

PSYCHOTROPIC MEDICATION IN CALIFORNIA: A PRESCRIPTION FOR ALTERNATIVE APPROACHES

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MISS FLINN. It's just medication, Mr. Taber, good for you. Down it goes, now.

MR. TABER. But I mean what *kind* of medication

. . . .

Miss, I don't like to create trouble. But I don't like to swallow something without knowing what it is, neither. How do I know this isn't one of those funny pills that makes me something I'm not?

— Ken Kesey, *One Flew Over the Cuckoo's Nest*

I. INTRODUCTION

An eleven-year-old girl from Los Angeles exhibits the normal tendencies of a preteen: she throws tantrums, is combative, and shows fear.¹ To be on the safe side, her mother brings her to a psychiatrist.² The girl leaves the appointment with a diagnosis of bipolar disorder and a prescription for *ten* different psychotropic medications—a mix of antimaniacs, anticonvulsants, and antipsychotics.³ Her mother's choice is not an easy one. Acting for her daughter's future-self based on scant

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¹ Melissa Healy, *The Push to Label*, L.A. TIMES (Nov. 5, 2007), <http://articles.latimes.com/print/2007/nov/05/health/he-psyckids5>.

² *Id.*

³ *Id.*

information on the side effects of psychotropic medications on children, “suspicion that the psychiatric profession is as confused about diagnosing and treating mental illness in children as she is,”⁴ and the potential of turning her daughter into a lifelong patient when her “problems” may disappear with age, should the mother refuse or medicate?

Kelly Thomas of Orange County was diagnosed with schizophrenia in his early twenties.⁵ He agreed to take psychotropic medication.⁶ After spending the time to find the right medication at the right dose, he concluded that everything was fine and stopped taking it, even though his father thought he “was better when he was on medication.”⁷ He began to live on the streets.⁸ In July 2011, he was horribly beaten, tased, and suffocated to death by police officers who were investigating a routine call and appeared unprovoked.⁹ The officers are now charged with murder.¹⁰ Could his death have been prevented with stronger community-based mental health programs that would have gotten him off the streets, provided therapy for his severe mental disability, and helped him make a more informed decision on whether to stop taking psychotropic medication?

Diane Rodrigues of San Jose was diagnosed with schizophrenia when she was twenty-eight.¹¹ The former kindergarten teacher grew up in a

⁴ *Id.*

⁵ *Police Beat Homeless Fullerton Man Kelly Thomas to Death*, HUFFINGTON POST (Sept. 26, 2011, 6:12 AM), http://www.huffingtonpost.com/2011/07/27/police-beat-homeless-full_n_911419.html.

⁶ Steve Lopez, *Kelly Thomas' Father Fights for Justice*, L.A. TIMES (Aug. 6, 2011), <http://articles.latimes.com/print/2011/aug/06/local/la-me-0807-lopez-kellythomas-20110805>.

⁷ *Id.*

⁸ Carmelo Valone, Op-Ed., *My Kelly Thomas Moment*, L.A. TIMES (Mar. 11, 2012), <http://articles.latimes.com/print/2012/mar/11/opinion/la-oe-valone-police-and-mental-illness-and-kelly-t-20120311>.

⁹ Abby Sewell & Richard Winton, *Kelly Thomas: D.A. Charges Two Officers with Murder, Manslaughter*, L.A. TIMES (Sept. 21, 2011, 11:16 AM), <http://latimesblogs.latimes.com/lanow/2011/09/da-announces-kelly-thomas-murder-charges.html>; Anna Almendrala, *Kelly Thomas Beating Video: Fullerton Homeless Man's Beating Revealed at Pre-Trial Hearing*, HUFFINGTON POST (May 8, 2012, 1:31 PM), http://www.huffingtonpost.com/2012/05/08/kelly-thomas-beating-video_n_1499771.html; R. Scott Moxley, *The Face of Kelly Thomas v. the Face of John Chamberlain*, OC WEEKLY (Aug. 10, 2011, 9:45 AM), http://blogs.ocweekly.com/navelgazing/2011/08/john_derek_chamberlain.php.

¹⁰ Sewell & Winton, *supra* note 9.

¹¹ Lee Romney & John Hoeffel, *California State Mental Hospitals Plagued by Peril*, L.A. TIMES (Apr. 15, 2012), <http://articles.latimes.com/print/2012/apr/15/local/la-me-mental-health-20120415>.

“close-knit . . . family with six siblings.”¹² While receiving treatment at Metropolitan State Hospital near Los Angeles, she “repeatedly somersaulted off her bed . . . in response to voices.”¹³ She was given Benadryl, an over-the-counter antihistamine and sedative, instead of being restrained or given a more powerful psychotropic medication.¹⁴ It did not help.¹⁵ When she flipped onto the floor again, she broke her neck and was paralyzed.¹⁶ She died of related causes in May 2010.¹⁷ Should she have been allowed to choose how staff would handle her psychotic episodes from a range of options such as psychotropic medication, seclusion, or restraint?

These tragic stories and looming questions highlight problems with the role of psychotropic medication in California’s mental health care system. Change is on the horizon, but the rights of those with severe mental disabilities must not be swept under the table in the process. Patient choice must be the primary consideration in treating severe mental disability with psychotropic medication. Further, the circumstances under which the state can force those with severe mental disabilities to take psychotropic medication must continue to be defined with an equal emphasis on patient rights.

This article analyzes the use of psychotropic medication in California’s mental health care system and advocates for a patient-centered approach in treatment decisions. Part II provides necessary background information on severe mental disabilities and the psychotropic medications used to treat these disabilities, highlighting the use of psychotropic medication on special populations with severe mental disabilities—children, homeless individuals, prisoners, and military personnel. Part III evaluates California law on psychotropic medication and proposed changes to the law.

Part IV.A recommends patient choice as the primary consideration in treating severe mental disability with psychotropic medication. Part IV.B notes the complications with patient choice. Part V.A advocates for a holistic and humane treatment approach towards those with severe mental disabilities. Part V.B proposes a model California law that gives some

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *See id.*

¹⁶ *Id.*

¹⁷ *Id.*

choice to those with severe mentally disability who are forced to take psychotropic medication. Part VI concludes this Note.

II. SEVERE MENTAL DISABILITIES AND PSYCHOTROPIC MEDICATIONS

A severe mental disability “*substantially* interfere[s] with a person’s ability to carry out major life activities.”¹⁸ About 11 million U.S. adults (one in every twenty) have a severe mental disability.¹⁹ About 1.2 million of these adults are in California, the highest number of any state.²⁰ Severe mental disabilities fall into three broad categories: mood disorders, anxiety disorders, and psychotic disorders.²¹

These three broad categories of severe mental disabilities correspond to three broad categories of psychotropic medications used to treat each: antimaniacs/anticonvulsants, antianxiety agents, and antipsychotics.²² Antidepressants and stimulants are sometimes also used to treat severe mental disabilities.²³ Antimaniacs/anticonvulsants, such as Lithium, stabilize mood and are used to treat bipolar disorder (manic depression) and severe personality disorders.²⁴ Antianxiety agents, such as Xanax, calm patients and are used to treat severe panic attacks, phobias, and post-traumatic stress disorder (PTSD).²⁵ Antipsychotics, such as Thorazine and Abilify, are used to treat schizophrenia, paranoia, hallucinations, and delusions.²⁶

The amount of money spent on psychotropic medications in the United States has increased by more than 600% in the past nine years (see

¹⁸ SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP’T OF HEALTH & HUMAN SERVS., MENTAL HEALTH, UNITED STATES, 2010, 10 (2012) [hereinafter MENTAL HEALTH REPORT] (emphasis added), available at <http://www.samhsa.gov/data/2k12/MHUS2010/MHUS-2010.pdf>.

¹⁹ *Id.* at 86–87 tbl.1.

²⁰ *Id.* at 242–43 tbl.98.

²¹ AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 273, 317, 393 (4th ed. 1994).

²² NAT’L INST. OF MENTAL HEALTH, U.S. DEP’T OF HEALTH & HUMAN SERVS., MENTAL HEALTH MEDICATIONS 2, 7, 10 (2010) [hereinafter MEDICATIONS REPORT], available at <http://www.nimh.nih.gov/health/publications/mental-health-medications/nimh-mental-health-medications.pdf>.

²³ *Id.* at 7, 10.

²⁴ *Id.* at 7.

²⁵ *Id.* at 10.

²⁶ *Id.* at 2.

Figure 1).²⁷ These medications can effectively treat severe mental disabilities by reducing the duration and severity of mental episodes, helping the mentally disabled lead productive lives in their communities.²⁸ However, as these medications are “treatments and not cures,” they “are expected to [be] use[d] . . . over an extended period of time,” and the “long-term effects [of many] have not been well-studied.”²⁹

Some of the known side effects of psychotropic medications can be permanently debilitating and even fatal.³⁰ Between 50% and 60% of those taking traditional antipsychotics for long periods of time develop tardive dyskinesia (TD), which causes permanent abnormal facial tics and body movements.³¹ Even newer antipsychotics can cause major weight gain, increasing a patient’s risk of developing diabetes and high cholesterol.³²

About 40% of U.S. adults with a severe mental disability did not receive treatment in 2009 (see Figure 2).³³ The consequences of untreated or undertreated mental disability for individuals and the community are significant. About 15% of individuals with untreated or undertreated mental disability commit suicide,³⁴ and the rate of suicide for those with

²⁷ MENTAL HEALTH REPORT, *supra* note 18, at 47 ex.14; *see also* IMS INSTITUTE FOR HEALTHCARE INFORMATICS, THE USE OF MEDICINES IN THE UNITED STATES: REVIEW OF 2011, at 29 (2012), *available at* http://www.imshealth.com/ims/Global/Content/Insights/IMS%20Institute%20for%20Healthcare%20Informatics/IHII_Medicines_in_U.S_Report_2011.pdf (indicating U.S. spending in 2011 for antipsychotics, antiepileptics, and antidepressants was over \$35 billion).

²⁸ *See* Brief for the American Psychiatric Association and the American Medical Association as Amici Curiae in Support of Petitioner, *Perry v. Louisiana*, 498 U.S. 38 (1990) (No. 89-5120), 1990 WL 10013108 at *10 (“[The American Psychiatric Association] has explained in detail in prior briefs . . . [that] psychotropic medication is, [when] properly used, a very effective form of treatment.”).

²⁹ PRESIDENT’S NEW FREEDOM COMM’N ON MENTAL HEALTH, ACHIEVING THE PROMISE: TRANSFORMING MENTAL HEALTH CARE IN AMERICA 71 (2003) [hereinafter PRESIDENT’S REPORT], *available at* <http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf>.

³⁰ MEDICATIONS REPORT, *supra* note 22, at 2, 13.

³¹ *Tardive Dyskinesia*, NAT’L ALLIANCE ON MENTAL ILLNESS, http://www.nami.org/Content/ContentGroups/HelpLine1/Tardive_Dyskinesia.htm (last updated Sept. 2003) (“Eight studies in young individuals (average age 29 years) receiving the older antipsychotics showed practically the same rate of 5% of those persons develop TD every year, year after year, until eventually almost 50–60% develop TD over their lifetime.”); *see also* MEDICATIONS REPORT, *supra* note 22, at 3.

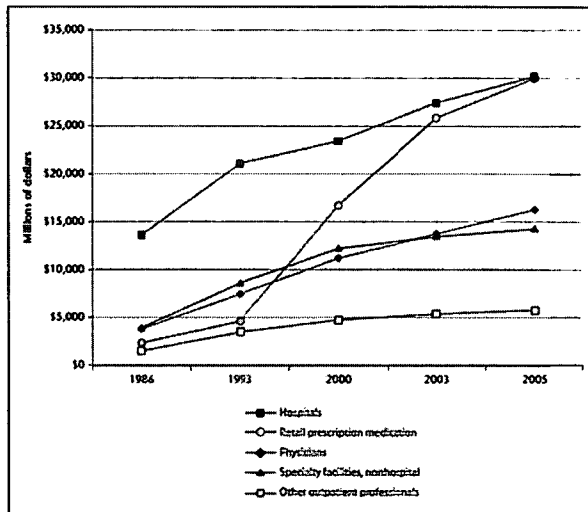
³² MEDICATIONS REPORT, *supra* note 22, at 2–3.

³³ MENTAL HEALTH REPORT, *supra* note 18, at 27 ex.6.

³⁴ LPS REFORM TASK FORCE II, SEPARATE AND NOT EQUAL: THE CASE FOR UPDATING CALIFORNIA’S MENTAL HEALTH TREATMENT LAW 4 (2012) [hereinafter LPS REFORM TASK FORCE II], *available at* <http://www.lpsreform.org/LPSTF2.pdf>.

schizophrenia is about sixteen times greater than the general population.³⁵ Individuals with severe mental disability are over two and a half times more likely to be the victim of a violent crime than the general population.³⁶ Additionally, untreated or undertreated mental disability is associated with unemployment, substance abuse, homelessness, and incarceration.³⁷

Figure 1: U.S. Mental Health Expenditures by Provider Type, 1986–2005.³⁸



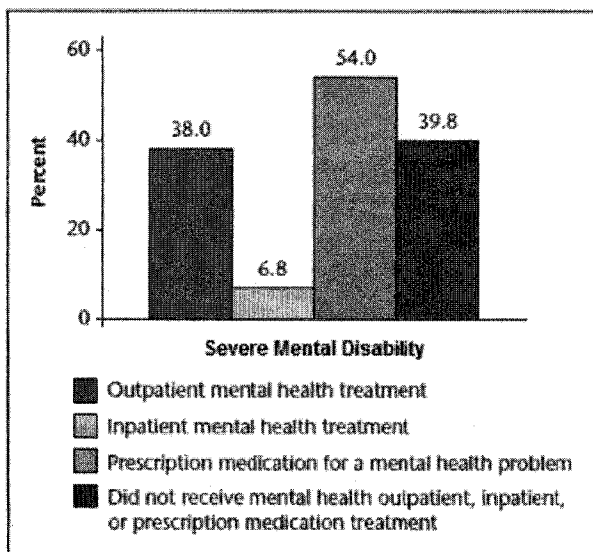
³⁵ Frédéric Limosin et al., *Ten-Year Prospective Follow-Up Study of the Mortality by Suicide in Schizophrenic Patients*, SCHIZOPHRENIA RES., Aug. 2007, at 23, 23.

³⁶ Virginia Aldigé Hiday et al., *Criminal Victimization of Persons with Severe Mental Illness*, PSYCHIATRIC SERVS., Jan. 1999, at 62, 62.

³⁷ See PRESIDENT'S REPORT, *supra* note 29, at 3.

³⁸ MENTAL HEALTH REPORT, *supra* note 18, at 47 ex.14.

Figure 2: Percentage of U.S. Adults with Severe Mental Disability Who Received Mental Health Treatment in 2009.³⁹



A. SPECIAL POPULATIONS

Special populations with severe mental disabilities—children, homeless individuals, prisoners, and military personnel—face unique issues. As such, the role of psychotropic medication in treating these populations is of special significance.

1. Children

About one in every eight children has a mental disability.⁴⁰ Mentally disabled children and the parents who care for them are especially challenged because the stigma attached to mental disability is even stronger when it strikes a child,⁴¹ though grassroots efforts to reduce stigma are taking place in California.⁴² The stigma is magnified and

³⁹ *Id.* at 27 ex.6.

⁴⁰ *Id.* at xxi–xxii.

⁴¹ *Making a Difficult Situation Worse: Stigma and Mental Health in Children*, IND. UNIV. NEWS ROOM (Apr. 30, 2007), <http://newsinfo.iu.edu/news/page/print/5488.html>.

⁴² See, e.g., *United Advocates for Children and Families (UACF) Awarded \$2.6M Prop. 63 Grant to Reduce Mental Health Stigma and Discrimination Across California*, BUS. WIRE (May

additional challenges arise when a child and parent are both mentally disabled.⁴³

Treatment of children with psychotropic medication has lifelong consequences. Once treatment with psychotropic medication begins, whether it is truly needed or not, it may need to be continued for the rest of a child's life.⁴⁴ Further, the medication can encourage suicidal thoughts in children and adolescents,⁴⁵ and many adolescents who attempt suicide do so by overdosing on psychotropic medication.⁴⁶ Additionally, many mentally disabled children receive incorrect treatment with psychotropic medication, causing them to fear and resist such medication later in life.⁴⁷

These issues make the choice of whether to treat children with psychotropic medication an extremely difficult one. The choice is either in the hands of their parents or, for children in the foster care or juvenile justice systems, in the hands of the state.⁴⁸ Still, at times parents and the state acquiesce to doctors, who play a large role in shaping perceptions and decisions and in effect serve as the true decision-maker in the choice of whether to treat children with psychotropic medication.⁴⁹ This acquiescence is especially true for the state, with its limited resources and overstretched social workers.⁵⁰

1, 2012, 2:06 PM), <http://www.businesswire.com/news/home/20120501006833/en/United-Advocates-Children-Families-UACFAwarded-2.6M>.

⁴³ Stephen P. Hinshaw, *The Stigmatization of Mental Illness in Children and Parents: Developmental Issues, Family Concerns, and Research Needs*, J. CHILD PSYCHOL. & PSYCHIATRY, May 2005, at 714, 720.

⁴⁴ See MEDICATIONS REPORT, *supra* note 22, at 1.

⁴⁵ Kim Murphy, *Army Encourages New Way of Looking at PTSD*, L.A. TIMES (Apr. 25, 2012), <http://articles.latimes.com/print/2012/apr/25/nation/la-na-army-ptsd-20120425> [hereinafter Murphy, *New Way of Looking at PTSD*].

⁴⁶ SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., *Emergency Department Visits for Drug-Related Suicide Attempts by Adolescents: 2008*, DRUG ABUSE WARNING NETWORK REP., May 13, 2010, at 2 tbl.1, available at <http://www.samhsa.gov/data/2k10/DAWN001/SuicideAttemptsHTML.pdf> (finding that among drug-related suicide attempts in 2008, 26.2% involved anti-anxiety drugs, 23% involved antidepressants, 7.4% involved antipsychotics, 5.1% involved narcotic painkillers, and 1.5% involved central nervous system stimulants).

⁴⁷ See JOANNE SOLCHANY, CTR. ON CHILDREN & THE LAW, AM. BAR ASS'N, PSYCHOTROPIC MEDICATION AND CHILDREN IN FOSTER CARE: TIPS FOR ADVOCATES AND JUDGES 13 (Claire Sandt Chiamulera ed., 2011), available at http://www.americanbar.org/content/dam/aba/administrative/child_law/PsychMed.authcheckdam.pdf.

⁴⁸ See generally *id.*

⁴⁹ AM. PSYCHIATRIC ASS'N, ETHICS PRIMER OF THE AMERICAN PSYCHIATRIC ASSOCIATION 13–14 (2001).

⁵⁰ *Id.*

Acquiescence to doctors in the choice of whether to treat children with psychotropic medication may be a cause for alarm. The diagnosis of bipolar disorder in children has increased 4000% in the past nine years.⁵¹ The effects of many psychotropic medications have not been studied in children.⁵² Further, many doctors prescribe these psychotropic medications to children on an “off-label” basis before FDA approval for the patient’s specific mental disability or age.⁵³ Even careful monitoring of children on these psychotropic medications may not be enough to justify the risks.⁵⁴

An alternative to immediately using psychotropic medication on children who seem to have a mental disability is California’s community-based approach to mental health care.⁵⁵ The approach reflects a national trend away from inpatient care in psychiatric hospitals to working with the mentally disabled in their communities.⁵⁶ Its focus on group therapy and community involvement could help determine which children are truly in need of psychotropic medication.⁵⁷ Additionally, California has also increased funding for school-based, early mental health intervention and prevention services for children.⁵⁸

However, using the community-based approach instead of specialized treatment centers to treat children with severe mental disabilities has downsides. For example, in April 2012, San Francisco closed its only inpatient treatment center for high-risk, low-income youth with severe mental disabilities—children with traumatic backgrounds who require so much care that most other programs turned them away.⁵⁹ The center’s

⁵¹ Jacqueline Marshall, *Children with Bipolar Disorder: Maybe True, Definitely Troubling*, WASH. TIMES (Apr. 23, 2012), <http://communities.washingtontimes.com/neighborhood/tango-mind-and-emotion/2012/apr/23/children-bipolar-disorder-true-troubling/>.

⁵² MEDICATIONS REPORT, *supra* note 22, at 14.

⁵³ *Id.*

⁵⁴ *See id.*

⁵⁵ CTR. FOR CHILD & FAMILY POLICY, TERRY SANFORD INST. OF PUB. POLICY, DUKE UNIV., CHILDREN’S MENTAL HEALTH: STRATEGIES FOR PROVIDING HIGH QUALITY AND COST-EFFECTIVE CARE 29–30 (2006), available at http://familyimpactseminars.org/s_ncfis02report.pdf.

⁵⁶ MENTAL HEALTH REPORT, *supra* note 18, at 223 tbl.87.

⁵⁷ Steven P. Segal & Uri Aviram, *Transition from Mental Hospital to Community*, in NAT’L CONFERENCE ON SOC. WELFARE, THE SOCIAL WELFARE FORUM, 1975, at 121, 121–22 (Dorothy Swart ed., 1976), available at <http://socialwelfare.berkeley.edu/Faculty/publications/ssegal/Transition%20from%20Mental%20Hosp.PDF>.

⁵⁸ CAL. WELF. & INST. CODE §§ 4343–4352.5, 4370–4390, 5585–5585.59, 5850–5883 (West 2013).

⁵⁹ Trey Bundy, *Mental Health Center for Youth Is Closing*, N.Y. TIMES (Apr. 19, 2012), <http://www.nytimes.com/2012/04/20/us/mental-health-center-for-youth-in-san-francisco-is->

founder said, “If I had to choose between community-based services and the [center], I would choose the community [services], but it’s like ‘Sophie’s Choice’”—an impossibly difficult decision to make.⁶⁰ The closing of these specialized centers, with their individualized attention on children with severe mental disabilities, may increase the number of young children who are left without specific recommendations for or against treatment with psychotropic medication, leaving the choice instead in the hands of less-informed generalized doctors, parents, and the state. Further, more children may end up in the juvenile justice system and later on in prison, leading to other complications with psychotropic medication discussed in Part II.A.3 below.

2. Homeless Individuals

“I just lost my mind, just like that.”⁶¹ These are the words of Anthony Hamilton, a man who had successfully worked in public relations in New York before he started to see colors, which meant to him that things were spiritually negative.⁶² Hoping that the colors he was seeing would pass, he did not seek treatment for his hallucinations.⁶³ The hallucinations only got worse.⁶⁴ Over time, he became fixated on sidewalks and began to sleep on the streets.⁶⁵

Hamilton’s horrified parents tried to help, but he fled to Los Angeles.⁶⁶ He ended up on Skid Row, an area of downtown that “teems with human misery.”⁶⁷ The air “reeks of urine, scorched asphalt and rotting trash.”⁶⁸ Homeless men and women sprawl on “filthy, rat-infested” sidewalks.⁶⁹ They “scream at ghosts. They stumble and rant and threaten

closing.html.

⁶⁰ *Id.* (internal quotation marks omitted); see also WILLIAM STYRON, *SOPHIE’S CHOICE* (1979) (describing mother’s choice between sending one child to concentration camp and another to gas chamber).

⁶¹ Steve Lopez, *Vicious Circle of Hope, Despair*, L.A. TIMES (Aug. 7, 2005), <http://www.latimes.com/entertainment/la-me-lopez7aug07,0,3650802,print.column> [hereinafter Lopez, *Vicious Circle*] (internal quotation marks omitted).

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ Steve Lopez, *A Ray of Hope for Future Nathaniels*, L.A. TIMES (Sept. 25, 2005), <http://www.latimes.com/news/local/la-me-lopez25sep25,0,1461524,print.column> [hereinafter

each other's lives."⁷⁰ "[H]uman forms disappear under piles of rags and casket-shaped cardboard boxes."⁷¹ "[N]ight after night," ambulances respond to 911 calls from the mentally disabled.⁷²

As a mentally disabled individual, it is not surprising that Hamilton ended up homeless and on Skid Row. About 50% of homeless individuals are mentally disabled,⁷³ and there are even allegations that law enforcement officers drop off the mentally disabled on Skid Row.⁷⁴ And so, Hamilton wandered around the streets of Skid Row until someone directed him to Lamp Community, a mental health facility nearby.⁷⁵

Lamp, part of California's community-based approach to mental health care, offers assistance to the whole person rather than just treatment for a disability.⁷⁶ Lamp gradually coaxes the homeless off of the streets—as many do not want to be “trapped in some apartment”⁷⁷—first by offering food, clothing, or a room to store belongings.⁷⁸ Lamp does not require psychological evaluations or any kind of medication regimen.⁷⁹ Instead, trust is built over time and residents are gradually introduced to therapy through group sessions.⁸⁰

Lamp founder Mollie Lowery made it a priority to help rescue Hamilton.⁸¹ Hamilton says the difference for him came when he stopped resisting help and acknowledged that something was wrong with him. He then gained insight into how sick he really was.⁸²

Lopez, *Ray of Hope*].

⁷⁰ Lopez, *Vicious Circle*, *supra* note 61.

⁷¹ Steve Lopez, *A Twilight Concerto for Rats and Cello*, L.A. TIMES (May 29, 2005), <http://www.latimes.com/entertainment/la-me-lopez29may29,0,6059540,print.column> [hereinafter Lopez, *Twilight Concerto*].

⁷² *Id.*

⁷³ PRESIDENT'S REPORT, *supra* note 29, at 30.

⁷⁴ Chris Coates, *Allegations of Homeless 'Dumping' Spread*, L.A. DOWNTOWN NEWS (Oct. 3, 2005, 12:00 AM), http://www.ladowntownnews.com/news/allegations-of-homeless-dumping-spread/article_6e39805c-8b1b-5e29-bf1d-b83aa7e41acc.html.

⁷⁵ Lopez, *Vicious Circle*, *supra* note 61.

⁷⁶ See *Lamp Community - About Lamp*, LAMP CMTY, http://www.lampcommunity.org/about_lamp.php (last visited Apr. 19, 2013).

⁷⁷ Lopez, *Twilight Concerto*, *supra* note 71 (internal quotation marks omitted).

⁷⁸ See *Lamp Community - About Lamp*, *supra* note 76.

⁷⁹ See *Lamp Community - Housing + Services*, LAMP COMMUNITY, http://www.lampcommunity.org/housing_services.php (last visited Apr. 19, 2013).

⁸⁰ *Id.*

⁸¹ See Lopez, *Vicious Circle*, *supra* note 61.

⁸² *Id.*

A diagnosis of schizophrenia gradually followed Hamilton's introduction to Lamp.⁸³ He spent five years visiting Lamp while on Skid Row before he was rehabilitated.⁸⁴ He now takes psychotropic medication for his mental disability, but insists that the mentally disabled cannot be pushed to take medication.⁸⁵

It is clear that what helped Hamilton most in making *his* decision to take psychotropic medication was having a friend like Lamp founder, Mollie Lowery, who believed in him for years and encouraged him to seek treatment for his disability. Now, following in Lowery's footsteps, Hamilton helps rescue others, strengthening Lamp's and California's community-based approach to mental health care.⁸⁶

The role that friendship plays in encouraging mentally disabled homeless individuals to seek and receive treatment can also be seen in the story of homeless schizophrenic Nathaniel Ayers and *Los Angeles Times* journalist Steve Lopez. Lopez befriended Ayers after hearing him play music on the street.⁸⁷ Lopez then found out that Ayers had been on full scholarship at Juilliard before he had a mental breakdown and ended up on Skid Row.⁸⁸ Lopez became a lifelong friend to Ayers and has helped him gradually move from the streets into an apartment at Lamp.⁸⁹ Lopez hopes that Ayers will one day be able to properly consider the possibility of taking psychotropic medication for his mental disability instead of dismissing it outright.⁹⁰ Hopefully Ayers will one day also be able to pay it forward and engage in meaningful work by helping others like him, as Hamilton did.⁹¹

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ See STEVE LOPEZ, *THE SOLOIST* 3–5 (2008) [hereinafter LOPEZ, *THE SOLOIST*].

⁸⁸ Lopez, *Twilight Concerto*, *supra* note 71.

⁸⁹ Lopez, *Vicious Circle*, *supra* note 61.

⁹⁰ See LOPEZ, *THE SOLOIST*, *supra* note 87, at 236.

⁹¹ Elyn R. Saks, *Successful and Schizophrenic*, N.Y. TIMES (Jan. 25, 2013), <http://www.nytimes.com/2013/01/27/opinion/sunday/schizophrenic-not-stupid.html?pagewanted=1&> (noting importance of engaging in meaningful work).

3. Prisoners

The degree of civilization in a society can be judged by entering its prisons.

– Fyodor Dostoyevsky, *The House of the Dead*

Jared Loughner was charged in the Arizona shooting that left six dead, including U.S. District Judge John Roll, and thirteen injured, including U.S. Representative Gabrielle Giffords.⁹² He was diagnosed with schizophrenia because of his delusions, hallucinations, and irrational distrust of his attorneys.⁹³ At court hearings, he has spat and lunged at one of his attorneys before guards restrained him, cursed and threw a chair at his psychologists, and hurled a wet roll of toilet paper at a camera that was recording the meeting with his psychologist.⁹⁴ He has also yelled epithets in court—“[t]hank you for the freak show,” “[s]he died right in front of me,” and “[y]ou’re treasonous”—before being removed.⁹⁵ Still, a court temporarily halted the involuntary administration of psychotropic medication on him, despite doubts as to whether he would ever be stable enough to stand trial.⁹⁶ At what point should mentally disabled prisoners be involuntarily treated with psychotropic medication?

More than 50% of prisoners have a mental disability.⁹⁷ The rate of severe mental disability for prisoners “is about three to four times that of the general U.S. population.”⁹⁸ A person with severe mental disability is

⁹² Richard A. Serrano, *Jared Loughner Expected to Plead Guilty to Tucson Shootings Today*, L.A. TIMES (Aug. 7, 2012), <http://articles.latimes.com/print/2012/aug/07/nation/la-na-nn-jared-loughner-expected-plead-guilty-20120807>.

⁹³ Cheryl Paradis, *Jared Loughner, Tucson [sic] Shooting Suspect, Found Not Competent to Stand Trial*, PSYCHOL. TODAY (May 26, 2011), <http://www.psychologytoday.com/blog/the-measure-madness/201105/jared-loughner-tucson-shooting-suspect-found-not-competent-stand-tri>.

⁹⁴ Donna Leinwand Leger, *Jared Loughner Violent in Prison, Prosecutors Say*, USA TODAY (June 30, 2011, 1:23 AM), http://www.usatoday.com/news/nation/2011-06-29-jared-loughner-arizona-shootings_n.htm.

⁹⁵ Marc Lacey, *Suspect in Shooting of Giffords Ruled Unfit for Trial*, N.Y. TIMES (May 25, 2011), http://www.nytimes.com/2011/05/26/us/26loughner.html?_r=0 (internal quotation marks omitted).

⁹⁶ Carol J. Williams, *Judges Halt Loughner’s Forced Medication*, L.A. TIMES (July 5, 2011), <http://articles.latimes.com/print/2011/jul/05/nation/la-na-loughner-drugs-20110706>.

⁹⁷ DORIS J. JAMES & LAUREN E. GLAZE, U.S. DEP’T OF JUSTICE, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 3 tbl.1 (2006), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf>; see also *Study Finds More than Half of All Prison and Jail Inmates Have Mental Health Problems*, U.S. DEP’T OF JUSTICE (Sept. 6, 2006, 4:30 PM), <http://bjs.ojp.usdoj.gov/content/pub/press/mhppjipr.cfm>.

⁹⁸ PRESIDENT’S REPORT, *supra* note 29, at 32.

more than three times more likely to be in prison than in a hospital.⁹⁹ Prisons and jails are California's biggest single repository for the mentally disabled, serving as make-shift mental institutions costing the state millions.¹⁰⁰

Over 15,000 prisoners in California receive psychotropic medication, double that of the next closest state.¹⁰¹ Still, many inmates in need of medication go untreated. Some claim that the use of the medication to treat prisoners reduces recidivism.¹⁰² Even if this were true, in many cases it would be at the expense of a prisoner's right to refuse psychotropic medication.¹⁰³ The importance of retaining this right has led the U.S. Supreme Court to place limits on the ability of lower courts to forcibly medicate criminal defendants to be competent to stand trial.¹⁰⁴ A troubling question remains: can defendants like Jared Loughner, who can be forcibly medicated to be competent to stand trial, be forcibly medicated to be competent for execution?

4. Military Personnel

Mental disabilities send more U.S. soldiers to the hospital than any other cause.¹⁰⁵ What makes this fact even more shocking is that mental disabilities are still the frontrunner despite the underreporting of them in the military, as fewer than 30% of military personnel actually seek treatment for such disabilities.¹⁰⁶ Common mental disabilities in the military include severe psychological distress and post-traumatic stress

⁹⁹ E. FULLER TORREY ET AL., MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES I (2010), available at <http://www.nami.org/Template.cfm?Section=CIT2&template=/ContentManagement/ContentDisplay.cfm&ContentID=101344>.

¹⁰⁰ *See id.*

¹⁰¹ MENTAL HEALTH REPORT, *supra* note 18, at 256–57 tbl.102.

¹⁰² ELYN R. SAKS, REFUSING CARE: FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL 72 (2002) [hereinafter SAKS, REFUSING CARE].

¹⁰³ Howard M. Kravitz et al., *Reducing Recidivism Among Mentally Ill Offenders: The Role of Psychotropic Medication in Correctional Psychiatry*, PSYCHIATRIC ANNALS, July 2001, at 409, 411.

¹⁰⁴ *Sell v. United States*, 539 U.S. 166, 179 (2003) (allowing forced medication for trial competency if medically appropriate, substantially unlikely to have side effects that may undermine trial's fairness, and necessary to further important government trial-related interests).

¹⁰⁵ Gregg Zoroya, *Mental Care Stays Are Up in Military*, USA TODAY (May 16, 2010, 2:57 PM), http://usatoday30.usatoday.com/news/military/2010-05-14-mental-health_N.htm.

¹⁰⁶ MENTAL HEALTH REPORT, *supra* note 18, at 188–89 tbl.67.

disorder (PTSD).¹⁰⁷

About 20% of military personnel take psychotropic medication.¹⁰⁸ Deploying troops can receive up to a 180-day supply of the medication.¹⁰⁹ This policy has led to a psychotropic medication problem in the military, as personnel take handfuls of pills after stressful combat days or take pills that they were not prescribed by trading with other soldiers.¹¹⁰

The Army has recently discouraged the use of antianxiety and antipsychotic medications for treating PTSD in favor of “more proven drugs.”¹¹¹ The policy states that these medications may: intensify rather than reduce combat stress symptoms, lead to addiction, and have long-term effects on health such as heart disorders, muscle spasms, and weight gain.¹¹² Further, as with children, these medications can encourage suicidal thoughts in military personnel.¹¹³ The policy endorses a combination of therapy and antidepressants, such as Prozac, as equally valid methods for treating PTSD.¹¹⁴

5. Other Special Populations

Other groups facing unique issues with severe mental disabilities include minorities¹¹⁵ and the elderly.¹¹⁶ American Indians, African Americans, and Hispanic Americans disproportionately suffer from severe mental disabilities.¹¹⁷ This higher proportion does not arise from a greater prevalence of severe mental disabilities in these groups.¹¹⁸ Rather, they receive less and inferior care because of different cultural ideas about mental disability, low rates of insurance coverage, and institutional

¹⁰⁷ *Id.* at 120–21 tbl.19.

¹⁰⁸ Bob Brewin, *Military's Drug Policy Threatens Troops' Health, Doctors Say*, NEXTGOV (Jan. 18, 2011), <http://www.nextgov.com/health/2011/01/militarys-drug-policy-threatens-troops-health-doctors-say/48321/>.

¹⁰⁹ *Id.*

¹¹⁰ See Kim Murphy, *A Fog of Drugs and War*, L.A. TIMES (Apr. 7, 2012), <http://articles.latimes.com/print/2012/apr/07/nation/la-na-army-medication-20120408>.

¹¹¹ Murphy, *New Way of Looking at PTSD*, *supra* note 45.

¹¹² *Id.*

¹¹³ See *id.* and accompanying text.

¹¹⁴ *Id.*

¹¹⁵ PRESIDENT'S REPORT, *supra* note 29, at 49.

¹¹⁶ MATRIX ADVOCARE NETWORK, *The Challenge of Mental Illness in the Elderly*, ISSUES ON AGING, 1998, at 1, 1, available at http://matrixadvocare.com/newsletters/V10_N5.pdf.

¹¹⁷ PRESIDENT'S REPORT, *supra* note 29, at 49.

¹¹⁸ *Id.*

discrimination.¹¹⁹ It follows that this deficiency in care results in fewer mental disabilities treated with psychotropic medication.

III. CALIFORNIA LAW

California law allows for forced administration of psychotropic medication on the mentally disabled under certain circumstances. Tragic current events have caused for a push to broaden these circumstances. Still, patient choice must be the primary consideration in treating severe mental disability with psychotropic medication.

A. LANTERMAN-PETRIS-SHORT ACT

The Lanterman-Petris-Short Act,¹²⁰ passed in 1967, allows mental health professionals, officers, and courts to involuntarily commit individuals who, as a result of a mental disability, are: (1) a danger to themselves or others; or (2) “unable to provide for [their] basic personal needs for food, clothing, or shelter” (“gravely disabled”).¹²¹ Involuntary commitment initially lasts three days.¹²² It can be extended two weeks for intensive treatment,¹²³ after which it can be extended an additional: (1) two weeks for threatening or attempting to commit suicide;¹²⁴ (2) thirty days for continual grave disability and unwillingness or inability to accept treatment voluntarily;¹²⁵ (3) 180-days for inflicting, attempting to inflict, or seriously threatening substantial physical harm on another;¹²⁶ or (4) one year under a court-ordered conservatorship for gravely disabled individuals.¹²⁷

Involuntarily committed patients can be forced to take psychotropic medication if there is: (1) an emergency; or (2) a court finding of incompetency to make treatment decisions.¹²⁸ An emergency is when

¹¹⁹ *Id.* at 49–50.

¹²⁰ CAL. WELF. & INST. CODE §§ 5000–5550 (West 2013).

¹²¹ *Id.* §§ 5150, 5200, 5225 (describing involuntary commitment procedures); *id.* § 5008(h)(1)(A) (defining “gravely disabled”); *see also id.* § 7102 (providing county psychiatric hospitals for involuntary commitments).

¹²² *Id.* § 5150.

¹²³ *Id.* § 5250.

¹²⁴ *Id.* § 5260.

¹²⁵ *Id.* § 5270.15.

¹²⁶ *Id.* § 5300.

¹²⁷ *Id.* §§ 5358, 5361.

¹²⁸ *Id.* §§ 5325.2, 5332(b), 5332(e); *see also* *Riese v. St. Mary’s Hosp. & Med. Ctr.*, 271

action is immediately necessary to preserve life or prevent serious bodily harm to the patient or others, and obtaining consent is impracticable.¹²⁹ During an emergency, treatment with psychotropic medication must be “in the manner least restrictive to the personal liberty of the patient.”¹³⁰

In deciding competency to make treatment decisions, courts consider whether a mentally disabled individual: (1) is “aware of his or her situation” (for example, can acknowledge a court’s finding of psychosis); (2) can understand the benefits of psychotropic medication (“resolution of the psychotic episode”), risks (inability to control movement), and alternatives (therapy); and (3) can “intelligently evaluate the information” given to patients whose informed consent is sought, which is assumed “in the absence of a clear link between an individual’s delusional or hallucinatory perceptions and his ultimate decision.”¹³¹ Under this three-part test, even patients who “believe they are bad and deserve to suffer” or “suspect their doctors’ motives” are competent to refuse medication.¹³² Is there a better alternative? The answer seems to be no. California’s standard survives comparisons to others that “give a more central role to mental illness and all of its disabling effects.”¹³³

Under a court finding of incompetency to make treatment decisions, psychotropic medication can be administered only after staff have determined that alternatives are unlikely to meet a patient’s needs.¹³⁴ Further, when a patient is involuntarily committed for more than two weeks, informed consent must be obtained from the patient’s responsible relative, guardian, or conservator before psychotropic medication is administered.¹³⁵

As soon as possible after involuntarily committed patients are forced to take psychotropic medication, they are to receive information on: (1) the probable effects and possible side effects of the medication; (2) the

Cal. Rptr. 199, 210 (Ct. App. 1987).

¹²⁹ WELF. & INST. § 5008(m).

¹³⁰ *Id.* § 5332(e).

¹³¹ *Riese*, 271 Cal. Rptr. at 211–12 (quoting THOMAS G. GUTHEIL & PAUL S. APPELBAUM, CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW 220 (1982) (internal quotation marks omitted)).

¹³² Elyn R. Saks, *Competency to Refuse Treatment*, 69 N.C. L. REV. 945, 998–99 (1991) [hereinafter Saks, *Competency to Refuse Treatment*].

¹³³ Elyn R. Saks, *Competency to Refuse Psychotropic Medication: Three Alternatives to the Law’s Cognitive Standard*, 47 U. MIAMI L. REV. 689, 758 (1993) [hereinafter Saks, *Three Alternatives*].

¹³⁴ WELF. & INST. § 5332(b).

¹³⁵ *Riese*, 271 Cal. Rptr. at 211–12 (quoting WELF. & INST. § 5326.7(g)).

nature of the mental disability that is the reason the medication is being given; (3) the likelihood of improving or not improving without the medication; (4) reasonable alternative treatments; and (5) the name and type, frequency, amount, and method of dispensing the medication, and probable length of time the medication will be taken.¹³⁶

B. LAURA'S LAW

Laura's Law,¹³⁷ passed in 2003, allows family members, mental health professionals, and officers to petition the court to order "assisted outpatient treatment" for six months for those who have been hospitalized at least twice in a three month period because of a severe mental disability.¹³⁸ Assisted outpatient treatment involves "community-based, mobile, multidisciplinary, highly trained mental health teams that use high staff-to-client ratios."¹³⁹ The treatment must be the least restrictive placement necessary to ensure a patient's recovery and stability.¹⁴⁰

Laura's Law is named after Laura Wilcox, a mental health clinic employee who was fatally shot, along with two other employees, by Scott Thorpe, a man suffering from schizophrenia who refused to take his psychotropic medication.¹⁴¹ It is based on New York's Kendra's Law,¹⁴² which has received positive reviews.¹⁴³ Unlike the Mental Health Services Act, discussed in Part III.C below, Laura's Law was developed without the input or approval of those with mental disabilities.¹⁴⁴

¹³⁶ WELF. & INST. §§ 5152(c), 5213(b).

¹³⁷ *Id.* §§ 5345–5349.5.

¹³⁸ *Id.* §§ 5346(a)(4)(A) (providing assisted outpatient treatment for repeated hospitalization), 5346(b)(2) (listing individuals who can petition the court), 5346(d)(5)(B) (authorizing six-month period).

¹³⁹ *Id.* § 5348(a)(1).

¹⁴⁰ *Id.* § 5346(a)(7).

¹⁴¹ Dan Morain, *The Conversation: A Woman Is Killed, a Cause Is Born*, SACRAMENTO BEE (Jan. 3, 2012, 10:28 AM), <http://www.sacbee.com/2011/12/11/v-wireless/4112773/after-a-rampage-by-a-mentally.html>.

¹⁴² Jens Erik Gould, *Should Involuntary Treatment for the Mentally Ill Be the Law?*, TIME (Oct. 27, 2011), <http://www.time.com/time/printout/0,8816,2098044,00.html>; see also N.Y. MENTAL HYG. LAW § 9.60 (McKinney 2013).

¹⁴³ See, e.g., N.Y. STATE OFFICE OF MENTAL HEALTH, NEW YORK STATE ASSISTED OUTPATIENT TREATMENT PROGRAM EVALUATION, at viii (2009), available at http://www.omh.ny.gov/omhweb/resources/publications/aot_program_evaluation/report.pdf; Allison R. Gilbert et al., *Reductions in Arrest Under Assisted Outpatient Treatment in New York*, PSYCHIATRIC SERVS., Oct. 2010, at 1, 1, available at <http://mentalillnesspolicy.org/kendras-law/research/aot-reduces-arrest.pdf>.

¹⁴⁴ Michael V. Gause, *Mental Health Clients Speak Out Against Laura's Law*,

Laura's Law is optional for counties to implement.¹⁴⁵ Counties that implement the law must develop a training and education program to improve the delivery of services to mentally disabled individuals "who are, or who are at risk of being, involuntarily committed."¹⁴⁶ Only Nevada County, where Laura Wilcox was killed, has fully implemented the law.¹⁴⁷ Los Angeles County has a pilot project.¹⁴⁸ The law was set to expire in 2013, but has been extended until 2017.¹⁴⁹ The extension was supported by the California chapters of the American Psychiatric Association and the National Alliance on Mental Illness.¹⁵⁰

C. MENTAL HEALTH SERVICES ACT

The Mental Health Services Act (MHSA),¹⁵¹ passed in 2004, expands California's community-based mental health services.¹⁵² The MHSA emphasizes client-centered and family-focused treatment of the whole person through prevention, early intervention, and integrated services.¹⁵³ The MHSA also focuses on traumatized youth and isolated seniors.¹⁵⁴ Current MSHA funding is around \$1 billion annually.¹⁵⁵

BEYONDCHRON (Sept. 16, 2010), <http://www.beyondchron.org/news/index.php?itemid=8507>.

¹⁴⁵ WELF. & INST. § 5349.

¹⁴⁶ *Id.* § 5349.1(a).

¹⁴⁷ *Bill to Extend Laura's Law Moves Forward*, KNCO.COM (Apr. 18, 2012, 11:48 AM), <http://knco.com/bill-to-extend-lauras-law-moves-forward/>.

¹⁴⁸ Stephanie O'Neill, *Grand Jury: Laura's Law Saves Money, Lives, Should Be Implemented in Other California Counties*, S. CAL. PUB. RADIO (June 25, 2012, 7:06 PM), <http://www.scpr.org/news/2012/06/25/32977/grand-jury-says-lauras-law-saved-nevada-county-hal/>.

¹⁴⁹ Act of Sept. 22, 2012, ch. 441, 2012 Cal. Stat. 441 (codified as amended at WELF. & INST. § 5349.5), available at http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_1551-1600/ab_1569_bill_20120922_chaptered.pdf.

¹⁵⁰ *AB 1569 Assembly Bill - Bill Analysis*, S. RULES COMM. (Aug. 8, 2012), http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_1551-1600/ab_1569_cfa_20120808_183432_sen_floor.html.

¹⁵¹ Mental Health Services Act (MHSA), 2004 Cal. Legis. Serv. Prop. 63 (West) (amended 2011), available at http://www.dmh.ca.gov/Prop_63/mhsa/docs/MHSAafterAB100.pdf (unofficial amended copy of MHSA).

¹⁵² The MHSA amends certain sections of California Welfare and Institutions Code, Division 5, Community Mental Health Services. See CAL. WELF. & INST. CODE §§ 5771.1–5898 (West 2013).

¹⁵³ MHSA, *supra* note 151, at § 2(e).

¹⁵⁴ *Id.*

¹⁵⁵ CAL. DEP'T OF MENTAL HEALTH, MENTAL HEALTH SERVICES ACT EXPENDITURE REPORT I (2011), available at http://www.dmh.ca.gov/prop_63/MHSA/Publications/docs/MHSA_May_Revise_Expend_Report_06-09-2011.pdf.

1. Integrated Services Agencies

The MHSA promotes the concept of the Integrated Services Agency (ISA) to treat mentally disabled homeless individuals by providing housing that is backed with essential services.¹⁵⁶ The concept has been recognized as a model program by the President's Commission on Mental Health.¹⁵⁷ One example of an ISA is Lamp Community, mentioned in Part II.A.2. Another example is the Village in Long Beach, which is run by Mental Health America of Los Angeles.¹⁵⁸ Its team of social workers, psychiatrists, and counselors offers a "menu" of housing, employment, and treatment options to adults with severe mental disabilities and to troubled youth who have had their first brushes with the law.¹⁵⁹ The Village believes that when the mentally disabled "help define their own treatment, they are better able to stick to it," rather than irregularly visiting mental health clinics.¹⁶⁰ The Village sends outreach workers onto the streets to entice those in need.¹⁶¹ Food or clothing is offered at first in an effort to build a trusting relationship.¹⁶²

With an average annual cost of \$18,000 per patient a year, the Village seems expensive.¹⁶³ But it is less than half as much as the up to \$44,000 annual cost of emergency room visits for a homeless individual,¹⁶⁴ or the \$47,000 annual cost¹⁶⁵ for imprisonment.¹⁶⁶ In addition, there is the "human cost" of ignoring the homeless, as seen in the "bodies regularly found on skid row at dawn," killed by disease, overdose, or violence.¹⁶⁷

¹⁵⁶ MHSA, *supra* note 151, at § 2(f).

¹⁵⁷ PRESIDENT'S REPORT, *supra* note 29, at 45.

¹⁵⁸ *MHA Village*, MENTAL HEALTH AM. OF L.A., <http://www.mhala.org/mha-village.htm> (last visited Apr. 19, 2013).

¹⁵⁹ Steve Lopez, *A Musician of the Streets*, L.A. TIMES (Jan. 3, 2006), <http://www.latimes.com/news/local/la-ed-homeless3jan03,0,5399524,print.story> [hereinafter Lopez, *Musician of the Streets*].

¹⁶⁰ *Id.*

¹⁶¹ Steve Lopez, *Stakes Are So High, It's Hard to Wait*, L.A. TIMES (Oct. 30, 2005), <http://articles.latimes.com/print/2005/oct/30/local/me-lopez30>.

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ *The Cost of Homelessness Facts*, GREEN DOORS, <http://greendoors.org/facts/cost.php> (last visited Apr. 19, 2013).

¹⁶⁵ *California's Annual Costs to Incarcerate an Inmate in Prison*, CAL. LEG. ANALYST'S OFF., http://www.lao.ca.gov/laoapp/laomenus/sections/crim_justice/6_cj_inmatecost.aspx?catid=3 (last visited Apr. 19, 2013).

¹⁶⁶ Lopez, *Musician of the Streets*, *supra* note 159.

¹⁶⁷ *Id.*

Another example of an ISA for mentally disabled homeless individuals is the St. George, a converted hotel in downtown Los Angeles.¹⁶⁸ It offers “big-windowed rooms, along with on-site counseling, psychiatric services, addiction programs and a staff nurse.”¹⁶⁹ There is also “a large communal kitchen, laundry facility and a comfortable lounge equipped with computers.”¹⁷⁰ St. George emphasizes alternative treatment programs rather than psychotropic medication.¹⁷¹

2. Criticism of the MHSA

The MHSA has received some criticism. For example, twenty percent of MHSA funds are diverted to promote “mental wellness.”¹⁷² Those programs include lunchtime yoga classes for city workers and their families, horseback riding “therapy” for teens, and massage chairs for students in Southern California.¹⁷³ MHSA funds are also used for involuntary commitment services, such as Nevada County’s Laura’s Law program and Los Angeles County’s pilot project.¹⁷⁴ Some, including Rose King (widely regarded as the mother of the MHSA), claim that a two-tiered system has been created in which “new clients receive ‘Cadillac services’ while existing clients” languish for months without treatment.¹⁷⁵ They also note that “[d]espite the influx of new funding through the MHSA, [California] leads the nation in cuts in mental-health care spending.”¹⁷⁶ When mental health funding is cut, “burdens only get shifted elsewhere—to emergency rooms, hospitals, schools, police, and local

¹⁶⁸ Anat Rubin, *Historic Hotel Offers Homeless Remedy*, L.A. DAILY J., Mar. 5, 2007, at 1, http://skidrow.org/pdf/LADailyJournal_Mar0507.pdf; Donna Kimura, *Skid Row Project Reaches Out to Chronically Homeless*, AFFORDABLE HOUSING FIN. (Aug. 1, 2005), <http://www.housingfinance.com/tax-credits/skid-rowproject-reaches-out-to-chronically-homeless.aspx>.

¹⁶⁹ Lopez, *Musician of the Streets*, *supra* note 159.

¹⁷⁰ *Id.*

¹⁷¹ Kimura, *supra* note 168.

¹⁷² Hannah Dreier, *Calif. Mental Health Dollars Bypassing Mentally Ill*, ASSOCIATED PRESS (July 29, 2012, 4 AM), <http://www.redding.com/news/2012/jul/29/calif-mental-health-dollars-bypassing-mentally-ill/>.

¹⁷³ *Id.*

¹⁷⁴ *Can Mental Health Services Act Funds Be Used to Fund Laura’s Law?*, MENTAL ILLNESS POL’Y ORG., <http://mentalillnesspolicy.org/states/california/mhsafundslauraslaw.html> (last visited Apr. 19, 2013).

¹⁷⁵ Amy Yannello, *Two-Tiered Mental-Health System*, SACRAMENTO NEWS & REV. (Sept. 15, 2011), <http://www.newsreview.com/sacramento/two-tiered-mental-health-system/content?oid=3687288>.

¹⁷⁶ *Id.*

courts. Businesses lose productivity. Families are broken. People end up living on the street or dead.”¹⁷⁷

D. PROPOSED CHANGES

[T]he greatest threats to our constitutional freedoms come in times of crisis.

– Justice Sandra Day O’Connor¹⁷⁸

Aaron Bassler of Northern California started showing signs of mental disability as a teenager.¹⁷⁹ He was arrested after tossing bags containing pictures of aliens onto Chinese consulate property.¹⁸⁰ A court ordered him to go through a federal pretrial diversion program, but he was never formally diagnosed or treated for a mental illness despite pleas from his father, and once the diversion program ended his condition deteriorated.¹⁸¹ In August 2011, while hiding in the woods, he fatally shot a city councilmember and a conservationist.¹⁸² A month later, after escaping from a search dog and shooting at sheriff’s deputies, he was fatally shot by a SWAT team.¹⁸³ Should the state have properly diagnosed and treated him, possibly with psychotropic medication, after his initial arrest and before he harmed others?

The tragic stories of California’s mentally disabled harming others and being harmed themselves—such as those of Aaron Bassler, Scott Thorpe in Part III.B, and Kelly Thomas in Part I—have caused for a push to broaden the circumstances under which the state’s mentally disabled are subject to involuntary confinement and conservatorship.¹⁸⁴ In March 2012, a reform task force composed of over sixty doctors, lawyers, and

¹⁷⁷ Ratan Bhavnani, *High Cost of Cutting Mental Health*, VENTURA CNTY. STAR (Apr. 28, 2012, 7:03 PM), <http://www.vcstar.com/news/2012/apr/28/bhavnani-high-cost-of-cutting-mental-health/>.

¹⁷⁸ Veronia Sch. Dist. 47J v. Acton, 515 U.S. 646, 686 (1995) (O’Connor, J., dissenting).

¹⁷⁹ Lee Romney, *Fort Bragg Manhunt Raises Mental Health Questions*, L.A. TIMES (Sept. 18, 2011), <http://articles.latimes.com/print/2011/sep/18/local/la-me-aaron-bassler-20110918> [hereinafter Romney, *Fort Bragg Manhunt*].

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² *Id.*

¹⁸³ Sam Allen & Sam Quinones, *Fort Bragg Slaying Suspect Killed by Sheriff’s Deputies*, L.A. TIMES (Oct. 2, 2011), <http://articles.latimes.com/print/2011/oct/02/local/la-me-ft-bragg-shooting-20111002>.

¹⁸⁴ LPS REFORM TASK FORCE II, *supra* note 32, at 5–6.

psychologists issued a report after thirty months of study that recommended: (1) adding competency to make treatment decisions to the definition of “grave disability”; (2) extending the intensive treatment period of involuntary commitment by two weeks; (3) extending the substantial physical harm period of involuntary commitment from 180-days to a year; and (4) implementing Laura’s Law statewide.¹⁸⁵ As all of these recommendations call for longer periods of involuntary commitment, they would subject California’s mentally disabled to more circumstances under which they would be forced to take psychotropic medication.

Still, some recommendations protect the rights of patients and their family members. For example, because some patients blindly accept medication, competency hearings should not be limited to committed patients who refuse psychotropic medication.¹⁸⁶ Further, considering conservatorship or assisted outpatient treatment as less restrictive alternatives to the intensive treatment period.¹⁸⁷ Also, combining hearings on probable cause for involuntary commitment with competency hearings to help family members avoid going to court multiple times for involuntarily committed loved ones who do not believe they are mentally disabled.¹⁸⁸

Some “strongly oppose[]” the recommendations to broaden the circumstances under which the state’s mentally disabled are subject to involuntary commitment and conservatorship.¹⁸⁹ They believe that while these recommendations may help some, there is “the potential of roping people in who don’t belong.”¹⁹⁰ A better alternative to these recommendations, which would infringe more on patient rights and increase state authority over the mentally disabled, may be for California to refocus on the community-based approach to mental health care so that individuals like Aaron Bassler and Scott Thorpe can get treatment more easily than they can get a gun, and so that individuals like Kelly Thomas can get off the streets. This refocus should be on programs that emphasize

¹⁸⁵ *Id.* at iii, 1, 5–6.

¹⁸⁶ *Id.* at 10.

¹⁸⁷ *Id.* at 11.

¹⁸⁸ *See id.* at 10; *see also* Lee Romney, *Task Force Seeks to Change California’s Mental Health Commitment Law*, L.A. TIMES (Apr. 8, 2012), <http://articles.latimes.com/print/2012/apr/08/local/la-me-mental-health-task-force-20120409> [hereinafter Romney, *Task Force*].

¹⁸⁹ Romney, *Task Force supra* note 188.

¹⁹⁰ *Id.* (quoting attorney with Disability Rights California) (internal quotation marks omitted).

prevention, early intervention, and the community support of families, mentors, and law enforcement—all of which would reduce the need for later forced administration of psychotropic medication and would more effectively treat severe mental disabilities before they fully take hold of individuals.¹⁹¹

IV. PATIENT CHOICE AND COMPLICATIONS WITH PATIENT CHOICE

As mentioned in Part III.A, California has limited circumstances under which mentally disabled individuals can be involuntarily committed and forced to take psychotropic medication. Further, patients who fall under these circumstances must receive certain information *after* medication is administered. But can California provide these patients with some choice *before* medication is administered?

A. PATIENT CHOICE WITH PSYCHOTROPIC MEDICATION

[T]here is no healing when force is involved.

– Charmaine Asher,
involuntarily committed bipolar patient in California¹⁹²

If those without mental disability do not always take medication exactly as prescribed, how can it be ethical to impose a policy of rigid adherence to prescriptions on involuntarily committed patients? For example, “more than half of patients who have had a heart attack stop taking . . . [their] lifesaving medications within three years,”¹⁹³ even though this choice may increase their risk of death.¹⁹⁴ Further, mentally disabled individuals often have the same concerns about side-effects, dependence, over-prescription, and unnatural cures.¹⁹⁵

¹⁹¹ PRESIDENT’S REPORT, *supra* note 29, at 57.

¹⁹² Romney, *Task Force*, *supra* note 188.

¹⁹³ *After Heart Attack Most Patients Stop Taking Life-Saving Drugs*, SCIENCE DAILY (Nov. 6, 2007), <http://www.sciencedaily.com/releases/2007/11/071105120607.htm>.

¹⁹⁴ Richard N. Fogoros, *Stopping Meds After Heart Attack Results in Death*, ABOUT.COM (Oct. 16, 2006), http://heartdisease.about.com/od/heartattack/a/MI_meds.htm.

¹⁹⁵ WORLD HEALTH ORG., ADHERENCE TO LONG-TERM THERAPIES: EVIDENCE FOR ACTION 44 (2003), available at http://www.who.int/chp/knowledge/publications/Adherence_section2.pdf.

1. Benefits of Patient Choice

Giving patients forced to take psychotropic medication some choice in the process has several benefits. Patients facing severe mental disability are highly stressed and suffer from fear, helplessness, and powerlessness at the prospect of being forced to take medication.¹⁹⁶ Providing some meaningful choice to patients forced to take medication could reduce these anxieties and arguably reduce the intrusiveness of any violation of their rights.

Patient choice provides a balance between the right to refuse and forced administration of psychotropic medication. Some autonomy for these patients would help reinforce the belief system of those who dislike taking medication and would help minimize the perception that the state is behaving paternalistically. Further, when there are alternatives to medication, patients avoid the potential side effects of psychotropic medications. Additionally, giving patients some choice may incentivize doctors to listen carefully to what patients have to say.

2. Choice of Medication

One way for California to provide choice to involuntarily committed patients would be to allow them to select the psychotropic medication that may need to be administered to them from among several equally effective medications. Mental health professionals could describe the benefits and drawbacks of different medications to patients at the time of diagnosis or admission to a facility. Patients could then make informed decisions about medications with their doctors. Although patients would still be coerced to a large extent—in that they would still have to take psychotropic medication—they may want to exercise even the narrow choice between two medications, regaining some autonomy in the process with the “right to refuse” one of the medications.¹⁹⁷

For example, assume there is a choice between two equally effective psychotropic medications—in the sense of protecting others and treatment efficacy—for a patient who needs medication.¹⁹⁸ Since neither medication is preferable, a patient’s preference should be the deciding factor, even if

¹⁹⁶ See SAKS, REFUSING CARE, *supra* note 102, at 103, 107.

¹⁹⁷ See Elyn R. Saks, *Putting Patients at the Center of Restraints*, 21 S. CAL. REV. L. & SOC. JUST. 1, 10 (2011) [hereinafter Saks, *Restraints*] (arguing similarly in the restraints context).

¹⁹⁸ *Id.* at 15.

he or she is incompetent.¹⁹⁹ Further, even if one medication is less optimal in terms of treatment efficacy, the patient should be allowed to choose this medication unless the benefits of the other medication are very large.²⁰⁰

This narrow ability of patients to choose may give doctors some incentive to listen more carefully to their patients' requests, as it gives patients some power in the ability to refuse medication. Further, patients are provided with true choice, unlike giving patients the choice to take psychotropic medication peacefully or have it forced on them.²⁰¹ Although the latter option of allowing patients to take required medication on their own volition may save them some trauma and is better than calming patients by lying to them that they will not be medicated, it inflicts additional costs by making patients an "instrument of their own maltreatment" and is more demeaning than providing a choice of medication.²⁰²

3. Choice of Emergency Modality

As mentioned in Part III.A, under a court finding of incompetency in California, psychotropic medication can be administered only after staff have determined that alternatives are unlikely to meet a patient's needs.²⁰³ However, in an emergency, staff need not consider alternatives to psychotropic medication.²⁰⁴ Another way for California to provide choice to involuntarily committed patients would be to allow them to rank how staff should handle their emergency psychotic episodes from a range of options: psychotropic medication, seclusion, physical restraint, or mechanical restraint.²⁰⁵ Because reasonable minds can disagree about which modality is more restrictive—with medication inhibiting thought, restraint inhibiting movement, and seclusion inhibiting interaction—patients should be free to choose for themselves.²⁰⁶ Staff should use the highest ranked modality that protects others the same as or better than the other modalities.²⁰⁷

¹⁹⁹ *Id.*

²⁰⁰ *Id.* at 16.

²⁰¹ *Id.* at 10.

²⁰² *Id.*

²⁰³ CAL. WELF. & INST. CODE § 5332(b) (West 2013).

²⁰⁴ *Id.* § 5332(e).

²⁰⁵ See Saks, *Restraints*, *supra* note 197, at 4.

²⁰⁶ *Id.* at 9.

²⁰⁷ *Id.* at 15.

Three states require that patients be allowed to choose among these four modalities for emergencies.²⁰⁸ Alaska provides “[w]hen practicable, the patient shall be consulted as to the patient’s preference among forms of adequate, medically advisable restraints including medication, and that preference shall be honored.”²⁰⁹ Oregon provides “[t]he patient’s or resident’s wishes for or against particular forms of intervention shall be respected . . . provided that primary consideration shall be given to the need to protect the patient or resident and others in the institution.”²¹⁰ Virginia requires staff to document the patient’s “preferred interventions in the event his behaviors or symptoms become a danger to himself or others.”²¹¹

A patient’s choice as to emergency modalities should be recorded when he or she first enters a mental health facility, or at another time when the patient is calm.²¹² Staff should explain the benefits and drawbacks of each modality and make sure the patient understands.²¹³ Staff should also ask and record what triggers the patient’s episodes and what calms him or her down.²¹⁴ Staff must be sensitive to the feelings of the patient and be careful not to use upsetting terminology, as it could trigger bad memories for patients who were forced into treatment before.

A drawback of eliciting choice when a patient first enters a facility is that he or she is “likely to be highly ‘activated’—that is stressed out, upset, or confused.”²¹⁵ Moreover, “[b]eing told about highly intrusive and degrading things that may or may not happen to him or her may further activate the patient.”²¹⁶ Also, a patient new to the system will have no experience with the different modalities and may not even know what some look like.²¹⁷ Thus, waiting to elicit choice until a patient has experience or showing him or her certain modalities before a choice is made may be better alternatives.²¹⁸

²⁰⁸ *Id.* at 4 & n.28 (citing ALASKA STAT. § 47.30.825(d) (2013); OR. ADMIN. R. 309-112-0015(2) (2013); 12 VA. ADMIN. CODE § 35-115-110(C)(1) (2013)).

²⁰⁹ ALASKA STAT. § 47.30.825(d).

²¹⁰ OR. ADMIN. R. 309-112-0015(2).

²¹¹ 12 VA. ADMIN. CODE § 35-115-110(C)(1).

²¹² Saks, *Restraints*, *supra* note 197, at 11.

²¹³ *Id.*

²¹⁴ *Id.* at 12.

²¹⁵ *Id.* at 11.

²¹⁶ *Id.*

²¹⁷ *Id.*

²¹⁸ *Id.*

4. Implementing Patient Choice

The success of a policy that gives patients choice among psychotropic medications or emergency modalities would depend on how information is shared. For the policy to be effective, a statewide database, similar to the one used for advance health care directives, would need to be created to share client choices between mental hospitals so there is access to the information in all treatment facilities.²¹⁹ If a patient can make a decision for a certain medication or emergency modality in one county, but is subject to all medications and modalities in another, the policy would be meaningless.

The idea of the narrow choice between different medications or emergency modalities can be expanded on to include a true partnership between mental health care providers and patients who share in decision-making and have the option to agree or disagree with treatment plans. Because patients respond differently to different medications,²²⁰ doctors and patients could try several psychotropic medications before finding the right drug at the right dose. Further, patients can be directed to an online resource to find out about the benefits and drawbacks of psychotropic medications. One example of such a resource is the shared decision-making tool on the Substance Abuse and Mental Health Services Administration website.²²¹

B. COMPLICATIONS WITH PATIENT CHOICE

While giving involuntarily committed patients who are forced to take psychotropic medication some choice in the process may be a good policy, implementing it would present significant problems, including determining patient lucidity at the time the choice is made. The incompetent patient scenario is especially problematic when a patient who has been given a choice of medication at diagnosis or a choice of emergency modality on admission to a facility changes his or her mind during an emergency.²²² Staff “may think that the choice patients made in advance, in a calm moment, is more likely to represent their true

²¹⁹ *Advance Health Care Directive Registry*, CAL. SEC’Y OF STATE, <http://www.sos.ca.gov/ahcdr/> (last visited Apr. 19, 2013).

²²⁰ MEDICATIONS REPORT, *supra* note 22, at 1.

²²¹ *Shared Decision Making in Mental Health*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP’T OF HEALTH & HUMAN SERVS., http://www.samhsa.gov/consumersurvivor/sdm/DA_files/Intro_pg1.html (last visited Apr. 19, 2013).

²²² See Saks, *Restraints*, *supra* note 197, at 16.

competent choice.”²²³ On the other hand, staff may think that patients about to receive forced psychotropic medication “have better information on what that is like, and so their contemporaneous choice may be better.”²²⁴ The best solution seems to be if the incompetent patient chooses a medication or emergency modality that is as effective as any other in terms of protecting others, the choice should be respected.²²⁵ However, if a different medication or emergency modality protects others better, there is no choice but for staff to try to assess patient competency during the emergency.²²⁶

The incompetent patient scenario highlights another issue in giving patients a choice between different psychotropic medications or emergency modalities: determining how well each “intervention protects others, which is usually something one cannot completely know.”²²⁷ Medication inhibits thought, but patients may physically harm others. Restraint inhibits movement, but patients may psychologically abuse others. Seclusion inhibits interaction, but patients may attack staff who bring them food.²²⁸

Giving patients a choice as to types of medications may pose a problem. For example, a patient may prefer one drug over another, but in the doctor’s opinion the one the patient is choosing is suboptimal. In addition, giving patients a choice between two drugs with equally terrible side effects may not protect patient autonomy adequately enough.

Finally, giving involuntarily committed patients choice means more will not take psychotropic medication, which could have serious negative consequences. These include preventing effective treatment through medication because severe mental disabilities are allowed to fully take hold of an individual. Further, there is the possibility of death. For example, staff may believe that less powerful psychotropic medications or the emergency modalities of restraint and seclusion are equally effective in terms of protecting others. If patients choose one of these options instead of a more powerful psychotropic medication that sedates them, their condition may continue to worsen, or, like Diane Rodrigues in Part I, they may have a fatal accident.

²²³ *Id.*

²²⁴ *Id.*

²²⁵ *Id.*

²²⁶ *Id.*

²²⁷ *Id.* at 15.

²²⁸ *Id.*

V. HUMANE TREATMENT AND A MODEL LAW

[I]t is the quality of heart . . . as much as the quantity of mind that cures . . . the insane.

– Clifford Whittingham Beers, 1908²²⁹

A. HUMANE TREATMENT

The mentally disabled have the same goals and dreams as other people: they want a decent place to live, suitable work, social activities, and friends they can turn to in times of crisis.²³⁰ Clifford Beers, a preeminent mental health scholar from the early 1900s who was a patient at several mental health institutions himself before reflecting on one he enjoyed,²³¹ puts it well:

What fostered my self-control was a sense of gratitude. The doctors and attendants treated me as a gentleman. Therefore it was not difficult to prove myself one. My every whim was at least considered with a politeness which enabled me to accept a denial with a highly sane equanimity. *Aside from mild tonics I took no other medicine than that most beneficial sort which inheres in kindness. The feeling that, though a prisoner, I could still command obligations from others led me to recognize my own reciprocal obligations, and was a constant source of delight.* The doctors . . . had no difficulty in convincing me that a temporary curtailment of some privileges was for my own good. They all evinced a consistent desire to trust me. In return I trusted them.²³²

. . . .

More fundamental, however, than any technical reform, cure, or prevention—indeed, a condition precedent to all these—is a *changed . . . attitude toward the insane*. They are still human: they love and hate, and have a sense of humor. The worst are usually responsive to kindness. . . . [And they] are oftentimes appreciative.²³³

Beers' point—that the mentally disabled are individuals with feelings—is often forgotten. Their requests of mental health care staff and reactions to forced psychotropic medication are formed as anyone else's

²²⁹ CLIFFORD WHITTINGHAM BEERS, *A MIND THAT FOUND ITSELF* 97 (5th ed. 1921), available at <http://www.gutenberg.org/files/11962/11962-h/11962-h.htm>.

²³⁰ *Helping People with Psychiatric Disabilities Lead Fulfilling Lives*, BOSTON UNIV. CTR. FOR PSYCHIATRIC REHAB., <http://www.bu.edu/cpr/about/> (last visited Apr. 19, 2013).

²³¹ NORMAN DAIN, CLIFFORD W. BEERS: ADVOCATE FOR THE INSANE 19, 25, 36 (1980).

²³² BEERS, *supra* note 229, at 234 (emphasis added).

²³³ *Id.* at 248–49 (emphasis added).

would be. Thus, in a fundamental way, their requests and reactions are reasonable, no matter how unreasonable they may seem. If staff respond politely and kindly to these requests and reactions, and patients feel as if they are listened to, given consideration, and have some choice in the process, they will recognize their own reciprocal duties and be more self-controlled.

These principles guide the model California law on patient choice set forth below.

B. MODEL CALIFORNIA LAW ON PATIENT CHOICE

Minor adjustments to the California Welfare and Institutions Code would substantially improve choice for involuntarily committed patients who are forced to take psychotropic medication. Similar to section 5325.2, titled “[R]ight to refuse antipsychotic medication,” the legislature should add a new section titled “Patient Choice.” Similar to the three state laws dealing with patient choice discussed in Part IV.A.3, the section should read:

A patient forced to take antipsychotic medication, as defined under Section 5008(*l*) to include all psychotropic medications, should be given the choice among medications that equally protect others and the patient, and are similar in terms of treatment efficacy. This choice should be elicited from the patient when antipsychotic medication is first prescribed, or at a later time when he or she is calm.

An involuntarily committed patient should be allowed to rank or provide some combination of the methods of treatment that are used during emergencies—antipsychotic medication, seclusion, physical restraint, or mechanical restraint. The ranking should be elicited from the patient when he or she first enters a facility and should be made available to any statewide database for collecting such information. The first ranked choice or combination should be used by staff during an emergency so long as it equally protects others and the patient.

An alternative to adding a new section to the Welfare and Institutions Code would be to adjust what is currently there. The first paragraph on psychotropic medication can be added as a new subsection (f) under the current section 5332, and titled “Administration of [A]ntipsychotic [M]edication.” The second paragraph dealing with all involuntarily committed patients can be added as a new subsection (i) in section 5325, titled “List of [R]ights . . .,” with the current subsection (i) moving to subsection (j), because it deals with the entire section and should therefore be at the end.

In combination with the model law, it is important to note another point of Beers:

[L]et every relative and friend of [the mentally disabled] remember the Golden Rule . . . *Go to see them, treat them sanely, write to them, keep them informed about the home circle*; let not your devotion flag, nor accept any repulse.²³⁴

Here, Beers recognizes one of the most important areas beyond psychotropic medication for helping the mentally disabled: the support and care of a family member or friend. Mollie Lowery and Steve Lopez, discussed in Part II.A.2, helped Anthony Hamilton and Nathaniel Ayers acknowledge their severe mental disability and accept lifelong treatment focused on therapy, with the option of psychotropic medication. Hamilton paid it forward and engaged in meaningful work by helping others like him. Implementing these concepts along with the model law will dramatically improve California's community-based approach to mental health care.

VI. CONCLUSION

The use of psychotropic medication in California must be defined by patient choice. Though patient choice poses some complications, it provides a humane and holistic approach to those with severe mental disability—including children, homeless individuals, prisoners, and military personnel—and compliments California's community-based approach to mental health care that emphasizes prevention, early intervention, and integrated services. A section similar to the proposed model law on choice of medication and emergency modality should be added to the California Welfare and Institutions Code, putting patient rights at the forefront of the medication decision and involving them in the process so that they truly accept treatment. Finally, treatment with psychotropic medication must be combined with therapy, strong relationships, and meaningful work activities.

²³⁴ *Id.* at 63 (emphasis added).