Los Angeles Times

April 3, 1995

Stereotyping Mental Illness

By RON SCHRAIBER

As an "ex-mental patient," I'm really quite disturbed. I'm disturbed by the dehumanizing way the media portray people identified as mentally ill as quintessentially violent beings.

The mass media are far and away the American public's primary sources of information concerning people identified as mentally ill—and it isn't nice. From the ubiquitous "psycho" and "mad bomber" story lines to the sensationalistic headlines of "Ex-Mental Patient Kills Two," violence incarnate goes by the name of "psychotic" and its variant terms.

Schraiber

Playing into the cultural myth of the "crazed murderer" (I have never heard of a "crazed peacemaker"), the latest of many movies to fall into this stereotypical trap is "Just Cause," which offers the serial killer role of Blair Sullivan as played by Ed Harris. Although The Times' Peter Rainer pans the movie, including the characters played by Sean Connery, Lawrence Fishburne and Blair Underwood, as unbelievable, he finds the one convincing role to be the out-for-blood Harris ("'Talented Cast Bogged Down in Mystery Thriller 'Cause,'" Calendar, Feb. 17). Favorably comparing Harris' character to Anthony Hopkins' Academy Award-winning role as Hannibal Lecter in "Silence of the Lambs," Rainer writes that Harris has "never before been this scary" and with head shaven "looks like a skinned rabbit, and when he goes into one of his crazy-man trances, his eyes seem to slide upward into his skull."

Talented Cast Bogged Do
in Mystery Thriller 'Cau

MOVIE REVIEWS

By PETER RAINER
TIMES STAFF WRITER

The murder thriller "Just Cause," starring Sean Connery and Laurence Fishburne, is set in the Florida Everglades. And a good thing, too. This is a thriller that needs all the fronds and storks and gators it can get.

It doesn't bog down in the bogs, but it's slow-moving just about everyplace else. It's the kind of ...al-eagle mystery where

But you don't have duty political to po Start with the castin such a staunch and ence that casting hir prof tiptoeing throug is a hoot. When a nasty cop tries to sc by shaking his h expect Connery to in two instead of w Brown tries to scar choking him with h expect more of a r mere gasping for Connery's scaled

Such pernicious stereotyping with all the grotesqueness that Rainer so lauds bears little resemblance to real human beings. Such distorted and formulistic images of the "homicidal maniac" impoverish the lives of people diagnosed with mental illness, who, research shows, are overwhelmingly not violent. The effect of such media stereotypes is to create for people identified as mentally ill a pariah status in a world made increasingly hostile to them. These portrayals are as dehumanizing and unacceptable as any racist or sexist stereotype, and should be scrutinized accordingly.

Persons identified as mentally ill have been embraced by the mass media as the secular version of the devil, transmogrified into the out-of-control madman bent on a rampage of seemingly inexplicable death and destruction. While recent research has shown a modest correlation between major mental disorders and violence, people diagnosed with such mental illnesses are, by far, not the most violent group in American society, and, in fact, according to the FBI Law Enforcement Bulletin, are responsible for no more than 3% of the violence in the United States. Such factors as age, gender, substance abuse and educational level are, among others, significantly greater contributors to violence than mental disorder.

Now, as a person who has been diagnosed with such major mental disorders as manic-depression and schizophrenia, I don't want you to get the wrong idea. I really have nothing against normal people. Just because normal people started World War I, World War II, dropped the atomic bomb on Hiroshima and Nagasaki, committed genocide against the Native Americans and instituted slavery, I have nothing against "normal" people, but I wouldn't want my daughter to marry one.

Unfortunately, malevolent and fear-invoking stereotypes of people identified as mentally ill are not limited to theatrically released movies. In the realm of television, a study of network dramas covering more than 25 years by the University of Pennsylvania's Annenberg School for Communication found that "mentally ill" characters were portrayed as the single most violent group on TV. Furthermore, only two out of 10 characters identified as mentally ill were considered clearly good, while about six out of 10 "normals" were depicted as good.

But, perhaps, the award for the most stereotypical statement goes to The Times when it proclaimed in a Feb. 27, 1985, editorial, "A mentally disturbed person with only the thinnest streak of violence can produce disaster any time, any place." The Times, continuing to be no stranger to throwing out psychiatric epithets to define global conflicts and social dislocation, called terrorism "The True Face of Insanity" (March 10, 1994), and homeless people labeled as mentally ill as "The Specter Haunting America"—and this around Halloween, no less (Oct. 24, 1991). Actually, according to the publication Science News, studies have found members of identified terrorist groups from Ireland, the Mideast and South Africa to all have personality scores that fall within the normal range.

And I thought that the purpose of responsible journalism was not to validate popular prejudice but to elucidate the truth. So much for my delusional thinking!

I'm not mad, I'm angry.

Ron Schraiber works as a patient rights advocate and is a member of the Well-Being Programs Inc. He writes on mental health-related issues and lives with his 7-year-old son.

YOU and ME

If you're overly excited
You're happy
If I am overly excited
I am manic.
If you imagine the phone ringing.
You're stressed out
If I imagine the phone ringing
I am psychotic.
If you're crying and sleeping all day
You're sad and need time out
If I am crying and sleeping all day
I'm depressed and need to get up.
If you're afraid to leave the house at night
You're cautious
If I am afraid to leave my house at night
I'm paranoid
If you speak your mind and express your opinions
You're assertive
If I speak my mind and express my opinions
I'm aggressive.
If you don't like something and mention it
You're being honest
If I don't like something and mention it
I am being difficult.
If you get angry
You're considered upset
If I get angry
I am considered dangerous.
If you over-react to something
You're sensitive
If I over-react to something
I'm out of control.
If you don't want to be around other people
You're taking care of yourself and relaxing
If I don't want to be around other people
I'm isolating myself and avoiding.
If you talk to strangers
You are friendly
If I talk to strangers
I'm being inappropriate.
For all the above you're not told to take
A pill or are hospitalized, but I am.

Debbie Sesula

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Still, the Stigma Remains

■ People who have overcome schizophrenia and regained their mental health have to contend with society's negative perception of the illness.

By LINDA MARSA, Times Health Writer

Nina Wouk's early childhood was marked by trouble in school, anxiety attacks and hallucinations. Things got worse in her teens when she was diagnosed with schizophrenia and sent to mental hospitals, where she spent years "totally numb" from the effects of powerful drugs.

Her symptoms gradually abated, and, with great difficulty, she weaned herself from medications. By her late 20s, Wouk began picking up the pieces of her life, though the label of ex-mental patient hampered her efforts: Employers were reluctant to give her a chance, and health insurance companies wouldn't offer coverage.

Recovered schizophrenics Pearl Johnson and Bill Compton both work for agencies who help others.
LORI SHEPLER / Los Angeles Times

Today she is a self-described "twitchy" person, with a nervousness that may have resulted from years of taking antipsychotic medications. But the 51-year-old Menlo Park, Calif., woman works in an occupation that is the very symbol of the clearheaded, organized personality that eluded her in her youth: She's an accountant. She also owns a home and has been in a stable relationship for 22 years.

"I am not a crazed killer," she says. "In fact, I'm highly typical" of recovered schizophrenics.

Extensive research conducted in this country and abroad indicates that Wouk's right: The stereotypical tortured souls who wander the streets responding to voices only they can hear are the exception, not the norm.

With the right treatment, more than 75% of diagnosed schizophrenics have a complete or at least functional recovery, experts say. While they may suffer occasional symptoms, they "hold responsible jobs, have relationships and lead satisfying lives," says Dr. Raquel E. Gur, director of neuropsychiatry at the Schizophrenia Research Center at the University of Pennsylvania School of

Medicine in Philadelphia.

Today, an estimated 2.5 million Americans--roughly 1% of the population--are diagnosed with schizophrenia. The illness usually emerges between the ages of 13 and 25 and often appears earlier in males than females. Symptoms include disordered thinking, paranoid delusions, hallucinations, and extreme apathy and social withdrawal. The National Institutes of Health pegs the total costs of the disease, including long-term care, at more than $30 billion annually.

Yet many experts say that our mental health system is ill-equipped to treat people with schizophrenia and that the psychiatric profession clings to outdated notions that patients deteriorate, not improve. It's no wonder, they say, that one of every 10 schizophrenics commits suicide within 10 years of diagnosis.

Because the disease carries such a profound stigma, those who do recover often live secretive lives, revealing their psychiatric histories only to their closest intimates. So the public seldom hears about the thousands of success stories.

Instead, we usually hear about headline-grabbing cases such as that of Michael Laudor, the charming Yale law graduate who was a poster boy for recovery from schizophrenia. With a movie deal based on his autobiography reportedly in the works, Laudor stabbed to death his 37-year-old pregnant girlfriend in 1998. According to reports, he had stopped taking his medication. The New York State Supreme Court later committed Laudor to a state mental institution for his crime. Although studies show that even severely mentally ill patients, if they receive treatment, are not any more violent than the average person, the negative image persists.

WARNING SIGNS

There is no test for schizophrenia, and doctors make a diagnosis based on symptoms. Here is a list of some of the early warning signs of schizophrenia:

- Hearing or seeing something that isn't there.
- Constant feeling of being watched.
- Peculiar or nonsensical way of speaking or writing.
- Feeling of indifference about important situations.
- Deterioration of academic or work performance.
- Changes in personal hygiene and appearance.
- Personality changes.
- Increasing withdrawal from social situations.
- Irrational, angry or fearful response to loved ones.
- Inability to sleep or concentrate.
- Inappropriate or bizarre behavior.
- Extreme preoccupation with religion or the occult.

Source: National Mental Health Assn.

"I spend so much of my time countering negative images; the label discredits and marginalizes people," says Dr. Dan Fisher, a psychiatrist and former schizophrenic who is co-director of the National Empowerment Center, a patients' rights organization in Lawrence, Mass.

Indeed, some sufferers, like Wouk or Fisher, seem to go into full remission, meaning they have no symptoms and don't need to take medications. Others with residual symptoms learn to ignore them.

"I still hear voices, from the refrigerator, the television, the washing machine--all the major appliances," jokes Bill Compton, who takes medication to control the paranoid delusions that overtook his life when he was 42. Compton, 55, is director of Project Return: The Next Step, a self-help organization for people with mental illnesses.

Compton worked for theater companies in New York and Los Angeles before his psychotic break. He bounced around the mental health system for two years and lived on the street for nine months, convinced that he was waiting to be

anointed as an archangel. He landed in a board-and-care home a decade ago, where he began his long climb out of the depths of madness.

Disturbed Patients Were Deemed Hopeless

The public's pessimistic view of schizophrenia has its origins in the research of Swiss psychiatrist Eugene Bleuler, who coined the term schizophrenia in the early 1900s to describe the disordered thinking, suffocating anxiety, and vivid auditory and visual hallucinations his deeply disturbed patients exhibited. He thought such patients were hopeless. However, his son, Manfred, also a psychiatrist, realized there was a big piece missing from the picture: The patients his father studied remained hospitalized, which is why the disease seemed intractable. When the younger Bleuler tracked down those who had drifted way, he discovered they were leading relatively normal lives.

"But he was dismissed as a cockeyed optimist and his findings discounted," says Sarnoff A. Mednick, a professor of psychology at USC who has studied schizophrenia.

However, a landmark study that was launched nearly half a century ago confirmed Manfred Bleuler's observations. In the 1950s, Yale University researchers began following 269 chronic schizophrenics at Vermont State Hospital. The patients, most of whom were middle-aged, poorly educated and had little social support, participated in a comprehensive rehabilitation program.

"The head of the hospital asked the patients what they needed to get out of the hospital, and they told him--jobs, friends and a decent place to live," recalled Courtenay M. Harding, a member of the Yale research team.

Patients in the Yale study lived in a hospital ward designed to resemble a home-like setting. They received self-help therapy, vocational counseling and jobs, and were linked to family and friends to provide support. When researchers checked back with the patients 20 and 25 years later, they were astonished to find that one-half to two-thirds of the patients showed no signs of schizophrenia, though they may not have been working or were socially isolated. Slightly more than 25% were completely well and had jobs, families and friends.

These were patients who had been considered hopeless, "who had been languishing in the back wards for years and couldn't dress themselves and had forgotten how to tell time," said Harding, who is now a professor at the Sargeant College of Health and Rehabilitation Sciences at Boston University.

For less severe patients who receive treatment, the recovery rates might be as high as 90%, Harding said.

"But the belief that schizophrenia is incurable is so deeply embedded," she noted, "that no amount of facts seem to make a difference."

Scientists don't know what causes schizophrenia, but the illness normally appears when the body undergoes hormonal and physical changes in late adolescence and young adulthood. Scientists speculate that people with schizophrenia may have an imbalance of dopamine and serotonin, two key brain chemical messengers that affect the way a person's brain reacts to sensory stimuli. Consequently, when these people face a crisis or are under stress, their senses become overloaded by sounds, sights, smells and tastes, which can spill over into hallucinations and delusions.

Schizophrenia seems to run in families, too. Compton, for instance, had an uncle with schizophrenia. But genetics doesn't explain all of it. Scientists believe that disturbances in the creation of normal pathways in the brain--viral infections

during pregnancy that can be toxic to the fetus, delivery complications that can deprive the newborn of oxygen--can push those with a genetic vulnerability over the edge. "Somehow, the wiring in the brain gets crossed, making people more prone to symptoms," said USC's Sarnoff Mednick.

The good news is that treatment has come a long way from the 1960s and early 1970s, said experts, when the severely mentally ill were written off, given debilitating medications and confined to locked wards.

"I was forcibly drugged and placed in solitary confinement," said Fisher, who had his first psychotic episode in 1968, when he was a biochemist at the National Institute of Mental Health in Bethesda, Md. "I was so upset, frustrated and frightened," he recalled of the three times that he was hospitalized for treatment. "That's when I resolved to become a psychiatrist. I thought if I ever get out of this, I'm going to unlock these doors and provide help in a way that I wish someone had been there for me."

Typical of that era was the experience of Pearl Johnson, a 71-year-old woman whose life started out with so much promise. An A student who played the saxophone and loved athletics, she ran away from home at age 16. Plagued by intense anxiety, paranoia and auditory hallucinations, she controlled her demons with heroin and other drugs.

Johnson spent the next 45 years on the street or in prison, where she was kept in an isolation cell under heavy sedation and sometimes beaten if she complained. While she was in isolation, her only real companions were the voices in her head.

In 1990, she ended up at Oasis House, a mental health program in South-Central. "Those people loved me to death, and that's where I began my road to recovery," said Johnson, now a community worker for the Los Angeles County Department of Mental Health.

Despite the advances in treatment, nearly half of severely mentally ill patients in California avoid treatment, studies have found. For many, the fear of involuntary hospitalization has driven them underground.

"Most people are poorly treated and slip through the cracks of the system," said Ronald F. Levant, dean of the Center for Psychological Studies at Nova Southeastern University in Ft. Lauderdale, Fla. "They self-medicate, become addicted to drugs or alcohol, and wind up on the streets, where they get beaten up and further traumatized."

Research indicates that fewer than half of schizophrenics receive any kind of psychological help, only one in four gets vocational help and just 10% receive family therapy. Schizophrenia usually strikes in late adolescence as people are making the transition to adulthood and careers. The emotional damage can be severe as people see their dreams abruptly derailed. Consequently, they need to learn job and social skills, as well as how to manage their symptoms, to take their place in society.

Rehab is not just window dressing, experts said; it's critical to a person's recovery.

"The real tragedy is we knew in the 1950s what we needed to do to reclaim lives, yet it hasn't been applied," said Harding, the Boston University professor. "But there are pockets of excellence."

The Mental Health Assn. in Los Angeles County, for instance, a private nonprofit agency, oversees a number of model programs that help people with mental illnesses become self-reliant. The MHA Village in Long Beach offers a

comprehensive treatment program that includes counseling, substance abuse recovery, employment and even money management classes to its 500 participants, about half of whom are schizophrenics.

Project Return: The Next Step, another MHA-funded program, is a network of 75 self-help clubs throughout Los Angeles that are operated by people with severe mental illness. The clubs offer peer support, social activities and part-time positions that provide a toehold into the work force for many of its member.

"People need to have services they can connect to," said Project Return's Compton. "Once they do, they can turn their lives around."

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U.S.News & WORLD REPORT
DECEMBER 20, 1999
www.usnews.com

For severe **mental illness**, a higher profile and new hope

BY SUSAN BRINK

It was 1970. The conspiracy trial of Abbie Hoffman and the Chicago Seven was ending. Rock stars Jimi Hendrix and Janis Joplin had just died of drug overdoses. And Christy James's sister, for the first time, lost her grip on reality. "People were doing drugs. All kinds of strange things were going on," says James. So a little bizarre behavior by her 19-year-old sister—dropping out of a top-tier college, alienating devoted parents—went practically unnoticed.

But one day it could no longer be ignored. James, summoned home by a phone call from her distraught, incoherent sibling, walked into a trashed bedroom, the humid St. Louis air wafting through a window her sister had broken by hurling a chair through it. A mirror was shattered, and bedclothes were strewn about the floor. On the bare mattress was her sister, curled in a fetal position, spent, disheveled, and sobbing. "She was repeating, 'They made me do it. The voices made me do this,' " says James. Eventually her sister, whose name the family does not want published, was diagnosed with schizophrenia.

This week, the surgeon general of the United States will shed a powerful light on the sorts of illnesses that affect families like James's in the office's first-ever comprehensive report on mental health. In previous special reports, the office has used its bully pulpit to call attention to such serious public-health problems as tobacco, violence, and AIDS. Ripe for a similar focus, mental illness has long been underfunded and misunderstood, even though about 1 in 5 Americans suffers from it at some point, about 3 percent to 5 percent of them so severely they find it hard to get through the day. The direct and indirect costs of mental illness totaled $148 billion annually as long ago as 1990, when the toll was last fully taken.

The surgeon general's report will carry three strong messages: Mental illness is as real as heart disease; patients can benefit from new treatments and medications; and, most important, sufferers can recover. New drugs and therapies have vastly improved the outlook for the 5 million or so people with the most severe mental illnesses. "People should expect to be doing better than they've ever done in the past," says Laurie Flynn, executive director of the National Alliance for the Mentally Ill. The problem is that too often people who need the most care are not getting it. Says Anthony Lehman, professor of psychiatry at the University of Maryland medical school: "Most persons with schizophrenia are not getting anything close to optimal treatment."

MARC ASNIN—SABA FOR USN&WR (2)

Dorian King, a 39-year-old schizophrenic, with his mother, Bettie, in Brooklyn, N.Y.
● *"I keep looking at my family members and wondering who is going . . . to take this on."*

Wrong dose. Mental illness is indeed among the most poorly treated of all diseases. A 1998 study of more than 700 patients, funded by the National Institute of Mental Health and led by Lehman, found that more than half of patients with schizophrenia received substandard care. It also found that more than 70 percent of patients received the wrong dose of antipsychotic medicines.

Such problems arise in part because many physicians still prescribe older medications or are untrained in the use of newer ones, or because patients and their families, frustrated by past disappointments, don't seek the latest treatment. Health insurance rarely covers mental illness as fully as it covers physical illness—a huge obstacle to treatment because new drugs can cost up to 100 times as much as the old ones.

These shortcomings affect an audience far beyond mentally ill patients and their families. Untreated mental illness has been a factor in countless episodes of public violence, including the July 1998 shooting deaths of two police officers at the U.S. Capitol and the death earlier this year of a young woman pushed in front of a New York City subway train. A noted study of 30 mass murderers found that 40 percent had clear psychotic symptoms at the time of the crimes and another 27 percent had signs of psychosis. With treatment, though, even the most severely mentally ill are no more violent than anyone else.

Until recently, the drugs available to treat schizophrenia, such as Thorazine and Haldol, had such severe side effects, including restlessness, insomnia, and dramatic, involuntary tics, that patients frequently stopped taking them. But newer medications such as Risperdal, Seroquel, and Zyprexa, while considerably more expensive, are safer and have fewer side effects. Clozaril, which came on the market in 1990 as the first in a parade of effective new drugs, works well in some people. But it carries a small risk of a fatal blood disorder, so is recommended only for patients who fail to respond to anything else.

Aging caregivers. If a sufferer of mental illness hasn't had a comprehensive evaluation within the past five years—by a team of mental health professionals that might include a psychiatrist, social workers, and rehabilitation specialists—it is likely his treatment could be improved, experts say. And, Lehman suggests, patients should be re-evaluated every year.

Proper treatment can help lay to rest an often unspoken concern, more pressing now that the parents of many mentally ill baby boomers are entering their 70s and 80s. "What is going to happen when we're not around?" asks Elizabeth Edgar, a Washington, D.C.-area mother of a 25-year-old daughter with schizophrenia. "That thought truly sends a lightning bolt of fear through family members." Christie James's sister is 49 and has lived with her mother and father, now 78 and 81, for nearly 20 years. James, too, has done her familial duty, enduring 30 years of obscene outbursts or driving through blizzards to rescue her sister, who was wandering the freezing night in nothing more than a bathrobe. After all that, she is realistic about her ability to care for her sister. "My big concern is for when something happens to Mom and Dad," says James.

Steele, hospitalized for years, is encouraged about fellow schizophrenic Frey (right). ● *"The medication worked.... The schizophrenic voices have disappeared."*

Likewise, Bettie King, 59, is already looking around for someone who will care as much as she does for her 39-year-old son, Dorian. "I keep looking at my family members and wondering who is going to be the one who is going to take this on," she says. Dorian's schizophrenia has been stable since he began taking Clozaril. But drugs alone aren't enough to ensure good care. Dorian lives in supervised housing and gets regular psychiatric care. Still, King finds she has to accompany him to some medical appointments to be sure he understands his disease.

It's just that kind of help, provided in an innovative Madison, Wis., program since 1972, that is beginning to spread nationwide. The Program of Assertive Community Treatment aims to give mentally ill people access to professionals who seek to be as dependable as family. Staff members go beyond the usual medical and psychiatric treatment by providing patients with such services as taking a cat to the vet. "They can count on us indefinitely," promises William Knoedler, psychiatrist with the Madison project. Such programs are in effect in five other states (Delaware, Idaho, Michigan, Rhode Island, and Texas), and another 19 states and the District of Columbia have begun pilot programs.

But the true success stories are those people who, properly treated, come to depend on themselves. Ken Steele spent 32 years locked in institutions, listening to voices that told him to kill himself. Six years ago, he stopped taking the older antipsychotic medicine Stelazine because it made him want to jump out of his skin. He is now on Risperdal and, he says, the voices have gone quiet.

But Steele is most heartened by the potential of people like Daniel Frey, 23. A year ago, Frey was in a mental hospital, diagnosed with schizophrenia. Today, he is in college and working with Steele on a mental health newspaper called *New York City Voices*. Steele will never get back the three decades he spent in institutions, but he is thankful that Frey, also successfully treated with Risperdal, lost only a year. "The medication worked within hours," Frey says. "The schizophrenic voices have disappeared."●

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THE "C" WORD

by Ron Schraiber

I had just picked up my six year old son, Joshua, from his after school care at the YMCA. As we arrived home, both of us knew it was time for the post school/YMCA wrap-up. Daddy would inquire, ritualistically, if not always poignantly, into the historic daily happenings of the life of my beloved first grader.

Joshua, however, did not usually view these weekday domestic news conferences as a time of sharing or parental interest. For him, it was a time of unwanted inquiries, of pulling teeth for information, an imposition on him of the stale past. To the question of, "What happened at school today." he would regularly answer, "I don't remember."

It was Joshua's way of saying he preferred to pay his present attention to more pressing and interesting matters, such as Power Rangers, X-Men, drawing dinosaurs or playing video games.

Today, however, was different. Joshua responded that someone had said the "C" word at school. Now, being a worldly sort of guy, I had already heard of the notorious "F" word. In fact, Joshua had actually questioned me about that one before. But the "C" word... what was that?

"Daddy, don't you know?... the "C" word—C-R-A-Z-Y! Got it? Nuts!"

I got it! Of course, I knew the "C" word—all too intimately and hurtfully so. During the 1970's, I had been involuntarily hospitalized in psychiatric institutions approximately 20 times with such diagnoses as schizophrenia and manic-depression. I knew the devastation and negation of being called "crazy" on both a formal and informal basis. I cannot fully express how hurtful and invalidating it can be to have your thoughts and feelings dismissed as crazy, or the product of a deluded mind or brain, whether it be couched in the professional jargon of mental health vernacular or the put-down of everyday discourse.

Yes, son, Daddy knew the "C" word.

Joshua had learned his sensitivity to the "C" word from our conversations related to treating all people with dignity and respect. In our father and son household, he has been taught that putting people down or making fun of them for being "crazy" is just as wrong and bad as ridiculing or denigrating someone because of their ethnic or religious background, or because of a person's different customs or language. In short, no hurtful name calling or prejudice.

I cannot fully express how hurtful and invalidating it can be to have your thoughts and feelings dismissed as crazy, or the product of a deluded mind or brain...

I guess that my talks about calling people crazy and making fun of other people have had some effect. It was Joshua, himself, who came up with the appellation of the "C" word for crazy, thus showing that I had somehow transmitted to him the gravity of my beliefs, that along with the "F" word and various other epithets, "crazy" was a word bathed in taboo and opprobrium.

To be sure, Joshua has become my living conscience. When I mimicked an Asian language news cast on cable TV, it was Joshua who set me straight about not making fun of other people and their language. After all, I had told him about anti-Semitism and how our Jewish ancestors had suffered so much because of prejudice. Ah, yes, the sensitivity of innocence and political correctness has truly arrived in Whittier in the form of the avenging angel called Joshua. Woe unto the Daddy who transgresses his just gaze!

While I continue to try to imbue Joshua with lessons of liberty and justice for all, *including* people commonly described as "crazy." I have never actually told Joshua that I have been a mental health client—and this, despite the fact that I have discussed my psychiatric history in the print and electronic media. Part of it is, that despite his obvious intelligence and compassion, he may still be too young to fully integrate what it means to have a father who has the stigmatizing identity of *"ex-mental patient."* It is often difficult for parents to admit any flaws to their admiring young ones, let alone a status that is guaranteed not to win you a welcoming party and the most sought-after new neighbor award. The discrimination and problematical status of being diagnosed with mental illness extends even to our loving children... and, God knows, how they will feel and react... and how I will react to their reaction, especially if it entails even a small form of rejection. The time for full disclosure is near, though, so get the reporter from Hard Copy!

When I worked at LAMP, a social service agency providing services for people diagnosed with serious mental illness on Los Angeles' Skid Row, I would periodically take Joshua there. I will always remember the reaction of the clients there, how much they enjoyed seeing and playing with Joshua. Ironically, such joyful scenes at LAMP made me angry—angry at a society that so often stereotypes and portrays people identified as mentally ill as subhuman pariahs bent on paths of destruction. I never told Joshua that these people were so-called "mental patients." For Joshua these people were individuals, to be enjoyed and appreciated based on their individual interactions with him. He did not know them as a category, only as people. Perhaps, Joshua will always treat people as unique individuals, and, hopefully, that will include his dad.

Interestingly, no matter how hard I try, Joshua continues to retain what seems a universal prejudice, at least, in America, of little boys dislike of "icky" little girls. Is if genetic or learned?

To think that I've been a single dad for the last few years. What a contrast to when I lived on the streets. To most, I would have been considered "the homeless mentally ill" (definitely a politically incorrect term). I liked to consider myself a vagabond, an internal refugee in America who lived by the dictum of Thoreau, *"If you see someone running after you, to help you, then run even faster."* Unfortunately, the police and the mental health system often caught up with me, telling me that my prognosis was poor. Now, I'm a 9 to 5 type of guy with all the responsibilities and joys of fatherhood *sans spouse.* (How I got sole custody of Joshua is a story that has more twists than "As the World Turns.") As for myself, I feel my prognosis is good whenever Joshua smiles or says, "I love you, Daddy." ■

RON SCHRAIBER is a patient's rights advocate at Metropolitan State Hospital in Norwalk, CA.

Los Angeles Times
Valley News
MONDAY, APRIL 20, 1992
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POSTER CONTROVERSY

The public education campaign on behalf of the mentally ill went awry and critics now say its use of a photo of a down-and-out man is offensive. B3

Groups Say Mental Health Assn. Education Poster Is Degrading

By JOHN JOHNSON
TIMES STAFF WRITER

The Mental Health Assn. in Los Angeles County wanted to shock people with a public education campaign on behalf of the mentally ill.

They succeeded so well that some advocacy groups are protesting that the campaign, titled "Mental Illness: The Way We Treat It Is Insane," is insulting and degrading.

In particular, protesters single out the campaign's "poster person," a disheveled man shown eating out of a soup can, as offensive and misleading. Not only does the picture degrade the mentally ill, says the Newhall-based Well-Being Programs Inc., the man pictured on the brochures and posters distributed nationwide was an alcoholic, not a mental patient.

"When I saw the poster I was offended by it," said Ron Schraiber, a spokesman for the advocacy group, which is made up of people who are now or have been mentally ill. "It perpetuates the helpless, hopeless image."

The controversy over the public education campaign is ironic since it was specifically designed to dispel myths and misconceptions about mental illness.

'When I saw the poster I was offended by it. It perpetuates the helpless, hopeless image.'

RON SCHRAIBER
Advocacy group spokesman

Schraiber said it ended up perpetuating those misconceptions.

He said a resolution objecting to the image was passed at Alternatives '91, a conference in Berkeley last year attended by former mental patients and representatives of self-help organizations from around the nation.

The protest caused the Los Angeles association to print an open letter of apology in the spring issue of the Mental Health Advocate, the association's newsletter.

"We want to apologize publicly to all those people diagnosed with a mental illness for our decision to use this image," said the letter. "Your responses have helped us recognize the most important lesson we could learn: When trying to make things better, most importantly do no harm."

Schraiber, however, says the apology does not go far enough. He has asked the mental health organization to stop distributing the offensive material and to recall what was mailed out earlier to high schools and media outlets around the country.

The association, one of 550 affiliates of the National Mental Health Assn., has rejected that idea.

"Apparently, our response is not enough," said Martha Sherwood, a spokeswoman with the Los

Please see POSTER, B4

RICHARD DERK / Los Angeles Times

Ron Schraiber with the poster of an alcoholic man.

POSTER: Groups Condemn Mental Health Assn.'s Picture of Alcoholic

Continued from B3

Angeles affiliate. "They want us to pull the entire campaign on a nationwide basis, which is impossible to do."

For one thing, she said, the campaign is mostly over. The association has removed the offending poster from the information packets it sends out to those who ask for them, but the packet still features the image of the man on its cover.

The Los Angeles association is funded by a $1.8-million grant from the state Department of Mental Health and smaller grants from the city and county of Los Angeles.

The campaign was originally aimed at high school students, but its focus was expanded to include the media and other groups. It was developed in 1990 by the Los Angeles advertising firm of Foote, Cone & Belding, which did much of the work free. Even so, the campaign's cost eventually reached $200,000, which was partially covered by a corporate grant.

Ann Stone, associate executive director of the association, said the advertising firm used the photo because it was an arresting image that would call attention to the campaign.

Susan Fairbairn, art director for Foote, Cone & Belding, found the image of a young man squatting down in New York's Bowery in an issue of American Photographer magazine. The man was eating out of a soup can, his hair wild, his face dirty, and his eyes wide.

"The picture says, 'Look at me. Any day you can also be in my shoes,'" Abraham Menashe, the photographer, was quoted as saying.

The picture haunted Fairbairn. "Those eyes," she said. "My reaction was really visceral. A lot of times you see pictures of the homeless that sort of push you away. This one drew you in. They look so innocent."

She said the use of the photo was appropriate, even though the man pictured was an alcoholic and not mentally ill.

She said it has been well-documented that the closing of mental health facilities has resulted in more mentally ill people becoming homeless. "You read stories about it all the time," she said.

With the photo as its centerpiece, the campaign included materials that listed the signs of mental illness, fact sheets and descriptions of various mental afflictions. A 30-minute videotape featuring former mental patients performing improvisational skits based on their experiences in mental hospitals is also part of the package.

'We acknowledged that if we did that campaign today we would not use that image again. We understand how that image is offensive to them.'

ANN STONE
Mental Health Assn.

The campaign won recognition from advertising professionals. The Media Access Office, a private, nonprofit liaison between the media and the disabled, gave the Mental Health Assn. its 1991 Award of Excellence for Public Affairs.

It also was a finalist for an award given by the Publicity Club of Los Angeles.

But, according to Schraiber, the campaign didn't sit well with former patients. Schraiber is himself a former mental patient who once was described by a state hospital psychiatrist as "almost a professional, dedicated psychiatry fighter."

He suffered a breakdown shortly before graduating from college and spent time in three different state mental hospitals, where he was subjected to electroshock therapy and drugs. After that, he founded a grass-roots group—Citizens Against Psychiatric Abuse and Bureaucratic and Legal Entanglements—and began fighting for patient rights.

Schraiber said the current protest is part of a growing willingness on the part of clients and mental health patients to speak up for themselves. He complained that no client was consulted about the choice of images used in the campaign.

"This photograph certainly did not promote positive human images of mental health clients or dispel negative stereotypes," wrote Jean Campbell, executive director of Well-Being Programs Inc., in a Dec. 31, 1991, letter to Richard Van Horn, the chief executive officer of the Mental Health Assn.

Underlying the debate over the Mental Health Assn. campaign is the question of how much control people should have over how their group is portrayed in the media.

Campbell's letter argued, for instance, that the Mental Health Assn. should not have used the term "mentally ill" because it dehumanizes people. She also said the use of the word "insane" in the title of the campaign equated "negative beliefs and behaviors with psychiatric conditions."

Are the critics going too far in this case?

"They're not going too far," Stone said. "They're going too long. We acknowledged that if we did that campaign today we would not use that image again. We understand how that image is offensive to them.

"We feel very badly, but we can't seem to satisfy them," she said. "We've done as much as we can do."

On Being Called "The Mentally Ill"

As long as mental health professionals refer to people as an illness, they and the public will see mentally ill people as one-dimensional beings whose only salient characteristic is their illness. I long for the day when people with mental health needs are viewed as people first—with red hair, or gentle hands or a good sense of humor, or an inquisitive nature—and as mentally ill second (or preferably last, with a number of other positive characteristics in between).

Pamela Hyde

Ten Warning Signs of "Normality"

by *Janet Foner, Support Coalition co-coordinator*

Mad scientists are working around the clock to discover the cure for "normality," a serious and persistent "chronic mental illness" afflicting much of the general population. Support Coalition International, an alliance led by psychiatric survivors and open to the public, has become very concerned recently as a "norm-demic" has hit the streets, forcing many people formerly safe from this affliction to recognize that they, too, have caught the dreaded disease.

Fortunately, our scientists have been able to uncover the ten warning signs of "normality."

Take this free self-test:

1. COOL: You're cool, you hold everything in and always put "a good face on it" — you never cry or laugh much, or show emotion in any way, certainly not in public. Your psychiatric label is *"tearlessnicity."*

2. SERIOUS: You always do the proper thing — never anything unusual, playful, spontaneous, "different," wild, or creative, if you can help it. You believe playing and being silly are beneath your dignity and only for children. You have a psychiatric label of *"stiff upper lippity."*

3. NICE: You always act nice even if you can't stand the person to whom you're talking. You never say what you're really thinking. Your diagnosis: *"inappropriate smiling."*

4. RIGHT: You always do everything right — wear the "right clothes", say the "right thing", associate only with the "right people"— you know there is only one right way, and it's your way. You are diagnosed as *"conformity prone."*

5. BORING: Your conversations, life and living space are dull and boring, and your lawn is always manicured no matter what. In the more advanced stages you have much inner "lifelessness" and "flat affect" — in other words, you are one of the "walking dead." Your psychiatric label is *"hyper-inactivity."*

6. OBEDIENT: You always try not to offend anyone, especially those in authority — your security seems to depend on that. So therefore you are willing to put expediency ahead of principles. Your psychiatric label is *"adjustment prone/adjustment reaction."*

7. GULLIBLE: You believe that the doctor always knows best, that the media is telling the truth (major newspapers always print the facts, right?), and that the medical model of "mental illness" has been proven scientifically. Your diagnosis is *"normal naiveté disorder."*

HEAL NORMALITY NATURALLY

8. AVOID FEELINGS: You are out of touch with yourself, with the natural world, and with what is going on with other people. It has become too hard to face how others are being oppressed, so you choose a more comfortable path. TV starts to look very, very good. You are labeled with *"severe blinder-itis."*

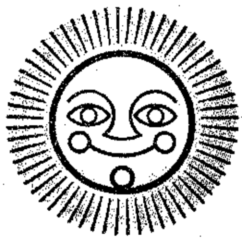
9. DON'T TRUST YOURSELF: You learned in school that it's important to always pay attention to those in charge and not to trust your own thinking. You learned to "play the game," and you are still doing that. You believe your own lies. You have an advanced case of *"schoolmania,"* which, if not stopped in its early stages can lead to severe overwork and, in advanced stages, *"corporate asskissingitis."*

10. INDOORISM: You lost touch with wildness in nature, and within your own strong feelings. You do not rebel against ecological destruction. Label: *"Tame."*

DON'T PANIC: If you have two or more of these signs, within any lunar cycle, it is not too late. Join SCI, read *Dendron News,* support one another, get out into nature, and especially take action to stop psychiatric oppression *before* serious persistent "normality" sets in.

For more information write: **Support Coalition International PO Box 11284, Eugene, OR 97440-3484 USA**

***"SNOWBALL"* this poster:** Please photocopy on 11 x 17 paper. Post this public service announcement.



Billings Gazette

The Source

114th year, No. 220 ■ City/State Edition ■ © 1999 Billings Gazette, a Lee Newspaper

Mental trips:

■ Taking patients to Warm Springs burdens local officials

By **PAT BELLINGHAUSEN**
Of The Gazette Staff

Yellowstone County sheriff's deputies travel with psychiatric patients to Warm Springs every few days. The deputies took 113 patients by patrol car or chartered airplane in the first 10½ months of 1999.

One in four patients admitted to Montana State Hospital this year has come from Yellowstone County, according to the hospital's count.

Some of the same people are transported again and again, Yellowstone County Sheriff Chuck Maxwell said. "We do a lot of repeat business, and that's unfortunate. There's not a lot of managing care. It appears there is no system in place."

Part of the reason for the surge in state hospital admissions from Yellowstone County is that the Deaconess Psychiatric Center's secure unit has been full to overflowing. When the five-bed unit is filled and another person who is severely disturbed or suicidal arrives at the Deaconess Emergency Department, something has to give.

The county attorney and the sheriff's office may get a call from Deaconess at any time of the day or night to notify them that an emergency transport to Warm Springs is needed.

INSIDE

New community program designed to keep seriously mentally ill adults healthy and out of the hospital.

—SUNDAY MAGAZINE, 1E

Maxwell told about one unforgettable evening when his department was called to transport two patients from Deaconess to Warm Springs by 8 p.m.

A plane was chartered, and deputies departed with the patients. Then, the sheriff's office received another call that two more people needed to go to Warm Springs before morning. No more planes were available, so

(More on Trips, Page 11A)

Gazette photo/LARRY MAYER

Construction worker Bruce Hayes, of Missoula, works in a hallway of the new building at the Montana State Hospital in Warm Springs.

Trips

From Page 1A

deputies made an eight-hour road trip with the second pair of patients.

On another occasion, Yellowstone County Attorney Dennis Paxinos recalled, he got a call at about 1 a.m. to authorize an emergency admission to the state hospital.

Paxinos knew that the patient would have to be returned to Billings for a commitment hearing later in the day, so he figured the sheriff's deputy could just as well drive the patient around town for several hours, instead of driving him 250 miles to Warm Springs and back again. So the patient and a deputy cruised Billings for a while in the wee hours before the man was returned to the Deaconess Emergency Department.

Maxwell and Paxinos, as well as everyone else interviewed for this report, recognized that the cross-country trips are a bad way of treating people with severe mental illnesses.

"We don't really believe this is a humane way to deal with mentally ill people, to pull them out of the (Deaconess) hospital in the middle of the night. There's got to be a better system than this," Maxwell said.

Air transports quicker

If Yellowstone County deputies drive a person to Warm Springs, the officers will spend more than eight hours on the round trip. Air transports seem to be best for everyone because they are quicker, Maxwell said.

Deputies place mental patients in a leather restraint for the trip to Warm Springs, Maxwell said. The restraint consists of a belt around the waist that restrains the arms and is considered safer, minimizing the risk that the restraint will injure the patient.

The Sheriff's Department calls the hospital to let the staff know a patient is coming. The planes land at a paved airstrip between Anaconda and the state hospital.

Staff members from the hospital meet the plane and take the patient the last couple of miles to the hospital.

Ed Amberg, public relations director for the state hospital, recently said the hospital may not be able to continue meeting planes because of the cost to the hospital, which will soon be reducing its staff.

Besides the issue of flying severely disturbed people across the state in a small airplane or confining them to a patrol car for a four-hour drive, all these trips cost time and money.

> **"We often have to take people off of regular duty for the transports. Public safety is affected because the patrol force is reduced."**
>
> Chuck Maxwell
> Yellowstone County sheriff

According to the Sheriff's Department, the least expensive charter plane costs nearly $500 per trip. Maxwell said his department has spent about $40,000 on mental-patient transportation this year.

The long trips also are a drain on his patrol force.

"Most of those are emergencies," Maxwell said. "We often have to take people off of regular duty for the transports. Public safety is affected because the patrol force is reduced."

In addition to the sheriff's expenses, the county has budgeted about $100,000 this year to pay a portion of the bills for some indigent people hospitalized at Deaconess or held on an emergency basis at Warm Springs before they are committed to Warm Springs, said Scott Turner, county budget director.

He isn't sure if that amount will be sufficient. Then, there are the legal expenses, including a contract of more than $30,000 a year with a Billings attorney who represents individuals in civil commitment hearings and the time of a deputy county attorney who handles the psychiatric commitments.

"The things that are difficult for us beyond the transports are the repeat trips," Maxwell said. "More often than we'd like to remember, we fly them up in the late afternoon and then have to turn around and fly them back in the morning."

The sheriff and attorneys who deal with these civil-commitment cases told The Gazette that patients taken to Warm Springs on an emergency basis without a court-ordered commitment must be brought back to Billings for a psychiatric evaluation and a District Court hearing before they can be committed for longer care.

Some emergency patients are discharged from the state hospital without ever being committed. Not infrequently, emergency patients from Billings are people who are both highly intoxicated and highly suicidal. They need a safe place to be for detoxification but don't necessarily need longer hospitalization.

Although the numbers are higher in Yellowstone County, transportation of mental patients is a statewide problem.

"This has always been an issue for the sheriffs across the state," said Maxwell, who is vice president of the Montana Sheriffs and Peace Officers Association. "It's an issue we're all facing, and we are looking for relief of some kind."

Kathy McGowan, executive director for the Montana Sheriffs and Peace Officers Association, agreed. Whenever the sheriffs meet, the discussion turns to Warm Springs transportation.

"The first thing they talk about is mental health," McGowan said last week from her Helena office. "It's probably a bigger problem in Billings because it's a larger population community, but it's a problem statewide."

In small-population counties that have only a couple of law-enforcement officers, every trip to Warm Springs requires the efforts of the entire force and leaves the county without a law officer.

"It's just a vicious cycle, and it's serious," McGowan said of people who are hospitalized repeatedly.

"We don't think we should work in isolation to solve this problem," McGowan said of the sheriffs' concerns.

The peace officers' association plans to work with the legislative interim committee as well as the new state Mental Health Advisory Council.

A nationwide problem

Paxinos, who has been a Yellowstone County prosecutor for a decade, said the problem of treating mentally ill people is faced by officials nationwide. Because people generally aren't institutionalized for the long term, many wind up living in the streets and not getting appropriate care.

"We're just a small microcosm of what's happening all over the country," he said, adding that the number of people in Billings who need care for serious mental illness is larger because there are services here that bring people to Billings.

(More on Trips, Page 12A)

Continued story

Trips

From Page 11A

although the services aren't always sufficient for everyone

Also, Paxinos said, some other communities tend to encourage people in need of psychiatric assistance to come to Billings.

"It's not unusual for a person to get off the bus and say, 'Where's the Deaconess psychiatric center?' " the county attorney said.

The justice system can't force people to get mental health-care unless two conditions are met, Paxinos said. The state can intervene only if the individual has a serious mental disease or defect and poses an immediate threat to himself or others.

Paxinos' staff has tried to reduce legal costs of handling commitments by having a Powell County judge and attorney from Deer Lodge conduct proceedings at the state hospital.

But Terry Seiffert, the Billings attorney who contracts to represent individuals on commitments, said that people still have to be returned to Billings for a commitment hearing after an initial appearance before the Powell County authorities.

The state hospital psychiatrists generally don't perform evaluations for commitments because they would also have to travel to Yellowstone County for the hearing. So Billings psychiatrists evaluate patients and attend the hearings at the Yellowstone County Courthouse.

> **"It's not unusual for a person to get off the bus and say, 'Where's the Deaconess psychiatric center?'"**
>
> Dennis Paxinos
> Yellowstone County attorney

So far this year, Seiffert has handled 160 civil commitments — double the number he saw when he started this part-time job a decade ago. But half of those cases resulted in community commitments where the judge ordered the person into a group home or other care in Billings. The Mental Health Center works with Seiffert to arrange community care.

About 20 percent of all commitment proceedings end with the commitment being dropped. The remaining people are committed to Warm Springs for up to 90 days. In fact, people usually are discharged in two weeks to a month, Seiffert said.

After they are discharged from the hospital, some people go home, and a limited number are placed in group homes. Others will become homeless with little support for staying well.

At Montana Rescue Mission in downtown Billings, Executive Director Gary Drake sees many mentally ill people. Although case managers from the Mental Health Center regularly see clients at the mission, these mental-health workers have so many clients that the workers are hard pressed to meet all of the needs, Drake said.

Between the Rescue Mission and the HUB, a drop-in center operated by the Mental Health Center, the word gets out to homeless people that help is available for mental illness. Most people who need it seem to get some mental-health service, but they don't always get all the service they need, Drake said.

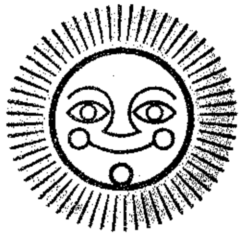
Some homeless people with mental illnesses avoid the enclosed space and group living of the shelters. To reach such people, mission staff members go out three nights a week in a van stocked with coffee, sandwiches and other necessities. The staff members talk to and minister to them.

"They could so easily disappear, and no one will ever know what happened to them," Drake said.

Americans worldwide warned about terrorists

WASHINGTON (AP) — Americans around the world were warned Saturday by State Department there is "credible evidence" terrorists could strike at large holiday gatherings.

The statement gave no details of the evidence but said "the information indicates that attacks could be planned for locations throughout the world where large gatherings and celebrations will be taking place" from now until early January, a period that coincides with Ramadan, a Muslim holy period that began this week.



Billings Gazette
The Source
114th year, No. 220 ■ City/State Edition ■ © 1999 Billings Gazette, a Lee Newspaper

Seeking solutions:

■ County officials, health experts call for better mental care

By **PAT BELLINGHAUSEN**
Of The Gazette Staff

Shuttling patients between Billings and Warm Springs seems to be the tip of the iceberg for gaps in local mental-health care.

From county officials to health-care professionals and mental-health advocates, everyone interviewed for this report agreed that the cross-country shuffle is bad for people and a waste of resources.

County officials said Billings needs greater capacity for holding psychiatric emergency patients. People in the mental-health field said solutions will involve more services outside hospitals — not necessarily increasing the capacity to lock people up.

(More on Solutions, Page 13A)

The Billings Gazette

Solutions

From Page 1A

"We'd like to see more community-based services," said Leanne Swanson, executive director of the Mental Health Association, Billings Chapter.

"One of the problems is there is no housing. We sometimes expect people to get out of the hospital and go back to their lives, and it doesn't happen."

Both Swanson and Dee Holley, executive director of the National Alliance for the Mentally Ill-Billings, want to see more emphasis on preventing emergencies.

"The PACT program might be the answer if they can make it work the way it's supposed to," Swanson said, referring to the pilot Program of Assertive Community Treatment that is starting this month in Billings and Helena.

"You have to go to the root cause, and the root cause is they are not getting the treatment they need," Holley said. "They need to have this human support system."

Holley said the community needs greater crisis-intervention services, intensive case management and care for people who are both mentally ill and addicted to alcohol or illegal drugs.

Regional needs

Yellowstone County commissioners and mental-health-care representatives have started talking together.

Commissioner Bill Kennedy hopes that a community solution will be found. He wants to look at ways that money now being spent on transportation could be spent on actually caring for seriously mentally ill people.

Kennedy, who also chairs the Mental Health Center board of directors, suggested that a regional approach might be appropriate because Billings mental-health-care providers serve patients from throughout a large region of Montana.

Yellowstone County Attorney Dennis Paxinos and Sheriff Chuck Maxwell believe that the solution will involve finding another safe place for the care of people in mental-health crisis.

One thing is certain: People who are mentally ill cannot be jailed. State law specifically forbids jailing people whose only offense is being ill, the sheriff said.

At Deaconess Psychiatric Center, Administrative Director Libby Artley said the growth in psychiatric emergency patients is part of a bigger problem.

"The problem is the crumbling of the mental-health system in this state so everything moves to the high end," Artley said.

The psychiatric center has been seeing more patients — adults and children — who are staying in the hospital longer. The higher numbers have strained staff. And, still, Deaconess cannot accommodate all the people who come to its emergency department needing temporary, secure care.

When the five secure beds for adults at Deaconess are filled, new arrivals may have to be transported to the state hospital in Warm Springs.

Losing money

"Our role as a nonprofit, community-owned health-care organization is to step up to the plate, which we have done," Artley said. "We reopened our youth unit in July. We're building one more secure (adult) bed."

Artley said Deaconess leaders have considered whether they should expand the inpatient unit. But she said that a larger hospital unit wouldn't address what she sees as the bigger problem: Lack of appropriate, continuing care outside the hospital.

Many of the people admitted to Deaconess or sent from Billings to Warm Springs could have been served in the community, if adequate preventative and outpatient services were available, Artley said.

"They shouldn't even need acute care. They shouldn't escalate to acute care," she said.

Money is a big factor in care of people with serious mental illnesses, especially in hospital care — the most expensive service.

"If Deaconess Billings Clinic were a for-profit, we certainly would've closed our doors" to psychiatric care, Artley said. "Mental-health services, at least at this level, are not financially viable."

Deaconess has a policy of treating people in need, regardless of their ability to pay.

Other mental-health-care professionals told The Gazette that they are worried about expanding services because they worry that the state mental-health program may run out of money with the budget cap imposed by the Legislature and the lack of information on actual program spending.

Deaconess attorneys are still working to collect about $2 million that the hospital says the state's former managed-care company owes the hospital for services provided last year.

While the new state payment system is easier to work with, Artley said the new payments are guaranteed money-losers for the hospital when it can't discharge patients to appropriate community placements.

The state pays the hospital a set fee based on diagnosis, a system used to pay hospitals for most Medicaid and Medicare services. The psychiatric center's problem is that patients routinely stay in the hospital days, even weeks, after they could leave because there is nowhere for them to get group home or residential care.

Step-down services

Artley said Deaconess leaders also are talking about the possibility of building those less-intensive community services. In the past, the hospital has partnered with other organizations on step-down services and hasn't seen its role as being the primary outpatient provider.

She said Deaconess wants to work on community solutions to these complex problems.

Mona Sumner, chief operating officer at Rimrock Foundation, echoed that commitment to be part of a solution.

Rimrock, which primarily provides chemical-dependency treatment, established a mental-health crisis stabilization unit earlier this year, Sumner said.

During the last few months of the now-defunct managed-care contract, the four-bed Rimrock unit received patients who were seen first at Deaconess or at the Mental Health Center. But, since July, few patients have been referred to Rimrock, even while the Deaconess Psychiatric Center has been full and sending people to Warm Springs.

Only some of the mental-health emergencies seen at Deaconess could be handled at the Rimrock unit, Sumner said. Rimrock's unit isn't locked, and whether it can take a suicidal patient or an intoxicated suicidal patient depends on "the level of suicidality," she said.

Sumner hopes that the type of patients who were served for a few months can be served again.

"I don't profess to know what all the stumbling blocks are," Sumner said. "We are committed to trying to help with this."

At Deaconess, Artley said it is unclear whether the Rimrock unit is available, but she expected to discuss it with Sumner. She said some issues about physician responsibility for transferred patients have to be resolved.

It's rare that a Deaconess emergency patient could be transferred to Rimrock, Artley said. If a person is suicidal, he needs to be admitted to the psychiatric unit, she said. But Deaconess has looked at discharging people who have been hospitalized for a while from the psychiatric unit to the Rimrock crisis unit.

Like Artley, Sumner and Bob Ross, executive director of the Mental Health Center in Billings, said they are concerned about state mental-health funding.

Although Ross agreed that Billings could probably use one or two more group homes for adults with mental illnesses, he is reluctant to ask his board of directors to put money into a new home because there may no way to pay for it if state funding falls short.

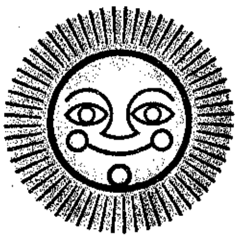
Dan Anderson, head of the state Addictive and Mental Disorders Division in Helena, recently said the overall mental-health program appears to be within its budget. However, the Montana State Hospital continues to have more patients and a bigger work force than budgeted.

Anderson admitted that he didn't have complete information on spending because the program changed dramatically on July 1 and because of problems with the new state computer system.

"We're cautious about program development because the state doesn't have the data on its spending," Ross said. "They've got a fixed budget without the ability to put more money into it."

Still, Ross said, the Billings community needs to address gaps in care of seriously mentally ill people.

"It's a community problem," Ross said. "It's our problem, and the only solution will be one we do collectively."



Billings Gazette
The Source
114th year, No. 220 ■ City/State Edition ■ © 1999 Billings Gazette, a Lee Newspaper

A NEW MINDSET

Pilot program offers better hope for life outside mental hospital

Stories By PAT BELLINGHAUSEN
Photos By LARRY MAYER
Of The Gazette Staff

WARM SPRINGS — Roger Crandall often bicycles around the dozens of buildings and acres of lawn that comprise the campus of Montana State Hospital.

The dark-haired, 36-year-old man knows this place well.

"I've been bounced in and out of here nine times," he told a recent visitor to the beige-colored duplex he shares with six other patients. His latest stay is "going on seven months."

"They adjusted my medications. I'm doing great," Crandall said during an interview in the living room of his temporary home.

Before his latest hospitalization, he was hearing voices and talking back to them, which caused trouble in his Helena apartment house.

In their transitional unit at the edge of the hospital campus, Crandall and his house mates arise at 6:45 a.m. every day. They have breakfast together and attend a morning meeting where a hospital treatment team "comes up with jobs" for them. He usually works on grounds, trimming trees and doing landscape jobs.

"If I got out, I could get a job as a landscaper," he said.

He has worked outside the hospital, holding down a job as a certified nursing assistant for several years and also working as a cook.

"I've kind of taken over the cooking deal," he said, explaining that he volunteers to prepare food for his house, a chore that all residents must share. "We've got a couple of guys who can't cook."

Crandall hasn't had an easy life. He's been hospitalized for mental illness at institutions in two states; he's been homeless; he's struggled with alcoholism and with methamphetamine.

Tough as his situation is, Crandall may be an ideal candidate for a new Montana care program.

The Program of Assertive Community Treatment, which will begin a one-year trial this month in Billings and Helena, was created about 25 years ago in Madison, Wis., to serve people, who, like Crandall, are seriously ill and have repeated hospitalizations and substantial difficulty staying well in their community.

At the request of a Gazette reporter, Montana State hospital administration asked some potential PACT participants if they would be willing to be interviewed for this report. Crandall and James Shannon agreed to share their stories and their ideas about community treatment.

With close-cropped dark hair, a long, loose-fitting T-shirt, baggy, below-the-knees red shorts and black sports shoes, Shannon looks like a teenage skate boarder. He used to be a skater.

At age 22, he spends a few hours a day minding a video library and popcorn machine. He showed off his T-shirt, emblazoned with the logo of alternate rock band Nine Inch Nails. He designed it on the computer.

"I'm on the computer as much as I can," he said, adding that he keeps in touch with his mother by e-mail.

"Another misconception about mental illness is that people with mental illness are stupid," the articulate young man said, leaning back in his office chair. "People come up to me and say 'You're so smart. How can you be mentally ill?' "

Shannon said he attended high school for two years and finished his schooling in Job Corps.

"I've been here for about nine months and a couple of weeks," Shannon said.

This is his first hospitalization at Warm Springs, but he has been a patient in private hospitals many times.

"When I first got here, I didn't want to leave. I wanted to die," he said. He held out his arm to show the scars from self-inflicted cuts and cigarette burns.

He has seen improvement: "Medications take away most of the symptoms. I say most. I still get depression."

"With my medications and whatnot, I'm doing well enough that I don't fit in here anymore. I'm not sure I'm ready for community. I'm hoping the program (PACT) can help.

"To be honest, I'm a little leery about it. I'm homeless and jobless. My SSI application is in the works."

Shannon said the Billings Mental Health Center people who talked to him about PACT said they would help tide him over until the Supplemental Security Income payments were available to him.

"I hope that everything is going to turn out OK, but I can't say that it will," he said. "This is a new program. We, the ones who first go through it, are the ones who are going to work the kinks out. But I think it would be a little better than going to a group home.

"In a group home, you are told when you can do stuff, when you can't do stuff, when to cook, when to eat. I know how to live in a structured environment. I do not know

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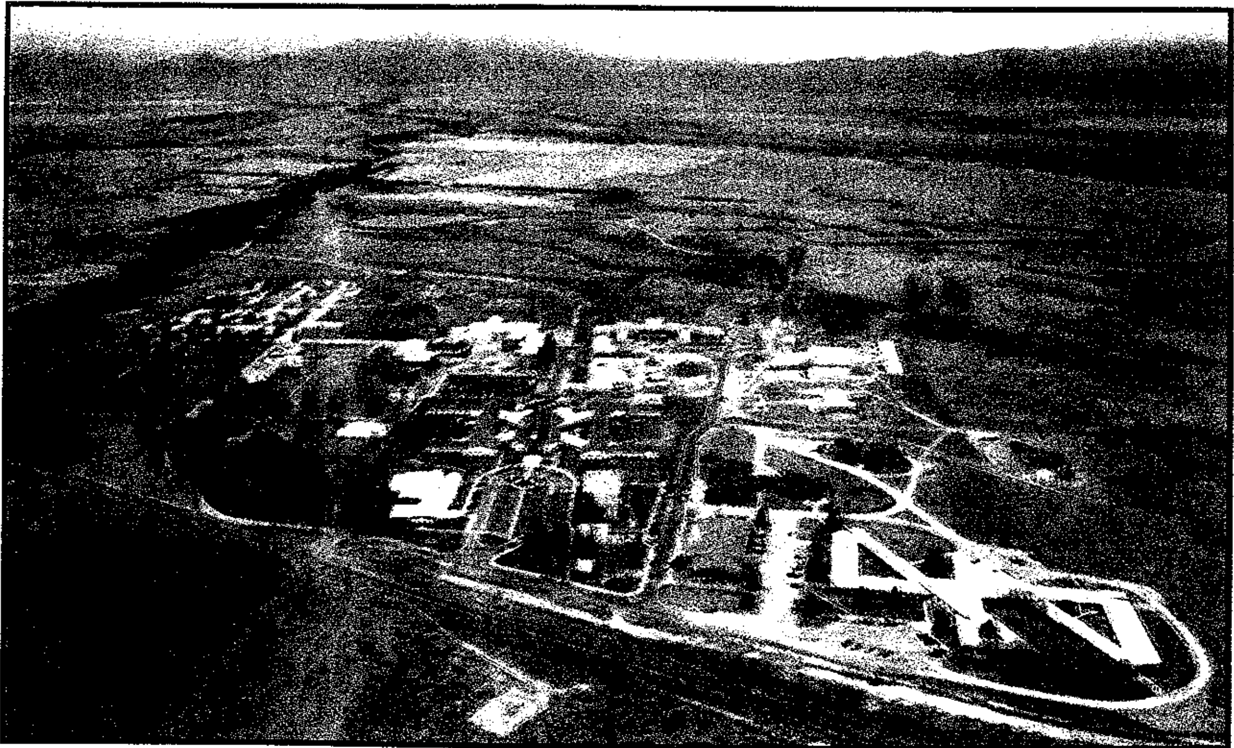
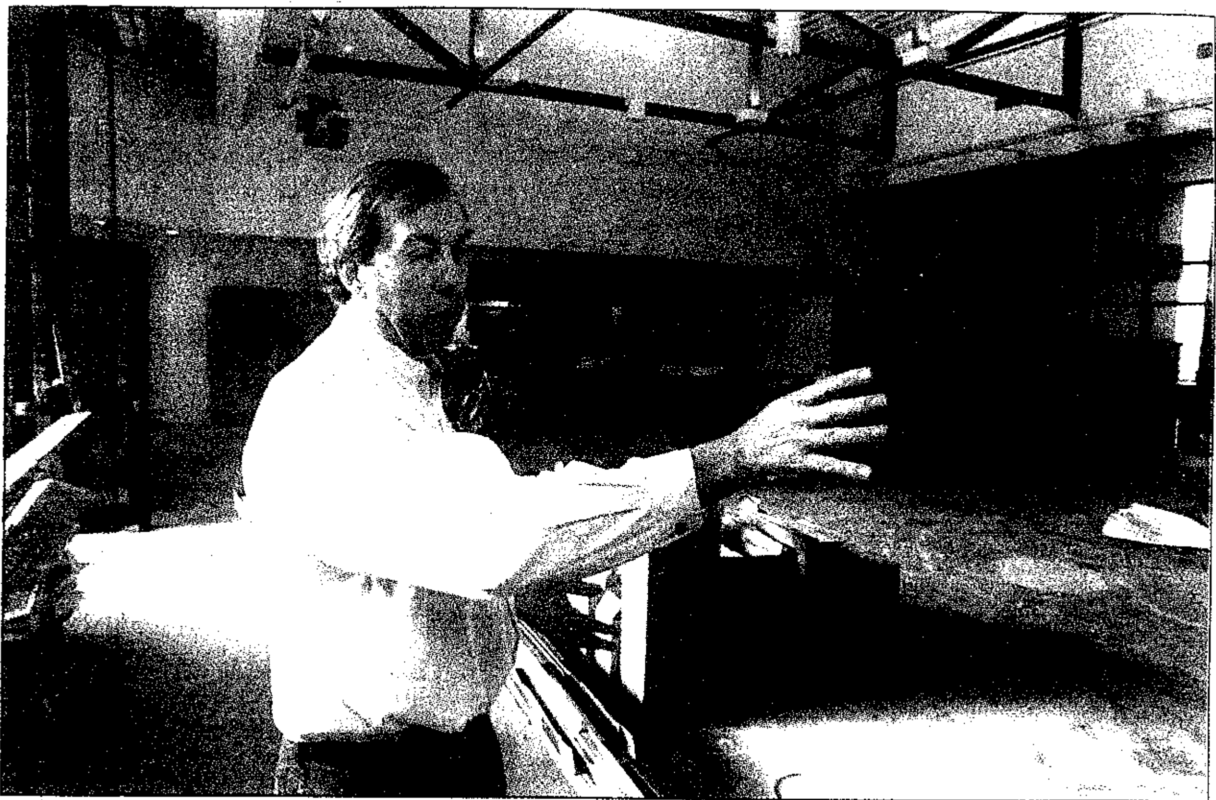
James Shannon works in the hospital's video library and is scheduled to return to Billings as a participant in the PACT program.



An aerial view shows the Warm Springs complex in the Deer Lodge Valley.



Gazette photo/LARRY MAYER

Warm Springs staff member Ed Amberg talks about the new hospital under construction.

PACT

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how to live in an unstructured environment."

But he would like to learn how.

What would be a good life?

"I've been thinking about going to cosmetology school," Shannon replied.

Crandall also has been thinking about what life could be like outside the hospital. He said he wants to get a job and some job training. For now, his entire income is a monthly SSI benefit.

The transitional home where he is staying was started just a couple of months ago at the hospital. It has helped him prepare for leaving, he said. "If I was to leave here in a few weeks, I think I'd be more comfortable living in the community."

Asked if he would like to be in the PACT, Campbell shared some insight into his illness.

"Mental health sets up appointments for me. Sometimes I don't make them," Crandall said, admitting he has a responsibility to keep appointments.

"If you miss an appointment with them, you don't hear from them for two or three weeks. I need somebody to remind me to take my medications."

Crandall said he needs medication twice a day. But sometimes he has stopped taking it and has "fallen apart in a few months."

In the PACT program, the mental-health team would have the job of keeping appointments with him. Instead of the client going to the office, the office would come to him.

A psychiatric nurse, a therapist or other mental-health worker would come to his home to check on him (more than once a day, if needed), to remind him to take his medicine, to take him grocery shopping, to help him solve problems with neighbors or whatever else he needed.

The team is akin to "a mobile psychiatric unit without walls," said Bill Coleman, a licensed therapist and chemical dependency counselor who is the Billings PACT team leader for the Mental Health Center. "These people are completely there for the client. The goal is to have the client stable and in the community."

On the day that a reporter talked with Crandall and Shannon, Coleman and most of the other people who will be working in these new community treatment teams were at Warm Springs, too. And they also were interviewing candidates for PACT.

Among 178 patients, the hospital staff identified 44 who need the comprehensive, continuing services of PACT, said David Proffitt, the hospital's director of treatment and rehabilitation.

These are people who have had multiple psychiatric hospitalizations within a year, have needed a lot of services, have been able to manage only briefly in the community and who have been diagnosed with serious long-term illnesses, such as schizophrenia and bipolar disorder.

"These are people who've reached maximum benefit, who by staying here longer aren't being helped," Proffitt said.

"The goals of PACT service are privacy, working, having friends, having some self-autonomy and control, the kind of goals that most people value in their lives," Proffitt said.

Long-term hospitalization can be detrimental to developing the skills needed to reach such goals, he admitted. "At the hospital, we develop good patients; we don't develop good community members."

"Mental health sets up appointments for me. Sometimes I don't make them. If you miss an appointment with them, you don't hear from them for two or three weeks. I need somebody to remind me to take my medications."

Roger Crandall
patient at Warm Springs

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When the people directly responsible for making the new program work sat down at a conference table, they counted collective experience of 71 years in the mental-health field.

Coleman and Roger Scarborough, director of alternative services for the Billings Mental Health Center, have been in mental health for 22 years. Jeff Sturm, director of tri-county services for Golden Triangle Mental Health Center in Helena, has been in a mental-health career 20 years, and Helena team leader Jenny Kelly for seven. None of them has any previous experience with PACT.

Each team will have two psychiatric nurses, a chemical-dependency counselor, employment specialist, licensed therapists and other mental-health-care workers for a total of six people on the Billings team and eight on the Helena team. In addition, each team will have a secretary and a part-time psychiatrist.

By May, the Helena team is committed to having 60 clients in PACT and the Billings team 40.

After three days of training at the end of November with consultants from Wisconsin and Texas, the teams will have to work quickly to start caring for clients in Billings and Helena. The mental-health centers' contracts with the state call for them to each take a dozen patients out of the hospital and into PACT by Jan. 1. and a dozen more by spring.

"We're taking some very high-need people into the program," Proffitt said. "There's no doubt in my mind we will have significant rehospitalization."

Proffitt expects that at least 50 percent of the PACT clients discharged from the hospital will come back in the first year. But he hopes that, instead of staying at Warm Springs for a few months, they may only stay a few weeks.

In addition to caring for people as they are discharged from the state hospital, the PACT teams will take people in the community who have serious mental illness and a history of cycling from hospital to community to hospital again. Some people in group homes or adult foster care may be candidates for PACT, Sturm said.

"We went down to our county jail and identified three people who probably meet criteria for PACT," Scarborough said. "We're going to be working with the public defender's office to try to get some of these people out of jail."

These are people with serious mental illnesses who have been incarcerated for what Scarborough described as mischievous behavior or drunkenness, not for major crimes. These are people who will be released from the jail and probably return to jail if they don't get treatment.

"PACT is not only to get people out of the hospital, it's to prevent that cycle," Scarborough said.

Asked how the PACT project will address community safety concerns, the program leaders noted that they will mostly be serving people who are in the community anyway or people who would soon be discharged from the hospital.

> **"We will learn a lot for getting into the PACT. This is really the beginning of a new era."**
>
> David Proffitt
> hospital director of treatment and rehabilitation

All but eight people on the list of 44 candidates have been admitted just this year, Proffitt said.

"Community safety is an issue when treatment is not provided," Sturm said. "Community safety should be improved because they'll be in treatment."

"Clients in this program are clients for life," Sturm said. "There won't be a lot of movement."

People get into the program because they have long-term illnesses.

The hope for PACT is that it will prove to be a more effective and cost efficient service for a seriously disabled population, so that Montana will expand the use of the program to serve more people who can benefit from it, Sturm said.

If this pilot program succeeds in keeping people healthier and longer in the community, it may lead to other changes in how the state delivers mental-health care as those who run the system start to look at what really works for people with serious mental illnesses.

"It's going to challenge us to look differently at things," Sturm said.

"We will learn a lot for getting into the PACT," Proffitt added. "This is really the beginning of a new era."

Gazette photo/LARRY MAYER

Billings and Helena PACT team members meet with staff at the Warm Springs State Hospital about the program.

Construction delays put pressure on mental-health program

WARM SPRINGS -- Like winter's cold delayed by the long, warm fall, change has been postponed at Montana State Hospital. A season of transition has finally arrived for this institutional village encircled by trout ponds and Pintler Mountains.

Montana State Hospital soon will have a new $26-million building. But it has more patients than the new structure can accommodate.

The state is collaborating with community mental-health centers in Billings and Helena to launch a new program that may ease the hospital-population dilemma while offering a better life to dozens of seriously disabled adults.

The construction company most recently has pledged to have the new, single-story building with block walls and room for 114 patients finished by Christmas, said Ed Amberg, director of quality assurance for Montana State Hospital. Over the following 60 days, hospital staff would furnish the new building and move in their offices and patients.

Originally scheduled to be completed by July 1, the construction has proceeded at a faster pace since Gov. Marc Racicot visited the work site in early August.

"We went from an average of 70 people to 120 people on the job," said Sonny Stotler, who monitors the construction project for the state.

The construction delay has added about $110,000 a month in operating expenses above what the Department of Public Health and Human Services expected to spend, Amberg said.

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Project

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The new facility will allow the hospital to operate with less staff because it will consolidate patients in fewer buildings.

The budget approved by the 1999 Legislature assumed that the move would be made by Oct. 1, so less money was budgeted for operations after that date.

Another cost pressure on the state's Addictive and Mental Disorders Division is the budget assumption that there would be an average of 135 patients a day at Warm Springs. The daily patient count has exceeded that number since the fiscal year began in July and stood at 178 patients on the November day that Gazette staff members visited the hospital.

By early December, there were 173 patients, Amberg reported.

Randy Vetter, hospital admissions coordinator, noted that the population had been down as low as 145 this year. But he said there had been a surge in admissions while group-home and foster-care placements weren't available to move other patients to community settings.

"We currently have more patients than was budgeted," Amberg said earlier this month. "Regardless of the budget issues, we will take care of the people who need it."

The Addictive and Mental Disorders Division is under another budget constraint. The Legislature stipulated that no additional state money can be shifted into mental-health services during the biennium.

Usually, the governor's administration has some ability to move funds between programs in a department as they deem necessary, but mental-health services are under a strict budget cap.

Even with the hospital construction delay and the higher-than-projected patient numbers at Warm Springs, the division may be staying within its overall budget, which includes community services.

"Overall, the best information we have is we are within budget," Dan Anderson, administrator of the Addictive and Mental Disorders Division, said early this month from Helena. "We haven't gotten very good expenditure reports out of the new (state computer) system."

To gauge how closely expenditures are staying on the budgeted track, the division has compared spending in recent months with what was spent back in 1996, before the state ventured into managed care. This is the best comparison, Anderson said, because the current state-paid system is similar to the system in place before the managed-care contract started in the spring of 1997.

Several years ago, when state government decided to build a smaller hospital, it also decided to privatize the publicly funded mental-health system.

Along with controlling costs, the contract with the managed-care business was supposed to create new community care for seriously mentally ill people and help reduce the state hospital population before the planned facility downsizing. Those new services didn't materialize.

When the new building opens, the hospital in Warm Springs will continue to use one older building to house up to 56 less-intensive patients, and it will continue to maintain transitional housing for up to 15 people, Amberg said.

Still, the number of patients at the hospital has to be decreased. And the state has a plan to help, a plan that has won wide support from mental-health-care advocates and professionals.

The new project, starting this month, is a version of the Program of Assertive Community Treatment, a model developed 25 years ago in Madison, Wis., and since replicated in counties and states across the country.

Over time, PACT has reduced hospitalization for its clients, according to a 1998 review PACT research that led the national Schizophrenia Patient Outcomes Research Team to conclude that the program is "superior to conventional case management for high-risk cases."

"Success will be measured by a reduction in use of hospital care, increase in employment, in the number of days employed, increase in the degree to which they are living independently, in consumer satisfaction, less arrests and jail time and consumer family satisfaction."

Dan Anderson
administrator, Addictive and Mental Disorders Division

Last summer, the director of the Health Care Financing Administration, which is responsible for the federal portion of Medicaid programs, encouraged state Medicaid directors to consider the findings on PACT.

Medicaid will cover Montana's new assertive community treatment, Anderson said. That means federal funding will pay 70 percent of the PACT costs for Medicaid-eligible clients.

What the state doesn't yet know is how many non-Medicaid clients will be served in the new program. The state would be paying all the costs of the non-Medicaid clients, people who have serious mental illness and low income, but don't qualify for Medicaid.

Anderson said the state has agreed to pay the mental-health centers about $1,100 a month for each PACT client being served. That's a fraction of the $300-a-day ($9,000-a-month) cost of hospitalization at Warm Springs.

The division has allocated $600,000 to fund the pilot programs through June, the end of the fiscal year. That doesn't mean the pilot will end then, but the state will take another look at the fee, Anderson said. He expects that it can be reduced because the initial monthly rate was set to cover the mental-health centers' start-up costs.

How will people know if the new program is working?

Anderson said the state doesn't have specific benchmarks to measure the program's performance, but may set some. Rusty Redfield, a member of the division staff, has the job of monitoring the pilot project.

"Success will be measured by a reduction in use of hospital care, increase in employment in the number of days employed, increase in the degree to which they are living independently, in consumer satisfaction, less arrests and jail time and consumer family satisfaction," Anderson said.

"We're looking at real practical kinds of things: Are you able to stay healthy and out of the hospital?"

U.S. Seeks More Care for Disabled Outside Institutions

By ROBERT PEAR

WASHINGTON, Feb. 12 — Following up on a Supreme Court decision, the Clinton administration has told states to evaluate hundreds of thousands of people in nursing homes, mental hospitals and state institutions to see whether they could instead be receiving care in their own homes or elsewhere in their communities.

In a policy statement with far-reaching implications, the administration has informed states that, to comply with the court ruling, they will almost certainly have to provide more medical and social services and shift more people out of institutions and into small group homes or apartments.

"No person should have to live in a nursing home or other institution if he or she can live in his or her community," Donna E. Shalala, the secretary of health and human services, said in a letter sent last month to all governors. Moreover, she said, "unnecessary institutionalization of individuals with disabilities is discrimination under the Americans With Disabilities Act."

People with disabilities welcomed the administration's action, saying it would help them enforce their rights. But state officials said the federal policy went beyond the court ruling and could impose substantial new costs on states.

The state officials said that compliance would cost tens of millions of dollars in individual states and could easily cost more than $2 billion a year nationwide. Federal officials said they had no immediate estimate of how much it would cost states to comply.

The federal government has some power to force states to comply with its new instructions, both because the states are required to meet federal standards as a condition of receiving Medicaid money, and because the federal government enforces the Americans With Disabilities Act. But officials said they would prefer that the states cooperate in developing acceptable practices and avoid a fight with Washington.

People who leave institutions to live in the community often need housing assistance, job training, medical care and personal attendants to help them with daily activities. Many people spend years in institutions because these services are not available in less restrictive settings.

Federal officials said they wanted to know about any disabled person being unnecessarily confined to an institution, and they promised to investigate every complaint. They said they had received 43 complaints from people in 20 states. But the number of people eventually affected by the new policy would be much greater.

The Supreme Court case, Olmstead v. L.C., involved two Georgia women, Lois Curtis and Elaine Wilson, who had been confined to a state institution for years, even though doctors had said they could receive appropriate care for their conditions — mental retardation and mental illnesses — in their community.

In its 6-to-3 decision last June, the court said "states are required to provide community-based treatment for persons with mental disabilities when the state's treatment professionals determine that such placement is appropriate," considering a state's resources and the needs of other people with mental disabilities.

Federal officials contend that the Supreme Court ruling applies to people of all ages with all types of disabilities in all institutions and all state programs.

Using a Supreme Court decision to get more humane care for the disabled.

Michael W. Auberger, a co-founder of Adapt, an advocacy group for that often uses civil disobedience as a tactic to promote the rights of disabled people, said: "State officials are nervous. They see the Olmstead decision as potentially busting the bank."

William Waldman, who represents state officials as executive director of the American Public Human Services Association, agreed.

"This ruling has deep and profound implications for all states," Mr. Waldman said. "It affects not only people in state psychiatric hospitals and centers for the mentally retarded, but also people in nursing homes and children in institutions who want to live somewhere else. States can redirect spending from institutions to community services. But very likely there will also be new expenses for states."

The Clinton administration policy, combined with the Supreme Court decision, is likely to lead to tangible changes in the lives of people with disabilities. Even before the court decision, state officials had been moving fitfully to increase community-based care, but the wait for such services exceeds eight years in some states. The new federal policy "will force states to step up the pace," said Sara Rosenbaum, a professor of health law and policy at George Washington University.

In its letters to state officials, the Clinton administration made these points:

¶The Supreme Court ruling applies not just to people with mental impairments, but also to those with physical disabilities.

¶The ruling applies not just to people in state institutions, but also to Medicaid recipients in private nursing homes.

¶The ruling applies not only to people in institutions, but also to people who are living at home and might have to enter an institution in the future if they do not receive proper services.

The Clinton administration told states it expected them to evaluate "all individuals with disabilities in institutional settings (such as state institutions, intermediate care facilities for the mentally retarded, nursing facilities, psychiatric hospitals and residential service facilities for children)," to see if their needs could be met in their communities.

Roger M. Auerbach, a senior official at the Oregon Department of Human Services, said he was "surprised at the broad interpretation that the federal government has given to the Olmstead decision."

Mr. Auerbach, a lawyer who is vice chairman of the National Association of State Medicaid Directors, said, "In a huge majority of cases, serving people in the community is much less expensive than serving the same people in an institution." But he said the Clinton administration's reading of the law could increase costs over all because it could require states to serve a larger population, including disabled people in their communities who have not received services they need.

Ira A. Burnim, legal director of the Bazelon Center for Mental Health Law, an advocacy group, said states should not be allowed to "claim poverty" as an excuse for not providing community care, but should try to get more money from Medicaid, state legislatures and other sources. In addition, he said, states can free money for community services by closing mental hospitals or reducing their size.

The Supreme Court decision has prompted advocates for the disabled to file other lawsuits, has helped them win lower-court judgments and has put new pressure on states to settle pending cases. In the last seven months, advocates for the disabled have won court victories in Hawaii, Pennsylvania and West Virginia and have extracted concessions from state officials in Massachusetts and Washington State.

In West Virginia, Judge Robert C. Chambers of Federal District Court ordered the state to eliminate long delays in providing community services to people who were mentally retarded. The federal Medicaid law requires states to provide services with "reasonable promptness." But in West Virginia, the judge said, "many eligible individuals remain on waiting lists for months or even years."

Officials of the New York State Health Department said they were still reviewing the Clinton administration letters and had not decided how to respond. Kristine A. Smith, a spokeswoman for the department, said the number of people in mental hospitals and other state institutions had declined sharply in the last 20 years.

But Sarah J. Gilmour, a disability rights lawyer in Rochester, said: "Thousands of people now in institutions in New York should be receiving home health care or personal care in their own homes. So far the state has done nothing to respond to the Olmstead decision." Disability rights advocates will soon file complaints about the state's inaction with the civil rights office of the federal Department of Health and Human Services, Ms. Gilmour said.

In recent years, many states have tried to increase community care, but advocates for the disabled say that spending is still biased in favors of institutions. Nationwide, Medicaid spending on long-term care totaled $59 billion in 1998. Seventy-five percent of that sum was for institutional care, while 25 percent was for community care.

Texas is not known as a leader in health and human services, but is ahead of many other states in responding to the Supreme Court decision. It has developed a detailed plan to identify people in institutions who could be served in their communities, and it is setting a timetable for action.

Experts suggest several reasons for the state's progress. Texas has a strong coalition of disability rights groups. Gov. George W. Bush is running for president. And his father signed the landmark law that the Clinton administration is now enforcing.

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