Commentary: The Law of Unintended Consequences

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I was pleased to be asked to comment on the American Psychiatric Association's new "Resource Document on Mandatory Outpatient Treatment."[1] As a long-time legal aid lawyer representing people with psychiatric disabilities, I am interested in the social organization of mental health care. I regret to say that I found the Resource Document frustrating because it fails to engage the knotty questions of public policy raised by mandatory outpatient treatment (MOT).

Like any lawyer who represents people with mental illness, I have met unhappy people who could not bring themselves to take medication that might have given them significantly better lives. Some of those people would undoubtedly have been better off if they had been forced to take that medication. Notwithstanding my recognition of these clients' needs, I still worked hard as one of the organizers of the successful campaign to defeat MOT in the Connecticut legislature. Is there a contradiction here? I do not think so. To make a determination that some people might benefit from coercion is merely the beginning of an inquiry into social policy, not the end of it. As my public administration teacher at the Kennedy School was wont to bellow to the class when the policy wonks were planning to revolutionize the country, "The law of unintended consequences has not been repealed."

This point seems to have been missed by the authors of the Resource Document. I am not really surprised to learn that "studies show" that some treatment-resistant mentally ill people do somewhat better when MOT is an available option in a fully funded and well run mental health system. I am more surprised that the observed effect of MOT is so marginal in programs that are ideologically committed to it. But even if some would benefit, the question that has to be asked before we pass a law is whether the potential benefits outweigh the costs that we can foresee.

It seems odd that the experience of the 44 states having MOT laws is hardly discussed. One might well think that such experience could tell us a lot about the relative costs and benefits. The total discussion of the matter in the Resource Document is limited to: ". . . although many of these states do not appear to implement this authority in any systematic way" (Ref. 1, p. 127).

I have talked to several advocates in states that have MOT. The stories seem similar. There was a shocking tragedy: a mentally ill person who was not taking medication committed a particularly heinous crime. The politicians rushed in with a bill to permit some sort of coercion to be applied to such people when a court made a finding that there was a "substantial risk to self or others." There has almost never been any appropriation of new funds to pay the costs of such intensive treatment. Usually, the law is a dead letter as soon as it is passed and the public memory fades.

In some places, the story plays out differently. There, family members, unable to cope with their difficult mentally ill relatives, go into court seeking medication orders. Because the MOT petition is presented as being for the individual's own good, it is approved. Again, since there is no extra money in the system, MOT collapses from the demands placed on an already overloaded mental health system.

If this is the history, why would anyone seek an-

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other such law and why would the American Psychiatric Association put out a paper supporting such an effort? I am particularly interested in why this issue is being pushed so intensely at present, when medication noncompliance is clearly becoming much less of a problem. When I started to practice mental health law full-time, 11 years ago, a large percentage of my caseload was made up of medication refusal cases. Many clients hated the typical antipsychotic drugs like haloperidol. They were frightened by the possibility of permanent tardive dyskinesia. They did not like the psychological effects of the drugs, which they described as separating them from their bodies. They did not like the painful dry mouth or the frequent impotence, and who could blame them?

Now, however, we have clozapine, risperidone, quetiapine, and similar atypical antipsychotic drugs. After a little trial and error, almost every patient will tolerate one of these drugs. In the last year or two, I have seen few medication refusal cases.* My colleagues tell much the same story, and, since we tend to get the most outspoken patients as clients, I think we are seeing something real.

I think that the real reason for the new push for MOT can be found in the last couple of sentences of the Resource Document:

> Finally, enacting mandatory outpatient treatment may also help to "commit" the legislature to provide the funding needed to provide enhanced community services for all patients, whether or not they are subject to a commitment order. In a political context, enacting mandatory outpatient treatment may provide the leverage for increased funding for community mental health services, particularly for the severely mentally ill population [Ref. 1, p. 142].

This remarkable claim needs a little dissection. Underlying the entire document is the fact that community mental health systems all over the country are being starved of the funds they need to operate minimally. In Connecticut in the last five years, the state appropriation for community mental health has increased 2% after inflation, while the number of clients has increased 27%.[2]

Nationally, state appropriations for mental health have decreased by 7% from 1990 to 1997, while total state spending on everything else has increased by 56 percent. From 1955 to 1997, state spending on mental health fell from $16.5 billion inflation-adjusted dollars to 11.5 billion.[3]

This is the reason for the interest in mandatory treatment, rather than an epidemic of noncompliance. It is no secret that the battle for MOT is being led by the Treatment Advocacy Center (TAC), an organization that was started because E. Fuller Torrey, MD, D. J. Jaffe, and others thought that the National Alliance for the Mentally Ill, the organization of family members of individuals with mental illness, was not pushing strongly enough on forced treatment issues. Although TAC has put out reams of papers on how to pass mandatory treatment laws, it is hard to find much material on their political strategy. One explanation of their direction, however, is given in a speech made by D. J. Jaffe at the 1999 National Alliance for the Mentally Ill convention:

> Laws change for a single reason, in reaction to highly publicized incidents of violence. People care about public safety. I am not saying it is right, I am saying this is the reality. We would say that, whatever you are advocating for. I went to a housing rally in New York where they had signs saying "We need no more incidents of violence. We need more housing." And those advocates were absolutely right, we're going to get more housing by tying it to incidents of violence, because that's what people care about—public safety. So if you're changing your laws in your states, you have to understand that. Now once you understand that, it means that you have to take the debate out of the mental health arena and put it in the criminal justice/public safety arena.[4]

In essence, the claim of TAC is that for mental health to get its rightful share of the public exchequer, expenditures have to be tied to increasing public safety. By making involuntary treatment the issue, mental health agencies will be able to get the kind of money usually reserved for police and prisons. One factual problem with this claim can be seen in the recent successful effort by TAC to get an involuntary treatment law enacted in New York state (Kendra's law). It is true that 13 million dollars was put in the bill to pay for the necessary medication, but, compared to the billions of dollars a year that New York spends on mental health, the increase was insignificant. It seemed evident that the statute was not a recognition of the state's obligation to provide treatment but a cynical attempt to quiet the public furor over several recent crimes, without spending any real money.

It already is beginning to look as if New York's failure to fund its MOT law will quickly make it a dead letter. In the five months since the law went into effect, only 20 people have had MOT orders granted, and only one person has been recommitted to a men-

* It is true that Connecticut is among the most generous states in paying for expensive atypical drugs.

tal institution,[5] notwithstanding the claim of TAC that there are 1.2 million people in the country who have untreated schizophrenia or manic depressive disorder. Interestingly, the only significant reported legal decision on Kendra's Law deals with the question of who pays for the ordered treatment. The decision in *Matter of Arden Hill Hospital (Daniel W.)*,[6] responding to the protests of the local county that it should not be required to pay for court-ordered MOT treatment, concluded that the legislature, in passing the act, had indeed intended that the counties should be the payer of last resort after all insurance was exhausted. Thus, the legislature got to take credit for responding to the public cry for greater security against dangerous acts by the mentally ill, while imposing a new, unfunded mandate on the counties.

In the early 1990s, the political situation, at least in Connecticut, seemed very different. Not only was the state closing hospitals and committing itself to putting much of the savings into community care, but the legislature actually appropriated some new money for the community system. Mainstreaming and reintegration were respectable ideas, and some deinstitutionalized people made very spectacular improvements. However, the legislature did not realize that its generosity was not going to solve the problem; some consumers might become self-sufficient, but many more would still need support indefinitely, albeit at a lower cost than in a hospital.

In my view, what happened was that our political support ran into a crucial American political limit: the impatience with problems that have no definitive solutions. It became clear that even with miracle drugs, we were not going to turn all of the twenty-seven thousand clients of the Department of Mental Health into fully self-supporting productive individuals. Because the advocates also had thought people could do much better than they were doing, they had not resisted the political fantasy of a full solution nearly as much as they should have. (Arguably, praiseworthy events like the Special Olympics and the push to move many mentally retarded people into competitive employment have created a similar fantasy, and a similar backlash is beginning to build.)

The only apparent exception to American impatience with social problems that do not go away is crime. Increases in crime create public demand for more prisons. Decreases in crime lead to greater public confidence in law enforcement officials and a willingness to give them what they want (i.e., more prisons). America has two million people locked up on any given day, and that number just keeps going up.

But do we who care about people with mental illnesses want to tap into the frightening emotions that give the criminal justice system a blank check? Some of those feelings arose when crime seemed to be increasing without end and no one was able to do anything about it. Even when the facts change, the emotions may not. Those emotions surely include racism, since African Americans are a high percentage of prisoners. Fear of drugs seems like another component, as does a desire for retribution against a despised class. Whatever the reasons, it is hard to imagine them leading to major funding of mental health programs unless such programs become vastly more punitive and their clients more stigmatized.

Aside from the unlikely event that MOT will open the public vaults for mental health services, the serious political disadvantages to the current campaign to adopt MOT should be looked at carefully. One disadvantage is the disregard of the history that is central to the adoption of the First Amendment. Millions of Americans believe that the more power the government is given, the more it will abuse that power. For this reason, we have not, for the most part, allowed coercion of individuals for their own good, and we ought to think hard about the direction in which MOT will be pushing us. I once was asked to give advice to the staff of a program for teenagers with Type I diabetes. I was told that the noncompliance rate with the essential regime of multiple blood tests, insulin injections, and careful diet was between 80 and 100 percent on any given day and that several of the kids were already showing serious symptoms of blindness and neuropathy. The program wanted to know whether it could get court orders to force these teenagers to give up their Big Macs. Well, why not?

The effort to bring about MOT is already creating major political disunity in the whole mental health movement. A few years ago, the Connecticut Department of Mental Health proposed a bill for a very limited trial of MOT. I was one of those who publicly opposed the bill, and we thought it would make sense to bring some consumers to the Capitol to explain to legislators why they opposed it. So, we sent out flyers explaining what was happening. On the day of the public hearing, over 400 consumers attended. For days afterward, consumers in great numbers appeared to talk to their own legislators. The

Director of Capital Security told me that the number of people who showed up to oppose the bill was the largest number of citizens who had appeared during that session to take sides on any proposed statute.

Why did these consumers show up in such large numbers? Virtually all of them were taking their medication, realized that they needed to do so, and had no intention of stopping. What they mostly said about the bill was something like, "First it will be him and then it will be me." They sensed that their freedom was precarious; that at any time someone might decide they needed to be locked up "for their own good."

Some of the more sophisticated consumers saw MOT as a power issue. In the age of managed care, it is a commonplace that the relationship of patient to psychiatrist is no longer just between them. There is always a third-party payer looking over the treater's shoulder. In the case of people with serious mental illnesses, there are many more onlookers. Relatives may be putting pressure on a treater to maximize a drug dose because the sedative effects of a high dose may make their mentally ill family member more tractable. The patient's vocational program may feel just the opposite, because he is falling asleep on the job, while the Department of Mental Health is trying to minimize both outpatient and inpatient treatment costs and does not seem to see the contradiction.

Sophisticated consumers are afraid that MOT will subtly change the power dynamics by decreasing their control over their treatment. Even without the overt threat that a noncooperative patient may be subject to a court order, that idea will always be in the air. Many consumers are already the recipients of coercion because their treaters are their social security payees, or are writing reports to their probation officers, or have control over whether they get to make that trip to New York City. MOT threatens to reduce the already small amount of control they have over their own lives.

The New York state experience shows that if the proponents of a MOT bill are willing to shout loudly enough, they can pass the bill over the fierce opposition of consumers; but future cooperation in getting commonly desired bills through will be a long time in coming. In Connecticut, after the MOT battle, all the advocacy groups entered into a tacit agreement that none would push anything that another group was totally opposed to. Even the people who support MOT think that the mistrust and anger are not worth it.

It is not just the consumers who have their doubts. The Connecticut bill also split the psychiatric and provider community. Although a number of clinicians were genuinely worried that some of their clients were dangerous and thought that MOT might help, most opposed it. The reason for this opposition can be found in the next to last argument in the Resource Document.

> There is abundant evidence that enacting and implementing [MOT] concentrates the attention and effort of the providers; that is, the judicial order may help to enhance the services by "committing" the providers to the patients' care. This is not an inconsequential effect [Ref. 1, pp. 141–2].

The question raised by many providers was "What are we being committed to?" If one of their clients was committed to them, they saw themselves having unlimited responsibility and virtually no power. In the Resource Document itself, the only power that treaters are recommended to have is the right to ask the police to bring a committed person to a treatment center for an examination. The idea is that even this limited amount of coercion will persuade a patient to accept medication. (Everybody recognizes that giving a treater the power to send someone back to the hospital is meaningless. It is extremely hard to get someone who is actively psychotic into a state hospital, much less someone who has stopped taking medications, but so far shows no symptoms.) People who are unwilling to take medication may be ill, but they are generally not stupid. How long will this empty threat work?

But even apart from that problem, how will we know when someone is refusing medication? The only obvious way is to have the person take it in front of a treater. This level of surveillance is not cheap, and few clinics are so well run that they can be positive they have checked on everyone. Who is liable when someone who has been committed to outpatient treatment commits a crime because he has stopped taking his medication? Traditionally, outpatient treaters have no liability for their patients' acts because they lack control over them. But if the patient were committed to the "care and custody" of the treater, would that not look like the "special relationship" that gives rise to treater liability in many states?[7†] A treater would have to be brave indeed to

† See Cansler v. State, 675 P.2d 57 (Kan. 1984), as cited in Ref. 7, for a typical explanation of the special relationship doctrine.

take on this level of responsibility, especially when that responsibility is rarely coupled with the resources necessary to fulfill it.

Although I think that TAC is mistaken in its enthusiasm for MOT, an element in its thinking is important and correct. I refer to Dr. Torrey's long crusade against the replacement of mental hospitals with jails as the primary mode of treatment for the most seriously ill people. As he often points out, the largest mental hospital in America is the Los Angeles County Jail. His accusation that the community mental health movement has abandoned the patients with the most serious illnesses is not entirely false, although his accusation that the abandonment is deliberate is surely wrong. Rather, it results from the financial pressures I have sketched out above. When money is tight, spending it in large amounts on people with a low likelihood of improvement seems irresponsible.

The struggle to bring about MOT laws has forced its proponents to make such absurd claims as "[unmedicated mentally ill persons commit] over a thousand murders a year."[8] It is true that the public fear of the psychotic maniac gets such claims an immediate audience. But those of us with a daily experience of mentally ill people know that the real criminal justice problem concerning people who resist treatment is that they are constantly being arrested and jailed for minor misdemeanors like public urination or defacing of property. Once arrested, since the criminal justice system has no idea what to do with them, they often end up spending a long time in jail.

Instead of continuing the sterile debate about MOT, could we not bring all sides together to find ways to take mentally ill people who commit nonviolent crimes out of jail and put them into treatment? Civil liberties organizations and consumers support giving people who have committed crimes the opportunity to receive mental health treatment instead of going to jail. Providers, also, would feel greater control over people who, as a condition of probation, must accept treatment; they would know that if these patients refused to comply, they would be returned to the criminal justice system. Correction departments would also be supportive of any plan that would remove from their systems mentally ill people who need expensive care and treatment.

Although the idea of moving people out of jail and into treatment is attractive to almost everyone who thinks about it, it requires the cooperation of three separate and often insular systems: mental health, the courts, and corrections. But if we are serious about protecting the community and people with mental illness, we have to struggle to force that cooperation. A resource document on criminal diversion, published by this august body, might benefit everybody.

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