Supreme Court Supports Community Care Under ADA But Limits Changes States Must Make for Compliance

The U.S. Supreme Court ruled in June that the Americans With Disabilities Act (ADA) requires states to provide care for persons with mental disabilities in community settings under certain conditions. However, the court stopped short of requiring states to make major changes in their mental health services and programs if the changes are unduly burdensome, disappointing some patient advocates who hoped to use the law to as a vehicle for ending unnecessary institutionalization and expanding community services.

The court's opinion, in *Olmstead v. L.C. and E.W.*, held that community placement is required when the state's treatment professionals have determined that it is appropriate, when it is not opposed by the individuals affected, and when it can reasonably be accommodated given the resources available to the state and the needs of other mentally disabled persons.

The court issued its 6-to-3 decision in the case on June 22. Justice Ruth Bader Ginsburg wrote the opinion for the majority. She was joined by Justices Sandra Day O'Connor, David Souter, John Stevens, and Stephen Breyer. Justice Anthony Kennedy wrote a separate concurring opinion.

The case centered on Title II of the Americans With Disabilities Act (ADA), which prohibits discrimination against disabled persons in the provision of public services, and the issue of whether undue institutionalization of mentally disabled persons qualifies as discrimination. Federal regulations governing Title II require states to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities" and to make reasonable modifications in programs and services to achieve that goal. However, the regulations allow states to resist modifications that entail fundamental alterations in programs and services.

The defendants in the case, L.C. and E.W., are mentally retarded women with psychiatric disorders who were voluntarily admitted to Georgia Regional Hospital at Atlanta, where they were confined for treatment in a psychiatric unit. They remained there even though their clinicians eventually concluded that they could receive appropriate care in a community-based program.

In ruling on a suit filed to obtain community placement for L.C. and E.W., the U.S. District Court for the Northern District of Georgia found that their continued institutionalization constituted discrimination under the ADA and ordered that the women be placed in an appropriate community program. In doing so, the court rejected the state's argument that inadequate funding, not discrimination, accounted for the women's continued institutionalization, and that requiring their community placement would be a fundamental alteration in state services.

On appeal by the state, the Eleventh Circuit Court of Appeals upheld the district court's judgment that undue institutionalization constituted discrimination and sent the case back to the lower court to resolve the fundamental-alteration issue. The appeals court declared that unless the state could prove that the additional expenditures would be so unreasonable as to fundamentally alter the services provided by the state, ADA requires the state to make the additional expenditures.

The Supreme Court upheld the lower courts' ruling that undue institutionalization qualifies as discrimination by reason of disability, but it found the appeals court's construction of the reasonable-modifications regulation unacceptable because "it would leave the state virtually defenseless once it is shown that the plaintiff is qualified for the service or program she seeks."

The court said that, sensibly construed, the regulation would allow states to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the state's responsibility for the care and treatment of a large and diverse population of persons with mental disabilities.

The court further declared that to

Federal Medicare Agency Issues New Regulations on Use of Restraints and Seclusion With Psychiatric Patients

Responding to reports of abuse and deaths of psychiatric patients from the use of restraints and seclusion (see the May issue, page 715), the Clinton Administration has announced new federal regulations prohibiting the use of restraints and seclusion in any form when used as a means of coercion, discipline, convenience, or retaliation.

The regulations, issued by the Health Care Financing Administration (HCFA), were included in a package of patients' rights standards designed to protect the health and welfare of hospitalized patients. They are part of the revised conditions of participation that hospitals must meet to participate in the Medicare and Medicaid programs and are scheduled to become effective 60 days after their June 25 publication in the *Federal Register*.

The new HCFA regulations governing seclusion and restraint are consistent with the standards used by the Joint Commission on the Accreditation of Healthcare Organizations to ensure that restraints and seclusion are used only in appropriate ways. HCFA's regulations also contain new requirements for staff training so that health care workers who have direct patient contact will learn the appropriate and safe use of seclusion and restraints.

maintain a range of facilities and to administer services with an even hand, states must have more leeway to use the fundamental-alteration defense than the lower courts' rulings allowed. The court said that a state should be considered in compliance with the law if it could demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings and a waiting list that moved at a reasonable pace.

In his concurring opinion, Justice Kennedy expressed concern that too much pressure on states to move patients to community settings might tempt them into "compliance on the cheap, placing marginal patients into integrated settings devoid of the services and attention necessary for their condition."

Chief Justice William Rehnquest, joined by Justices Clarence Thomas and Antonin Scalia, dissented from the opinion, arguing that temporary exclusion from community placement does not amount to discrimination.

Cocaine and Methamphetamine Abuse Are Primary Focus of New Guidelines for Treating Stimulant Use Disorders

Guidelines for the treatment of disorders related to abuse of stimulants such as cocaine and methamphetamine were issued recently by the Center for Substance Abuse Treatment. The guidelines were accompanied by a warning from the consensus panel of experts who drafted them that cocaine use is still at high levels nationwide and that methamphetamine has surpassed both alcohol and cocaine as the primary substance of abuse among patients treated in some areas of the country.

The consensus panel emphasized that it is a misperception to believe that the devastating crack cocaine epidemic of the 1980s is over, because survey data indicate that it rages as strong as ever in cities such as Atlanta, Denver, Indianapolis, Phoenix, and St. Louis. Methamphetamine use is particularly strong in the West and Midwest, the panel noted. It has brought many of the health, legal, and social problems associated with cocaine to smaller and more rural communities and has raised concerns about an epidemic similar in proportion and destructiveness to the crack epidemic.

The guidelines, entitled *Treatment for Stimulant Use Disorders,* are based on evidence of the effectiveness of several treatment approaches found in clinical trials and on treatment techniques supported by leading addiction specialists. Several psychosocial treatments for stimulant abuse have been found to be effective, the guidelines note, but no reliably effective pharmacological treatments exist.

To help clinicians understand the treatment needs of stimulant abusers, the guidelines describe the immediate and intense euphoric effects of stimulants—the "rush," which is followed by a "crash"—a drastic drop in mood and energy levels. To avoid crashes, users administer repeated doses of the stimulant, a cycle of use that may continue for up to three sleepless days. Users may not eat and may lapse into severe depression, followed by increasingly agitated paranoia, extreme frustration, belligerence, sleeplessness, and aggression.

The guidelines also describe the chronic psychological effects of stimulant use, which include psychosis, paranoia, and severe depression with suicidal tendencies. For methamphetamine users, psychotic symptoms may persist for months or years after use stops. New research findings described in the guidelines suggest that neurological deficits, particularly in the brain's ability to manufacture dopamine, may last up to two years after stimulant use ceases.

Stimulant users typically seek treatment because of the highly negative consequences of use and the intense anxiety, fear, guilt, and shame that result, the guidelines point out. Extreme financial irresponsibility, severely deteriorated employment, lack of routine self-care, and failure to provide care for children often lead users to feel that their life is out of control. However, the guidelines stress that few stimulant users enter treatment with enthusiasm, and many are hostile to fundamental elements of the treatment plan, such as ceasing use of alcohol and secondary substances and participating in self-help programs.

The consensus panel recommends 12 to 24 weeks of treatment, followed by some type of support group participation, such as Alcoholics Anonymous. The panel also endorses use of treatment manuals to ensure that clinicians deliver a uniform set of services.

One treatment approach for stimulant use disorders that has been proved effective in three randomized clinical trials involves community reinforcement plus vouchers. This individualized treatment is designed to promote lifestyle changes in areas critical to successful recovery. During the initial 12 to 24 weeks of treatment, clients earn vouchers that can be exchanged for retail items if urinalysis shows them to be stimulant free. In the clinical trials, the value of the vouchers across the course of treatment was about $980. Clients are also offered marital therapy, disulfiram therapy, vocational assistance, support in developing drug-free social networks and recreational practices, and various types of skills training, including substance refusal and relapse prevention, time management, and mood-regulation training.

Whatever treatment approach is used, the panel recommends a quick and positive response to telephone inquiries from stimulant users who seek treatment. Initial interviews should occur within 24 hours. Clients should be scheduled for multiple visits during the first two or three weeks of treatment, even if the visits are only 30 minutes or less. As soon as clients enter treatment, they should be placed on a mandatory and frequent urine-testing schedule. Testing should continue throughout the treatment process, although with less frequency as treatment progresses.

A separate section of the guidelines addresses medical management. The guidelines also address the treatment of toxic psychosis, in which stimulant-intoxicated individuals experience intense fear-invoking delusions and hallucinations. The guidelines recommend inpatient management of patients with acute stimulant-induced psychosis.

An appendix to the guidelines includes 44 one- or two-page worksheets designed to help treatment participants use a variety of recovery tools, such as identification of drug triggers, abstinence from use of secondary substances, anger management, nutrition and exercise, and relationship skills. Nine screening tests for cognitive impairment are also reproduced to help clinicians identify clients with special needs.

Treatment for Stimulant Use Disorders is number 33 in the Center for Substance Abuse Treatment's Treatment Improvement Protocol (TIP) series. All TIPs are available on the CSAT Web page at www.samhsa.gov. They can be ordered free of charge by contacting the National Clearinghouse for Alcohol and Drug Information at 800-729-6686.

NEWS BRIEFS

New COPE program: Zeneca Pharmaceuticals has launched a comprehensive resource program for people with psychosis-related disorders and their families called COPE: caring, outreach, partnership, and education. COPE provides information for understanding and coping with serious mental illness through a series of four guides reviewed and supported by the National Alliance for the Mentally Ill (NAMI). The guides, developed in consultation with psychiatrists, mental health consumers and their families, social workers, and other experts in the mental health community, focus on consumers, families, and housing and are supplemented by a resource directory. COPE materials are available from doctors and from NAMI state organizations. Phone numbers for NAMI state offices can be obtained from NAMI national headquarters at 800-950-6264.

Nominations sought for research award: The American Psychiatric Association is seeking nominations for the one-year Lilly Research Fellowship, which carries a stipend of $35,000 and provides an opportunity for a postgraduate trainee in psychiatry to focus specifically on research and personal scholarship. Each chairman of an academic department of psychiatry is invited to nominate one outstanding resident for the fellowship. Eligibility requirements are an M.D. or D.O. degree, completion of residency training in general or child psychiatry immediately before the fellowship commences, demonstration of significant research potential, lack of extensive research training before residency, and APA membership. For a copy of the application guidelines, contact the Office of Research, American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005; phone, 202-682-6292. The deadline for applications is October 14, 1999.

Treatment of depression in teens: The Agency for Health Care Policy and Research has awarded a four-year, $2.3 million grant to Kaiser Permanente Center for Health Research in Portland, Oregon, to find a more effective way of treating depression in teenagers seen in managed care practices. A team of researchers led by Gregory N. Clarke, Ph.D., will examine the effectiveness of cognitive-behavioral therapy when used as an adjunct to antidepressant medication to treat adolescents between ages 12 and 18 who are experiencing depression for the first time. The randomized clinical trial will be conducted in four large managed care practices that provide primary care and will involve teaming pediatricians with trained mental health therapists.

Grants for suicide research: The American Foundation for Suicide Prevention is offering a variety of grants for young and established investigators designed to encourage research in understanding and preventing suicide. For more information about the grants program, contact the American Foundation for Suicide Prevention, Research, and Education, 120 Wall Street, 22nd Floor, New York, New York 10005; phone, 888-333-AFSP.

PEOPLE & PLACES

Appointment: ***Arthur Lazarus, M.D., M.B.A.,*** has been appointed to the newly created role of vice-president and corporate medical director of behavioral health at Humana, Inc., in Louisville, Kentucky. He will develop strategies to better integrate primary care and behavioral health care services to enhance early treatment of behavioral disorders among Humana health plan members. He will also be responsible for expanding disease management programs and preventive services related to mental health.

Award: ***H. Westley Clark, M.D., J.D.,*** director of the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration, received the 1999 Dr. Solomon Carter Fuller Award from the American Psychiatric Association during the APA annual meeting in May in Washington, D.C. The award honors pioneers in work that has significantly improved the quality of life for black people.