable of being cured, unable to care for themselves, and an overall threat to the community (Scheid & Brown, 2009). As a result, these populations were hidden away in asylums, confined to small living quarters, abused, and neglected (Parry, 2006). Parry wrote that in the late 1800s, an English school teacher by the name of Dorothea Dix began the movement to deinstitutionalize the mentally ill. Closely following Britain's madhouse reforms, she submitted a petition to the Massachusetts legislation exposing the inhumane treatment and living conditions within asylums (Parry, 2006). According to Parry, Dix demanded social reform to establish state mental hospitals and encouraged following a model of more compassionate care when treating those with mental illness. Scholars have speculated that Dix experienced symptoms of depression, herself. As a result of her efforts, there were more state hospitals established and they were the central treatment locations for those with mental illness (Scheid & Brown, 2009). Unfortunately, the shift created overcrowding of state institutions, resulting in poor living conditions and hygiene, malnutrition, and continued mistreatment of those with mental illness (Fakhoury & Priebe, 2007). State mental health institutions lacked the moral care they were intended to provide partly due to the mass amount of individuals who were housed there, but were also inaccessible to most state cities as the institutions were built in the center of every state (Grob, 1994). This forced most cities to once again build institutions to house the chronically mentally ill, who were once again deemed untreatable and incapable of living in the community, thus defeating the primary purpose of the shift toward state mental health treatment (Grob, 1994).

Grob (1994) wrote that Adolf Meyer, along with other prominent psychiatrists by way of neurology, began planting the seed of what they coined dynamic psychiatry, which stated that mental illness lay on a spectrum from normal to abnormal, with an emphasis on the individual's life experiences. From dynamic psychiatry, Meyer also developed psychobiology which criticized what was then the sole focus on biological aspects of mental illness without considering the physiological, environmental and negative behavioral patterns and how they related to mental illness (Grob, 1994). This led to the notion that intervention outside of mental institutions could potentially prevent the necessity of acute psychiatric care. While these theories did not make a significant change in mental health treatment at the time they were developed, it was extremely influential in terms of mental health treatment post-World War II (Grob, 1994).

Concurrent with the institutional changes (or lack thereof), the early- to mid-1900s were rife with experimental treatments on those in state mental hospitals. With the onset of sexually transmitted diseases that caused neurological dysfunction in the early 1900s, various experiments to combat the symptoms created the hypothesis that seizures alleviated psychosis associated with mental illness (Getz, 2009). Getz stated that this led to further experiments, which then established the idea that by lowering the individual's blood sugar, their symptoms diminished. This was done through injecting patients with high levels of insulin multiple times a day, which often put them into a short-term coma, and even led to death (Getz, 2009).

Eugenics, which stemmed from Charles Darwin's *survival of the fittest* theory, was a sweeping movement that heavily impacted those with mental illness in the beginning of the 20th century (Sharav, 2005). Those with mental illness and other disabilities were believed to be unfit for breeding, as eugenics was about perfecting the heredity in the human race (Sharav, 2005). As a result, those institutionalized were involuntarily sterilized and unable to marry due to their negative genetics (Sharav, 2005). Also common during this time period were transorbital lobotomies, made notable by neurologist Walter Freeman (Getz, 2009). Lobotomies were the standard treatment in state mental hospitals as they were a faster, less invasive alternative to the initial prefrontal leucotomy established by Egas Moniz, in which brain surgery was performed to kill off the brain tissue connecting the thalamus to the frontal lobes (Getz, 2009). According to Getz, lobotomies were thought to make mentally ill patients more manageable despite the high failure rate, as severing the frontal lobes created a severe change in affect. Lobotomies were at times used as a form of punishment for those who were found to be uncooperative. Getz wrote that soon after, electroconvulsive treatment became the standard treatment for psychosis as it essentially served the same function as previous treatments until the 1950s, when the psychopharmaceutical Thorazine (Chlorpromazine) was introduced.

The post-war era introduced psychotherapy, resurfacing the idea that those who were institutionalized could recover enough to live successfully in the community (Grob, 1994). According to Grob, it was unfortunate, as most who received psychotherapy were affluent and well educated while those who needed it most were the lower class, institutionalized, chronic mentally ill. This left much room for criticism surrounding the effectiveness of psychotherapy.

In 1963, President Kennedy passed the Community Mental Health Centers Act in an effort to shift mental health treatment from institutionalization to community-based programs (Harcourt, 2012). This act reduced the population in mental institutions by 59% during the first decade of implementation in the United States, surpassing the initial goal of 50% (Harcourt, 2012). Advocates of those with mental illness supported this law, as they felt institutionalization was abusive, a violation of the individual's rights, and an inappropriate method of treatment (Mayerhoff, 2006). According to Grob (1994), the values at the core of this movement were social justice, end to structural barriers preventing effective mental health treatment, and community empowerment. Community mental health placed an emphasis on collaborative care between the general public and mental health professionals in an effort to make the system function more efficiently. In this bill, however, there was little detail regarding what services would look like in the community; instead, it was left to the Department of Health, Education, and Welfare to decide what services were necessary. Grob further stated there were no linkages to state hospitals, which was understandable given the purpose of the movement, but there were a large number of individuals who were institutionalized that lacked a reintegration plan.

Grob (1994) explained in 1965, after Kennedy's assassination and Johnson's subsequent presidency, the final national program was instituted combining elements of the original 1963 act and Johnson's propositions to fill in the gaps of the original bill. Grob wrote that over the course of the 1960s and 1970s hospitalizations decreased significantly, though ironically admissions rose at the same rate. Discharge plans for continuing community care were implemented, but it was largely within centers that had little capability or interest to follow through with mental health services for those with persistent mental illness. Instead, services for the large population of individuals who had co-occurring substance and/or alcohol disorders to those with marital struggles were implemented, leaving the population it was meant to care for without any services to help them with their basic human needs (Grob, 1994).

Moreover, according to Grob (1994), the late 1960s and 1970s brought heavy criticism to the field of mental health by social activists as they believed diagnoses only served to label individuals for non-conformity, thus creating stigma, and that psychodynamic treatment was a method of controlling behaviors of individuals. With this criticism, psychoanalytic treatment began diminishing, and once again the biomedical model (and consequently the medical model of treatment) overtook the field of mental health. At the same time, Richard Nixon's war on drugs overloaded jails and prisons with those who were mentally ill as many had co-occurring substance use disorders, beginning a new wave of criminalization of the mentally ill (Pinals, 2014).

Frank and Glied (2006) stated that the election of Ronald Reagan reversed decades of effort to shift the responsibility of mental health from a local to federal level. Reagan's Omnibus Budget Reconciliation Act of 1981 significantly reduced funding to community mental health, lumping substance abuse and mental health treatment into one block grant, and once again made policy a matter of state concern. According to Slate and Johnson (2008), more money was collectively allocated to those on Supplemental Security Insurance (SSI) and Social Security Disability Insurance (SSDI) than was allocated to community mental health centers. Stricter SSI and SSDI application screenings enacted in 1983 cut benefits to 30% of those receiving them, all of which were deemed mentally disabled (Grob, 1994). While these cuts were protested and later reversed, this was a testament to how little priority community mental health was. Due to underfunding as well as the general mentality of wanting those with mental illness out of sight and out of mind, further implementation of community based treatment was once again close to nonexistent (Slate & Johnson, 2008).

The late 1990s brought about the development of mental health courts, aiming to protect society yet minimize criminal punishment and establish viable treatment options for the individual (Slate & Johnson, 2008). According to Slate and Johnson (2008), this was the birthplace for outpatient treatment statutes across the country, as early studies suggested that those who were mandated to treatment through mental health court were less likely to recidivate than those who were not.

In 2003, President Bush called for a reform in the mental health system with the New Freedom Commission on Mental Health, promoting the recovery paradigm in helping those with mental illness (L. D. Miller & Moore, 2009). L. D. Miller and Moore state that this commission demanded a more client-centered, collaborative approach to make treatment and recovery more efficient. In 2004, California passed the Mental Health Services Act, increasing funding to community mental health agencies to provide resources directed toward early intervention and prevention of mental crises (CDHCS, 2012). As a result of these acts, states such as California have made movement toward implementing the recovery paradigm in all community mental health settings throughout the latter 2000s to present time; however, prisons and jails are still housing a disproportionate number of those with mental illness (CDHCS, 2012; Slate & Johnson, 2008).

Historical Legislation of Coerced Treatment

In 1969, California passed the Lanterman-Petris-Short Act, reforming the state's involuntary hospitalization criteria (W. Fisher & Grisso, 2010). Prior to this act, Fisher and Grisso stated that criteria was ill-defined, thus giving those with legal authority the power to commit those with mental illness as they saw fit. The passage of this act influenced states across the country to enact similar criteria, which at the foundation of each mandate required an individual be a danger to themselves or others or gravely disabled due to their mental illness (W. Fisher & Grisso, 2010). Institutions were held more accountable for ensuring that the criteria was met before an involuntary hold after the passage of this act, according to W. Fisher and Grisso, making it much more difficult for hospitals to admit and retain individuals with mental illness. Slate and Johnson (2008) wrote that despite this attempt at providing civil liberties to those with mental illness, a San Mateo study showed that incarceration rates for those with mental illness increased four and a half times what they were prior to the implementation of the Lanterman-Petris-Short Act.

R. Miller (1997) states that there has been a heavy reliance on the criminal justice system in terms of coerced treatment for those with mental illness for many years, especially in the area of involuntary inpatient commitment. Law enforcement is often the first response to those with mental illness and given initial control of determining competency of an individual, especially in regard to initiating involuntary hospitalization

(R. Miller, 1997). While officers do not partake in the clinical treatment of those with mental illness, they are still considered part of the clinical process for this reason until the gatekeepers (the courts) relinquish day to day control to clinicians (R. Miller, 1997).

According to R. Miller (1997), the judicial system addresses those with mental illness under the criminal justice model despite mental illness typically being considered a civil matter, and as a result those individuals are represented by criminal defense lawyers. Though lawyers are trained to express the wishes of their clients, they are also trained to evaluate competency. Because those with mental illness are often thought to be incapable of rational decision making, preferred clinical treatment (or lack thereof) for this population is rarely considered in the decision making process, resulting in coerced treatment (R. Miller, 1997). Herein lies the distinguishing factor between the legal and clinical systems when dealing with mental illness: criminal defense is focused on minimizing the legal ramifications without regard to the individual's motivation, and clinicians revolve treatment plans solely around the client's motivation (R. Miller, 1997).

Justification for Coerced Treatment

Anosognosia is a term used to describe a lack of insight to one's illness typically due to neurological dysfunction, and is often present in individuals with schizophrenia (Breggin, 2006; Mohamed et al., 2009). This term reinforces the idea that coerced treatment, especially in terms of medication compliance, is necessary and effective as the individual is less likely to enter and remain in treatment (including taking medication) if they do not identify as ill (Mohamed et al., 2009). Concepts such as this encourage the necessity of IOT laws, as it makes the assumption that the individual is unaware or in denial of their mental illness. This concept also exacerbates the paternalistic nature of mental health and political systems; that people are incapable of knowing what is best, so the decision must be taken out of their control, and instead placed in the control of authority (Drake & Whitley, 2014).

Breggin (2006) discussed society's use of alcohol, drugs, nicotine and caffeine as *intoxication anosognosia,* or medication spellbinding. He also stated that a larger portion of the population is using psychiatric medication, and that prescriptions given to those with serious mental illness often further hinders brain function, which is correlated to the definition of anosognosia (Breggin, 2006). Breggin even goes so far as to say that these medications often make the symptoms they are meant to treat worse, but the medication blinds the individual to the additional adverse effects and overestimates the positive.

Evidence for Coerced Treatment

Swartz et al. (2010) analyzed data from the New York Office of Mental Health (OMH) to measure the effectiveness of Kendra's Law. The sample size ($N = 3{,}609$) was gathered from hospitalization claims and case manager reports that resulted in IOT in New York, then narrowed down to those who had Medicaid (Swartz et al., 2010). The results were overwhelmingly positive from the clinical perspective of recovery. Hospitalization length of time was reduced, a high percentage (81%) of those who had been prescribed medication had access to it, there were lower rates of victimization, and case mangers additionally reported higher levels of engagement after 6 months for those who had IOT combined with assertive community treatment (ACT) than those who had ACT alone (Swartz et al., 2010). It was not stated how many of the individuals were actually taking the medication they had access to, nor was it outlined whether there was a difference in services provided to those who received ACT with IOT and those who received ACT without IOT.

Swartz and Swanson (2004) examined several states' data to analyze the effectiveness of IOT. While the data showed that it was effective much in the same way that Kendra's Law was effective, there were several limitations that were found to have potentially biased the results (Swartz & Swanson, 2004). While length of time played a key role in the effectiveness of IOT, it could not be generalized as there may have been lower-risk individuals assigned to IOT for longer periods of time, thus creating an overstatement of positive results (Swartz & Swanson, 2004). There was not a standard level of care provided across all individuals assigned to IOT in this study. The intensity of services provided varied by participants, which Swartz and Swanson stated could have influenced outcomes.

Biomedical Model

In the clinical sense, recovery is about the dissolution of symptoms associated with mental illness (Slade, 2009). From a biomedical model perspective, mental illness is a biological, neurological disease that should be treated by the use of pharmaceuticals (Deacon, 2013). At the start of the biomedical model, psychiatric medications were the standard treatment used to correct neurotransmitter imbalances, despite the lack of evidence that psychotropics correct imbalances, or that they are even safe to use (Deacon, 2013). Further, there is no evidence proving that all mental illness stems from chemical imbalance, nor is there a concrete biological cause of mental illness (Deacon, 2013). While the biomedical framework currently incorporates some aspects of various psychosocial theories, the majority of the emphasis is still placed on the biological aspect of disease, leaving little room for social, psychological, or behavioral explanations (Deacon, 2013).

Deacon (2013) states that the lack of medically diagnostic tests required for a diagnosis as well as a lack of criteria meeting the scientific definition of disease has forced the pharmaceutical industry to reduce the production of new psychotropic medications. However, that has not reduced psychotropic medications being administered to those with mental illness, despite the lack of evidence that they are any more effective than the medication that was administered in the early 20th century (Deacon, 2013). In fact, current psychiatric medications produce poorer long-term outcomes, such as lower remission and maintenance rates for those who take them, especially with mood disorders (Deacon, 2013). Despite the billions of dollars provided for continued biomedical research of mental illness, the severity of disorders has not improved as a result of psychotropic medication (Deacon, 2013). The continued reliance on the biomedical model has prevented adequate and effective treatment to those with serious and persistent mental illness (Deacon, 2013).

Recovery Model

The mental health profession has begun moving away from the clinical definition of recovery and placed a higher emphasis on personal recovery (Slade, 2009). The definition of personal recovery is subjective in nature, given the understanding that every individual will perceive recovery in a different manner (Le Boutillier et al., 2011). In its most basic form, personal recovery revolves around helping an individual attain the best possible quality of life despite the symptoms associated with their mental illness by promoting four key domains: hope, empowerment, meaningful roles, and self-responsibility (Slade, 2009). Recovery-oriented practices emphasize autonomy and the ability to live functional independent lives rather than reliance on mental health professionals (Le Boutillier et al., 2011). The recovery paradigm has also allowed for a shift between focusing on the mental illness, or the individual as a perceived problem, to the individual as a person, first and foremost (Le Boutillier et al., 2011). This takes the focus away from the diagnosis and allows practitioners to focus on the individual, their personal journey, and minimizing stigma associated with mental illness (Le Boutiller et al., 2011).

Hope is central to personal recovery from mental illness (Corrigan, Salzer, Ralph, Sangster, & Keck, 2004). Hopelessness is at the core of the definition of many mental illnesses (Kinghorn, 2013). For individuals that lack hope, there is a sense of learned helplessness perpetuating the idea that they cannot achieve goals they would like to set for themselves (Kinghorn, 2013). C. R. Snyder established The Hope Theory that recognized hope as a central component of motivation (Coduti & Schoen, 2014). The instillation of hope through encouragement and validation of thoughts and ideas that are relative to establishing and attaining goals helped individuals shift self-talk from defeat to recognizing their capacity to succeed (Coduti & Schoen, 2014).

Recovery-oriented practices are intended to reflect collaboration rather than control (Le Boutillier et al., 2011). In the face of societal stigma many individuals feel disempowered, resulting in feelings of loss of control over their lives (Corrigan & Rao, 2012). By placing emphasis on the collaborative nature of the overall journey of recovery, this allows individuals to have control over treatment choices, recognize their own life choices where they may feel they lack control, and ultimately results in feelings of empowerment (Drake & Whitey, 2014).

Community integration is a large part of recovery-oriented services. Social isolation is common among those with mental illness, as they may feel that they have fewer opportunities and/or limited access to engagement (Townley, Miller, & Kloos, 2013). Corrigan et al. (2004) found that those who felt they had a support network they could ask for help and rely on reported higher scores on a Recovery Assessment Scale (RAS), which evaluated the perception of the participant's individual's recovery. Mental health practitioners play an integral role in social support during the recovery process; however, establishing new support and identifying existing support outside of the mental health system plays a substantial role in the process as well (Le Boutillier et al., 2011).

Personal recovery is difficult to measure statistically, as it is based on the individual's internal perception of their progress in the process (Drake & Whitley, 2014). Tools such as the Milestones of Recovery Scale (MORS) have been developed for agency evaluation of personal recovery (D. Fisher et al., 2009). The MORS assesses the individual's level of risk (harm to self or others, risky behaviors, and level of co-occurring disorder), level of engagement in the mental health system, and level of skills and network of support (D. Fisher et al., 2009). In a study conducted by Miller, Brown, Pilon, Scheffler, and Davis (2010), MORS data from The Village Integrated Services in Long Beach, California was used to assess patterns of the recovery model. The data showed that after approximately 10 months of care, about 90% of individuals who were initially at extreme risk had improved at least one level (Miller et al., 2010). Miller et al. also found that within the first 6 months, roughly 80% of individuals who were highly disengaged at the beginning of the process had left that stage within the first 6 months of treatment. After two years of treatment, 40% were in an active phase of recovery (Miller et al., 2010). While there was a 5-7% chance of individuals regressing to a more severe state within the first 6 months, the majority maintained a steady level of improvement for the duration of treatment that was assessed in the study (Miller et al., 2010).

Stigma

It is estimated that 50% of adults with mental illness do not receive treatment (CHCA, 2013), and stigma plays a significant role in this statistic (CHCA, 2013; Corrigan, Druss, & Perlick, 2014). Stigma at the societal, political, economic, and cultural level often results in dehumanization of an individual and may prevent those who would otherwise benefit from mental health treatment from seeking it out (Corrigan et al., 2014; Martinez, 2014). The prejudice and discrimination that often comes with mental illness is not only present on the societal level, but within the individual themselves (Corrigan & Rao, 2012). Corrigan and Rao describe self-stigma as the internalization of perceived prejudice and negative stereotypes. Individuals who self-discriminate endorse the negative stereotypes, leading to feelings of unworthiness and dissolution of confidence in their ability to achieve goals (Corrigan & Rao, 2012). Individuals who self-stigmatize often experience poor health as there is typically a decrease in health care use due to isolation (Corrigan & Rao, 2012).

Self-stigma is observed in four stages: awareness, agreement, application, and harm. In the awareness stage, the individual knows what the public perception of their illness is. This leads to the agreement stage, in which the individual begins to have the same opinion of a group as the public. Application is a direct result of the former stage, as an individual then beings to apply the negative stereotypes of a group to themselves. This results in the final stage of harm, as it causes lower self-esteem and lower belief in their ability to achieve goals. The collective result of these four stages is what is coined as the why-try effect (Corrigan & Rao, 2012).

The why-try effect has three components: self-stigma, mediators, and life goal achievement (Corrigan, Larson, & Rüsch, 2009). According to Corrigan et al. (2009), when individuals experience and internalize the components of self-stigma, there is a decrease in the effectiveness of mediators such as self-efficacy and self-esteem. With the loss of self-worth, there is a loss of motivation and the individual's belief in their own ability to create and attain life goals (Corrigan et al., 2009).

The deviance associated with stigma of mental illness largely contributes to social rejection (Feldman & Crandall, 2007). According the Feldman and Crandall (2007), social rejection is a result of society as a whole associating mental illness with danger and aggression, and valuing norms and conformity. Mental illness is outside of the norm, therefore a diagnosis and any resulting symptoms are viewed as nonconformity, furthering social distancing (Feldman & Crandall, 2007).

Feldman and Crandall (2007) completed a study with undergraduate students (*N*=297) on their perception of mental illness based on the characteristics of 40 diagnoses from the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) to measure social distancing. The data showed that mental illness and symptoms that result from it are viewed as controllable, and individuals often tend to hold those with mental illness personally responsible for symptoms they experience (Feldman & Crandall, 2007). The results also showed that perceived severity of the mental illness, rarity, danger, and if a person is receiving psychotherapy contribute more to social distancing and stigma than taking medication (Feldman & Crandall, 2007). These factors are directly related to those that create internalized stigma, inevitably producing the same negative effects to an individual (Feldman & Crandall, 2007).

Stigma of Mental Health/Health Professionals

According to Horsfall, Cleary, and Hunt (2010), many professionals in the field of mental health develop negative attitudes toward those with chronic and persistent mental illness. This is likely as a result of working with a number of individuals with the same diagnosis or similar behaviors and developing low tolerance and apathy toward individuals they work with (Horsfall, Cleary, & Hunt, 2010). Mental health and health professionals may be influenced by societal stereotypes of those with mental illness being dangerous, unpredictable, and unmotivated and automatically stigmatize those they work with, to the extent of ignoring the wishes and requests of their clients (Horsfall, Cleary, & Hunt, 2010).

Co-Occurring Mental Health and Substance Use Disorders

According to the 2013 National Survey on Drug Use and Health, 3.2% (n = 7.7 million) of the United States' population aged 18 and older had any mental illness and a substance use disorder, and 1% (n = 2.3 million) had a serious mental illness and a substance use disorder (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013a). The 2008 and 2009 National Survey on Drug Use and Health found that only 7.4% of those with co-occurring disorders received treatment for both substance use and mental health, while 55.8% of those with co-occurring disorders received no treatment (SAMHSA, 2010). African American's have higher prevalence rates of both serious mental illness and substance use disorders, but are less likely to receive treatment for both (SAMHSA, 2013b).

SAMHSA (2013a) cited lack of insurance as the main reason individuals chose not to get treatment. According to Harris and Edlund (2005), most insurance companies are more likely to cover mental health care than substance use treatment; however, according to data from the 2001-2002 National Surveys on Drug Use and Health, utilization rates of both mental health and substance use treatment were significantly low. Societal, perceived, and self-stigma are just as prevalent for those who use substances as it is for those with mental illness, and according to Luoma et al. (2007), self-stigma is a major contributing factor in delayed treatment for co-occurring disorders.

Family Burden

According to Caqueo-Urizar et al. (2014), community-based treatment places a heavy burden on family members of those with mental illness. Many family members experience the social stigma and isolation that their loved one does, even amongst other family members. Caqueo-Urizar et al. also state that this isolation could lead to pessimism regarding their loved one's ability to reach goals as well as limited access to community resources. According to Tan et al. (2012), individuals who are in recovery for serious mental illness such as schizophrenia largely rely on social support, and family support is ideal. This places an even larger responsibility on family members, and without proper knowledge of resources, family burden continues to increase, placing extra stress on the caregiver that could lead to their own decline in mental health and overall well-being (Tan et al., 2012).

The National Alliance of Mental Illness (NAMI) is an organization that aims to educate consumers, providers, family members, and the general public about serious mental illness (NAMI, 2013). NAMI also focuses on advocating for individuals with serious mental illness as well as family members of those with a mental illness. While NAMI considers mental illness a brain disorder and strongly recommends pharmacotherapy, there is an emphasis on collaborative (including family members), person-centered treatment and the belief services should be available to anyone at any given time in the least restrictive environment possible. The Los Angeles chapter of NAMI has made no official statement regarding its stance on Laura's Law; however, surrounding chapters, such as NAMI Orange County, are in favor of the law (NAMI, n.d.).

Violence and Mental Illness

A number of studies have been conducted aiming to determine if those with serious mental illness (SMI) are more likely to be violent than those who do not have SMI (Van Dorn et al., 2012). While there is, of course, a higher risk of violence associated with SMI, the results suggest that there is no empirical evidence to support those claims (Van Dorn et al., 2012). Another issue with studies examining the relationships between violence and mental illness is that many have results with extreme variances (Fazel, Gulati, Linsell, Geddes, & Grann, 2009). The mixed findings have occurred for three primary reasons: First, many studies compare past violent tendencies to a lifetime history of mental illness, which can compromise the temporal validity of results as it does not prove that mental illness was there prior to the violent outbursts. Second, samples are typically not representative of the general population of those with serious mental illness; instead, the populations typically come from those who have been hospitalized, and thus limits the ability to generalize the findings. Finally, rather than studying individual variables that may contribute to violence as a result of mental illness, researchers often do not control for potentially confounding variables, which, again, limits the ability to accurately distinguish the true predicting factor (Elbogen & Johnson, 2009).

In a two wave study conducted by the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), data indicated that those reporting recent violence with mental illness alone represented 2.9% of the population, while those who reported recent violence and were diagnosed with mental illness in addition to frequently using drugs and alcohol were 9.4% of the population (NESARC, 2006; Van Dorn et al., 2012). In the 2001 MacArthur Violence Risk Assessment Study, individuals who had mental illness alone were no more likely to be violent than non-substance users without mental illness (Stuart, 2003). The Macarthur Violence Risk Assessment Study also found that those individuals who had mental illness and exhibited violent behavior were less likely to target the general public than the control group (Stuart, 2003).

Summary

The literature reviewed suggests that the evidence regarding the relationship between mental illness and violent behavior is limited and inconclusive. There is strong evidence regarding co-occurring mental health and substance use disorders predicting a greater likelihood for violence. Moreover, the reviewed literature suggests many important biological, psychological, and sociological factors are not considered when determining the propensity for violent behavior in those with mental illness (Rueve & Welton, 2008). This review has provided the context for a policy analysis on Laura's Law.

CHAPTER 3

METHODOLOGY

The policy underlying Laura's Law was analyzed using Gil's Policy Analysis Framework (1992). This framework was adapted to focus on issues relevant to Laura’s Law as a result of perceived association of violence and mental illness. The framework had two primary objectives: first, to understand the issues surrounding the policy, and second to identify the effects or consequences occurring as a result of this policy’s implementation. To achieve these objectives, this policy analysis utilized three sections of the framework. The first section examined the problem Laura’s Law was intended to resolve by exploring the nature and scope of the issues. Causal theories were identified and examined, as well as overt and covert objectives of the policy. The values underlying the objectives of Laura’s Law were discussed, including the theoretical perspectives of the policy. The targeted population was described and the intended and unintended effects of the policy were identified and explored. Lastly, this analysis documented changes in resources, services, and rights since the implementation of the policy, and how these impacted social change.

Policy Analysis Framework

Section A: The Issue or Problem Constituting the Focus of a Social Policy Planning Task

1. Nature, scope, and distribution of the issue or problem.

2. Causal theory (ies) or hypothesis(es) concerning the dynamics of the issue or problem.

Section B: Objectives, Value Premises, Theoretical Positions, and Effects of a Specified

1. Policy objectives
2. Value premises underlying policy objectives
3. Theory or hypothesis underlying the strategy and the concrete provisions of the policy.
4. Target segment(s) of society - those intended to be directly affected by the policy.
   a) Demographic, biological, psychological, social, economic, political, and cultural characteristics
   b) Numerical size of relevant groups, projected over time
5. Short- and long-range effects of the policy on the target and non-target segments of the society in demographic, biological, psychological, social, economic, political, cultural, and ecological spheres.
   a) Intended effects (policy objectives)
   b) Unintended effects
   c) Overall costs and benefits (including economic and social costs and benefits)

Section C: Implications of the Policy for Social Structure and the Social Policy System

1. Changes in the development of life-sustaining and life-enhancing resources, goods and services.

a) Quantitative changes

b) Qualitative changes

c) Changes in priorities

2. Changes in the allocation, to individuals and to social units, of specific statuses within the total array of tasks and functions

a) Elimination of existing statuses, roles, and prerogatives

b) Development of new statuses, roles, and prerogatives

c) Changes in criteria for selection and assignment of individuals and social units to statuses

d) Changes in institutionalized relationships among statuses

Sampling

This study is a qualitative design, analyzing both primary and secondary data regarding Laura's Law. The primary source of data came from Assembly Bill 1421, also titled Laura's Law. Secondary sources of data included journal articles, government publications, law reviews, and books regarding violence as a result of mental illness.

CHAPTER 4

POLICY ANALYSIS

Nature, Scope, and Distribution of the Issue

The primary component of assisted outpatient treatment (AOT) being established was the idea that those who exhibiting symptoms of serious mental illness were more of a danger to the community without intervention. High-profile AOT policies were all implemented as a response to tragic circumstances resulting from symptoms of mental illness (Kiesly & Campbell, 2007).

There are a number of reasons behind the implementation of Laura's Law. According to a RAND report in 2001, one-half of all commitments were involuntary, including those with prior involuntary commitments, those with a diagnosis of schizophrenia or psychosis, and those who had no documented attempt at outpatient services (A. 1421, 2002). According to Assembly Bill 1421, many individuals considered high-risk do not respond to traditional outpatient treatment, and often do not seek services. This is directly related to the bill stating that the belief that those who enter involuntary treatment have had limited access to services is false (A. 1421, 2002). Assembly Bill 1421 states that Assertive Community Treatment (ACT) programs are extremely beneficial for those with serious mental illness, particularly with those who have schizophrenia and other psychosis, in that it lowered hospitalization and recidivism.

Causal Theories or Hypotheses Concerning the Dynamics of the Issue

Social control theory is relevant to the involuntary treatment process as it proposes that those who lack power and have access to fewer resources are more susceptible to coercive repercussions (Lincoln, 2006).

According to Markowitz (2011), while public knowledge of mental illness has increased in the past two decades, the belief that mental illness and danger are highly associated has increased as well. The endorsement of coercive treatment is often associated with the idea that an individual's mental illness is under their control, and that symptoms of mental illness are synonymous with dangerousness. This generates a reaction of coercive control that is a direct result of anger and fear (Markowitz, 2011).

The modified labeling theory and secondary deviance theories are subcategories of the stigma theory also related to coercive treatment (Link, Castille, & Stuber, 2008). Secondary deviances represent the societal responses to perceived problematic behaviors, and how those responses further separate those individuals who exhibit those behaviors. The modified labeling theory states that as a result of these secondary deviances, society develops negative misconceptions about mental illness and reacts accordingly, particularly if they have not experienced mental illness themselves (Link et al., 2008). Link et al. argue that because of these theories, those who experience mental illness may self-stigmatize, causing them to withdraw from treatment, linking back to the perceived need for coercive control.

The coercion to beneficial treatment perspective relates back to anosognosia, and the idea that some level of coercion is needed in mental health because of their lack of insight, which could create dangerous and detrimental consequences (Link et al., 2008).

Policy Objectives

The intent of Laura's Law was to provide more intensive community-based services to those with severe and persistent mental illness (A. 1421, 2002). This law was developed as a way to be able to provide mental health treatment to those who were seen to be in need of care but did not meet criteria for involuntary hospitalization (LACDMH, 2013a).

According to the 2001 RAND report, policy makers were focused on the high cost of those who consistently utilized acute psychiatric services. Reducing the use of these emergency services as well as jails and prisons to significantly reduce cost was a primary objective when considering involuntary community-based treatment (Ridgely, Borum, & Petrila, 2001).

Prevention was another objective behind Laura's Law. Families and other advocates proposed prior to the passing of Assembly Bill 1421 that the narrow criteria of the Letterman-Petris-Short Act be broadened (Ridgely et al., 2001). Proponents wanted the law to allow significant others to petition if the individual was considered gravely disabled (meaning they were deemed unfit to care for themselves) and were in need of treatment, and eliminate the requirement that they were a danger to themselves or others (Ridgely et al., 2001). Laura's Law did include these requests as a way to provide preventative services to those that did not meet involuntary inpatient requirements (Ridgely et al., 2001).

Value Premises Underlying Policy Objectives

Public safety is a core value underlying the objectives of Laura's Law. According to the LPS Reform Task Force II (2012), Laura's Law is an important policy to implement as it targets a small portion of the population, but one that poses a huge safety risk to others.

The RAND report stated that there had been an increase in homelessness among those with mental illness, prompting the community to question the quality of life of those individuals. These life circumstances were likely to make the individual to be considered gravely disabled, prompting a need for treatment (A. 1421, 2002; Ridgely et al., 2001).

Theory Underlying the Strategy and the Concrete Provisions of the Policy

Assembly Bill 1421 (2002) cites the importance of individuals getting services in the least restrictive environment. By receiving outpatient services, despite it being involuntary, the individual still has the ability to be involved in the community outside of treatment, which is necessary in their recovery and stability (A. 1421, 2002).

Target Segment(s) of Society

Laura's Law targets those 18 and older who have a severe and persistent mental illness. Criteria for involuntary outpatient treatment under Assembly Bill 1421 includes the following:

1. The individual must show signs of deterioration.
2. The individual must have a history of not adhering to recommended mental health treatment.
3. The individual has received involuntary mental health services at least twice within 36 months.
4. The individual has been a danger to self or others through serious or violent acts at least once within 48 months.
5. It is assumed that the individual would benefit from community-based treatment. (Cal. Welf. & Inst. Code §5346)

While forced medication is not allowed under Laura's Law, courts can mandate medication compliance as a condition of their AOT order (Cal. Welf. & Inst. Code §5348). According to Jarrett, Bowers, and Simpson (2008), many individuals coerced into taking medication were required to do so as a result of a court order, likely because they had not been compliant with voluntary medication rather than any one incident requiring forced medication.

For the purpose of Laura’s Law, serious mental illness includes Schizophrenia, PTSD, Bipolar, and other mood disorders that are persistent in nature and interfere with the individual’s ability to function independently without outside intervention (Cal. Welf. & Inst. Code § 5600.3).

Laura’s Law affects families, friends, and other community members who interact with those who have a mental illness. Laura’s Law gives anybody over the age of 18, who is either family or lives with the individual, permission to petition an investigation with the county health department for an AOT order (Cal. Welf. & Inst. Code § 5346).

According to Assembly Bill 1421 (2002), the implementation of Laura’s Law is voluntary statewide. For this law to take effect, the county board of supervisors must approve implementation, and the county must include the program’s funding estimate in their annual fiscal plan. Once established, MHSA funding could be used toward the cost of implementation, as well as any other funds for mental health services distributed from the Controller (Cal. Welf. & Inst. Code §5349).

In order for counties to utilize AOT services, a report by a qualified petitioner must have been issued to the county health department (Cal. Welf. & Inst. Code §5346). Once petitioned, a licensed mental health professional must have visited the individual being petitioned for assessment. If the clinician believed the individual met criteria or was in need of services, they must have been offered on a voluntary basis at least 10 days prior to submitting a petition to the courts. If the provider was unable to engage the individual for voluntary services and believed the individual met criteria for AOT services, the county mental health director must then file a petition including sufficient evidence that all criterion were met (Cal. Welf. & Inst. Code §5346). The clinician must be willing to testify in person during the established court hearing.

California Welfare and Institutions Code §5346 states that once the courts have been petitioned, a date is set for a civil hearing. The individual being petitioned has the right to counsel and to be present at the hearing. While reasonable attempts to bring the individual to the hearing must be made, their presence is not required for the case to be heard and ruled upon. If the individual does not agree to the initial examination the courts have the authority to appoint a clinician to perform the assessment. If the individual still does not consent to the examination, the courts have the authority to order a 5150 for the individual to be evaluated involuntarily. If the courts are in agreement that criteria have been met for mandated services, they can require AOT for up to six months, with the understanding that a follow-up hearing could extend this sentence depending on the progress (or lack thereof) of the individual (Cal. Welf. & Inst. Code §5346). Assembly Bill 1421 (2002) strictly prohibits the use of AOT services as a means of punishment or time served in criminal courts, as the law is a civil matter.

When the Senate Floor proposed the most recent extension of the sunset date in 2012, a number of organizations were in support of this, including the California Psychiatric Association, California Probation, Parole, and Correctional Association, NAMI California, and the California Medical Association (A. 1569, 2012). Supporters of this extension agreed that voluntary mental health services are not 100% effective, and (once again), anosognosia clouded the judgment and ability of an individual with a serious mental illness to seek appropriate services (A. 1569, 2012). Supporters argued that these individuals fell between voluntary and involuntary treatment, thus creating the need for AOT services (A. 1569, 2012). Supporters also cited the positive fiscal impact Laura's Law had on Nevada County, as well as the need to target the revolving door epidemic (A. 1569, 2012).

Opposition to the extended sunset date brought forth in Assembly Bill 1569 (2012) included agencies such as Mental Health America of California, California Association of Mental Health Patients' Rights Advocates, California Association of Social Rehabilitation Agencies, Disability Rights California, and American Civil Liberties Union of California. Those opposing this bill disagreed with AOT services as they strongly felt that any involuntary services were a direct violation of an individual's due process rights. They argued against the concept of anosognosia and extreme resistance to treatment as the reason for needing AOT services, and instead argued that there are a lack of services available to those willing to accept them (A. 1569, 2012). Opponents stated that Laura's Law was inconsistent with the core components of the recovery model that California had adopted, and that the state should, instead, expand upon existing voluntary programs (A. 1569, 2012).

The 2013-2014 report in Nevada County showed a disproportionate number of Caucasian individuals receiving AOT services; only 12.5% (collectively) were minority groups, though the breakdown of who was court-ordered and who was voluntary was not provided. According to Nevada County's city data, however, these percentages are representative of the population as a whole (City-data, 2012). Swanson et al. (2009) analyzed data taken from Kendra's Law in New York, with results showing a disproportionate number (35% of the total 17% population in the state) of African Americans were court-ordered for AOT services compared to their Caucasian counterparts (33% of the total 61% of the population). These results were attested to other factors, such as poverty and funding toward public health care, as African Americans tended to utilize public services more than Caucasians (Swanson et al., 2009). These are barriers that exist nationwide, so it could then be assumed that AOT services under Laura's Law would, eventually, deliver the same results statewide.

Upon full implementation in Los Angeles County, Laura's Law is intended to expand Full Service Partnerships (FSP) to accommodate 300 enrollees at any given time, with approximately 500 evaluations being completed annually (Los Angeles County Department of Mental Health [LACDMH], 2013b). Additionally, Urgent Care Centers (UCC) will be established as an alternative to hospitalization and arrest, and up to 60 residential crisis beds (also referred to as IMD step down programs) will be available to enable individuals recovering from crisis (including homelessness) to stabilize, receive medication, and develop rehabilitation skills to effectively reintegrate into the community (LACDMH, 2014a). Assembly Bill 1421 (2002) explicitly states that no existing voluntary services can be minimized to make room for court-ordered referrals.

In 2014, Orange County voted unanimously to adopt Laura's Law. In the most current MHSA three year fiscal plan for Orange County, the annual budget for Laura's Law implementation is $4.4 million, with an estimated 125 individuals being served each year (Orange County Health Care Administration [OCHCA], 2014).

Placer County board of supervisors also adopted Laura's Law in 2014. The county's 2014-2015 fiscal plan included an estimated $400,000 cost per year for implementation, using only state mental health funds (Placer County Health and Human Services [PCHHS], 2014). The county anticipated a small number of referrals per year (approximately 20), with some of those agreeing to voluntary services (PCHHS, 2014).

Intended Effects

The intended objectives of Laura's Law, as was the case with most AOT programs, were to reduce the revolving door epidemic plaguing the criminal justice and hospital systems (Stettin, 2014). The objectives were to reduce violent behaviors, incarceration, homelessness, and to improve quality of life of those with serious mental illness (Cal. Welf. & Inst. Code §5348).

Cost effectiveness has been consistently mentioned as a benefit to counties implementing Laura's Law. The idea is that early intervention can not only prevent tragedy, but will also cut costs as the more a person has deteriorated, the more costly their treatment will inevitably be (LPS Reform Task Force II, 2012). In Nevada County's pilot program, 17 individuals entered AOT for a little over two and a half years. The total amount the county paid for AOT services was $428,443. The year prior to the participants entering AOT, each participant incurred $425,100 in hospitalizations and/or incarceration, whereas during participation, the costs reduced to $136,200. Nevada County estimated that the amount they would have spent without AOT for the two and a half years the participants were involved was close to $1.2 million (Nevada County Grand Jury, 2012). Nevada County published AOT results between May 2013 and April 2014, stating that of 40 individuals served under ACT, 19 were court-ordered (Providence Center, 2014). While the results did show an overall decrease in hospitalizations, homelessness, and incarceration, thus still maintaining the premise of cost effectiveness, 75% of the hospitalizations, 76% of arrests, and 69% of homeless days accrued were from those who were court-ordered (Providence Center, 2014).

Unintended Effects

One of the most prominent unintended effects was the lack of ability to enforce this policy. Under Assembly Bill 1421, if an individual is non-compliant with an AOT court order, a licensed clinician can have the individual involuntarily taken to a hospital for evaluation; however, if the individual does not meet criteria for an involuntary hold, the individual must be released according to criteria established from the Lanterman-Petris-Short Act (Cal. Welf. & Inst. Code §5346). This directly contradicts one of the primary objectives of Laura's Law: to eliminate the revolving door epidemic.

Another unintended effect was the responsibility of legal fees for the petition process. Under Assembly Bill 1421, MHSA funds are only available to be used for a provision of services, which does not include administrative or legal costs (Cal. Welf. & Inst. Code §5349). According to the California Welfare and Institutions Code §5346, legal fees are to be paid by the individual if they are able to. This, then, bares the question of who is responsible for the legal fees if the individual is unable to acquire the funds themselves. It is also unknown whether or not assistance is available for individuals who are unable to pay out of pocket, or if there are any legal repercussions if the fees are not paid.

The lack of ability to implement Laura's Law statewide is also an unintended effect. From its inception through present time, Assembly Bill 1421 has been an elective implementation county-by-county basis, and only if it's a majority vote (Cal. Welf. & Inst. Code §5349). Proponents of Laura's Law have been arguing to change this requirement and develop a more concrete statewide expansion for implementation (LPS Reform Task Force II, 2012).

Overall Costs and Benefits

Initially, a lack of funding prevented other counties from implementing Laura's Law, as it was unclear in the initial MHSA bill whether funds could be used for this policy (S. 585, 2013). In 2011, Governor Jerry Brown authorized the use of MHSA funds for the implementation of Laura's Law, allowing for an annual budget specifically allocated for AOT programs (S. 585, 2013). According to the most recent MHSA 3 Year Fiscal Report, Medi-Cal is also providing funding for Laura's Law (LACDMH, 2014a). The MHSA funding for FSP teams and other inclusive services is estimated around \$5.3 million, with \$1.2 million of that going directly toward step-down programs. Medi-Cal is providing additional funding of approximately \$4.7 million for AOT services. Collectively, the annual estimated total to implement Laura's Law in Los Angeles County is \$10,032,000 (LACDMH, 2014b).

Changes in the Development of Life-Sustaining and Life-Enhancing Resources, Goods and Services

While Nevada County was the only county fully implementing Laura's law until 2014, there are currently seven of the 58 counties in California that have proposed the implementation (County of Orange Health Care Agency [COHCA], 2011). The board of supervisors in Los Angeles County proposed a full pilot implementation of Assembly Bill 1421 in 2004. Due to a law suit by opponents of the implementation, an alternative pilot program similar to Laura's Law was developed that removed all references to Assembly Bill 1421, as the law requires proceedings to be that of a civil matter and not criminal, and was limited to service a small population of those who had committed low level crimes (COHCA, 2011). Currently, Los Angeles County has developed a plan for implementation of Laura's Law but has not set a date to initiate these plans.

The supervisor of the San Francisco County board of directors proposed the implementation of Laura's Law in 2010, but legislation never voted on it (San Francisco Department of Public Health [SFDPH], 2014). In 2011, an alternative, voluntary AOT program titled the Community Independence Placement Project was piloted, which aimed to encompass both mental health and substance use for those reentering the community from the criminal justice system. While a full implementation of Laura's Law was proposed by the mayor in 2014 with the intention of taking it to the November 4, 2014 election, it did not appear on the ballot (Department of Elections, 2014; SFDPH, 2014).

Yolo County became the second county to fully implement Laura's Law after a year-long pilot program implemented in 2013. In June of 2014, the Yolo County board of supervisors voted 4-1 to make Laura's Law a permanent implementation, allowing for five openings through MHSA and Medi-Cal funding (Yolo County Department of Health Services, 2014).

In August of 2014, Placer County was the sixth county to adopt Laura's Law (PCHHS, 2014). The county projected a four month period in late 2014 that would be dedicated to program planning, hoping to officially implement the law in January of 2015. Currently, there is no update on the program's development.

As of February 2015, Contra Costa County voted to implement Laura's Law (Contra Costa Health Services, 2014). The program itself has not been designed, nor has a budget been established. The county established a meeting date of April 2015 in an attempt to review the discretionary funds available to use toward implementation (County of Contra Costa, 2014).

Fear and the ability to take action in the wake of crises was the driving force behind the implementation and rallying for Laura's Law. A number of interest groups, including the Treatment Advocacy Center, NAMI, and MentalIllnessPolicy.org, have established agendas to push the implementation of Laura's Law, as well as H.R. 3717, nationwide. It is important to consider that NAMI is publicly known to be funded by major pharmaceutical corporations. Treatment Advocacy center explicitly states they are not funded by corporations that distribute drugs, however, they are largely supported by the Stanley Medical Research Institute, a major mental health and repurposed drug research corporation (NAMI, 2014; Stanley Medical Research Center, 2008). Though literature has stated medication is not necessarily the best treatment option for serious mental illness, organizations such as these with support from major drug corporations could potentially prevent future development and implementation of more comprehensive alternatives (Deacon, 2013).

Serious mental illness still remains a priority in the implementation of Laura's Law in various counties, particularly with individuals who are perceived to have a history of resistance to treatment. Other counties (such as Alameda County) who have yet to obtain the approval of their county board continue to push for the implementation of Laura's Law to provide AOT services for the same priorities: increased treatment compliance for those with serious mental illness (Alameda County Behavioral Health Care Services [ACBHCS], 2013).

Changes in the Allocation, to Individuals and to Social Units, of Specific Statuses within the Total Array of Tasks and Functions

Under Senate Bill 585 (2013), AOT services were to be paid for by federal funds, insurance, and other mental health funding. Counties were allowed access to funds from the Mental Health Subaccount, the Mental Health Equity Subaccount, Vehicle License Collection Account of the Local Revenue Fund, Mental Health Account, and the Behavioral Health Subaccount within the Support Services Account of the Local Revenue Fund to supplement the costs that insurance would not cover (S. 585, 2013). The U.S. Mental Health Parity and Addiction Equity Act of 2008 restricted insurance companies from limiting mental health services provided under group policies, but was amended under the Affordable Care Act to extend to individual plans as well (CHCA 2013; United States Department of Labor, 2010). Also under the Affordable Care Act was the Medicaid expansion, which was estimated to extend eligibility for up to 2 million individuals in California, with approximately 124,000 requiring mental health services (CHCA, 2013).

The sunset date (meaning the date it ceases to have effect) of Laura's Law has been extended multiple times. Originally, it was supposed to sunset in 2008, which was extended to 2013, then finally (and currently) 2017 (S. 585, 2013).

Under Laura's Law, courts would play a much more prominent role in the oversight of AOT services within counties, as they would ultimately decide how many individuals would be under a court order and whether or not referrals qualified for services (Cal. Welf. & Inst. Code §5346).

Currently, any person who is 18 years of age or older, resides in the same household, is a spouse or blood relative, or oversees an agency in which the individual being petitioned resides or receives services has the ability to request an evaluation for AOT services (Cal. Welf. & Inst. Code §5346). This puts relatives and loved ones in a position of power over the individual, which was ultimately the purpose of organizations such as NAMI petitioning for this change after the initial implementation of Laura's Law (Ridgely et al., 2001). This could, however, be seen as coercion by the individual being petitioned as they had little to no control over the matter, potentially creating hostility within relationships (Link et al., 2008).

Once petitioned, individuals have five business days from the date the petition was submitted to the court to review the request, acquire an attorney if they choose, and prepare their defense against the petition (Cal. Welf. & Inst. Code §5346).

The Strengthening Mental Health in Our Communities Act of 2014, also called H.R. 4574, aimed to address the most critical problem we face—the unavailability of community-based services, and the impact the services provided have within the targeted population (H.R. 4574, 2014). This act would require more federal accountability in community mental health services, diversion programs in the criminal justice system, preventative programs for emotionally disturbed youth, and same-day access to behavioral health services in primary care settings. This act would also eliminate certain ceilings, such as the 190-day lifetime inpatient treatment cap, that are currently in place, and re-establish mental health block grants (H.R. 4574, 2014).

Though we currently have services that enable individuals with serious mental illness to succeed on their own and within their communities, many individuals who would benefit from these services do not have access to them. As a result, many individuals deteriorate to the point of necessitating coercive treatment (such as hospitalization or incarceration), costing counties and states more money when these outcomes could have potentially been avoided had access to comprehensive services been available (Bazelon Center for Mental Health Law, 2014).

The Affordable Care Act would allow those who were insured to be covered for AOT services under Laura's Law, as the CHCA (2013) listed provisions for coverage of community-based treatment were implemented. While the Medicaid expansion allowed for more involuntary hospitalizations under insurance plans, it is unknown how or if hospitalizations as a result of non-compliance of an AOT court order would be counted as a hospitalization.

Services under Laura's Law were to be provided by community-based, multidisciplinary mobile teams who handled a relatively small case load of ten individuals per team (Cal. Welf. & Inst. Code §5348). California Welfare and Institutions Code §5348 stated that services provided by the teams could include (but were not limited to) family outreach and education, access to medication, psychiatric services, substance abuse services, housing assistance, vocational rehabilitation, and services for veterans. Services for Transition Age Youth (TAY), individuals with disabilities, and older adults should be provisioned to meet the needs of these individuals (Cal. Welf. & Inst. Code §5348). All providers within the team should be educated and trained to meet the cultural and linguistic needs of individuals being served under Laura's Law. California Welfare and Institutions Code §5348 stated that under this act, all services should be a collaborative effort aligned with the recovery model principles, though what principles should be highlighted as well as ways in which these mandated services could be provided under the recovery model was not explicitly stated.

The criteria warranting a petition for AOT services under Laura's Law have remained the same since the act was established in 2002.

The Helping Families in Mental Health Crisis Act of 2013 (also referred to as "Murphy's Bill" after Rep. Tim Murphy [R-PA-18]) is still currently pending in Congress, but this act would establish four-year pilot programs to oversee and monitor AOT programs (H.R. 3717, 2013). H.R. 3717 would also allow up to 50 grants each year only to counties and cities who were providing AOT services and agreed to implement these pilot programs. As with H.R. 4574, it would also allow both mental health and primary care same-day services to be billed under Medicaid (H.R. 3717, 2013). With this bill, however, it allows family members and/or caregivers to have control over the release of information without the individual's consent, essentially allowing for conservatorship as they would be allowed to make treatment decisions for the individual (H.R. 3717, 2013). The focus of this act was expansion of psychiatric services to individuals who have a mental illness, as well as children with emotional disturbances. It would also effectively limit SAMHSA programs regarding services they could provide, eliminate unauthorized SAMHSA programs (e.g., peer support programs), and restrict lobbying within agencies accepting federal funding, essentially eliminating the ability for the Protection and Advocacy for Individuals with Mental Illness to advocate for clients (H.R. 3717).

CHAPTER 5

CONCLUSION

The literature reflects both positive and negative aspects of Laura's Law. This policy was, ultimately, created to make the public feel safe, give family members more control over the treatment options of their loved ones, and to provide more options for treatment to those with serious and persistent mental illness (A. 1421, 2002). While it has been stated in literature that AOT services under outpatient commitment effectively reduce hospitalizations, incarcerations, and homelessness, the levels in which they are actually effective for court-ordered individuals is questionable, as are the methods in which these factors are counted (Providence Center, 2014).

Counties have begun proposing the full implementation of Laura's Law at a rapid pace. Many counties who currently provide intensive case management services have brought forth the proposal to the board of supervisors to expand the range of services they are able to provide (Alameda County Department of Public Health, 2014). While a number of counties have approved the development of programs under Laura's Law, only two counties are actually implementing the policy (Yolo County Department of Health Services, 2014). This still leaves the vast majority of counties electing not to implement this law, which raises questions as to how effective or necessary it is perceived to be statewide.

California has adopted the recovery paradigm for mental health services (CDHCS, 2012). While Laura's Law was written with the intent of utilizing recovery practices in the services provided, the ways in which core principles such as client self-determination and empowerment as well as collaborative treatment can be utilized under a court order still has yet to be demonstrated. While literature suggests it is not unlikely for mandated individuals to engage with their provider or to benefit to some extent from services provided, the underlying coercive factor is likely to be a barrier to treatment that would not be present if the individual was seeking treatment voluntarily (Swartz et al., 2010).

While the intentions of Laura's Law appears to be good, the overarching concept of separating mandated services and the criminal justice system while effectively being able to implement these programs are fundamentally flawed. Without any method of accountability if the individual is not compliant with treatment, there is no concrete way to enforce this law without involving the criminal justice system. Instead, individuals who choose not to comply with their order will continue to cycle through hospitals for evaluation then exit back into the community until there is probable cause for another involuntary evaluation, still leaving counties with the revolving door epidemic (Cal. Welf. & Inst. Code §5346).

Policy Alternatives

Literature (including those that advocate for Laura's Law) has referenced ACT as a highly effective treatment model for those with serious mental illness, as well as co-morbid substance use (Herman, 2014; Lamb & Weinberger, 2011). ACT consists of a multidisciplinary team that works intensively with an individual to develop life skills, independent living skills, positive role models, and healthy relationships within the community (Herman, 2014). This model also emphasizes self-determination and family support, which aligns with the recovery principles California claims to practice by (Herman, 2014). Herman states that ACT has effectively reduced hospitalizations, increased the willingness of the individual to continue treatment, and created better housing outcomes. While there is a heavy emphasis on treatment compliance, it is still voluntary in nature and targets many of the same objectives Laura's Law intends to.

San Diego County has implemented, with successful results, an in-home outreach team (IHOT) to engage individuals in the community with serious mental illness identified to potentially benefit from services (County of San Diego Health and Human Services Agency [CSDHHSA], 2013). While this team does not directly provide mental health services, their goal is to engage individuals, and build trust and relationships that would pave the way for linkage with outpatient services they will feel comfortable enough to utilize (CSDHHSA, 2013). FSP teams, an extension of ACT, have also been implemented in San Diego County, as well as within many community mental health agencies (CSDHHSA, 2013).

Alameda County requested to establish something similar to IHOT in their recommendation to the county board of supervisors, as efforts to implement a pilot program for Laura's Law have been opposed on numerous occasions. Alameda County has also requested development of co-occurring FSP teams to provide both mental health and substance use outpatient services (ACBHCS, 2014). These recommendations have been alternative treatment options to target the same population Laura's Law is targeting on a voluntary basis (ACBCHS, 2014).

As is the case with most proposed policies to address a social problem, Laura's Law simply skims the surface of the issue at hand. The problem is not solely serious mental illness and its correlation with violence; the primary problems are the biological, sociological, economic, and political systems that collectively stigmatize and create barriers for individuals with mental illness from receiving preventative services (Rosenberg, 2014; Rueve & Welton, 2008; Van Dorn et al., 2012). This biopsychosocial approach is what drives the profession of Social Work. Laura's Law states that, despite what proponents claim, the issues at hand are not a direct result of lack of access to services (A. 1421, 2002); however, agencies who successfully and directly provide services to individuals with serious mental illness maintain that is a core issue within community mental health services (A. 1569, 2012).

Multicultural Implications

Literature has shown that those most in need of mental health services, and who have the most access to mental health services, are predominately Caucasians; yet it is primarily African Americans that receive coercive treatment. This may be a result of the lack of access to mental health services in minority groups, be that because of socioeconomic status, lack of insurance, geographic location, stigma, or a number of other barriers these groups face (Primm et al., 2010). With the Affordable Care Act, more individuals than ever qualify for public health insurance such as Medicaid, which requires mental health services to be covered (CHCA, 2013). This may influence more individuals who did not receive services as a result of lack of insurance to voluntarily seek services; however, for those experiencing other barriers, efforts to establish more accessible services have to be made.

Implications for Social Work

As social work is fast-growing in the mental health field, many social workers may be faced with agencies that are implementing AOT services. Social workers should have more knowledge of what Laura's Law actually entails, and the consequences of its implementation (both positive and negative) in an effort to become educated and maintain cultural competence, as outlined in the NASW Code of Ethics (NASW, 2008).

Social workers also have a duty to respect an individual's right to privacy, self-determination, provide services that benefit the individual, and respect the individual's right to refuse services (NASW, 2008). Under Laura's Law, social workers may encounter ethical and value dilemmas as they are legally obligated to provide mandated services. This is not something social workers are unfamiliar with, as many in the profession work with mandated individuals for substance use, parenting classes, anger management, etc. It is important, then, for social workers who are working with mandated individuals to collaborate with the individual and create a reasonable, partnered treatment plan that is both aligned with the individual's and the profession's values (NASW, 2008).

Social Work Speaks (NASW, 2012) stated that as a whole, the profession of social work in regard to the field of mental health did not align with coercive treatment; however, when faced with AOT services, social workers should, to the best of their ability, find a balance between the best interest of the individual, families, the public, and the individual's rights.

For the social work profession, NASW (2012) stated that research, education, and funding was integral to continuing to find the best possible treatment options for individuals with serious mental illness. Social workers should continue to advocate for more evidence-based, culturally competent interventions at the organizational and political level to ensure that marginalized populations are given access to the best possible treatment options, and improve the overall quality of care (NASW, 2012).

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