Behavioral Health Care in Virginia: Mental Health, Mental Retardation & Substance Abuse Treatment and Prevention

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Important Categories Of Mental Illness:
- Psychotic disorders
- Mood disorders
- Personality disorders
- Anxiety disorders

Psychotic Disorders:
- Disturbances in thinking, perception, communication, and behavior
- Usually first observed during adolescence or early adulthood
- Chronic, variable course
- Most common is schizophrenia

Psychosis
- Refers to the degree of severity of symptoms, not to a specific psychiatric disorder
- Thinking is so impaired that it interferes with ability to meet the ordinary demands of life

Two Types Of Psychotic Symptoms:
- Delusion - false belief that an individual holds in spite of logical proof to the contrary - interferes with social adjustment
- Hallucination - a false perception; a sensation of sight, hearing, smell, or taste that has no real world stimulus to cause it

Other Psychotic Symptoms:
- Disturbance of affect or emotion
- Bizarre behaviors
- Paranoid behaviors
- Cognitive disturbances
- Thought disorder
Mood Disorders

- Disturbances of a person's mood which are not due to alcohol or drugs, physical illness, or other types of mental illness.
- Two extreme abnormalities of mood – depression and mania – exist on either end of the continuum of the two basic, normal moods of sad and happy.

Mood Disorders Are Classified Into Two Categories:

- Bipolar disorders (manic depression) are shown by distinct manic episodes that occur with or without the presence or history of depression.
- Depressive disorders involve depression symptoms only, not manic symptoms.

Manic Episode

A distinct period of abnormally and persistently elevated, expansive, or irritated mood that is severe enough to cause marked impairment in occupational, social, or interpersonal functioning.

Depressive Symptoms

May appear in emotional, cognitive, motivational, and physical ways including dejected mood, negative feelings toward self, withdrawal, crying, lack of energy, sleep and appetite disturbances.

Personality Disorders

Enduring patterns of inner experience and behavior that:
- deviate markedly from the expectations of the individual's culture
- are pervasive and inflexible
- often recognized in adolescence or early adulthood
- are stable over time
- lead to distress or impairment

Personality Disorders Are Clustered Into Three Areas:

- Odd or eccentric features (paranoid, schizoid, schizotypal)
- Dramatic/emotionally erratic features (antisocial, borderline, narcissistic, histrionic)
- Significant features of anxiety (avoidant, dependent, obsessive–compulsive)
Antisocial Personality Disorder
- A pervasive pattern of disregard for, and violation of, the rights of others
- Deceit and manipulation are central features
- Criminal justice staff might be more familiar with the related terms of "criminal thinking", "psychopathy" or "sociopathy"

Borderline Personality Disorder
- A pattern of instability in interpersonal relationships, shifting self–image and emotions, and frequent impulsive actions
- Impulsivity, difficulty tolerating boredom, and inappropriate anger combine to create situations that arouse the attention of law enforcement

Anxiety Disorders
- Anxiety: sensations of nervousness, tension, apprehension, and fear that come from the anticipation of danger, which may be internal or external
- Panic attack: distinct period of intense fear or discomfort that develops abruptly, usually peaking within a few minutes or less
- Phobias: the focus of anxiety is a person, thing or situation that is dreaded, feared, and probably avoided

Substance Related Disorders:
- Substance Use Disorders – substance abuse and dependence
- Substance–Induced Disorders – intoxication, withdrawal, and clinical syndromes caused by substances

Substance Abuse
- A maladaptive pattern of substance use shown by recurrent and significant negative consequences related to the repeated use of substances
- Unlike Substance Dependence, it does not include tolerance, withdrawal, or a pattern of compulsive use
- Could be any level of use coupled with problems experienced as a result of same

Substance Dependence
- A cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance–related problems
- An often progressive pattern of repeated self–administration that usually results in tolerance, withdrawal, and compulsive drug–taking behavior
Tolerance And Withdrawal Vary Across Substances

- **Tolerance**: need for increasing doses of a substance to maintain its effects
- **Withdrawal**: physical and psychological effects that occur when use of drug is significantly decreased or stopped
  - There is a craving for the drug when one is abstinent and these symptoms are relieved when the drug is taken again

Remission:

- **early** (at least one month) or **sustained** (at least one year) depending on how long ago the remission began
- **partial** or **full** depending upon how complete the remission is
- Individuals typically return to some intermittent pattern of use after they attempt to establish abstinence.

Mental Retardation

- **Old Definition**: I.Q. of less than 70 (100 is theoretical average) not due to alcohol or drugs, physical illness, or other types of mental illness
- **New Definition**: Measured on three axes – (a) “sub-average I.Q.”, plus (b) some “functional limitation(s)”, plus © age of onset prior to age 18.
- Either way, psychological testing is/was required for diagnosis

Services for People with Mental Retardation

- **Old Approach**: Institutional care for a lifetime; person was managed and cared for in either state facilities, or, for very wealthy Americans, private institutions designed to accomplish the same thing.
- **New Approach**: Treatment or services provided in the least restrictive environment, preferably the home community.
- Advocacy for **de-institutionalization** has been very strong among a very vocal parental advocacy base; however, the parents of those with Mental Retardation are actually split into two opposing camps—a minority support facility-based care, support institutions, others vehemently opposed to it.

Funding for Services for People with Mental Retardation

- **Old Approach**: State general funding, plus whatever else the family could afford to contribute to improve the amount, level or quality of care.
- **New Approach**: Rehabilitation services funded largely by States’ Medicaid Waivers; this involves state funds used to draw down additional federal dollars.

What Do the Terms "Dual Diagnosis" or "Co-Occurring Disorders" Mean?

Usually, the presence of any two of the following classes of disorders:

- Substance abuse or dependence
- A major mental disorder, usually Major Depression, Bipolar Disorder, or Schizophrenia
- Mental Retardation
Criminal Justice Populations:

Rates of both substance abuse and mental illness disorders are higher in the criminal justice populations than in the population at large.

Core Features Of Relapse Prevention:

- Psychoeducation
- Identifying high risk situations and warning signs
- Development of coping skills
- Development of new lifestyle behaviors
- Increasing self-efficacy
- Drug and alcohol monitoring

DMHMRSAS Expenditures FY 02 (754.5 Million)

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>$ Millions</th>
<th>%</th>
<th>Pie Chart Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilities</td>
<td>293.6</td>
<td>62</td>
<td>$293.6</td>
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<tr>
<td>CSB’s</td>
<td>43.2</td>
<td>32</td>
<td>$43.2</td>
</tr>
<tr>
<td>Central Office</td>
<td>7.3</td>
<td>8</td>
<td>$7.3</td>
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</table>

Total Services System Funding FY 02 (1.253 Billion)

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>$ Millions</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Facility/CO General Fund</td>
<td>234.3</td>
<td>19</td>
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<tr>
<td>CSB Gen Fund</td>
<td>174.1</td>
<td>14</td>
</tr>
<tr>
<td>Facility Medicaid/care</td>
<td>250.4</td>
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<tr>
<td>CSB Medicaid</td>
<td>279.7</td>
<td>22</td>
</tr>
<tr>
<td>CSB Local Gvr</td>
<td>149.3</td>
<td>12</td>
</tr>
<tr>
<td>Federal Grants</td>
<td>72.2</td>
<td>6</td>
</tr>
<tr>
<td>Other (Fees/Insurance)</td>
<td>86.0</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>$ 1,252.8</td>
<td>100</td>
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</table>
Rank and Per Capita State Expenditures for Inpatient and Community MH Services

<table>
<thead>
<tr>
<th></th>
<th>FY '01</th>
<th>Virginia Per Capita</th>
<th>Rank</th>
<th>National Per Capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Inpatient</td>
<td>$277 M</td>
<td>$38.80</td>
<td>7th</td>
<td>$25.62</td>
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<tr>
<td>State Community</td>
<td>$162 M</td>
<td>$22.74</td>
<td>41st</td>
<td>$51.50</td>
</tr>
</tbody>
</table>

Number of Individuals Receiving CSB Services by MH Core Service in FY 2002

<table>
<thead>
<tr>
<th></th>
<th>Total Individuals Served</th>
<th>Total Unduplicated Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>176,735</td>
<td>107,351</td>
</tr>
</tbody>
</table>

Mental Health Facility Average Daily Census (ADC)
FY 2003

<table>
<thead>
<tr>
<th>Facility</th>
<th>ADC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catawba Hospital</td>
<td>93</td>
</tr>
<tr>
<td>Eastern State Hospital</td>
<td>280</td>
</tr>
<tr>
<td>Southern VA MH</td>
<td>76</td>
</tr>
<tr>
<td>Central State Hospital</td>
<td>35</td>
</tr>
<tr>
<td>Northern VA MH</td>
<td>120</td>
</tr>
<tr>
<td>Southeastern VA MH</td>
<td>147</td>
</tr>
<tr>
<td>CCCA</td>
<td>35</td>
</tr>
<tr>
<td>Piedmont Geriatric</td>
<td>122</td>
</tr>
<tr>
<td>Western State Hospital</td>
<td>252</td>
</tr>
<tr>
<td><strong>Total State MH Facility ADC</strong></td>
<td><strong>1609</strong></td>
</tr>
</tbody>
</table>

State Facility Cost Per Day

- **Mental Health Facilities**: $508.42/day
- **Mental Retardation Facilities**: $321.86/day
- **Total**: $418.08/day ($152,600/year)

Eastern State Census and Staffing

<table>
<thead>
<tr>
<th></th>
<th>FY 92</th>
<th>FY 93</th>
<th>FY 94</th>
<th>FY 95</th>
<th>FY 96</th>
<th>FY 97</th>
<th>FY 98</th>
<th>FY 99</th>
<th>FY 00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pts.</td>
<td>867</td>
<td>736</td>
<td>645</td>
<td>553</td>
<td>504</td>
<td>496</td>
<td>505</td>
<td>496</td>
<td>485</td>
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<tr>
<td>Staff</td>
<td>1445</td>
<td>1417</td>
<td>1418</td>
<td>1297</td>
<td>1203</td>
<td>1207</td>
<td>1207</td>
<td>1193</td>
<td>1193</td>
</tr>
<tr>
<td>MDs</td>
<td>21</td>
<td>25</td>
<td>28</td>
<td>25</td>
<td>28</td>
<td>27</td>
<td>28</td>
<td>27</td>
<td>27</td>
</tr>
</tbody>
</table>

CSB Mental Health Waiting List Count

<table>
<thead>
<tr>
<th></th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with Serious Mental Illnesses</td>
<td>5,038</td>
</tr>
<tr>
<td>Children &amp; Adolescents At Risk of Serious Emotional Disturbance</td>
<td>1,314</td>
</tr>
<tr>
<td>Total MH</td>
<td>6,344</td>
</tr>
</tbody>
</table>

Source: Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services
Comprehensive State Plan 2004-2010
### CSB Mental Retardation Waiting List Count

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSB Non-Waiver Services</td>
<td>2,656</td>
</tr>
<tr>
<td>MR Waiver Urgent Waiting List</td>
<td>1,176</td>
</tr>
<tr>
<td>MR Waiver Non-Urgent Waiting List</td>
<td>1,259</td>
</tr>
</tbody>
</table>

Source: Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services Comprehensive State Plan 2004-2010

### CSB Substance Abuse Waiting List Count

<table>
<thead>
<tr>
<th>Substance Group</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with Substance Dependence or Abuse</td>
<td>2,997</td>
</tr>
<tr>
<td>Adolescents with Substance Dependence or Abuse</td>
<td>287</td>
</tr>
<tr>
<td>Total SA</td>
<td>3,284</td>
</tr>
</tbody>
</table>

Source: Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services Comprehensive State Plan 2004-2010

### Total CSB Mental Health, Mental Retardation, and Substance Abuse Services Waiting List Count

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Total on All CSB Waiting Lists</td>
<td>12,284</td>
</tr>
</tbody>
</table>

Source: Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services Comprehensive State Plan 2004-2010

### State Facility Waiting Lists

- 109 patients in state mental health facilities whose discharges have been delayed due to extraordinary barriers and
- 173 residents of state mental retardation training centers who, with their legally authorized representative or family member, have chosen to continue their training and habilitation in the community instead of a state training center.

### Relevant System Goals for the Future

- Provide quality services closer to where people live.
- Expand services available in the community, while maintaining state facility services as an essential component of the services system.
- Develop more state, regional, and local partnerships among CSBs, state facilities, consumer and family organizations, private providers, and the Department.
- Facilitate local and regional collaborative management and “shared ownership” of state facility and community inpatient services.

### Median LOS for Adult State Hospital Patients

![Graph showing median LOS for adult state hospital patients from 1996 to 2002](graph.png)
Long-Term System Restructuring

Increased Community Services

Reinvestment

Bed Closures

Challenges

System Challenges

- Developing sufficient community capacity to restructure local systems of care and address growing community need in a chronically under-funded system.
- Responding to the needs of specific and distinct populations, particularly children and adolescents, forensics, geriatrics, mental retardation, and substance abuse.
- Continuing uncertainty about the availability of local acute psychiatric beds across the Commonwealth.
- Developing innovative new service models such as crisis stabilization to address treatment needs in the community.

Key Concerns in a Period of Transformation:

- State of the art Risk Assessment
  - “life or death” issues
    - Suicide risk
    - Homicide or other risk of violence to others
  - Clear understanding and ability to educate about Best Practices

Key Concepts in a Period of Transformation: RECOVERY

- Has become a popular concept in guiding system reform
  - President's New Freedom Commission Final Report
  - SAMHSA vision
  - Commonwealth of Virginia DMHMRSAS Strategic Plan

President's New Freedom Commission on Mental Health

Achieving the Goal: Recommendation 2.2

Involves consumers and families fully in orienting the mental health system toward recovery

Vision Statement:

“We envision a future where everyone with a mental illness will recover…”
What is Recovery?
A Conceptual Model
Jacobson and Greenley; Psych Services; April 2001

- Internal Conditions
  - Attitudes, experiences and processes of change of individuals who are recovering
    - Hope
    - Healing
    - Empowerment
    - Connection
- External Conditions
  - Circumstances, events, policies and practices that may facilitate recovery
    - Human Rights
    - A positive culture of healing
    - Recovery-oriented services

What is Recovery?
A Conceptual Model

- Hope: the individual’s belief that recovery is possible
  - Attitudinal components of Hope are:
    - Recognizing, accepting that there is a problem
    - Committing to change
    - Focusing on strengths rather than on weakness or possibility of failure
    - Looking forward rather than ruminating on past
    - Celebrating small victories
    - Reordering priorities
    - Cultivating optimism

What is Recovery?
A Conceptual Model

- Healing
  - Recovery is NOT synonymous with ‘cure’
  - Recovery concept is not necessarily a return to “normal”
  - Two components of Healing in Recovery:
    - Defining the self apart from illness
    - Control

What is Recovery?
A Conceptual Model

- Empowerment: a corrective for the lack of control and dependency that many consumers develop after long-term interactions with the mental health system
  - 3 Components
    - Autonomy
      - Knowledge
      - Self-confidence
    - Availability of meaningful choices
    - Courage
      - Willingness to take risks
      - To speak in one’s own voice
      - To step out of safe routines
    - Responsibility

Implications for Providers
(Torrey and Wyzik, Comm. Mental Health Journal, April 2002
The Recovery Vision as a Service Improvement Guide)

- People with psychotic illnesses and other severe mental illnesses have written about their life experiences
- Customer feedback is an essential ingredient of healthcare quality improvement
- Consumer’s insights should be valuable to providers who wish to improve services

Recovery Vision Implementation:
(Torrey and Wyzik)

- Promoting Hopefulness
  - The restoration of morale
- Supporting consumers’ efforts to take personal responsibility for their health
- Helping Consumers develop broad lives that are not illness-dominated
“The Interim Report of the New Freedom Commission on Mental Health emphasizes a “recovery” approach for the treatment of the seriously mentally ill. Although not incompatible with a biomedical and public health approach, the “recovery” model is based on rehabilitative and psychosocial concepts. Another approach which should be pursued is based on the biomedical and public health perspective…”
Recent Examples of Disasters
- Traumatic Wars (Defeat, purposelessness, societal polarization) e.g. US in Vietnam
- Genocides (Rwanda genocide 1994)
- Accidents (Chernobyl reactor meltdown)
- Loss of National Leaders (Kennedy)
- Military or Terrorist Strikes such as recent events – “9/11”

Phases of Disasters
- Predisaster: Warning and Threat
- Impact
- Heroic acts
- “Honeymoon” (community cohesion)
- Disillusionment (the reality of loss and mourning)
- Working through grief (coming to terms) with trigger events and anniversary reactions
- Reconstruction (a new beginning)

Acute Stress Disorder
- Three of the following: numbing, detachment, absence of emotions, reduction in awareness, derealization, depersonalization, amnesia
- One of the following: recurrent images or thoughts, dreams, nightmares, flashbacks
- Avoidance of reminders
- Anxiety, insomnia, irritability, hypervigilance, startle reflex, restlessness
- 2 days-4 weeks duration within 4 weeks of event.

Post-Traumatic Stress Disorder
- If symptoms persist more than one month
- Can be delayed in onset—6 months or more
- Can be chronic—duration >3 months
- Additional symptoms include: intense stress from reminders, loss of interest in activities, isolation from others, loss of emotions, loss of sense of future; occupational/social dysfunction.

Increased Risk for Other Illness
- People exposed to trauma are at higher risk for:
  - Major Depression
  - Panic Disorder
  - Generalized anxiety disorder
  - Substance Use Disorders
  - HTN, asthma, chronic pain

Epidemiology of PTSD
- 5-6% of men and 10-14% of women have had PTSD at some time in their lives.
- 4th most common psychiatric illness
- PTSD can develop in someone without any history of psychiatric problems.
- 55% chance of PTSD from rape; 7.5% chance from accident
### Prediction and Prognosis
- Nearly everyone has some degree of acute stress disorder some time in their life but recover rapidly.
- Based on data from the Oklahoma City Bombing in 1995, 35% of those directly exposed to the September 11 attacks will develop PTSD: 100,000 * .35 = 35,000 cases

### Recovery from PTSD
- 26% resolve within 6 months
- 40% resolve within 12 months
- Females recover much slower than males.

### Prevention
- At least four major reviews in 2002 of so-called “psychological debriefing” found no evidence that debriefing prevents or reduces the severity of PTSD.
- Meta-analysis of incident stress debriefing studies (Lancet 2002) found debriefing does not improve natural recovery from trauma.

### Treatment
- Various forms of psychotherapy
- Medications: antidepressants, mood stabilizers, anti-psychotics
- Combinations of psychotherapy and medications

### Mental Health Deployment Assets
- Federal Government
  - Dept. of Defense
  - Department of Veterans Affairs
  - Federal Emergency Management Agency
  - National Inst. Of Health and PHS

### Other Deployment Assets
- Local Community Mental Health Centers
- American Red Cross Disaster Mental Health Services
- Non-governmental agencies: APA
Psychological Preparation

- Experiences in many disasters and military experiences have shown that the most important method of preventing psychiatric casualties is…..(do you know?)

DISASTER TRAINING

- Persons with disaster training feel a greater sense of control during the disaster.
- Greater control during disasters reduces the risk of acute stress disorder and PTSD.
- Training reduces the fear of the unknown, invisible nature of chemicals, infectious agents and radiation.