Metro Hospital--Place of Little Hope
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DESPAIR FOR MENTALLY ILL

Metro Hospital— Place of Little Hope

BY LOIS TIMNICK
Times Human Behavior Writer

It is 3:30 a.m. on the darkened, locked wards of Metropolitan State Hospital, the hour that belongs to demons, nightmares, cold sweats and fears. A mockingbird is singing monotonously in a scrawny bush outside Ward 406. And inside, 20-year-old Dudley Stewart is screaming, "I don't want no shots, no drugs!"

Armed only with a towel and waste can, like a lion tamer with a chair, the small black youth from Southeast Los Angeles is holding off seven persons as they slowly back him into a shadowy corner of the day room. The scene is surreal, lit only by lights of the glassed-in nurses' station where the staff locks itself in and talks, reads or knits through the night.

Young Stewart (not his real name), a paranoid schizophrenic said to walk the streets at night and kick down doors while "dusted" (high on the drug PCP, known as "angel dust"), has been pacing, threatening and growing more and more agitated.

Posing as a graduate psychology student, Times Human Behavior Writer Lois Timnick worked for two weeks inside Metropolitan State Hospital, gaining an unprecedented firsthand look at what goes on behind the locked doors of the psychiatric wards. This report and other articles on Page 3 reveal a mental-health program that in many ways has no better chance of succeeding than the patients it purports to serve. It is underfinanced, poorly staffed and riddled with conflict.

The female night staff has summoned several burly aides from a neighboring ward, and a psychiatric technician has gone for the Haldol, a major tranquilizer.

"What's the matter, man?" the security guard asks gently.

"I don't want no shots, no drugs," Dudley repeats. "I promised my mother I wouldn't."

"Come down and talk about it," the guard says, taking his arm and steering him toward the seclusion room in which he spent three hours tied down last night. "We're trying to help you so you can go home. You want that, don't you?"

"Not necessarily."

"Why?"

"It's all messed up."

"Would you consider not keeping him in here (the seclusion room)," the guard asks the psych tech holding the hypodermic, "if he agrees to a shot?"

"Yes," she says, "if he'll behave himself."

Dudley drops his pants and braces for the injection. It is twice the amount recommended by the drug manufacturer for severely agitated patients (but not uncommon in treating PCP psychotics).

"Would you like me to stay around and talk awhile?" the guard asks.

"Yeah," Dudley whispers. The wall that separates him from reality has a chink in it, but no psychiatrist or psychologist is on duty at this hour to widen it. Not even a nurse or psych tech with sufficient skill or interest to offer him anything other than a standing order for medication.

At 3:55, Dudley shuffles back to the men's dorm where, by now, hardly anyone is asleep. At 3:57 he is back out again. He lies down at 4 a.m., is up again at 4:02, pacing more and more furiously.

"You want me to go to sleep," he glares at the night staff, "so you can mess my mind." They do not respond.

While Dudley paces the dorm, a scarred, alcoholic street fighter named Mike sucks an unlit cigarette and meticulously tears a magazine to bits, page by page. A Mr. Brown, flipping in and out of craziness from "angel dust," sits sucking his thumb. Aretha, shut off in a seclusion room down the hall, finally stops shouting obscenities.

At 5 a.m. Dudley falls asleep in a torn plastic armchair, and Ward 406 is quiet again but for that insistent mockingbird.

It does not last.

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ROAD TO NOWHERE--A patient wanders the halls of the Metropolitan State Hospital, little more than a way station for the mentally ill. At rear, a man sleeps on the floor in a corner.
Times photo by Michael Mally

STATE'S METROPOLITAN HOSPITAL

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At 5:35, "the Reverend," a schizophrenic who has spent the better part of 15 years in institutions, rushes from the men's dorm with news that Francisco, a 28-year-old Mexican who speaks little English, is sick. He awoke with chest pains and is terrified and sobbing.

It will take the next hour and 15 minutes, two calls to a doctor annoyed at having to get up, and a bumpy ride across the grounds to Metropolitan's own emergency room, in a van—minus stretcher or wheelchair—before Francisco is finally "rushed" by ambulance to County-USC Medical Center with a possible heart attack. A student who is upset at the delays is told, "Look, this isn't a regular hospital." But crazy people have heart attacks too, and it is impossible to know yet whether Francisco's symptoms are feigned, imagined or real.

Meanwhile, the sun has crept up behind the red brick buildings that hold about 750 patients from Los Angeles and Orange counties, and another night in "the looney bin" is over. The mood has shifted dramatically from yesterday morning, when records indicate "ward tone mellow." But at least things didn't get out of control like last week when Smith dragged his bedsheets into the communal bathroom and set them on fire.

Soon, puffy-eyed patients will stagger to the nurses' station bumming cigarettes, hair cream, toothpaste, combs and safety razors. They will dress in state-supplied clothes and gather in the day room—a cavernous, drab space furnished with peeling plastic chairs, a TV set, pool table and outdated magazines, and filled with stale cigarette smoke and boredom. Through one set of locked doors lies a stark concrete patio; through another, a corridor down which they'll be herded to the cafeteria for a breakfast of cereal, sausage, apple sauce, sweet rolls, toast and coffee.

BLAMES FUNDING— Dr. Dale Farabee, state mental health director, in Sacramento office.
Times photo by Michael Mally

Later in the morning, a psych tech or nurse will attempt group therapy with as many as 48 patients, some of whom are trembling or grotesquely frozen with drug reactions, dozing off, unable to speak or understand English, hallucinating or delusional, or just present because they want a grounds pass. For most, these twice-a-day group sessions, along with three meals and medications four times a day, are the only structured activities.

Ward 406, much like Metro's 21 other wards, takes on a life and rhythm of its own. It is a small community with its own patient government, its own geographical base (Southeast Los Angeles), its own staff (1½ psychiatrists, 2½ psychologists, 3 social workers, a recreational therapist, and one nurse or psych tech for every 8 patients during the day), and its own peculiar mix of crazies. There is the tiny West African schizophrenic who loves to dance but has not uttered a word since her admission, the boy who tried to pluck out someone's eyes, the depressed mother of five who wants to die, the bearded, bear-like man who jumps on every female visitor, the public masturbator, the woman who sits knocking her fists together, and the old lady who wanders the halls asking, "Won't you help me? My people are all gone."

Ward 406, however, is particularly heavy (75%) with violent young men and women made psychotic by chronic use of "angel dust" and "Shermans" (cigarettes dipped in any one of several chemical stimulants).

Dudley Stewart is one "angel dust" victim. (The chemical is stored in the body's fat tissue and released in unpredictable amounts under stress; the permanency of its brain damage varies.) He will remain at Metro for 19 days, 16 of them against his will.

During that time he will never see his psychiatrist or psychologist except for an initial interview (although a social worker will spend a total of two hours with him). And like 60% of Metro's patients, he probably will be back within the year. His psychiatric history, in fact, includes a week at Camarillo State Hospital and four days at Metro.

But because of jammed wards and California law limiting the amount of time patients can be held and treated involuntarily without court action, the average length of stay at Metro is nine days on the acute wards, and between 14 and 17 days facility-wide. Patients who still need hospitalization

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TO PASS THE TIME—Patients sing during a meeting on one ward at state's Metropolitan Hospital, while in another area a solitary patient watches television, passing time until he's released.

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after 30 days are transferred to long-term wards where they stay an average of two months. A few never leave, like the 80-year-old schizophrenic who has been there since 1917, a year after the hospital opened.

Conservatorships are sought for about one in six, but fewer than half are granted.

Two weeks is too short a time to accomplish much, one ward psychiatrist said, so he relies on drugs and does not even attempt to initiate psychotherapy. Only the wide-eyed and young on the staff talk about curing anyone anyhow.

"We don't cure anybody," an older psychologist said. "We just patch them up to the level where they were before the crisis that landed them in here and send them out again. Most of them are never going to be functioning, employed, tax-paying citizens."

However, this reporter, who worked for two weeks at Metropolitan, posing as a graduate psychology student, found few instances even of effective "patching."

Little therapy, aside from drugs, is available, and some patients never see a psychiatrist once they are admitted to a ward and given a diagnosis. Few staff members attend or participate in the group therapy sessions, which usually focus on getting patients to recognize their illness ("What did you do, Mr. Smith, that so disturbed someone that they thought you should be in here?") and to take responsibility for their own lives, illness and all.

But on some wards, group therapy consists of no more than a psychologist's draping his legs over a chair and asking a handful of patients who are calm enough to sit still in a circle, "What do you all want to talk about today?"

Patients are seldom seen individually or regularly and then only if they are causing trouble: "The squeaky-wheel principle in operation," the man who runs one ward calls it. The impressive schedule of activities posted on the ward bulletin board seldom actually happens. A reporter looking for one of the small group sessions scheduled with a social worker three afternoons a week was told, "We haven't been doing them lately; we've got too much paperwork."

Two psychiatrists are assigned to each acute ward, but their offices may be in a separate building and they do not make daily rounds or even appear on their ward some days. The nursing staff sometimes has to make several calls to reach them with an urgent patient problem, then the staff is often merely given telephone instructions.

This indifference can result in near tragedy. Staff horror stories are legion: the doctor who without seeing her, prescribed Valium for a known Valium abuser; the physician who dismissed another patient's weird behavior as "acting out" only hours before she was rushed to a hospital in a diabetic coma; the psychiatrist who had a drug forcibly administered to a resistant epileptic who knew it would cause him to have a seizure, which it did.

Each patient has a "team" of professionals assigned to his or her case, but they seldom meet with that person or with each other to discuss the case.

The staff includes many persons who are either untrained or incompetent or "burned out" and who keep their interactions with patients to a minimum.

Psychiatric technicians, who have one year of training beyond high school and earn a starting salary of $12,700 a year, virtually run the hospital.

Psychologists, who start at $23,500, do very little testing or therapy. Their ranks include a retired military psychologist who recommends books on existentialism to uneducated patients who can't even pronounce the word; a 15-year veteran who still hasn't managed to earn his Ph.D. and limits his activities, he says, to "going to meetings and making sarcastic comments at therapeutic community (the group sessions)," and a woman recently fired by Los Angeles County.

The "staff psychiatrists" who make diagnoses and prescribe drugs are MDs whose background may be in anesthesiology or gynecology but not necessarily psychiatry. Twenty percent are neither board-certified nor board-eligible in psychiatry; 15% are not fluent in the English language or American culture. Some can barely make themselves understood to the hospital staff and have little comprehension of what their disturbed patients are trying to say. One psychiatrist said Metropolitan's reputation for hiring psychiatrists who cannot get jobs elsewhere and its low starting salary were so embarrassing to him he would not list his work there on his resume. At the time, the starting salary was $35,000, but it was raised this month to $40,500.

Patients are overdrugged—"30% more than is therapeutic, " by one psychiatrist's admission. While drugs are considered indispensable in bringing patients sufficiently off their wildness so they can begin to respond to other forms of therapy, drugs are used at Metro to control wards crammed with explosive, potentially violent persons.

Doctors frequently write standing drug orders allowing the largely psych tech nursing staff to decide when to administer the drugs. But often the technicians are ignorant of their effects:

"I've never seen Navane do much good OR bad, but it's supposed to be a mood elevator," one technician explained to a student when asked about the drug whose name appears on pencil boxes, note pads and coffee cups throughout the hospital. In fact, Navane is not a mood-elevating drug but is a potent antipsychotic agent.

Some of the psychiatrists conduct only brief, perfunctory diagnostic examinations, and routinely prescribe the same drug for nearly all their patients, despite the existence of an increasingly wide variety of subtly differing drugs.

The diagnosis does not affect the treatment, one psych tech explained, "because each of the doctors has a favorite drug. Dr. X for example, gives everybody Valium, while Dr. Y likes Haldol." His statement was confirmed by the nurse in charge of medications on that ward and a cursory check of medical records.

Only 4% of Metro's patients do not get drugs, a recent pharmacy study found.

Despite the fact that Metropolitan is Los Angeles' nearest state mental hospital and California's largest as measured by number of admissions (10,000 a year), it has no strong academic affiliation or residency training program, and it conducts almost no research, factors which would make first-rate care more likely.

Physical conditions, which one administrator described as "reminiscent of a Marine barracks," do not meet minimal standards for federal certification (which means the government will not reimburse the hospital through Medicare or Medi-Cal, a loss of about $1 million a year) or for accreditation by the Joint Commission on Accreditation of Hospitals. Although it is relatively clean, the hospital does not meet federal health and safety standards. There is no privacy —for bathing, sleeping or meeting with family, friends or therapist. One psychiatrist was seen holding hurried conferences with patients' relatives standing in a corridor. Patients sleep dormitory style—with 24 men on one side, 24 women on the other, and the day room and nurses' station in between.

After-care or follow-up is minimal or nonexistent. Patients who do not sign voluntary papers and on whom conservatorships are not granted are often discharged onto Norwalk Blvd. suitcase in hand. (Metro sprawls across 170 acres in the heart of Norwalk, 17 miles southeast of downtown Los Angeles.)

Sometimes the system fails at the start. One man was brought in, handcuffed, by sheriff's deputies after he said he was going to jump off the Orange County courthouse roof. First, he had been taken to a local treatment center which said it did not admit suicidal patients.

The admitting psychiatrist at Metro, noting the man's middle-class demeanor and dress, told him, "Look, you don't belong with the kind of people we have here. Do you really want to kill yourself?" Not really, the man said, it was just that he was despondent over the deaths of several family members. Could the doctor recommend a place where he could get help? The physician suggested that the man call the mental-health association or look in the Yellow Pages.

Then the doctor called the Orange County center that had sent the man, explained that the patient was no longer suicidal and would they please come and get him. No, they said, they believed he WAS suicidal.

The man was denied admission to Metro, given transportation money and told to get back to Orange County on his own.

Prospective patients, who may be brought directly to the hospital by police or family or routed through crisis evaluation units scattered around Los Angeles, are treated more like prisoners than persons in need of psychiatric help. They must often wait several hours in an uncomfortable waiting room before a series of impersonal admission procedures begin—mug shots, interview, physical and mental status exam, lab tests. No one welcomes them or atempts to allay their justifiable anxiety, and they are often confused about why they are there.

Helen, a large black woman of 47 with diabetes and a history of mental problems, is a good example of how the system works—or doesn't. Her husband brought her to the crisis evaluation unit at Metropolitan on a Saturday complaining that she had refused to take her prescribed drugs.

But since no psychiatrists work the wards on weekends, she was not seen on Ward 406 by a psychiatrist until Monday—after a Sunday night spent in leather restraints and on Valium for throwing pool balls.

The psychiatrist asked her one question, "How are you Helen?" He listened to her incoherent reply for a minute, said, "Thank you," and had her taken away. "Manic-depression," he said, writing out an order for lithium carbonate. He did not ask that her insulin levels be monitored, records show. The entire diagnostic procedure, which supposedly would determine her course of treatment, lasted less than five minutes.

During the next few days Helen's mood alternated: One minute she was agitated, pounding on doors and talking in a crazy word salad, the next she was withdrawn but "pleasantly delusional and cooperative," the records say. Still the next, the records add, she was disoriented, curled up on the floor and refusing to eat or walk. ("Leave her alone," a psych tech told a student. "She just wants attention.")

Then a nursing staff member reading her chart noticed her diabetic history and called it to a doctor's attention. She was sent to the emergency room and infirmiry for five days of evaluation and treatment.

Helen was discharged 16 days after her arrival without ever having seen her assigned psychiatrist again after that initial five-minute session, medical records show.

What should have happened? Helen's case, which combined mental and physical problems, would have been a difficult one in any facility. But a hospital official said her insulin levels (which can cause psychotic behavior when improper) and eating habits should have been carefully monitored from the beginning. The psychiatrist should not only have seen her regularly as well, but also should have talked with her husband and social worker about what behavior or danger signals to watch for at home. A plan should have been drawn up for continuing outpatient care. None of that happened.

But, for all these shortcomings, Metropolitan State Hospital is no snake pit. It has improved dramatically since its beginnings 63 years ago when newspaper exposes were soon to allege "shocking brutality," mysterious deaths, staff attacks on patients, a common drinking cup and two towels for 50 patients, meals of bread and molasses and wards crowded with up to 100 patients.

It has improved since 1976, when it lost its accreditation (and, later, its federal certification) and made national headlines with a rash of unexplained deaths.

But the halcyon days before former Gov. Ronald Reagan slashed its budget (a trend continued by the Brown Administration) and its standing, along with the rest of California's mental health system, as something of a national model, are only a faint memory.

There remain, however, a sprinkling of skilled, dedicated staff members who are determined, as one male nurse put it, to prove that "you CAN make a cake out of horseshit." He was referring not only to Metro's meager budget and bureaucratic mentality, but to the patient population itself, people often described as the dregs of Los Angeles.

They are the sickest and poorest of psychiatric patients, primarily schizophrenics. Ninety per cent are there involuntarily and thus not motivated to change. Most are uneducated, relatively inarticulate and lacking any insight into their own illnesses: "I'm here because of this bunion on my toe," one psychotic explained.

Their families are often fed up and unsupportive. Unemployed, they have no insurance plan that would cover private treatment. And their cases are not even sufficiently interesting to get them admitted to teaching hospitals, which want to expose their students to a wide variety of mental disorders.

Even were they to have first-rate, personalized treatment, certainly a desirable goal from a humanitarian point of view, it is unclear whether their final prognosis would be more hopeful.

But there Steve is, anyhow, a nurse fresh from the nighttime second nursing job he finds necessary to make ends meet, facing the 8:30 a.m. therapeutic community. He zeroes in on a PCP psychotic: "Mr. Gold," he said, holding an imaginary cigarette in the air. "I have here some of the finest PCP known to man. Would you like to share it?" Gold grabs the air. Steve stalks across the circle in apparent disgust. "Sit down, Mr. Gold," he orders. Gold obeys. "Stand up." "Lie on the floor." "Get on your knees." "Sit there."

"Do you see that?" he asks, looking around the group.

"Yeah," another patient says, "he's like a puppet."

"Right," Steve says, whirling to face his subject. "Mr. Gold when are you going to take charge of your life?"

"What d'ya mean?"

"I mean, how long are you going to let me or PCP control you?"

The point is not lost—on either Gold or the group.

Except for the charge that drugs are overused, these facts are not in question. But there is disagreement about how to solve these problems and when.

"We are paying for the mistakes of the 1950s," says California's mental-health director, Dr. Dale Farabee, who said any noticeable turnaround is "two years ahead, not tomorrow."

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He and most other mental-health professionals trace the problems to lack of money and bureaucratic administration, and lay the bulk of the blame at the public's and Sacramento's feet.

Metropolitan Director Mal Towery says California is getting, unfortunately, exactly what it is willing to pay for. "And if they don't like what we're doing here, they can damn well do something about it." He notes that Metro spends an average of $110 per patient per day (the actual cost ranges from $90 on long-term wards to a top of $140 on acute care units), compared with an average of $193 at UCLA's Neuropsychiatric Institute, $164 at Edgemont Hospital (excluding psychiatrist's charges of $200-400 a week), and $200 at Cedars-Sinai Medical Center (plus $50-80 per visit by a private psychiatrist).

"If you spend money wisely on the right kind of program, you get less days of hospitalization and the patient stays out longer," Towery said. "But you need to zap 'em good the first time. You need a well-rounded diagnostic workup and treatment program —not just day hall TV therapy or milieu therapy like we have here—and after-care or day treatment as well."

However, he said that Metro views its role largely as one of "crisis management" in which a combination of drugs and sheltered environment, with a bit of verbal therapy added in, can be effective. He said drugs are not overused; a recent in-house survey found that while 96% of Metro's patients in a given week receive drugs, the routine use of more than one mind-altering drug per patient is steadily going down.

After the scandals of '76 and a much-publicized visit to Metro by Gov. Brown, there were talk of the hospital's becoming "the Menninger's of the West" and promises of millions to upgrade the state's mental health system and establish alternative community programs.

But Proposition 13 undercut those promises. However, an $18 million renovation program finally is getting under way, and staffing has been increased somewhat.

But the final version of the state budget for the current fiscal year, which will give Metropolitan about $36 million, is $3 million short of what hospital officials say they need to handle properly the nearly 10,000 admissions a year. Psychiatric treatment in state mental hospitals accounts for some $164 million of California's total mental-health budget.

Towery's method of dealing with an increasingly disturbed and violent patient load and increasingly shrinking resources has been to close wards. Vowing that patients would never again have to sleep on shower-room floors as they did a few years back, he has cut Metro's patient population from 1,100 to a top of 800. Plans call for further reductions on the assumption that community facilities will be funded and put in place in time to take up the slack.

Current state plans call for a three-tiered program that would maintain only 300 acute psychiatric beds, with another 500 for intermediate care, and 128 in a skilled nursing facility.

Discussions are under way, too, that may enable Los Angeles County to take over the operation of Metro, integrating it into a system of regional community mental-health facilities. The state is contemplating selling off some of its unused acreage there.

More money could mean a lower ratio of staff to patients, smaller wards with four-bed dorms and more private space, a more pleasant setting, higher-caliber therapists, and an intensive inpatient therapy program linked with follow-up outpatient care.

But money alone will not cure Metro's ills. Even with competitive salaries and improved working conditions, Towery says it will still be hard to recruit professionals interested in Metro's kind of patient:"They'd rather deal with articulate patients who have concerned families and a desire to improve," he said. "You don't see patients get well here. And their relatives say, 'Look, don't call me; I've had this turkey 10 years.' They rent out Uncle Harry's room, give his clothes to Goodwill and don't want to see him again. So there's little sense of achievement.

"We get the most difficult patients; the easy ones don't come here."

Towery says he looks first for "a warm body" to fill his staff slots, then prays that that warm body will also be competent and caring. But, given a staff of about 900 and a Civil Service system, there are bound to be some rotten apples. To deal with those, he wants performance standards and a peer review system.

His boss, Farabee, agrees. "I don't blame techs who say the doctor knows nothing," he said. "But if we fired all the incompetent doctors, we

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wouldn't have enough to run the place."

Farabee says Civil Service or no, those who don't "shape up and put their feet on the floor" will get the ax in coming months. He says he has recruited eight new psychiatrists for Metro, appointed a task force to implement a peer review program, will insist that doctors make daily rounds, and will give foreign doctors a choice between getting fluent (in a special English-language course the state will offer this fall) or getting out.

Metro staffers say current rivalries between psych techs, doctors, psychologists and social workers could be lessened by a system in which role and responsibility are clear-cut, in which peer review committees meet regularly and in which each discipline has a coordinator to review credentials, recruit, hire and fire in his particular field—not a program director who picks a name from a Civil Service list.

Ultimately, Farabee believes the answer is to phase the state out of providing services, though it would help finance county mental-health programs. He also wants counties to contract with local hospitals so that indigent patients would be mixed with those from the rest of society's strata. So long as the government's role is one of caring for "the residue," he said, places like Metro become the bottom of the pit and yet are expected to be top flight facilities.

But Los Angeles County's mental-health director, Richard Elpers, says private hospitals don't want any part of state contracts, and is critical of Farabee's "visions" and unilateral decisions. Elpers' and Farabee's ideas of what lies ahead for Los Angeles County are completely different; yet a coherent county-state plan depends on these two men being able to sit down together and work out their differences.

Farabee said his department is exploring the possibility of establishing psychiatric residency training programs in the state hospitals (Metro has a small contract with UC-Irvine), which would mean an influx of good doctors and expanded research.

Metropolitan, Towery and Farabee said, will reapply for accreditation in late fall.

Farabee said he believes Gov. Brown will support a variety of expanded mental-health programs if given proof that they work. But since patients are not followed up after discharge, it is impossible to know how many—and as a result of which treatment—get better, are able to lead normal lives, hold down jobs and maintain stable personal relationships.

Readmission rates alone, which reflect a host of other factors, do not indicate success or failure, mental-health experts agree.

A mental hospital can be evaluated by the degree to which it is able to convey a sense of caring, to provide adequate clinical supervision and to be available for consultation. But that still doesn't tell whether its patients improve.

Meanwhile back on Ward 406, Dudley signed voluntary papers to stay on for treatment, then changed his mind three days later and went home—against medical advice—to live with his mother. Helen went home to her husband with a two-week supply of tranquilizers. And Francisco was placed in a board-and-care home. They're all still crazy, and they'll probably be back.