Introduction

• Major problems underlying policy
  • Difficult to enforce (Sabella, 2014)
  • Perpetuates the idea that mentally ill individuals are violent and to be feared when association is moderate (Van Dorn, Volavka, & Johnson, 2012)
  • Further perpetuates stigma associated with mental illness (Rueve & Welton, 2008)

• Goals/Purpose of project
  • Analyze the policy from a social work and recovery-oriented perspective
  • Establish the effectiveness of involuntary outpatient treatment (IOT) as evidenced in literature
Social Work Resonance of the Policy

• Multicultural Relevance
  • Racial/ethnic minorities are disproportionately represented in inpatient treatment and insufficiently represented in outpatient treatment (Primm et al., 2009; Swanson et al., 2009)
    • Caucasians have more access to community mental health services, though the need for IOT laws have been emphasized using crimes committed by White men
    • Racial minorities have less access to community mental health services due to structural barriers

• SW Implications (National Association of Social Workers [NASW], 2008, 2012)
  • NASW policy statement is in direct conflict of coercive implications of Laura’s Law
  • NASW Code of Ethics promotes cultural competence; this includes public education of risk factors associated with mental illness
  • Advocating to reduce stigma associated with mental illness
Literature

• Those with serious mental illness (SMI) have received coerced treatment dating back to 1800s [state asylums; cruel experimental “treatments” (e.g., lobotomy, sterilization, electroconvulsive treatment)] (Getz, 2009; Grob, 1994; Sharav, 2005).

• Post-war era introduced psychotherapy and psychopharmaceuticals (such as Thorazine) (Grob, 1994).

• Community mental health services began with Kennedy’s 1963 Community Mental Health Centers Act, though Reagan’s Omnibus Budget Reconciliation Ace of 1981 significantly reduced funding to community mental health services, reversing decades of activist efforts and shifting control back to states (Frank & Glied, 2006; Harcourt, 2012).

• 2000s brought back community mental health focus, but prisons/jails still house a disproportionate number of individuals with SMI (L.D. Miller & Moore, 2009; Slate & Johnson, 2008).

• Lanterman-Petris-Short Act (LPS) of 1969 introduced guidelines for involuntary hospitalization (W. Fisher & Grisso, 2010).

• Other IOT programs, such as New York’s Kendra’s Law, were referenced to justify coercive treatment (Swartz et al., 2010).

• Biomedical model has been used more often in treatment of mental illness despite the lack of medically diagnostic tests required for diagnosis; focus on dissolution of symptoms in reference to recovery (Deacon, 2013; Slade, 2009).

• Mental health professionals have been shifting to recovery-oriented care, focusing on four core components of hope, empowerment, personal responsibility, and meaningful roles as well as coping with symptoms associated with mental illness in day to day life (Slade, 2009).

• Stigma (societal and self-stigma) plays a significant role in the estimated 50% of adults who do not receive treatment for SMI (California Health Care Almanac, 2013; Corrigan, Druss, & Perlick, 2014; Corrigan & Rao, 2012).

• High variances in study results limits the ability to generalize findings; suggests evidence of relationship between mental illness and violence is limited and inconclusive, likely due to lack of consideration of biological/psychological/sociological factors and other confounding variables when determining propensity for violent behavior in those with SMI (Rueve & Welton, 2008; Van Dorn et al., 2012).
Methods

- Gil’s 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
Methods (cont.)

• Data sources
  • Primary
    • Assembly Bill 1421 (Laura’s Law)
  • Secondary (regarding violence as a result of mental illness)
    • Journal articles
    • Government publications
    • Law reviews
    • Books
Policy Analysis

• Nature, Scope, and Distribution of the Issue
  • Those with SMI are more of a danger to the community without intervention (Kiesly & Campbell, 2007)
  • Assisted outpatient treatment (AOT) policies were implemented as a response to tragedy associated with SMI (Kiesly & Campbell, 2007)
  • Assembly Bill 1421 (2002) states that most “high-risk” individuals do not respond to traditional treatment and/or do not seek out services, thus creating the need for coercive treatment

• Causal Theories or Hypotheses Concerning the Dynamics of the Issue
  • Social Control Theory: Lack of power and access to resources increases susceptibility to coercive repercussions (Lincoln, 2006)
  • Modified labeling theory/secondary deviance: Societal responses can lead to negative misconceptions about SMI, resulting in negative reactions (Link, Castille, & Stuber, 2008)
  • Coercion to beneficial treatment perspective: lack of insight of SMI (anosognosia) creates dangerous and detrimental consequences (Link et al., 2008)

• Policy Objectives
  • Increased community-based treatment for those with serious and persistent mental illness (A. 1421, 2002)
  • Reduce costs associated with acute psychiatric services and incarceration (Ridgely, Borun, & Petrila, 2001)
  • Prevention of tragedy (Ridgely et al., 2001)

• Value Premises Underlying Policy Objectives
  • Public safety (LPS Reform Task Force II, 2012)
  • Quality of life/need for treatment for those with SMI (A. 1421, 2002; Ridgely et al., 2001)

• Theory Underlying the Strategy and the Concrete Provisions of the Policy
  • Services in the least restrictive environment (A. 1421, 2002)
Policy Analysis (cont.)

- Target Segment(s) of Society (Cal. Welf. & Inst. Code §5346)
  - 18+ with SMI
  - History of noncompliance with treatment
  - History of involuntary mental health services within past 36 months
  - Danger to self or others/serious or violent act at least once within past 48 months
  - Assumption that individual would benefit from community-based treatment

- Intended Effects
  - Reducing revolving door epidemic; cost effectiveness; reduction of violent behaviors, incarceration, homelessness; and improving quality of life ((Cal. Welf. & Inst. Code §5346); Stettin, 2014)

- Intended Effects
  - Lack of ability to enforce; legal fees for petition process due to inability to use Mental Health Services Act (MHSA) funds for court fees; lack of ability to implement statewide (Cal. Welf. & Inst. Code §5346)

- Overall Costs and Benefits
  - MHSA funding: $5.3 million; Medi-Cal: $4.7 million; Total funding: $10,032,000 (LACDMH, 2014b)

- Changes in the Development of Life-Sustaining and Life-Enhancing Resources, Goods, and Services
  - Nevada County and Yolo County are the only two in California to fully implement Laura's Law (Yolo County Department of Health Services, 2014)
  - Orange County, Los Angeles County, Placer County, Contra Costa County have approved proposals to implement Laura's Law (Contra Costa Health Services, 2014; Orange County Health Care Administration, 2014; Placer County Health and Human Services, 2014)
  - Interest groups supporting Laura's Law are primarily funded by major pharmaceutical corporations; this could prevent future development/implementation of alternative treatments (Deacon, 2013)

- Changes in the Allocation, to Individuals and to Social Units, of Specific Statuses within the Total Array of Tasks and Functions
  - Senate Bill 585 (2013) stated AOT services were to be paid for by federal funds as well as county mental health funds
  - Medicaid expansion under Affordable Care Act extended eligibility of services for up to 2 million individuals
  - Sunset date of Laura's Law has been extended three times; current date is in 2017
  - H. R. 5474 is still pending in Congress; allows family members conservatorship over treatment options, limits SAMHSA programs and eliminates peer-run groups
Summary of Strengths/Challenges

• **Strengths/Challenges of the Policy**
  • **Strengths**
    • Focus on community mental health in the least restrictive environment
    • Provides more treatment options
    • Includes family/gives them more control over well-being of loved ones
    • Focus on public safety (A. 1421, 2012)
  • **Challenges**
    • Difficult to enforce (Sabella, 2014)
    • Coercive in nature (NASW, 2012)
    • Perpetuates societal stigma/fear of violence and mental illness when association is moderate (Rosenberg, 2014)
    • Results of effectiveness are questionable (Providence Center, 2014)
    • Difficult to align with recovery paradigm (Swartz et al., 2010)

• **Policy’s Impact on social work clients/oppressed groups**
  • Ethnic minorities, particularly African Americans, are more likely to receive coercive treatment (Swanson et al., 2009)
  • Social workers must work under NASW Code of Ethics (NASW, 2008, 2012)
    • Should be knowledgeable of what the law entails to maintain cultural competence
    • Educate public on statistics of violence and SMI and advocate on behalf of the population to address stigma
    • Coercive treatment does not align with Code of Ethics, but balance between best interest of families/public/individual’s rights must be attained

Cal. Well. & Inst. Code § 536.6


