

WHY IT MATTERS: THE SYSTEM DOESN'T WORK

In March 1998, 11-year-old Andrew McClain died at Elmcrest psychiatric hospital in Portland, Conn. Officials blamed cardiac arrest. A few reporters at *The Hartford Courant* didn't buy it.

Eric Weiss, a reporter in the paper's Middletown bureau, across the Connecticut River from Portland, started investigating. Weiss discovered that Andrew had been placed in a padded "time-out" room because he'd disobeyed instructions to move to another table at breakfast. Two aides restrained him by lying on top of him. The boy – 4 feet 6 and about 90 pounds – died of "traumatic asphyxiation, chest compression." He was crushed and suffocated.

As Weiss covered the case, he began to wonder: How often do deaths like this occur nationwide? What safeguards protect patients? Weiss figured he simply had to locate the right database or bureaucrat to find answers. But the federal government didn't track restraint-related deaths or even consider them a problem.

Weiss and several colleagues spent five months calling everybody who might know anything, in all 50 states: health directors, mental health officials, patient advocates, coroners. The painstaking work produced a powerful series.¹ "Deadly Restraint," which ran Oct. 11 through 15, 1998, reported that people are dying because of restraint misuse in facilities for the mentally ill and retarded. The newspaper confirmed 142 deaths nationwide from 1989 through 1998, but said the real number could be as high as 1,500 because most cases go unreported. Children were the most likely to die.

The series found that the aides who provide the bulk of hands-on care and use restraints most had the least training and the lowest wages in their field. Government oversight was haphazard. Cover-ups were common. Although many deaths happened in outrageous circumstances – patients begging for air, shoddy emergency response – almost nobody was held accountable.

The report drew swift, emotional response. Hundreds of readers posted comments on the *Courant* Web site. Many told heartbreaking stories of restraint misuse. The Health Care Financing Administration soon issued rules on restraint use and worker training in federally financed facilities. Connecticut banned the type of hold used on Andrew McClain. And President Clinton signed a law, drafted by Connecticut's senators, restricting the use of restraints on people with mental disorders.

Efforts are under way across the country to improve mental-health treatment. Some key players and strategies come straight from the quality movement in medicine. Performance evaluations, benchmarks, evidence-based analysis – all are being developed and tested in hopes of raising standards of care for people with mental illness and addictive disorders.

But America's mental health-care mess – by no stretch can it be called a system – poses enormous challenges for the quality gurus. Services are severely underfunded. Only a small percentage of people who need treatment are properly diagnosed, and only a fraction of those patients receive

appropriate, comprehensive care. “The system has been decimated by funding changes,” said Dr. Charles Homer, executive director of the National Initiative for Children’s Healthcare Quality in Boston, which promotes improvement in pediatric medical and mental-health services. “The infrastructure is so weak, it’s hard to talk about improvement,”

Situations that the public wouldn’t tolerate in medical care are status quo in mental health. Insurers set arbitrary time limits on treatment – say, 30 days in a psychiatric bed – no matter what a person needs. Around the country, teens with mental and psychosocial disorders are warehoused in juvenile halls because outpatient treatment is not available. Imagine jailing a kid with cancer because the oncology beds are full.

In theory, the quality of mental-health care should be at an all-time high. Never before have so many proven, effective therapies been available. But America’s ability to deliver care has eroded because of deep cuts in funding. The characteristics of serious mental illness – disorganized thinking, despair, sometimes paranoia – make it all the more difficult for patients to fight for what they need.

This presents a huge opportunity – and a responsibility – for journalists. Important, poignant stories are everywhere. If the press doesn’t tell them, chances are nobody will.

These stories are not easy to pull off. Reporters may find it daunting to get their arms around such a fragmented array of services. Patient privacy and confidentiality, sensitive in any medical reporting, take on heightened importance because mental illness carries such a strong stigma. And as Eric Weiss discovered, information may not be centralized, because nobody tracks essential aspects of care. “The federal government — which closely monitors the size of eggs — does not collect data on how many patients are killed by a procedure that is used every day in psychiatric and mental retardation facilities across the country,” the restraint series said.

But good journalism can have an enormous impact. As far back as the 1970s, when Geraldo Rivera (yes, *that* Geraldo) documented horrible conditions at Willowbrook State School for the Mentally Retarded, on Staten Island, N.Y., media exposure has been one of the only things besides lawsuits to spur changes. Dr. Joshua Sharfstein, a pediatrician who has written about the failure of mental-health care for children in Massachusetts, says reporters have considerable power as watchdogs. “The press plays an essential role,” he said.

BACKGROUND

MONEY, MANAGED CARE AND MADNESS

In the past decade, mental treatment underwent one of the most sweeping changes that has ever taken place in health care: the rapid, broad move to managed care for both privately insured patients and people on Medicaid. Funding – never overly generous – is wholly inadequate to serve the vast numbers of people who need help. The upshot: severe restrictions on services.

KEY FACTS: HUGE GAPS IN TREATMENT

- Roughly 53 million Americans – one in five – have some form of mental disorder.² About half of Americans will suffer mental illness, addictive disorders or dementia during their lifetimes, according to the 1999 landmark Surgeon General’s Report on Mental Health. Critics say these estimates are overblown.
- About 90 percent of mental-health benefits are under managed care, compared with roughly 50 percent of general-health benefits. Many states, too, have moved to managed-care programs for mentally ill people on Medicaid. Little is known about the effect of this profound shift on the quality of care.
- Spending for mental-health care has shrunk as a percentage of overall health expenditures, from 6.1 percent in 1988 to 3.2 percent 10 years later.
- Nearly two-thirds of people who have a diagnosable mental disorder receive no care. Most patients who do seek care get inappropriate or incomplete treatment. By some estimates, only 5 percent of people with serious mental disorders receive proper, comprehensive care.

It is almost impossible for journalists to cover quality of mental-health care without addressing the economics and politics of treatment. True, there is a strong push to improve quality — mental-health advocates and researchers are working hard to establish standards of care and systematic evaluation mechanisms. But reporters covering these efforts will inevitably have to deal with funding shortages and limited access to services. And that means journalists must understand how care is organized and paid for.

If this sounds dry, take heart. Many reporters have found that these are not arcane issues, but fodder for powerful stories.

Managed care of mental health has gotten a bad rap – for good reasons, as we’ll see in a minute. But reporters should recognize that the old fee-for-service days were rife with problems, too. During the 1980s, for-profit psychiatric hospitals seemed to sprout as quickly as fast-food drive-ins. Most insurers automatically covered 90 days of inpatient care. And patients would spend – surprise! — 90 days in the hospital, whether or not the treatment worked. For the most part, the psychiatric profession kept silent about the failures, and no wonder: Many psychiatrists had financial stakes in the hospitals. (It was journalists who exposed the problems and conflicts of interest.) Now, psychiatrists stand among the loudest critics of managed care.

Managed care has achieved one goal: controlling costs. From the mid-1980s through the mid-1990s, mental-health spending grew 7 percent a year, compared with an annual increase of more than 9 percent in health-care spending overall, according to the Surgeon General’s Report on Mental Health. The big question is: Has quality changed? Researchers have yet to determine the answer. But the media have exposed extensive problems, especially for Medicaid patients.

PUBLIC CARE: CAN CHEAPER BE BETTER?

The Infinite Mind, an independently produced weekly radio program on public-radio stations, reported the story of Blake Hansen of Wichita, Kan.³ An 18-year-old with schizoaffective disorder, Blake had tried several times to commit suicide. After one attempt he went to an emergency room to have his wrists bandaged. He begged for a referral to a state psychiatric hospital.

A psychiatrist agreed to send him. But a Medicaid worker who had 52 hours of college credits and prior job experience at Wendy's, overruled the doctor. Blake was "diverted" to a community-based program, a popular (and cheaper) alternative. Nobody followed up, even after he failed to attend. Thirty-seven days after he was discharged from the hospital, Blake climbed into a bathtub, closed the shower curtain and killed himself with a shotgun.

Blake's story gives *The Infinite Mind* segment its emotional resonance. But what makes the piece "Managing Madness" so powerful is its thorough analysis of managed care – history, economics, a provider's view, an example of a model program. In context, Blake's death seems not only tragic, but also outrageous, an almost inevitable byproduct of the drive to cut costs in government programs for society's most vulnerable people.

Because debilitating mental disorders are strongly associated with unemployment and poverty, the lion's share of treatment for serious illness falls on Medicaid. The shift of public programs to managed care has been controversial. Patients desperately need help and they don't have the emotional or financial resources to fight for it.

Arizona's managed mental-health-care program was such a fiasco it resulted in years of litigation. Some states are considering abandoning managed care and returning to some form of reimbursement for services. But traditional payment arrangements also were fraught with problems – even abuse. That's why managed care came along.

A study released in May 2000 by the respected Bazelon Center for Mental Health Law and the Milbank Memorial Fund found that under managed mental-health care, Medicaid programs used less inappropriate treatment, and showed more accountability and attention to measuring outcomes.⁴ On the downside, programs tended to overemphasize acute care and neglect rehabilitation and other essential services with long-term payoffs — a considerable shortcoming in the treatment of chronic, recurring mental illnesses.

Reporters should track developments in public managed mental-health care. Ask tough questions about "solutions" championed by policymakers, especially when those solutions do not include adequate funding.

PRIVATE INSURANCE: RESTRICTIONS AND RED TAPE

Almost all behavioral health insurance benefits are under managed care – an extraordinary shift

that received almost no public notice until recently. “With little public attention,” Milo Geyelin wrote in the *Wall Street Journal* on May 8, 2001, managed care “transformed the treatment of mental illness and substance abuse.”⁵

Geyelin’s story focused on Magellan Health Services Inc., the nation’s largest managed-care company for mental health and treatment of substance abuse. “As Magellan has grown,” Geyelin wrote, “so have complaints.” Therapists say they spend hours filling out paperwork and fighting with case managers for authorization to treat patients. Many providers have pulled out of Magellan’s network, citing cuts in reimbursements and delays in getting paid. The company says it is addressing problems, but contends that some of the criticism is simply backbiting by doctors.

According to the surgeon general’s mental-health report, “There is little direct evidence of problems with quality in well-implemented managed care programs.” Researchers say quality under managed mental-health care overall remains an open question because large, independent evaluations have yet to be done. The standard approaches to such studies – reviewing claims data and medical records – have proven difficult, given the bureaucratic complexities of mental-health contracts and the sensitivity of psychiatric charts. “We have almost no information about how these changes have affected quality,” said Dr. Kenneth Wells, director of the NIMH Research Center on Managed Care for Psychiatric Disorders, a joint program of UCLA and RAND Corporation.

But as Geyelin found, many consumers and clinicians are unhappy. In a 1999 survey by Caredata.com, an Atlanta-based provider of health care information, more than 24,000 consumers rated their health plans’ ability to treat a variety of conditions. Depression ranked at the bottom. Patient satisfaction is a debatable yardstick for quality, especially in mental health. But when treatment of the most common mood disorder gets low marks from so many people, reporters (and providers) should take note.

Ask patients, psychiatrists, psychologists and employee-benefits managers and consultants about behavioral care in your community: what’s working well, what’s not and what’s being done about it. You’re bound to pick up a story. You’re also certain to hear two buzzwords: parity and carve-outs. These peculiarities of mental health insurance influence the type of care people receive, and whether they get care at all.

“Parity” refers to efforts to eliminate a giant disparity: A health plan’s mental-health benefits may be far more restrictive than its medical benefits. For years, health plans set lower limits on mental-health coverage. A 1996 federal parity law marked a step toward leveling the benefits, but left significant loopholes and excluded certain conditions, such as eating disorders.

In 2001, as the law was set to expire, a huge fight erupted on Capitol Hill. Mental-health organizations made parity extension (and expansion) a chief legislative priority. To help push for parity, Mike Wallace wrote of his struggle with depression in a *New York Times* op-ed piece.⁶ But insurance and employer groups lobbied furiously against extending the law, claiming that it cost

too much. In December 2001, a House-Senate conference committee voted to drop the parity amendment. No doubt the issue will surface again.

Carve-outs explain why companies like Magellan rose to dominance. Health plans typically “carve out” mental health benefits from the standard package, and hire a firm to administer the services. Health plans are responding, in part, to their customers: Employers want to hold down costs. But these nearly ubiquitous arrangements can be a nightmare for consumers, who generally never heard of a carve-out until they need care.

Carve-outs can splinter treatment and make the bureaucracy difficult to negotiate. Mental-health care generally requires a cast of providers. Illnesses often are accompanied by substance abuse: 40 percent of people with mental illnesses wind up self-medicating. Often, psychotherapy falls under the carve-out, alcohol treatment is provided through an employee assistance program, and prescriptions – Prozac, say – are handled through the original HMO or insurance plan. A person struggling against emotional or psychiatric collapse is left to put together the pieces.

SHORT-TERM TREATMENT, LONG-TERM ILLNESS

Mental-health financing – public and private alike – is based on an acute-care model of treatment. But just about all the clinical research suggests that mental illnesses are chronic and recurring. The disconnection between what we pay for and what patients need should inform all serious reporting.

Many experts say that if reporters make a mistake in covering mental health, it is in assigning blame. Certainly, the caseworker who makes an inappropriate referral for a suicidal patient, or the aide who puts a boy in a restraint hold until he suffocates, should be held accountable. But by singling out a given player, especially a low-paid, inadequately trained player, reporters may oversimplify the system’s flaws and overlook the financial incentives that encourage less-than-optimal care.

Good mental-health care requires diligent management. A child with bipolar disorder may have a psychiatrist, a pediatrician, a support group, a vocational therapist and a school counselor. But the key to effective care isn’t any single provider; it’s regular communication among all, and especially between the doctor and the school, according to research by the Center for the Advancement of Children’s Mental Health at Columbia University. Doctors, however, rarely talk to the school. “They’re not paid to make the contact with the teacher,” said Dr. Peter Jensen, the center’s director. “There’s no code that will let them get reimbursed for that.”

Effective treatment also takes time, more time than many insurers will pay for. Researchers and psychiatric organizations are developing standards of care for common mental disorders. But without more generous coverage – we’re back to parity again – the effort may have little effect. “We’ve developed some treatments that are as good as you’ll find,” says Dr. Kelly Kelleher,

professor of pediatrics, psychiatry and health-services administration at the University of Pittsburgh. “But we can’t use them because nobody can afford them.”

MEASURING QUALITY: THE GULF BETWEEN IDEAL TREATMENTS AND REALITY

In a way, mental-health care is ahead of medicine in the quality game. *The Diagnostic and Statistical Manual for Mental Disorders*, the clinicians’ bible, is the most extensive compendium of illnesses and diagnostic criteria in health care. The manual has limitations, particularly for diagnosing children, the elderly and minorities. Still, the DSM, originally published in 1952 by the American Psychiatric Association and now in its fourth edition, lays the foundation for evidence-based treatment by providing good working definitions of all disorders.

But it is tough to build on that foundation. Treatment philosophies run the gamut from pharmaceutical management and quick-hit talk therapies to long-term Freudian analysis. Providers come from disparate backgrounds – psychiatrists, psychologists, counselors, social workers, family therapists and general physicians. Guidelines issued by one group may hold little sway with others.

As with other aspects of health care, there is a significant gap between standards of mental-health treatment developed by researchers and professional organizations, and the care that patients receive. The National Institute of Mental Health has reported that fewer than half of patients under treatment for schizophrenia receive proper doses of medications or appropriate psychosocial interventions. Similarly, NIMH says only half of children in treatment for attention deficit/hyperactivity disorder receive care consistent with psychiatric guidelines.

Schizophrenia is the most debilitating mental illness. ADHD is the most common behavioral disorder of childhood. Leading psychiatric groups have issued guidelines for the treatment of both conditions. Yet care of ADHD and schizophrenia remain inconsistent. It’s a safe bet that the quality of treatment for most disorders is uneven, at best.

But the failure to apply treatment guidelines is only half the quality story. The other half is organizational performance – evaluating just how well a health plan or a program serves.

Industry, professional and quality-improvement groups have developed various evaluation mechanisms. Leading advocacy organizations, such as the National Mental Health Association, publish lists of the elements of good care. In 2001, several prestigious organizations, including the federal Substance Abuse and Mental Health Services Administration and the Institute for Healthcare Improvement, a non-profit organization in Boston, launched efforts to develop a set of performance measures acceptable to providers, insurers and consumer groups.

Reporters should watch these developments; they will provoke fascinating debates. How do you gauge patient outcomes when there may be no clear onset of symptoms, no discrete treatment, no obvious moment of remission? How do you evaluate one-on-one psychotherapy,

an intimate process that may have more to do with the human connection than with professional technique?

What performance measures truly matter, if you hope to improve patient care?

Until these questions are resolved, reporters should ask hard questions about performance measures. Sharfstein, the Boston pediatrician, did just that – and produced a powerful article in *The American Prospect*.⁷ Every major news outlet in New England picked up his findings.

Sharfstein initially witnessed the deterioration of mental-health care for children from his vantage point in a hospital emergency room. Suicidal and out-of-control kids were “boarding” in the pediatric beds because psychiatric facilities were full. Sharfstein decided to investigate. As he later wrote in the article, he fantasized that somewhere, “corrupt official had absconded with money intended for troubled children.”

He discovered something even more unsettling: The Massachusetts Behavioral Health Partnership, the state’s largest mental-health insurance company and the manager of benefits for tens of thousands of children on Medicaid, had met all its contractual obligations. What’s more, it had reaped millions of dollars in performance bonuses. Meanwhile, hundreds of kids were stuck in locked psychiatric wards because community placements were full. Other children were housed in pediatric beds, awaiting an opening in a psychiatric center. Still others languished in emergency rooms or jails.

How could a health plan be applauded as a national model while patients were stacked up like planes flying over Logan? Sharfstein found answers in the contract. Initially, bonuses for the Partnership hinged almost wholly on administrative efficiency – for instance, processing claims on time. Later, the state provided incentives to encourage provider training and other vital support services. “Yet something important was missing,” Sharfstein wrote. “Nothing in the contract held the Partnership accountable for providing basic access to mental health care for all enrolled children.”

In October 2001, parents and guardians of nine children with mental illnesses filed a class-action lawsuit against Massachusetts, claiming that the state failed to provide adequate home- or community-based treatment, in violation of federal law. The state has passed legislation creating a mental-health commission for children. It will collect and release data on state-funded and private providers of community-based, residential and inpatient mental care for children.

TREATMENT FOR CHILDREN

Sharfstein was not the first to discover that mental-health services for young people are one of the most ragged links in a frayed chain. In a three-part series in 1998, Leslie Sowers of the *Houston Chronicle* reported that only one-third of children who need mental-health services receive them.⁸ It’s a tragic statistic when you consider the mountain of evidence that early help makes a significant difference.

In a four-part series in 1999, Sally Kestin of the *Florida Sun-Sentinel* exposed dismal conditions in many privately run psychiatric centers in the state.⁹ Officials admitted that at least one-quarter of the children did not belong there, but no one else wanted them.

John Hubner of the *San Jose Mercury News* wrote a poignant 1998 story about a 15-year-old boy who was on life support after hanging himself in county juvenile hall.¹⁰ The hall, designed 40 years earlier as a temporary placement for teens in trouble, was now full of kids with serious psychiatric problems. “Some days it feels like a psych ward in here,” a veteran staffer told Hubner. “We don’t have any special training on how to deal with psychotic behavior or how medication works.”

Journalists have done much distinguished reporting on mental health and children. Let the work inspire you. Given the numbers of children in need and the inadequate funding for prevention and treatment, it is hard to imagine that you would *not* find compelling stories if you looked. What percent of inmates in your county juvenile hall have been diagnosed with a mental or addictive disorder? How long are waiting lists at local drug-treatment programs for teens? How many schools have counselors? Where do kids receive the help they need?

According to estimates in the surgeon general’s mental-health report, almost 21 percent of young people ages 9 to 17 have a diagnosable mental or addictive disorder with at least minimum impairment. Slightly more than half those kids – 4 million – have significant impairment. Overwhelmingly, these children get no care.

But over-diagnosis and over-treatment are common, too. ADHD is a case in point. While only half the children known to have the disorder receive treatment consistent with professional guidelines, many children are mislabeled and treated inappropriately – often because they display one or two symptoms. “There is no question there is both over-diagnosis and under-diagnosis,” said Homer of the National Initiative for Children’s Healthcare Quality. A recent analysis by the *Cleveland Plain Dealer* found that use of Ritalin, the stimulant of choice for ADHD, varies widely by geography, suggesting that treatment is influenced by physician habit, local sentiment or other reasons that have nothing to do with a child’s condition.¹¹

All the factors that influence quality of mental-health care for adults also affect children. But special issues come into play. School systems are the No. 1 provider of mental-health services for children and teens; 17 percent of kids a year receive services from schools, while 9 percent get treatment through the health-care sector, according to the surgeon general. Schools are largely out of the loop on the quality movement in health care. And the press generally ignores school counseling services until a child goes on a shooting rampage.

Children’s psychiatric medication is another important, evolving story. The use of stimulants, antidepressants and some other drugs is increasing sharply, even among children ages 2 through 4, reporter Erica Goode wrote in *The New York Times* in February 2000.¹² Few of these drugs are approved by the U.S. Food and Drug Administration for use by preschoolers.

Until recently, children generally did not participate in drug trials; medications for physical and mental conditions were prescribed for kids solely on the basis of adult studies. Now that scientists are testing drugs on young people, it is clear that they do not respond simply as little adults. Until the late 1990s, for instance, tricyclic antidepressants were used commonly to treat depression in children. But 13 studies have failed to demonstrate that these medications had any effect on young patients.

Recent trials suggest that children may respond better to a newer class of antidepressants, selective serotonin reuptake inhibitors (such as Prozac and Zoloft). But not all SSRIs work equally well in this age group. Reporters should track the research, follow the rapid development of new pharmaceuticals, and find out if clinicians are keeping up.

STORY IDEAS: DISPARITIES AND NEW DIRECTIONS

Racial and ethnic disparities in mental health care. Disparities in medical care have been well-documented. In mental health, the gaps are just as big – but they’ve received almost no attention. In August 2001, the surgeon general issued the first comprehensive report on the issue, “Mental Health: Culture, Race and Ethnicity.” For journalists, the subject is wide open – and long overdue.

Geographic disparities. It is often said that geography is destiny in medicine. The same probably goes for mental-health care. The Cleveland *Plain Dealer* reported substantial geographic variations in the use of Ritalin. What about the use of antidepressants or antipsychotics in your community?

Mental illness and the elderly. Many symptoms and behaviors once attributed to age, such as forgetfulness and isolation, are now recognized as possible signs of treatable mental illness, particularly depression. Additionally, the emotional issues of old age, and the psychological effects of medications and physical ailments, are gaining increasing attention. Some hospitals are adding “geriatric psychiatry” wards. What’s happening in your community?

Switching plans. What happens when an insurer drops its mental-health subcontractor and hires new providers? What may be a business move by an insurance company can cause turmoil for patients.

Abandoning managed care. A growing number of psychologists and psychiatrists are dropping out of managed-care systems. Find out what’s happening in your community: Is there an exodus from a particular plan or network? Another angle: How have private psychiatric hospitals or drug-treatment programs changed in response to managed care?

Mental illness in the workplace. You can’t overestimate the difficulties – and the importance – of a person’s ability to support himself and keep his health benefits. Workplace accommodation can be a moving story. (In the movie *A Beautiful Mind*, based on the life of John Forbes Nash Jr., a brilliant mathematician who had paranoid schizophrenia, Princeton University comes off as

nearly heroic. Faculty members allow Nash to hang around, do math and, eventually, resume teaching. It's not a cure, but it is salvation.) The Academy for Health Services Research and Health Policy has a booklet on workplace issues, available at <http://www.academyhealth.org>.

Mental-health courts. Many counties and states are developing courts for people accused of crimes and known to have mental illness or mental retardation. The idea is to divert them from the criminal justice system (see the next story idea) and provide appropriate treatment in the community. Mental-health advocates, such as the National Mental Health Association, applaud the goal, but are wary: Will these new courts protect the rights of the accused? In 2000, Congress passed legislation to create up to 100 demonstration courts, making this a trend ripe for coverage.

Locking up the mentally ill. Jails and prisons have become the nation's leading residential programs for people with mental and addictive disorders. What's happening in your community? What therapy is provided to the incarcerated – and what training is provided to staff on the floor?

Celebrity breakdowns. Don't be shy about perusing the gossip columns for ideas that can be a starting point for serious stories. Carrie Fisher became a poster child (and *Psychology Today* cover girl) for bipolar disorder. Robert Downey Jr.'s drug problems shined the national spotlight on a new California mandate to treat, rather than imprison, some addicts. But be wary when stars become shills for a particular treatment. Margot Kidder got a lot of press touting alternative, unproven diets and supplements for the treatment of schizophrenia and manic-depressive illness.

Substance-abuse benefits packages. Are employees in your community adequately covered for the treatment of abuse or addiction? Are plans cutting benefits? Do employers fear that such benefits merely keep substance abusers on the job? Are enough services available?

Mental health and the family doctor. Primary-care physicians play a significant role in identifying and treating psychosocial disorders and mental illness. They write roughly half of all prescriptions nationwide for antidepressants. In some rural areas, all mental-health care falls to family physicians — or at least those willing to deal with it. Examine mental-health care from the family physician's perspective: Does she have the training to deal with the problems that walk through her door? Is he reimbursed for delivering such care?

The growing role of consumers and family advocates. A strong consumer movement has swept the mental-health system in the past 10 years. These groups are pushing for improvements in diagnosis and treatment. Identify organizations in your area. Document their efforts and successes. Talk with members: Each one has a story.

TIPS AND TRAPS: BREAK THROUGH YOUR BIASES – AND THOSE OF YOUR EDITORS

TRAP: Be aware of your own attitudes toward mental illness. “People are afraid of mental illness. That includes reporters,” said June Peoples, series producer of *The Infinite Mind*. “Everyone’s worst nightmare is that something might happen to their mind, leaving them less than they were before. But fear is not a good place to start from when you’re trying to explain things to the public.”

TRAP: Mental-health stories can be hard to sell to editors. Be prepared to explain why the story matters to a broad audience. Try to get the editor to talk openly about his or her attitudes and any personal experiences with mental illness. Finally, appeal to your editor’s lust for great journalism. Point out stories, including several mentioned here, that helped change laws and policies – and won prestigious awards.

TIP: Read the 1999 Surgeon General’s Report on Mental Health. Dr. David Satcher did for mental illness what Dr. Everett Koop did for AIDS: Raised public awareness of a large-scale problem and pierced myths and stigmas that pose obstacles to good care. The first Surgeon General report ever on mental health, it runs 487 pages and synthesizes more than 3,000 research articles and patient accounts. Critics said the report used overly broad definitions of mental disorders, and grossly inflated the numbers of mentally ill. Nevertheless, the report offers excellent background on ailments, treatments and reimbursement policies.

TIP: Get to know the interest groups. Far more than general medicine, mental health can be seen through the lens of various camps: consumers and their families, legal watchdogs, providers (not just psychiatrists and psychologists but also family doctors, school counselors and people in the criminal-justice system), and public advocates.

TIP: Be alert to signs of the times. Sally Kalson, a writer for the *Pittsburgh Post Gazette*, got a call asking her to plug a fundraiser for a community mental-health center. She discovered that some money raised through the online auction of celebrity autographs would be used to pay for direct services for clients, such as therapy for a depressed teen. Instead of a publicity piece, Kalson wrote a pointed column about the “brave new world of managed care.”¹³

TIP: Tread cautiously when faced with confidentiality concerns. You cannot overestimate the stigma that surrounds mental illness. Patients may agree to talk only on the condition of anonymity. Be sensitive, but also keep looking for people who are willing to be named. You may be surprised by how many people will identify themselves and talk openly about painful, personal subjects. Above all, if you make a promise to protect confidentiality – keep it.

TRAP: Be skeptical when reporting on performance indicators. Never say a health plan got high or low marks unless you understand what those grades measure. Maybe the office staff simply answered phones and processed claims on time.

TIP: Enlist the graphics department at the inception of a project. Include a photographer on the reporting team. *The Hartford Courant* neglected to do this on the restraints series, then wound up playing catch-up with art. Reporter Eric Weiss recalls that the series was about to be published when everyone realized they didn't have a photo of a patient being restrained.

REPORTERS' STORIES

AN OLD-FASHIONED INVESTIGATION

“Deadly Restraint,” by Eric M. Weiss, Dave Altimari, Dwight F. Blint, Kathleen Megan. *Hartford Courant*, Oct. 11 through 15, 1998.

Eric Weiss and his colleagues used old-fashioned reporting methods to investigate restraint misuse nationwide. The federal government kept no statistics. Only one state, New York, systematically tracked restraint-related deaths in psychiatric facilities. “The best advice I got was that I'd have to call all 50 states,” Weiss said.

Weiss labeled 50 file folders, one per state. Then he and his colleagues got on the phone to state health directors, mental health directors, coroners, public mental-health advocates — anybody who might know of a death. Stories did not come easily. Many officials insisted there was no problem. In some states, officials denied requests for information, even without patient names, on the grounds of confidentiality.

“In almost every case we either blustered, bluffed, threatened, begged or intimidated,” said Weiss, who went on to cover the governor, the state legislature and politics for the *Courant*.

The reporters did hundreds of newspaper searches, mostly using Dow Jones and other databases, hoping to catch every restraint-related death. (Nexis was beyond the budget, though the reporters used it toward the end.) The reporters tried every keyword imaginable, in every combination — restraint, death, suffocation, mental health, mental illness, psychiatric, hospital. A newspaper librarian helped with clip searches, since the project looked back 10 years and predated some electronic news archives.

The reporters learned of most cases through short articles or obituaries. The cursory coverage stunned Weiss. “I was taken aback,” he said. “Kids would die and the newspaper would run a brief. Seven times out of 10, the newspaper would take the word of a doctor or hospital and that would be the end. The police didn't want to get involved. It was just, ‘These people are crazy.’ Everyone took at face value what someone in a white lab coat said.”

The reporters quickly realized they would never be able to pinpoint the number of people who had died in restraints or shortly after. “Whatever number we came up with would be the tip of the iceberg,” Weiss said. The paper hired a statistician to estimate a total. Weiss said he felt “discomfort” about paying an outsider to come up with a key piece of information. But he

knew the series could not simply say, “Trust us. There are many more deaths than the 142 we confirmed.”

A MODEL OF FINE STORYTELLING

“Managing Madness,” *The Infinite Mind* radio show, Lichtenstein Creative Media, aired on public-radio stations Oct. 18, 1999 (<http://www.lcm.com>).

“All our operators are busy...Your call will be answered by... Stay on the line... Please hold. Please hold. Hold. Hold. Hold. Hold.”

Managed care may not seem like a natural subject for broadcast. But listen to the opening minute of “Managing Madness,” by the weekly radio show *The Infinite Mind*. Hold messages and busy signals go on and on. Long after they stop, and the interviews begin, you still hear the echo.

This is a compelling, exhaustive account of the effects of managed care on mental-health services. At the heart is the story of Blake Hansen. His mother, Connie Masters, recalls in eloquent, painful detail his efforts to be sent to Topeka State Hospital. But the county mental health program, which received money from the state for keeping people out of Topeka hospital, sent Blake to a local day-treatment center. After Blake committed suicide, Masters sued the local hospital and mental-health program. She won a jury verdict of \$275,000 and reached several out-of-court settlements.

June Peoples, series producer, said she approached “Managing Madness” much as she does all her programs: “I just jump into it, spinning tendrils in all directions.” She figures out what voices she needs – not names, initially, but perspectives. “It’s really important to go beyond your Rolodex for sources,” she said. “We try really hard to have people who are foremost experts in their field. But we also make room for people nobody has ever heard of, who have important things to say.”

Her reporting technique is essentially Journalism 101, with good judgment. She figures out what perspectives she needs and calls everyone she knows, then everyone they know, then every name those people give her. She may screen three or four experts to find the one who can explain things best to a radio audience. She interviews most people by phone. Even the interview with Connie Masters was by phone.

“I don’t find that to be handicapping,” Peoples said. “It’s often easier for people to talk about painful material on the phone.”

Every reporter who covers mental health should listen to *The Infinite Mind*, produced by Lichtenstein Creative Media. (A list of programs and tapes and transcripts are available at <http://www.LCM.com>. Peoples said she’s willing to talk with reporters about mental-health coverage.) The program is a model of fine storytelling, and it demonstrates how to make highly

complex subjects accessible and even gripping. Most important, the show conveys its respect and appreciation for people with mental illness.

“It’s really important if you’re covering issues that are life-and-death issues, that you be passionate about what you do,” Peoples said. “Reporters are fond of standing on the outside looking in, being dispassionate observers. Your stories will be better if you let yourself care about the people they’re about, and that means you have to open your heart a little and let people in. Sometimes that means letting people in who are very different from you. When I’m covering mental health, I ally myself with the person who is receiving care. I try to look at it from their perspective.”

In the late 1990s, when station managers heard the pilot of *The Infinite Mind*, many wondered: Who would listen to a show about things like neurotransmitters? Now the program airs on 170 public-radio stations, with an estimated half-million listeners. It has won many prestigious journalism awards.

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