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A Schizophrenic, a Slain Worker, Troubling Questions

By **DEBORAH SONTAG**

BOSTON — Last November, Yvette Chappell found herself increasingly anxious that her 27-year-old son, Deshawn James Chappell, was spiraling downward into deep psychosis. He was exhibiting intense paranoia and calling late at night to complain about deafening voices in his head.

For over a year, Mr. Chappell, a schizophrenic with a violent criminal record, had seemed relatively stable in a state-financed group home in Charlestown. But after a fight with another resident, Mr. Chappell was shuttled from home to home, and his mother believed that he had fallen off his medication along the way.

Ms. Chappell said she had tried to communicate this concern to his caretakers, but it was not until mid-January that she found somebody who listened.

The woman introduced herself as Stephanie and said she would be Mr. Chappell's counselor at his new group home in Revere. She confirmed that Mr. Chappell had stopped getting his antipsychotic injections but made his mother a promise: "She said: 'Don't worry. I'm going to get Deshawn back on track.'

"I thought everything was going to be O.K. because he had somebody who cared," Ms. Chappell said,

her voice breaking.

Two days after that conversation, Stephanie Moulton, a petite, street-smart 25-year-old, was dead, and Mr. Chappell was accused of murdering her. They had been alone at the Revere home, where, her family said, Ms. Moulton generally worked a solo shift. Mr. Chappell beat her, stabbed her repeatedly and then dumped her partially nude body in a church parking lot, prosecutors said.

The killing on Jan. 20 stunned the mental health care community in Massachusetts. The “shattering event,” as one former state mental health official called it, occurred days before Gov. Deval Patrick, a Democrat, released his proposed budget, which would slash mental health spending for the third year in a row. And it raised the timely but uncomfortable question of whether such continuous belt-tightening had played a role in Ms. Moulton’s death.

Many people wondered aloud whether the system had failed both the suspect and the victim. How had Ms. Moulton ended up alone in a home with a psychotic man who had a history of violence and was off his medication? How had Mr. Chappell been allowed to deteriorate without setting off alarms? Should he have still been living in a group home, or did he need the tighter supervision of a hospital?

“People are reeling right now,” Dr. Kenneth Duckworth, a former medical director for the State Department of Mental Health, said after the killing. “Will this case be the canary in the coal mine? Will it signal that we’ve gone too far in reducing client-staff ratios, in closing hospitals, in pushing independence for people who may still be too sick?”

Massachusetts, which compared with other states faces a relatively modest budget shortfall of \$1.5 billion, is hardly alone in cutting money for mental health care. State mental health departments, serving vulnerable populations with little political clout, almost always get disproportionately squeezed during tough times. During the current fiscal crisis, many states have sharply reduced both inpatient and community-based mental health care.

Yet Massachusetts has been in the mental health vanguard since it opened the country’s first large

public asylum in the early 19th century. It handled deinstitutionalization better than most states, forging a comparatively robust community system — group homes, outpatient clinics, day treatment centers — to replace shuttered hospitals. And it has a Democratic-led legislature, historically progressive on social welfare policy, as well as a governor who has acknowledged his own wife's battle with crippling depression.

The state mental health commissioner, Barbara A. Leadholm, said she believed her department was providing high-quality care despite the budget cuts it was obliged to accommodate.

“We have to be responsive to what the administration and the legislature feel they can financially afford,” she said, adding that a “major recontracting initiative” had transformed the system positively while cuts were being made.

But advocates for the mentally ill, along with mental health care providers and experts, paint a picture of an underfinanced department straining to meet the varying needs of its clients — 19,900 people like Mr. Chappell with severe and persistent mental illness, many of whom function quite well in subsidized housing with support services.

Over the last two years, the department has increased its reliance on private community providers who say they are underfinanced and struggling to stay afloat. It has closed one state hospital and a small inpatient psychiatric center. It has whittled its client list by almost a thousand. And it has laid off a quarter of its case managers, severing important relationships for thousands of people with serious mental illness and transferring them to younger, lower-paid workers in the private sector.

In the cuts being debated now, Mr. Patrick proposes to eliminate roughly a quarter of the 626 long-term care beds left in the state's psychiatric hospital system. This unnerves many mental health professionals. Not only do they believe that there are already far too few beds for new cases — “It's harder to get into a state hospital than into Harvard Medical School,” Dr. Duckworth said — but they also worry about discharging long-institutionalized patients into communities whose resources are clearly strained.

“It’s sort of a cross your fingers and pray approach,” said Scott Bezzini, a mental health outreach worker who is on leave to work for his union.

Hospital, corrections and municipal officials have long complained about people with mental illness crowding emergency rooms, homeless shelters and prisons in Massachusetts, saying mental health budget cuts transfer obligations to them. A quarter of the state’s inmates now need mental health treatment, compared with 15 percent in 1998, Department of Correction data show.

The first time Mr. Chappell secured a state hospital bed — and the treatment that comes with it — was when he ended up behind bars. After a conviction for assault and battery in 2007, he was sent briefly to a prison psychiatric hospital, Bridgewater State. That is where he is now being detained once again.

The Arraignment

On the day in late March when Mr. Chappell was arraigned on first-degree murder charges, Stephanie Moulton’s relatives filed grimly into a high-ceilinged courtroom in Boston.

They were unprepared, they said later, for some of the details that would be revealed: the “multiple, deep penetrating stab wounds to her neck,” the “blunt impact injuries to her head, torso and upper extremities,” the pants and underwear “dangling from one ankle.” The victim’s fiancé, Ryan Papazian, face hidden beneath a Bruins cap, bounced his legs as the facts of the case were read.

Seated beside his court-appointed lawyer, Jeffrey T. Karp, Mr. Chappell appeared dazed. He looked backward myopically, and his mother put her index finger to her lips and emphatically mouthed “Shh.”

A court forensic psychologist testified that Mr. Chappell, despite two months of treatment at Bridgewater, was “still very, very psychotic.”

The psychologist, Jeffrey Miner, cited non sequiturs that Mr. Chappell had spouted in a private session. He said that Mr. Chappell, a native of nearby Chelsea, told him variously that he hailed from

Texas and rooted for the Washington Redskins and that he wanted “a lawyer from U.C.L.A. with a 3.5 grade-point average.” When Dr. Miner asked a follow-up question, Mr. Chappell responded, “Masseuse.”

“My sense is he is no way competent to stand trial,” Dr. Miner told the judge, recommending that he be returned to Bridgewater to see if his competency could be established through further treatment. The judge agreed. A trial date of April 26, 2012, was set.

Ms. Moulton’s relatives sat frozen, mouths agape, on the edge of their seats. Suddenly, her fiancé sprang to his feet, whisked off his cap and hurled it at the defendant. “Clear the court, clear the court,” the court officers ordered, tackling Mr. Papazian as other relatives rushed forward.

Kimberly Flynn, Ms. Moulton’s mother, shouted: “He kills my daughter, and you’re roughing up my family? He sits there and pretends he’s crazy, and you come down on us?”

Mr. Chappell was hustled away, and his mother fled, shaking. “My heart goes out to them because I am also in the same shoes,” Ms. Chappell said later, explaining that her brother had recently been murdered and that she alternately visited courthouses as the mother of a murder suspect and the sister of a murder victim. “But that was not cool. There’s something wrong with my child.”

A Desire to Help, Then Fear

A few weeks later, Ms. Flynn, 46, wearing blue scrubs after her shift as a visiting nurse, sat calmly in her kitchen in a public housing unit outside Boston. She showed off the centerpiece she had designed for a memorial fund-raiser at the Peabody Elks Lodge — a vase filled with marbles and her daughter’s favorite knickknacks: a frog, a butterfly, mini flip-flops.

Ms. Flynn said she hoped to raise enough money to bury Ms. Moulton’s ashes. “I got to put my daughter to rest,” she said. “She’s still upstairs in an urn on her bureau.”

At the kitchen table, Ms. Moulton’s father, a welder, and her teenage brothers wore new tattoos —

“Stephanie” written atop a cross adorned with a rose.

Ms. Moulton, the first in her family to graduate from college, got an associate’s degree in mental health and a bachelor’s in social work. She was drawn to the field because she was close to an uncle with schizophrenia and had observed intimately the effects of the illness on his family, said her brother Anthonee Flynn, 18.

“Personally, I told her she was crazy,” he said of her career choice, “but she wanted to help.”

After graduating, Ms. Moulton managed a Victoria’s Secret store for a year before landing an entry-level position with the North Suffolk Mental Health Association, which, like other agencies under contract with the state, offers starting salaries of \$12 to \$14 an hour.

“With the resources we have, with the dollars in the system, we can’t pay the kind of wages people should get for this work,” said Jackie K. Moore, the chief executive of North Suffolk, one of the state’s largest behavioral health care providers, with an annual budget of \$43 million.

Over the last half-century, as Massachusetts eliminated over 20,000 long-term psychiatric hospital beds and many of the public, unionized jobs that went with them, the state developed a network of private agencies, mostly nonprofit, to provide care for severe mental illness.

The community system never had enough money, many experts say, but recent budget cuts, combined with Medicaid reimbursement rates that did not keep pace with rising costs, have seriously weakened it.

“The outpatient treatment system in Massachusetts is dying on the vine,” said Vicker V. DiGravio III, the chief executive of the Association for Behavioral Healthcare, which represents providers in the state.

Providers have trouble finding psychiatrists and other clinicians who are willing to work in the community; they depend on recent social work graduates, who usually move on quickly to better-

paying jobs at hospitals or in private practice. They also have difficulty recruiting and retaining quality workers for group homes, and many hired do not have even have the college degree that Ms. Moulton possessed.

“The end result,” Mr. DiGravio said, “is a system where the folks with the least professional experience are serving the clients with the most intensive needs — because the Department of Mental Health serves only those people with the most severe mental illness.”

At North Suffolk, workers in group homes get at least a week’s training, as Ms. Moulton most likely did before starting her job at a residence in Chelsea.

“People go through an orientation,” Ms. Moore said. “They learn about mental illness. They learn ways to de-escalate a situation.”

Initially, Ms. Moulton loved her new job, where she supervised residents, accompanied them to appointments, distributed medication and cooked, her mother said. “Stephanie was like me,” she said. “We have the patience of saints when it comes to patients.”

Then, one Friday last fall, something happened. The residents were receiving small cash allowances, Ms. Flynn said, and one, believing he was owed more than he got, “flipped out.” He screamed, tossed furniture, threw objects. Ms. Moulton, 5-foot-1 and about 100 pounds, locked herself in an office and called for help.

Afterward, she grew frightened.

“She had to take anxiety pills,” her brother said, “and she started carrying around a knife.”

“A knife?” her mother said, looking alarmed. “She did?”

“She didn’t have it on her the day that stuff happened,” he said, referring to her stabbing death. “I found it in her room.”

Ms. Moulton began making plans to pursue a nursing degree. She also asked North Suffolk for a transfer and started working a shift from 3 to 11 p.m. at the home in Revere. Her family said she always worked alone at the home, which usually had seven residents, whom she described as easy and placid.

“She said they were all old people, in their 50s and stuff, so there was nothing to worry about,” Ms. Flynn said. “When this guy was sent in there, she must not have known what she was dealing with.”

A Rapid Descent

Tucked away in a recessed corner of the basement cafeteria of Massachusetts General Hospital, Mr. Chappell’s mother kissed an old picture of her son dressed in a white tuxedo.

“He took a girl with a prosthetic leg and arm to her senior prom because nobody else would,” said Ms. Chappell, an operations associate in the hospital’s gastroenterology department. “That was the kind of stuff he’d do before he changed.”

Ms. Chappell, 44, and her husband, a carpenter, raised five children in Chelsea. The second oldest, Deshawn, a stocky 5-foot-7, was a running back on his high school football team and went to work as a deliveryman after graduation. He had been an outgoing, churchgoing boy, and his mother thought he would grow up to be a minister.

Ms. Chappell said she first grew concerned when her son, a snappy dresser, began neglecting his appearance and wearing “his pants hanging all the way down his behind.” But that was a style. It was when he stopped talking about God and started talking about the Devil that her worry deepened.

“He would say the Devil was telling him to do things,” she said. “He would talk about curses and hexes and a lot of things that didn’t make sense.”

Symptoms of schizophrenia usually manifest in men during late adolescence and early adulthood. Ms. Chappell saw in her son what she called “familiar patterns” — her mother suffered from schizophrenia, too, she said.

Ms. Chappell said she urged her son to seek help but had little control over his life. He moved out of her home and, as his condition deteriorated, started getting in trouble with the law.

The arrests began in the summer of 2003 when Mr. Chappell, then 19, was charged with armed robbery and assault. The victim was a homeless man with \$96 in his pocket. Mr. Chappell accosted the man twice, slashing his forehead the first time and then punching him in the eye, causing an injury that required surgery, according to court records. The charges were dismissed.

Mr. Chappell's record also includes drug and alcohol charges; he was apparently drinking and smoking marijuana while his schizophrenia was emerging, which can be a combustible mix.

By the time he turned 21, he was in such agony that he asked for help, his mother said. He told her that the voices in his head prevented him from sleeping and that he was showering constantly because his skin was crawling. He said he felt so angry that he feared he would hurt himself or somebody else, and he asked her to take him to her hospital, she said.

Mr. Chappell was admitted to Massachusetts General for a couple of weeks. That is when schizophrenia was diagnosed and he was prescribed antipsychotic medication, his mother said. Over the next couple of years, though, he did not take his medication consistently because the side effects bothered him, she said.

He was hospitalized in acute-care hospitals at least four more times, including once in a center known for substance abuse treatment. During that time, he was also arrested several more times on assault charges, which were ultimately dismissed.

Because Mr. Chappell's medical records are private, it cannot be determined if acute-care hospitals tried to discharge him to a state hospital for continuing care but, as sometimes happens, could not find a bed available.

"This guy, with his history, certainly would have spent time in a state hospital 20 years ago," said Dr.

William Fisher, a psychiatry professor at the University of Massachusetts Medical School.

A Focus on Recovery

Deinstitutionalization was the result of a struggle to end protracted and unnecessary confinement. It was also a way for states to offload considerable expense to the federal government.

Care in “institutions for mental disease” has never been covered by Medicaid; community care is. Indeed, in the view of experts on public psychiatry like Dr. Jeffrey Geller of the University of Massachusetts Medical School, cost-shifting has been “the major driving force” behind deinstitutionalization, “with the philosophy a tag-on.”

Community care, if done right, is nonetheless widely considered the most humane and effective way to treat people with serious mental illness.

But many in the field worry that deinstitutionalization has gone too far, stripping states of the minimum number of long-term psychiatric beds needed to accommodate people during acute stages of illness, as well as those with high-risk behaviors that make discharge dangerous. Massachusetts will have 466 such beds if proposed cuts are approved.

Today only 3 percent of the Mental Health Department’s clients live in state hospitals. For those in the community, the department has shifted in recent years from a model of care that sees serious mental illness as a long-term disability to a “recovery” model, which seeks to move clients into increasingly less restrictive, less supervised and less costly living situations.

“It’s all about getting people discharged as opposed to getting them treatment,” said Jill Homer, a state-employed case manager for three decades, who nonetheless feels that the system has “fumbled through” its downsizing fairly well.

Dr. Marie H. Hobart, medical director of Community Healthlink in Worcester, said she worried that the new approach “pretends” serious mental illness is linear, that people who improve will never suffer

setbacks. She said that seriously ill clients were being allowed to leave the care of the Department of Mental Health, with some ending up homeless or in jail.

“In the past, D.M.H. would recognize that this is a person with schizophrenia, a condition that is ongoing and not something that can be cured,” she said.

Jennifer Ives, 37, a client of the department, said she appreciated the new focus on recovery. “It’s saying you’re not going to be like this forever,” said Ms. Ives, who has borderline personality disorder. But the recent loss of her case manager of eight years has made her feel isolated and anxious about “slipping backwards.”

“I was highly upset when she told me she had to terminate my case,” Ms. Ives said. “She helped me put out fires when they were just a little smoke. She was my mediator with the system, and there are real flaws with the system. Nobody knows what the other hand is doing. Nobody ever has time for you.”

One mother of a grown man with schizoaffective disorder said her son’s condition, relatively stable for 15 years, declined when the department started pushing him to become more independent. “We started hearing ‘He can take his medication on his own,’ ” said the mother, who asked that her name be withheld to respect her son’s privacy.

“He lost his therapist,” she said. “He lost his case manager. The professional level of the workers he encountered was lower. And our son was not able to take care of himself. He was not eating properly, he started playing around with his medications, and he just became very, very symptomatic. In the end, we got him checked into a private psychiatric hospital. It was his first hospitalization in 15 years.”

Within the System

For young adults with new psychotic disorders like Mr. Chappell, becoming a client of the Department of Mental Health is difficult. “You have to have had a lot of trouble to get into the system,” Dr. Hobart said.

Mr. Chappell finally made it in after his fifth arrest on assault charges resulted in a conviction.

That arrest occurred in November 2006 after Mr. Chappell's stepfather, who had raised him and occasionally hired him to work construction, dismissed him from a job. Mr. Chappell, using "an unknown hard object," responded by fracturing three bones in his stepfather's left eye socket, a police report said. When officers arrived, the stepfather was "holding his head with a cloth and had blood running from his mouth."

In 2007, Mr. Chappell, sentenced to a year in jail but required to serve only three months, ended up at the prison psychiatric hospital. When his mother visited him there, she said, she was heartened to see the effects of an enforced medication regimen. "This was the son I raised," she said. "He talked about going back to school and getting a college degree."

After his release, Mr. Chappell spent nearly a year living with his grandmother before he got off a waiting list and into a group home in Charlestown. That living situation appeared to stabilize him, his mother said, although she thinks he mostly stayed in his room and did not participate in day programs. He got antipsychotic injections every other week from a nurse at a clinic until he apparently stopped going.

Ms. Moore, the chief executive of North Suffolk, would not discuss Mr. Chappell's case. Asked what her employees did if residents became noncompliant with their medication, she said: "I don't like to use the word 'compliant.' That implies you can force people to take medication, which you can't." Still, she said, "Our staff is trained to observe and document, to note and report any changes, any symptomology. We would not ignore it."

When Mr. Chappell went home for Thanksgiving, his behavior was alarming. "He was talking intensely about people watching him," his mother said. "He felt too uneasy to leave the house. When Shawn was on his medicine, you could tell. He was quiet. He was not agitated like he was then."

After that, Ms. Chappell called the home in Charlestown one day and learned that her son had been

transferred after fighting, she said. She tracked him to a temporary residence in Chelsea. She called there repeatedly, but nobody returned her calls.

Her son, she said, “felt like they weren’t helping him anymore. He felt like they were bouncing him all around.” He declined to join the family for Christmas because he did not have gifts. He began phoning relatives and “making delusional statements,” said Mr. Karp, his lawyer. “I uncovered many witnesses who describe his deterioration as obvious.”

Over all, the risk of violence from people with mental disorders is considered low. But studies have shown that it can be elevated by various factors apparent in Mr. Chappell’s profile — delusions and hallucinations, a lack of treatment or failure to take medication, abuse of alcohol or drugs. The strongest predictor of violence by a mentally ill person is believed to be past violence.

In early January, Mr. Chappell was transferred to the Revere home. Ms. Moulton was not the only one there who realized he was not taking his medication, Mr. Karp said. But it is unclear what she or anybody else knew about Mr. Chappell’s medical and criminal history. Many providers, doctors and workers say that collaboration on cases is rare in an increasingly fragmented system with fewer case managers.

After Ms. Moulton’s killing, a local newspaper headline said, “Group home blind to man’s criminal past.” But Ms. Moore said “an inference was made” that North Suffolk did not have criminal offender record information on Mr. Chappell because it does not run criminal background checks on all residents. She declined to elaborate.

That Ms. Moulton was left alone in the home with a resident was apparently not unusual. Under new contracts with providers, the state government does not specify staffing levels, and providers are free to allocate employees as they see fit while stretching dollars to cover their programs.

“If providers want to leave a house unstaffed or single-staffed, they can — and they do,” said Toby Fisher, a senior field policy specialist for the Service Employees International Union, which represents

many of the state's mental health workers.

Ms. Moore said: "There are times when there's only one person on a shift. We have reduced the staffing at some places where we feel the clients are independent enough that they don't need staff."

That Day in January

On Jan. 20, Anthonee Flynn heard a few staccato raps on the door. "Cops were standing there, asking where my mom was," he said. Located at work by her fiancé, Ms. Flynn was told there was an emergency. She asked if Anthonee was all right; he was. "I said, 'Stephanie's dead, isn't she?'" She imagined a car accident. A state trooper arrived to escort her to a police station.

"He said Stephanie was murdered, that they knew who the man was and that he was one of the patients," Ms. Flynn said. "I was screaming and screaming and screaming."

Prosecutors say that shortly after Ms. Moulton arrived to work a day shift, the other residents left to attend programs. She had been scheduled to accompany Mr. Chappell to a counseling session. Another employee stopped by to pick them up and discovered blood in the driveway where Ms. Moulton usually parked her Chrysler PT Cruiser. The car was missing.

Mr. Chappell killed Ms. Moulton inside the residence, prosecutors say.

"The hardest part is not being able to know what transpired between those two," Ms. Flynn said. "I keep thinking, was she yelling for me?"

After depositing her body in a parking lot, Mr. Chappell abandoned the car and stole clothes to replace his bloody ones, prosecutors say. He then called his grandmother.

His mother, at Massachusetts General, was getting calls from North Suffolk looking for him. "I didn't know what was going on," she said. "Then I got a phone call stating that somebody saw my son on the news. Everything else is a blur."

Learning that her son was heading toward her mother's house in Roxbury, Ms. Chappell started driving there herself. She also alerted the police.

"Yes, I turned my son in," she said. "I was nervous about how it might go down if I didn't. I begged the police not to hurt him. When I got to my mom's, I just hugged my son and I told him I loved him. He looked scared. Then they took him away."

Looking to the Future

After Ms. Moulton's funeral drew hundreds of mourners, the mental health commissioner convened a task force to review the system's safety and training practices.

At the first of a series of statewide hearings, in a cavernous college auditorium in Fitchburg, several panel members expressed discomfort with their mission.

"The overwhelming majority of consumers are not more dangerous than the general population, although there is a very small group that does cause concern," said Dr. Kenneth Appelbaum, a co-chairman of the task force. "How to go about addressing safety concerns without adding stigma is a challenge."

Rising to address the panel, Laurie Martinelli, the executive director of the National Alliance on Mental Illness in Massachusetts, said the issue raised by Ms. Moulton's case — and by the subsequent killing of a homeless shelter employee — was not whether people with mental illness were violent.

"The elephant in the room is the state mental health budget," she said. "Did the murders have something to do with funding cutbacks?"

The "historical budget levels" posted on the department's Web site show a nearly 10 percent decline in appropriations for mental health from 2009 through 2011. Additional information requested for this article — on midyear cuts, budget supplements and trust fund spending — indicates that the money available to the department probably declined somewhat less, by about 6 percent.

Joellen Stone, a client of the department trained to help others with mental illness, told the panel that the people she counsels are living in “utter poverty — in apartments with bed bugs and rats and drug dealers in the hall.”

“They’re closing hospitals, and people are ending up in nursing homes or substandard housing. It just saddens me,” she said. “If we don’t get funding, we’re either on the street, in prison, dead or rather be dead. And when people are disempowered, that’s when they’re likely to become violent.”

Throughout the spring, the legislature, especially the Senate, showed resistance to the governor’s proposed mental health cuts. Budget reconciliation talks are taking place this month.

In mid-May, Mr. Chappell returned to court, standing taller and looking less puzzled. Judge Carol S. Ball said prison hospital officials now found him competent to assist in his own defense but acknowledged that “there’s a certain amount of in-and-out-ness.” Scrutinizing him from the rear of the courtroom, his mother noticed that he was mumbling to himself.

On the courthouse steps afterward, Ms. Flynn turned toward a warming sun and said she had finally buried her daughter the previous week. Exhausted by her loss, she had taken a leave from her job but could not stop thinking about what had happened in Revere.

She filed a wrongful death suit against North Suffolk and was planning to testify at the Statehouse about worker safety. She wanted answers, she said, and justice.

“Stephanie should be here now, planning her wedding and rolling her eyes at me like she always does,” Ms. Flynn said. “It was just totally unnecessary for her to get killed and murdered on the job when all she was trying to do was help people.”

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