FROM INSTITUTIONS TO PHARMACEUTICALS: THE UNINTENDED CONSEQUENCES OF MENTAL HEALTH REFORM

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ABSTRACT

California's mental health system has undergone a series of reforms over the past six decades, each framed as a meaningful improvement on what came before. The deinstitutionalization movement of the 1960s and 1970s, formalized through the Lanterman-Petris-Short Act of 1967, ended indefinite involuntary commitment and was widely understood as a civil liberties victory. But the community-based system that was supposed to replace state hospitals was never funded at the scale it required, and as institutional beds declined without a comparable expansion of outpatient services, individuals with serious mental illness increasingly cycled through emergency holds, county jails, and conservatorship placements. This paper argues that forced psychiatric intervention in California did not disappear after deinstitutionalization but instead changed where and how it occurred, particularly for unhoused individuals, for whom the gap between the promise of community care and its reality has been most acute. Drawing on legal scholarship, legislative history, and recent policy data, it traces that shift from the mid-twentieth century to the present. It concludes by examining California's CARE Court program, established in 2022 and expanded in 2025, as the latest instance of a pattern that has defined the state's approach to mental health policy for more than half a century: legal mechanisms that expand before the infrastructure they depend on is in place.

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Introduction

For more than half a century, California has wrestled with how to balance civil liberties with psychiatric intervention. Beginning in the 1960s, reforms aimed to limit indefinite confinement and protect individual rights reshaped the state's mental health system, shifting treatment away from large institutions and toward community-based care. These changes were widely understood as progressive, shaped by growing concern about the overcrowding and coercive practices in mid-twentieth century psychiatric hospitals.

The long-term outcomes of these reforms have not matched their intentions. California's mental health system now faces a psychiatric bed shortage severe enough that the state falls below the minimum threshold identified by the Treatment Advocacy Center as necessary for adequate care, a benchmark it was actually meeting more closely in 1995 than in 2017.[1] Individuals with severe psychiatric conditions cycle between emergency rooms, short-term involuntary holds, and incarceration because long-term treatment options are scarce.[2] This has become especially visible in larger urban areas, where the presence of people experiencing untreated psychiatric illness in public spaces has intensified political pressure for new forms of intervention.

In response to these challenges, California has introduced policies such as the Community Assistance, Recovery, and Empowerment (CARE) Court system, which allows courts to mandate structured treatment plans for individuals with certain severe mental illnesses.[3] Although CARE Court is framed as expanding access to care, it also signals a renewed reliance on court-involved psychiatric intervention. This shift raises questions about the unintended

[1] Treatment Advocacy Center, Psychiatric Bed Loss and Its Consequences (Arlington, VA: Treatment Advocacy Center, 2024).
[2] California Health Care Foundation, Mental Health Almanac 2022 (2022).
[3] California Governor's Office, Fact Sheet: CARE Court (March 2022); California Health and Human Services Agency, CARE Court Framework (March 2022).

consequences of earlier reforms, and whether efforts to reduce coercion have instead reshaped how and where it operates. This paper looks at how California's mental health system changed from the mid-twentieth century to the present, focusing on the shift away from large state institutions and toward community-based care and, more recently, court-involved treatment. By drawing on historical and policy sources, it explores how efforts to limit long-term confinement didn't eliminate forced psychiatric intervention, but instead changed how and where it shows up, especially for people without stable housing.

Before Reform: Institutions and State Control

To understand why policies like CARE Court have gained traction amid psychiatric bed shortages and rising rates of homelessness, it is necessary to look back at earlier transformations in California's mental health system. During the mid-twentieth century, large state psychiatric institutions were the primary sites of care for individuals with severe mental illness. However, by the 1950s and 1960s, these institutions were increasingly criticized for overcrowding and for functioning more as custodial environments than therapeutic spaces.[4] At the same time, the introduction of antipsychotic medications led many reformers to believe that individuals could stabilize outside of long-term institutional settings. This belief contributed to the expansion of community-based treatment and the broader movement toward deinstitutionalization.[5]

In California, these changes were formalized through the Lanterman-Petris-Short (LPS) Act of 1967, which ended indefinite involuntary institutionalization and narrowed the state's authority to detain individuals for psychiatric treatment.[6] While deinstitutionalization occurred

[4] Andrew Scull, "The Discovery of the Asylum Revisited," in Madhouses, Mad-Doctors, and Madmen (Philadelphia: University of Pennsylvania Press, 1981), 144–165; Rab A. Houston, "Asylums: The Historical Perspective Before, During, and After," The Lancet Psychiatry 7, no. 4 (April 2020): 354–362.
[5] George W. Paulson, Closing the Asylums (Jefferson, NC: McFarland & Co., 2012); Houston, "Asylums," 354–362.
[6] California Welfare and Institutions Code §§ 5000 et seq., Lanterman-Petris-Short Act, Chapter 1667 of the 1967 California Statutes, signed by Governor Ronald Reagan, September 2, 1967; Mark Alan Hart, "Civil Commitment of the Mentally Ill in California," Loyola of Los Angeles Law Review 7 (1974): 93–110.

across the United States, California's implementation was shaped by stricter legal limits on involuntary treatment and a decentralized, county-based system. In practice, this meant that even though legal standards for involuntary treatment became stricter, access to consistent care varied widely across counties.

Historians and legal scholars have often examined deinstitutionalization as a civil liberties reform, emphasizing the shift away from indefinite confinement and the expansion of patient rights. Others have focused on the criminalization of mental illness and the growing role of law enforcement in psychiatric crises.[7] However, less attention has been paid to how forced psychiatric treatment itself evolved over time in response to gaps in community infrastructure, particularly among unhoused populations.

Building on this scholarship, this paper traces the shift from large state asylums to community-based care and, more recently, court-involved treatment. It argues that efforts to reduce long-term confinement did not eliminate forced psychiatric intervention in California, but instead changed how and where it occurred. As institutional beds declined, there wasn't a comparable expansion of community-based services. This gap led to greater reliance on emergency psychiatric holds, conservatorship, and, more recently, court-supervised programs such as CARE Court. These patterns are especially clear for individuals who lack stable housing or consistent access to treatment.

To understand how these structural shifts developed, it is necessary to begin with the institutional model that dominated mid-twentieth-century mental health care. By the mid-twentieth century, state psychiatric hospitals were central to the treatment of serious mental

[7] Raymond H. Brescia, "The Criminalization of Mental Illness," Albany Government Law Review 8, no. 2 (2015): vii–xiv; Frank M. Webb, "Criminal Justice and the Mentally Ill," Texas Tech Law Review 49, no. 4 (2017): 817–846; Carl Wu, "Out of Sight, Out of Mind," University of Pennsylvania Journal of Law and Social Change 26, no. 3 (2023): 333–370.

illness in California and across the United States as a whole.[8] These institutions had originally been established with reform-oriented goals, but by the post–World War II period, many were struggling with overcrowding and limited staff resources.[9] As patient populations grew, asylums increasingly functioned as long-term custodial facilities rather than short-term treatment centers. Instead of preparing patients for reintegration into society, many institutions housed individuals for extended periods, sometimes for years.

In California, these institutions were also sites of coercive medical practices. Between the early twentieth century and the 1950s, more than 20,000 individuals were sterilized under the state's eugenics program, and many of them were patients in psychiatric hospitals.[10] These procedures were often carried out without meaningful consent, and disproportionately targeted individuals who were labeled as mentally ill or "unfit". Other interventions used during this period, including psychosurgical procedures such as lobotomies, show how invasive treatments were accepted as part of care in these institutional settings.

The same period that produced the LPS Act was also shaped by a broader reckoning with state authority over medical decision-making. In the early 1970s, congressional investigations and journalistic accounts brought widespread public attention to documented abuses in human subjects research, including experiments conducted on prisoners, institutionalized individuals, and other vulnerable populations without meaningful consent. These revelations contributed directly to the passage of the National Research Act of 1974, which established the framework for institutional review boards, and ultimately to the Belmont Report of 1979, which enshrined the principles of informed consent, beneficence, and justice as foundations of ethical research

[8] Gerald N. Grob, The Mad Among Us: A History of the Care of America's Mentally Ill (Free Press, 1994).
[9] Scull, "Discovery of the Asylum Revisited," 144–165.
[10] Alexandra Minna Stern, Eugenic Nation (Berkeley: University of California Press, 2005).

and treatment.[11] For psychiatric patients, this context mattered in a specific way. Many of the coercive and invasive treatments used in state hospitals, including electroconvulsive therapy administered without consent and psychosurgical procedures performed under institutional authority, were precisely the practices that the emerging medical ethics framework was designed to constrain. The LPS Act and the national movement toward informed consent were therefore connected developments, both responding to the recognition that institutional authority over individuals with mental illness had operated for decades with inadequate legal or ethical limits.

Deinstitutionalization and the LPS Shift

The critique of institutional psychiatry was not only academic. Leonard Frank, a San Francisco activist who had been forcibly committed to a psychiatric hospital in 1962 and subjected to fifty insulin coma treatments and thirty-five rounds of electroconvulsive therapy without his consent, became one of the most influential voices in the psychiatric survivor movement. His 1978 anthology *The History of Shock Treatment* compiled accounts from patients and clinicians documenting what involuntary institutionalization looked like from the inside.[12]

At the same time that public opinions on psychiatric institutions were declining, new pharmaceutical developments contributed to growing optimism about alternatives to long-term hospitalization. Although medication did not eliminate the need for inpatient care, it changed assumptions about what treatment required. If symptoms could be stabilized with medication, then long-term confinement appeared less necessary. This shift helped strengthen political and professional support for community-based care models, which were seen as a more flexible and less restrictive alternative to institutionalization.[13]

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[11] National Research Act of 1974, Public Law 93-348; The Belmont Report (Washington, D.C.: U.S. Department of Health, Education, and Welfare, 1979).
[12] Leonard Roy Frank, ed., The History of Shock Treatment (San Francisco: Leonard Roy Frank, 1978).
[13] Paulson, Closing the Asylums; Houston, "Asylums," 354–362.

Federal policy soon reflected this changing outlook. President John F. Kennedy supported the development of community mental health centers, which were designed to provide outpatient services, crisis intervention, and short-term inpatient care. The goal was to replace large, centralized institutions with smaller, localized systems that would allow individuals to remain connected to their communities. Deinstitutionalization was therefore framed as a progressive reform that would protect autonomy while still ensuring access to treatment.

President Kennedy's proposal aimed to reduce custodial hospital populations by 50 percent, and replace long-term institutionalization with community-based alternatives.[14] Early examples such as Dammasch Hospital in Oregon and community programs in Illinois were cited as evidence that smaller, decentralized systems could reduce costs while maintaining therapeutic outcomes.[15] These models reinforced the belief that large-scale institutions were not only therapeutically outdated but economically inefficient.

In California specifically, this shift toward community-based care was formalized through the Lanterman-Petris-Short (LPS) Act of 1967, which ended the practice of indefinite commitment and introduced more clearly defined criteria for involuntary psychiatric detention. Individuals could only be held if they were considered a danger to themselves, a danger to others, or gravely disabled. Extensions beyond the initial 72-hour hold required additional procedural safeguards and judicial oversight.[16] Legal scholars at the time described LPS as a major civil liberties reform that sought to prevent arbitrary confinement.[17] Although the LPS Act did not eliminate involuntary treatment entirely, it significantly narrowed the circumstances

[14] National Library of Medicine, "Community Mental Health Centers Act," 1963.
[15] Ibid.
[16] Hart, "Civil Commitment of the Mentally Ill," 93–110; Carol A. B. Warren, "Involuntary Commitment for Mental Disorder," Law and Society Review 11, no. 4 (1977): 629–649.
[17] Meredith Lenell, "The Lanterman-Petris-Short Act: A Review After Ten Years," Golden Gate University Law Review 7 (1976): 733–758.

under which the state could impose it and shifted the state's overall system away from long-term institutionalization.

At the same time, narrowing detention authority placed pressure on local systems to provide alternatives. If the state could no longer rely on indefinite hospitalization, then outpatient programs, housing support, and follow-up services became essential rather than optional. Yet as historians of deinstitutionalization have noted, the political momentum for closing hospitals was often stronger than the momentum for funding long-term community infrastructure.[18] Over time, the consequences of that imbalance became increasingly difficult to ignore.

When Community Care Falls Short

These pressures exposed underlying weaknesses in the community-based model itself. While reformers presented deinstitutionalization as both progressive and cost-effective, its success depended on consistent funding, trained personnel, and reliable follow-up care to function. Mike Gorman, executive director of the National Committee Against Mental Illness and one of the most influential mental health policy advocates of the postwar era, warned in a 1969 address to the American Psychiatric Association that the success of community-based programs depended on sustained investment and coordination that federal and state governments had so far failed to provide.[19] After the establishment of Medicaid in 1965, funding for psychiatric services remained inconsistent, and outpatient visits were often only partially covered or excluded altogether.[20] State-level cuts to Medicaid mental-health benefits further jeopardized the stability of community mental health centers.[21] Although community-based care was

[18] Paulson, Closing the Asylums; Scull, "Discovery of the Asylum Revisited," 144–165.
[19] Mike Gorman, "Models of Delivery of Mental Health Services to the Community in the 1970's," address to the 125th Anniversary Meeting of the American Psychiatric Association, May 6, 1969 (Washington, D.C.: National Committee Against Mental Illness, 1969).
[20] National Library of Medicine, "Funding and Community Mental Health," 1966.
[21] Ibid.

presented as both progressive and cost-effective, its long-term viability depended on funding structures that were never fully stabilized.

By the 1970s, observers began noting that the new procedural safeguards under the LPS Act added administrative complexity to psychiatric detention. Involuntary holds required documentation, judicial oversight, and formal review processes.[22] Although these protections were essential for due process, they also made extended commitments more difficult to pursue. Reporting from the period suggests that some psychiatrists were hesitant to initiate longer-term holds because of the legal scrutiny involved.[23] As a result, short-term holds increasingly became the primary tool for crisis stabilization rather than long-term management.

Over time, this structure reshaped the role of psychiatric intervention in California, making it reactive rather than preventative. Rather than addressing instability early, the system was more likely to respond only in moments of visible breakdown. Treatment became concentrated in short-term crisis management, as opposed to sustained and preventative care.

From Care to Control: Homelessness and the Criminal System

At the same time, this shift toward crisis-based care exposed deeper structural gaps in the system, especially around housing and long-term support. Community mental health centers never expanded at the scale reformers had envisioned. Although federal initiatives promoted the development of local treatment facilities, funding was often fragmented and inconsistent. In California, this was especially noticeable because counties were responsible for implementation, meaning that access to care varied widely depending on where someone lived. By the 1980s, broader fiscal pressures further reduced public investment in mental health infrastructure.

[22] Hart, "Civil Commitment of the Mentally Ill," 93–110; Warren, "Involuntary Commitment for Mental Disorder," 629–649.
[23] Harry Nelson, "Mental Health Act: Burden on Public, Police," Los Angeles Times, April 11, 1970, p. 1, ProQuest Historical Newspapers.

Reporting from this period began to document rising homelessness among individuals with serious mental illness, particularly in large urban areas across the state.[24]

Deinstitutionalization alone did not cause homelessness, and it would be overly simplistic to frame it that way. Housing markets, economic shifts, and broader social policy changes all played significant roles. However, the reduction of long-term institutional beds removed one of the few forms of stable, state-supported housing for individuals with severe psychiatric conditions. Without adequate supportive housing or consistent outpatient follow-ups, maintaining stability became far more difficult. In this context, short-term involuntary holds increasingly took the place of long-term hospitalization, but they rarely provided the kind of sustained support needed to prevent repeated crises.

These gaps didn't just leave people without care, but also shifted who responded when crises occurred. As emergency holds became central to psychiatric intervention, police officers increasingly acted as first responders in situations involving severe mental illness. This meant that many individuals experiencing psychiatric crises were more likely to be met by the criminal justice system, rather than receiving consistent medical care. Scholars describe this shift as part of the broader criminalization of mental illness, in which jails and courts began operating as extensions of the mental health system.[25]

This pattern became more pronounced in the decades following deinstitutionalization, particularly as broader political shifts emphasized law enforcement and incarceration. In this context, jails and prisons increasingly functioned as de facto mental health institutions, even though they were never designed to provide any real treatment at all.[26]

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[24] Sherry Bebitch Jeffe, "California: Good Aims, Bad Results," Los Angeles Times, March 22, 1987, p. E3, ProQuest Historical Newspapers; Webb, "Criminal Justice and the Mentally Ill," 817–846.
[25] Brescia, "Criminalization of Mental Illness," vii–xiv; Webb, "Criminal Justice and the Mentally Ill," 817–846.
[26] Michael Rembis, "The New Asylums," in Disability Incarcerated, ed. Liat Ben-Moshe, Chris Chapman, and Allison C. Carey (New York: Palgrave Macmillan, 2014), 139–159.

The growing involvement of law enforcement in psychiatric crises also changed how mental illness was managed in public spaces, especially for unhoused individuals. This shift was not necessarily the result of a single policy decision to criminalize mental illness. Instead, it reflected the absence of stable alternatives. When hospitals discharged patients quickly and outpatient services lacked continuity, law enforcement often became the default response to visible psychiatric instability. Rather than eliminating state intervention, the post-LPS framework redistributed it across emergency departments, short-term holds, and the criminal justice system.

This shift also raises broader questions about what interventions like emergency holds and police involvement in psychiatric crises are actually meant to do. Legal scholar Carl Wu, who studies the relationship between homelessness policy and state intervention, argues that policies aimed at addressing homelessness often operate through psychiatric intervention, effectively removing individuals from public spaces under the justification of treatment.[27] In this sense, forced psychiatric intervention can function both as a form of care and as a form of social regulation.

This does not mean that all interventions are punitive or unnecessary. However, it does suggest that the line between treatment and control is often blurred, particularly in cases where individuals lack consistent access to care or long-term support. This is especially relevant for unhoused individuals, whose living conditions make their symptoms more visible and more likely to be interpreted as something requiring emergency intervention. As a result, those with the least access to consistent care are the ones who instead end up relying on repeated, short-term forms of intervention. This means that the system doesn't just fail to reach certain populations, it interacts with them through moments of crisis, which reinforces cycles of instability rather than resolving them. When intervention becomes one of the only available responses to visible

[27] Wu, "Out of Sight, Out of Mind," 333–370.

instability, it starts to do two things at once. It addresses immediate crises, but also serves as a way to manage who is allowed to remain in public spaces. These dynamics carried into the 1990s, shaping the conditions under which a new framework for psychiatric care would take hold.

Recovery Without Resources

By the early 1990s, a new framework had begun to reshape how mental health professionals, advocates, and policymakers talked about psychiatric care in California and across the country. Recovery-oriented models, which had been developing within clinical psychology and advocacy communities since the late 1980s, gained increasing institutional traction during this period. Where earlier psychiatric models had often treated serious mental illness as a chronic condition requiring long-term supervision, recovery discourse reframed psychiatric conditions as manageable with appropriate support, emphasizing that individuals could lead meaningful, self-directed lives outside of institutional settings. This shift aligned on the surface with the civil liberties goals that had motivated deinstitutionalization two decades earlier. Both frameworks were skeptical of long-term confinement, and both emphasized the importance of community integration and individual autonomy.

What made this era distinct, however, was the political and fiscal environment in which recovery ideology took hold. The consequences of earlier policy decisions were still shaping California's public health infrastructure in ways that constrained what recovery-oriented care could actually accomplish. As governor of California, Ronald Reagan had signed the LPS Act in September 1967, a move that accelerated the closure of state hospitals and the reduction of the Department of Mental Hygiene's workforce, with more than 2,000 state mental health workers laid off in the years that followed. The community mental health centers that reformers had

envisioned as the backbone of the post-institutional system were never funded at the scale required to absorb that capacity. When Reagan later became president, his administration converted federal mental health funding into block grants to states through the Omnibus Budget Reconciliation Act of 1981, repealing the Mental Health Systems Act that the Carter administration had passed the previous year and reducing federal oversight in ways that allowed states to redirect funds with fewer restrictions.[28] California absorbed those changes unevenly, and many of the community programs that were supposed to provide sustained outpatient care remained chronically underfunded throughout the 1980s. The recovery framework, whatever its clinical merits, therefore emerged at a moment when state budgets were under significant strain. Outpatient and short-term crisis services were comparatively cheaper than inpatient care, and the recovery model fit within a policy environment that was looking for ways to reduce institutional spending without appearing to abandon vulnerable populations.

At the same time, California's political landscape was being reshaped by forces that had little to do with mental health policy and everything to do with where people with mental illness would end up. The War on Drugs, accelerating through the 1980s under federal mandatory minimum sentencing guidelines, vastly expanded the criminalization of behavior that overlapped substantially with the survival strategies of people with untreated serious mental illness. California's own "three strikes" law, passed by ballot initiative in 1994, further accelerated incarceration rates across the state.[29] As historian Anne Parsons documents in *From Asylum to Prison: Deinstitutionalization and the Rise of Mass Incarceration after 1945*, the decline of the state psychiatric hospital and the rise of mass incarceration were not isolated but connected developments.[30] The same population that had been managed through institutionalization was

[28] Omnibus Budget Reconciliation Act of 1981, Public Law 97-35.
[29] California Proposition 184, Three Strikes and You're Out, 1994.
[30] Anne E. Parsons, From Asylum to Prison (Chapel Hill: University of North Carolina Press, 2018).

increasingly managed through the criminal justice system, which was neither designed nor funded to provide psychiatric care. By the late 1990s, California's county jails held a disproportionate share of individuals with serious mental illness who had no other consistent point of contact with any institutional system at all.

These failures weren't incidental to the recovery framework. Instead they revealed exactly the gap between what the model assumed and what actually existed: that the material conditions necessary for self-directed recovery, including stable housing, reliable medication access, consistent case management, and transportation, were not reasonably available to those who needed them. For individuals with moderate symptoms and stable living situations, outpatient care was often workable. For individuals without housing, however, the same system functioned very differently.

Laura's Law and the Push for Earlier Intervention

The case of Laura Wilcox illustrates how these structural failures became visible in California and eventually pushed the legislature toward new forms of intervention. In January 2001, Wilcox, a nineteen-year-old college sophomore working as a temporary receptionist at the Nevada County Department of Behavioral Health during her winter break from college, was shot and killed by Scott Harlan Thorpe, a forty-year-old man with a documented history of severe mental illness who had been a patient at the clinic and had arrived for a scheduled appointment to see his psychiatrist that day. Thorpe had been receiving outpatient mental health counseling but had resisted his family's and a social worker's attempts to have him hospitalized. Under the existing standards established by the LPS Act, he did not meet the threshold for involuntary intervention until he had already caused serious harm. His situation reflected a pattern that advocates and clinicians in California had been documenting for years: individuals with serious

psychiatric conditions who declined or resisted more intensive voluntary care, and whose families had no legal mechanism to compel treatment short of an acute crisis. Laura's death, along with the deaths of two others killed in the same rampage, became the basis for what would become known as Laura's Law, California's assisted outpatient treatment statute, passed by the state legislature and signed by Governor Gray Davis in 2002.[31] The law faced immediate resistance from disability rights advocates and psychiatric survivor organizations, who warned that expanding involuntary outpatient treatment risked replicating the coercive patterns that earlier reforms had been designed to correct, a tension that would remain unresolved well into the following decade. The law allowed courts to order outpatient treatment for individuals who met certain criteria related to prior hospitalizations and danger, though it stopped short of mandating medication and left implementation to individual counties. As of the early 2010s, the majority of California counties had not implemented it, citing cost and civil liberties concerns, which itself reflected the ongoing tension between the desire for earlier intervention and the institutional and ideological resistance to it.

For individuals with stable housing and access to consistent outpatient care, the post-LPS system offered meaningful alternatives to institutionalization. For individuals cycling between encampments, emergency rooms, and short-term holds, the same system offered very little continuity. This divergence had been visible for years, but by the 2000s it had become impossible to ignore, particularly as California's unhoused population grew and the overlap between homelessness and serious mental illness became more pronounced in public spaces across the state's urban areas.

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[31] California Assembly Bill 1421, Laura's Law, signed by Governor Gray Davis, September 28, 2002; Maia Szalavitz, "How Can We Treat the Seriously Mentally Ill Before Tragedy Occurs, Instead of After?" *Pacific Standard*, January 4, 2016, psmag.com/social-justice/how-can-we-treat-the-seriously-mentally-ill-before-tragedy-occurs-instead-of-after/

A System Under Strain: Beds, ERs, and Crisis Care

At the same time, a separate but related crisis was reshaping California's broader institutional landscape. The consequences of mass incarceration, which had been building since the 1980s, reached a point of acute pressure in the first decade of the 2000s. California's prison system was so severely overcrowded that in 2011, the United States Supreme Court ruled in Brown v. Plata that conditions in the state's prisons constituted cruel and unusual punishment, ordering California to reduce its prison population significantly.[32] The decision prompted a major shift in state policy through Assembly Bill 109, known as prison realignment, which transferred responsibility for lower-level offenders from state prisons to county jails.[33] For the mental health system, this was significant because a disproportionate share of those being realigned had histories of psychiatric illness. Counties were now absorbing a population with complex needs at precisely the moment when their mental health infrastructure was already strained.

The physical consequences of these layered pressures are visible in how California's mental health system actually operates on the ground. A 2021 study by RAND researchers, drawing on occupancy rates, wait list volumes, and requested transfers, estimated that California requires approximately 50.5 inpatient psychiatric beds per 100,000 adults to meet existing demand, a figure consistent with the benchmark the Treatment Advocacy Center has identified as a reasonable minimum for adequate care.[34] California has historically fallen far below that standard, and a California Legislative Analyst's Office review confirmed that the state was performing worse on this metric in 2017 than it had been in 1995.[35] This gap is not the result of a single decision but of decades of institutional closures that were never offset by equivalent

[32] Brown v. Plata, 563 U.S. 493 (2011).
[33] California Assembly Bill 109, Public Safety Realignment Act, signed by Governor Jerry Brown, April 4, 2011.
[34] Treatment Advocacy Center, Psychiatric Bed Loss and Its Consequences.
[35] California Legislative Analyst's Office, The 2021-22 Budget: Behavioral Health Continuum Infrastructure Funding Proposal (Sacramento: LAO, February 2021).

reinvestment in inpatient capacity. The hospitals that closed under deinstitutionalization were not replaced. The community mental health centers that were supposed to absorb that demand were chronically underfunded. What remained was a system in which the physical infrastructure for sustained psychiatric care had contracted dramatically, while the population requiring it had not.

In practice, this shortage has pushed emergency departments into a role they were not designed to fill. When someone in California experiences a severe psychiatric episode, the first point of contact is often an emergency room, where they may wait for hours or days for an available inpatient bed. This phenomenon, known as psychiatric boarding, has been documented extensively in California hospitals. Patients in acute psychiatric distress occupy emergency department beds while awaiting placement, sometimes for days at a time, in spaces that lack the staffing and clinical environment appropriate for sustained psychiatric care. When beds do become available, they are often in facilities at significant distances from the patient's county of origin, making follow-up care more difficult to coordinate once someone is discharged. In cases where no bed can be located at all, individuals may be stabilized briefly and released back into the same conditions that produced the crisis.

This dynamic shapes what stabilization actually means in the current system. The immediate clinical goal becomes managing acute symptoms well enough to allow discharge, rather than addressing the conditions that led to the crisis in the first place. Clinicians working in emergency settings often recognize that a patient requires more sustained care than the system can provide, but the absence of available beds forecloses that option. Stabilization, in this sense, has come to substitute for treatment in a way that keeps the immediate crisis from escalating while doing little to prevent the next one.

The population most affected by these structural gaps is not evenly distributed. According to data from the National Alliance on Mental Illness, approximately 161,548 individuals in California are unhoused, and roughly 25 percent of that population lives with a serious mental illness.[36] This overlap is not incidental. It reflects the cumulative consequences of a system that reduced long-term institutional capacity without building the housing and community support infrastructure that would have allowed individuals with serious psychiatric conditions to maintain stability outside of those institutions. For this population, the absence of stable housing does not simply make recovery harder. It makes the assumptions underlying both the recovery framework and the post-LPS outpatient model functionally unreachable.

What makes California's situation distinct from other states is the combination of its legal framework, its decentralized county structure, and the scale of its unhoused population. Other states that underwent deinstitutionalization experienced similar patterns of bed decline and increased reliance on emergency intervention, but California's strict LPS standards, its size, and the significant variation in county-level resources have produced a system in which the gaps are both broader and more difficult to address through statewide policy. The visibility of untreated mental illness in California's cities, particularly in Los Angeles and San Francisco, reflects not simply a failure of political will but the predictable outcome of decades of decisions that prioritized reducing institutional capacity without comparably investing in what was supposed to replace it.

For unhoused individuals with serious mental illness, the system's primary point of contact is not a clinician or a case manager. It is a police officer, an emergency room, or a short-term hold. Research on how psychiatric crises unfold for this population in California shows that the same individuals frequently cycle through the same emergency departments,

[36] NAMI California, State Fact Sheet (2023).

accumulating repeated holds without any corresponding improvement in their housing or treatment stability. Each contact with the system is, in isolation, a response to a crisis. Taken together, they constitute a pattern that the system does not have the infrastructure to interrupt.

Researchers studying the long-term consequences of deinstitutionalization have described the phenomenon as transinstitutionalization, referring to the process by which the decline of state psychiatric hospitals corresponds not with a reduction in institutional involvement in the lives of people with serious mental illness, but with a shift in which institutions bear that involvement. In California, what was once concentrated in state hospitals has dispersed across emergency departments, county jails, short-term inpatient units, and conservatorship placements. The setting changes; the underlying dynamic of state-managed confinement and crisis response does not. The conservatorship system offers one of the clearest illustrations of this shift. A study of psychiatric hospitalizations among unhoused individuals in Los Angeles, published in *Psychiatric Services* in 2022, found that those placed under conservatorship remained hospitalized for significantly longer periods than other patients, staying on average more than five months compared to less than one month for the broader patient population.[37] The authors noted that while conservatorship can provide a degree of structured supervision for individuals who have repeatedly cycled through emergency holds without stabilizing, extended placements of this length also occupy the limited inpatient beds that other patients in acute crisis need access to. The result is a system under pressure from multiple directions at once, in which the tools available for managing the most severe cases are the same tools that constrain capacity for everyone else.

[37] Kristen R. Choi et al., "Mental Health Conservatorship Among Homeless People With Serious Mental Illness," Psychiatric Services 73, no. 6 (2022): 613–619.

County jails have absorbed a share of this burden at the same time. As inpatient psychiatric capacity declined and emergency holds remained short, individuals whose psychiatric crises intersected with minor criminal offenses increasingly moved through the criminal justice system rather than the mental health system. California's jails are not equipped to provide sustained psychiatric treatment, and the conditions of incarceration often worsen psychiatric symptoms rather than addressing them. Yet for many individuals with serious mental illness and no stable housing, repeated short-term incarceration has become one of the few consistent points of contact with any institutional system at all. This is what transinstitutionalization looks like in practice: not a return to the large state hospital, but a dispersal of the same population across settings that are less equipped, less funded, and less designed to provide care than even the institutions that reformers rightly criticized half a century ago.

CARE Court and the Return of Court Involvement

The failures documented across California's mental health system did not go unaddressed politically, but the responses they generated were shaped by the same constraints that had produced the failures in the first place. By the late 2010s, public pressure around visible psychiatric distress in California's cities had intensified considerably. Encampments in Los Angeles, San Francisco, and San Diego had grown substantially, and the presence of individuals experiencing severe and untreated psychiatric illness in public spaces had become a focal point for media coverage, legal disputes, and legislative debate. Advocacy organizations representing families of people with serious mental illness pushed for stronger intervention tools. Business associations and local governments in urban areas pressed for policies that would move individuals off streets and into treatment. The political coalition that formed around these

concerns was ideologically unusual for California, drawing together voices from both ends of the spectrum who agreed, for different reasons, that the existing system was not working.

The legislation that emerged from this moment was Senate Bill 1338, signed by Governor Gavin Newsom in September 2022, which established the Community Assistance, Recovery, and Empowerment Court system.[38] CARE Court represented a significant departure from the post-LPS framework in one specific sense: it created a civil court mechanism for mandating structured treatment plans for individuals who had not necessarily met the criteria for involuntary psychiatric detention. Where the LPS Act had responded to the abuses of indefinite institutionalization by raising the threshold for state intervention, CARE Court responded to the failures of the post-LPS era by creating a new pathway for intervention that operated below that threshold. It did not restore the old commitment standard, but it introduced a form of court-supervised treatment that had no direct predecessor in California law.

The political context in which CARE Court was developed is worth noting. The COVID-19 pandemic had deepened existing disparities in access to psychiatric care across California. Outpatient services that were already inconsistently available became harder to access during periods of closure and reduced capacity, and the economic disruption of 2020 and 2021 contributed to increased housing instability across the state. For individuals with serious mental illness who were already marginally housed, the pandemic period accelerated deterioration that the existing system had limited tools to address. Legislative discussions leading up to SB 1338 explicitly referenced these conditions, framing CARE Court as a response to a crisis that had become visible enough to demand a structural answer.

[38] California Senate Bill 1338, Community Assistance, Recovery, and Empowerment (CARE) Court Program, signed by Governor Gavin Newsom, September 14, 2022.

Under the CARE Court framework, petitions may be filed by a defined set of individuals and entities, including family members, first responders, and county behavioral health agencies. To qualify, an individual must have a diagnosis of a severe psychotic disorder, including schizophrenia, schizoaffective disorder, bipolar I disorder with psychotic features, or another psychotic-spectrum condition, and must demonstrate a pattern of deterioration suggesting impaired decision-making capacity. The court evaluates whether the individual meets eligibility criteria and, if so, orders the development of a Care Plan that can last up to twelve months, with the option to renew for an additional twelve months. A 2025 expansion of the program through Senate Bill 27, also authored by Senator Tom Umberg and signed by Governor Newsom in October of that year, broadened eligibility criteria further and clarified guidance for courts, in part to address the high dismissal rates that had emerged during the program's first two years of implementation.[39] Care Plans are individualized and may include prescribed medications, housing support, case management, and other supportive services. All counties in California are required to participate in the program, which was phased in beginning with seven pilot counties in 2023 before expanding statewide.

Several features of CARE Court's design reflect an attempt to distinguish it from earlier and more coercive forms of psychiatric intervention. The program does not authorize involuntary medication, and individuals retain the right to legal representation throughout the process. If a participant fails to comply with a Care Plan, the court's primary recourse is to refer the case to conservatorship proceedings rather than to impose direct sanctions. Supporters of the program have argued that this structure places it meaningfully between purely voluntary outpatient care and full conservatorship, offering a middle pathway that can facilitate earlier intervention without the deprivation of rights that conservatorship entails. The framing used by Governor

[39] California Senate Bill 27, signed by Governor Gavin Newsom, October 10, 2025.

Newsom and other proponents emphasized treatment and connection to services rather than compulsion, presenting CARE Court as an expansion of access to care rather than an expansion of state authority.

The early implementation data, however, reveal a significant gap between the program's stated ambitions and its actual reach. As of May 2025, early reports suggested that approximately 2,008 petitions had been filed across California since the program launched in October 2023, according to the California Health and Human Services Agency. By July 2025, that number had reached 2,421 total petitions filed, of which only 528 had resulted in treatment agreements or plans, according to the Judicial Council of California.[40] The program's designers had initially estimated that between 7,000 and 12,000 individuals in California would qualify for CARE Court, meaning that even accounting for the program's early stage of implementation, participation remained far below projected levels. By the end of October 2025, following SB 27's expansion, petitions had climbed to 3,092, with 684 treatment agreements approved and only 22 court-ordered plans, suggesting that even as the program expanded, courts were ordering far less than the program's structure implied they could.

Reform Without Support

The high dismissal rate reflects several overlapping problems. In some cases, individuals did not meet the eligibility criteria as narrowly defined by the statute. In others, petitions were filed without adequate documentation to satisfy the court's requirements. In still others, individuals connected voluntarily to services before the formal court process was completed, which in some counties resulted in petition dismissal even when the underlying need for care remained. For participants who did receive formal Care Plans, early data suggest improved

[40] California Health and Human Services Agency, CARE Act Implementation Update (Sacramento: CalHHS, July 2025); Marisa Kendall, Jocelyn Wiener, and Erica Yee, "Is Newsom's CARE Court Making a Difference?" CalMatters, September 2, 2025.

access to medication and housing support compared to their prior circumstances. These outcomes are meaningful for the individuals involved. But they do not alter the larger picture, which is that CARE Court as currently implemented reaches only a small fraction of the population it was designed to serve.

The reasons for this limited reach are not primarily procedural. They reflect the same structural constraints that have shaped California's mental health system throughout the period this paper has examined. CARE Court can mandate the development of a treatment plan, but it cannot create the housing placements, outpatient providers, and psychiatric workforce capacity that those plans depend on. Because California's mental health system remains decentralized and county-administered, the resources available to fulfill a court-ordered Care Plan vary significantly depending on where a petition is filed. A participant in a county with robust housing stock and an adequate psychiatric workforce has meaningfully different prospects than a participant in a county where both are scarce, even if both receive identical court orders.

This gap between court authority and resource availability is not a design flaw that could be corrected by adjusting the statute. It is the same gap that has undermined every preceding layer of reform. The LPS Act narrowed detention criteria without guaranteeing that the outpatient alternatives would be funded. Laura's Law authorized assisted outpatient treatment without compelling counties to implement it. The recovery framework emphasized community integration without ensuring that the housing and services required for integration would exist. CARE Court mandates treatment plans without ensuring that the components of those plans are available. In each case, the legal mechanism expanded before the infrastructure it depended on was in place, and in each case the populations with the least access to stable housing and consistent care were the ones most affected by that gap.

Conclusion: New Systems, Old Problems

What CARE Court does expand, in ways that earlier reforms did not, is the scope of formal judicial involvement in psychiatric care. Court oversight introduces a new institutional actor into the treatment relationship, one with its own procedural requirements, timelines, and forms of authority. Whether that added layer of oversight improves outcomes for participants depends almost entirely on whether counties can deliver the services that Care Plans specify. In the counties where resources are most limited, court involvement may add administrative complexity without adding meaningful support.

Critics of CARE Court, including disability rights organizations and psychiatric survivor advocates, have argued that the program's framing as a treatment expansion obscures its function as an expansion of state authority over a population that already faces disproportionate surveillance and intervention. These concerns are not without historical grounding. The populations most likely to be subject to CARE Court petitions are the same populations that have been most affected by the failures documented throughout this paper: individuals who are unhoused, who lack consistent access to care, and whose symptoms are most visible in public spaces. Legal scholar Carl Wu, writing on the relationship between homelessness policy and psychiatric intervention in California, has argued that policies framed around treatment often simultaneously function as mechanisms for managing who is permitted to remain in public spaces, and that this dual function is not incidental but structural. Whether CARE Court ultimately serves primarily as a treatment pathway or primarily as a form of social regulation will depend in large part on whether the housing and services it mandates are actually delivered, and for which participants.[41]

[41] Wu, "Out of Sight, Out of Mind," 333–370.

Supporters, meanwhile, point to early cases in which CARE Court participation connected individuals to housing and medication who had previously cycled through the system without any stable treatment relationship. For some participants, the program has provided a degree of structured support that voluntary outpatient services had not.[42] These outcomes are real and should not be dismissed. The question is not whether CARE Court can help some individuals, but whether it can address the scale of the problem it was created to respond to, and whether the structural investments required to make it work will follow the legislation that created it.

Forced psychiatric treatment in California did not end with deinstitutionalization, and it has not simply returned in the form it took before the LPS Act. What this paper has traced is something more gradual and more diffuse: a series of reforms, each responding to the failures of the one before it, that have collectively shifted where and how psychiatric intervention occurs without resolving the conditions that make intervention feel necessary in the first place. The large state hospital gave way to the community mental health center that was never adequately funded. The community mental health center gave way to the emergency hold and the county jail.[43] The emergency hold gave way to conservatorship for those who cycled most frequently. And now conservatorship is joined by CARE Court, a civil legal mechanism that extends the reach of court-supervised treatment to individuals who do not yet meet the existing threshold for involuntary detention.

Each of these transitions has been framed, at the time, as a progressive improvement on what preceded it. Each has addressed some of the most visible problems of the prior system

[42] California Health and Human Services Agency, CARE Act Implementation Update (Sacramento: CalHHS, July 2025); Kendall, Wiener, and Yee, "Is Newsom's CARE Court Making a Difference?" CalMatters, September 2, 2025.
[43] Rembis, "The New Asylums," 139–159; Parsons, From Asylum to Prison.

while leaving structural gaps that produced new forms of instability for the most vulnerable populations. The through-line across all of them is not a failure of legislative intent but a failure of investment: a persistent unwillingness to fund the housing, workforce, and long-term community infrastructure that would allow individuals with serious mental illness to maintain stability outside of institutional settings. Legal mechanisms have repeatedly expanded faster than the resources they depend on, and the populations with the least access to stable housing and consistent care have borne the costs of that imbalance most directly.

The debates that produced the LPS Act, that generated Laura's Law, and that ultimately created CARE Court share a common structure: a visible crisis, a legislative response, and an assumption that the legal mechanism will be sufficient without the accompanying investment in infrastructure. If California's history suggests anything, it is that the next iteration of reform will face the same limitations unless it is accompanied by real commitments to housing, outpatient infrastructure, psychiatric workforce expansion, and the kinds of sustained community support that allow individuals with serious mental illness to live outside of crisis. Without that foundation, court orders will continue to mandate care that counties cannot deliver, and the system will continue to respond to the same people in the same moments of visible breakdown, shifting where that response occurs without changing what produces it.

Bibliography

The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research. Washington, D.C.: U.S. Department of Health, Education, and Welfare, 1979.

Brescia, Raymond H. "The Criminalization of Mental Illness." *Albany Government Law Review* 8, no. 2 (2015): vii–xiv.

Brown v. Plata, 563 U.S. 493 (2011).

California Assembly Bill 109. Public Safety Realignment Act. Signed by Governor Jerry Brown, April 4, 2011.

California Assembly Bill 1421. Laura's Law. Introduced by Assemblywoman Helen Thomson (D-Davis). Signed by Governor Gray Davis, September 28, 2002.

California Governor's Office. *Fact Sheet: CARE Court*. March 2022. www.gov.ca.gov/wp-content/uploads/2022/03/Fact-Sheet_-CARE-Court-1.pdf.

California Health and Human Services Agency. *CARE Act Implementation Update*. Sacramento: CalHHS, July 2025.

California Health and Human Services Agency. *CARE Court Framework*. March 2022. www.chhs.ca.gov/wp-content/uploads/2022/03/CARE-Court-Framework_web.pdf.

California Health Care Foundation. *Mental Health Almanac 2022*. 2022. https://www.chcf.org/wp-content/uploads/2022/07/MentalHealthAlmanac2022QRG.pdf.

California Legislative Analyst's Office. *The 2021-22 Budget: Behavioral Health Continuum Infrastructure Funding Proposal*. Sacramento: LAO, February 2021.

California Proposition 184. Three Strikes and You're Out. 1994.

California Senate Bill 1338. Community Assistance, Recovery, and Empowerment (CARE) Court Program. Authored by Senators Tom Umberg and Susan Talamantes Eggman. Signed by Governor Gavin Newsom, September 14, 2022.

California Senate Bill 27. Authored by Senator Tom Umberg. Signed by Governor Gavin Newsom, October 10, 2025.

California Welfare and Institutions Code §§ 5000 et seq. Lanterman-Petris-Short Act. Chapter 1667 of the 1967 California Statutes. Signed by Governor Ronald Reagan, September 2, 1967.

Choi, Kristen R., Enrico G. Castillo, Marissa J. Seamans, Joseph H. Grotts, Shayan Rab, Ippolytos Kalofonos, Meredith Mead, Imani J. Walker, and Sarah L. Starks. "Mental Health Conservatorship Among Homeless People With Serious Mental Illness." *Psychiatric Services* 73, no. 6 (2022): 613–619. https://pmc.ncbi.nlm.nih.gov/articles/PMC9132544/.

Frank, Leonard Roy, ed. *The History of Shock Treatment*. San Francisco: Leonard Roy Frank, 1978.

Gorman, Mike. "Models of Delivery of Mental Health Services to the Community in the 1970's." Address to the 125th Anniversary Meeting of the American Psychiatric Association, Session VII: Patterns of Delivery of Mental Health Services, May 6, 1969, Miami, Florida. Washington, D.C.: National Committee Against Mental Illness, 1969. http://resource.nlm.nih.gov/101743403X86.

Grob, Gerald N. *The Mad Among Us: A History of the Care of America's Mentally Ill*. Free Press, 1994.

Hart, Mark Alan. "Civil Commitment of the Mentally Ill in California: The Lanterman-Petris-Short Act." *Loyola of Los Angeles Law Review* 7 (1974): 93–110.

Houston, Rab A. "Asylums: The Historical Perspective Before, During, and After." *The Lancet Psychiatry* 7, no. 4 (April 2020): 354–362. https://doi.org/10.1016/S2215-0366(19)30395-5.

Jeffe, Sherry Bebitch. "California: Good Aims, Bad Results." *Los Angeles Times*, March 22, 1987, p. E3. ProQuest Historical Newspapers.

Kendall, Marisa, Jocelyn Wiener, and Erica Yee. "Is Newsom's CARE Court Making a Difference? What the Data Show." *CalMatters*, September 2, 2025.

Lenell, Meredith. "The Lanterman-Petris-Short Act: A Review After Ten Years." *Golden Gate University Law Review* 7 (1976): 733–758.

NAMI California. *State Fact Sheet*. 2023. https://www.nami.org/wp-content/uploads/2023/07/CaliforniaStateFactSheet.pdf.

National Library of Medicine. "Community Mental Health Centers Act." 1963. http://resource.nlm.nih.gov/101743403X6.

National Library of Medicine. "Funding and Community Mental Health." 1966. http://resource.nlm.nih.gov/101743403X10.

National Research Act of 1974. Public Law 93-348.

Nelson, Harry. "Mental Health Act: Burden on Public, Police: New State Legislation Stirs Up Complaints but Also Gains Supporters." *Los Angeles Times*, April 11, 1970, p. 1. ProQuest Historical Newspapers.

Omnibus Budget Reconciliation Act of 1981. Public Law 97-35.

Parsons, Anne E. *From Asylum to Prison: Deinstitutionalization and the Rise of Mass Incarceration after 1945*. Chapel Hill: University of North Carolina Press, 2018.

Paulson, George W. *Closing the Asylums : Causes and Consequences of the Deinstitutionalization Movement.* Jefferson, N.C: McFarland & Co., 2012.

Rembis, Michael. "The New Asylums: Madness and Mass Incarceration in the Neoliberal Era." In *Disability Incarcerated: Imprisonment and Disability in the United States and Canada*, ed. Liat Ben-Moshe, Chris Chapman, and Allison C. Carey, 139–159. New York: Palgrave Macmillan, 2014.

Scull, Andrew. "The Discovery of the Asylum Revisited: Lunacy Reform in the New American Republic." In *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, 144–165. Philadelphia: University of Pennsylvania Press, 1981.

Stern, Alexandra Minna. *Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America*. 1st ed. Berkeley: University of California Press, 2005.

Szalavitz, Maia. "How Can We Treat the Seriously Mentally Ill Before Tragedy Occurs, Instead of After?" *Pacific Standard*, January 4, 2016. https://psmag.com/social-justice/how-can-we-treat-the-seriously-mentally-ill-before-tragedy-occurs-instead-of-after/.

Treatment Advocacy Center. *Psychiatric Bed Loss and Its Consequences*. Arlington, VA: Treatment Advocacy Center, 2024. https://www.tac.org/wp-content/uploads/2024/03/TAC_ORPA_ResearchSummary1.24.pdf.

Warren, Carol A. B. "Involuntary Commitment for Mental Disorder: The Application of California's Lanterman-Petris-Short Act." *Law and Society Review* 11, no. 4 (1977): 629–649.

Webb, Frank M. "Criminal Justice and the Mentally Ill: Strange Bedfellows." *Texas Tech Law Review* 49, no. 4 (2017): 817–846. HeinOnline, https://heinonline.org/HOL/P?h=hein.journals/text49&i=857.

Wu, Carl. "Out of Sight, Out of Mind: Removing Unhoused People by Proxy of Mental Illness." *University of Pennsylvania Journal of Law and Social Change* 26, no. 3 (2023): 333–370. https://scholarship.law.upenn.edu/jlasc/vol26/iss3/2.