FINAL REPORT OF

THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

INVESTIGATION ON DUAL DIAGNOSIS CLIENTS

TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

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ABSTRACT

The following report was generated in response to Senate Joint Resolution 8 which charged the Department of Mental Health and Mental Retardation with the responsibility of studying the dual diagnosis client, estimating the number of these clients, and recommending ways of assuring that dual diagnosis clients receive the services they need. Because existing literature provided little insight into the problems of the dually diagnosed client, a major exploratory study was conducted to map the domain of dual diagnosis. Using a working definition designed solely for sample selection (and not for diagnostic or treatment planning purposes), the study

1. Identified all dually diagnosed individuals in the department's institutions (N = 788; 47.6% from psychiatric facilities, 52.4% from training centers) and a significant portion of the estimated 4200 dually diagnosed individuals in the community (N.B., the actual number probably falls within the range of 3400 and 5000) for study

2. Performed two functional assessments on each of the 1371 identified dually diagnosed individuals.

3. Analyzed the results to identify dimensions underlying dual diagnosis.

Individuals identified as dually diagnosed were seen to display a wide variety of adaptive and maladaptive behaviors. The majority of these behaviors, though representative of an equally broad range of diagnostic groupings and etiologies, were shown to have a common underlying dimension: deficits in impulse control. It should be noted that a small percentage of cases do, however, show a combination of mental retardation and a clear cut psychiatric disorder. In such cases, mentally retarded individuals (i.e., developmentally-based retardation) show acute psychotic behavior.

A crucial finding regarding this deficit in impulse control (and its concomitant maladaptive behaviors) is that, looking across the entire population of mentally retarded individuals (i.e., dually diagnosed individuals and all other retarded persons), there is a continuum in this deficit that can be modeled as a statistically normal distribution (see Figure 3 in the text). With deficits in impulse control a cardinal feature of mental retardation, most retarded individuals show some degree of impulse control-related problems. For the majority of all retarded individuals, these deficits have resulted in few if any behavior management problems; these individuals can be seen in Area 1 of Figure 3. Beyond a certain level, however, these deficits in impulse control result in a management problem for service providers; these individuals come to be labeled as dual diagnosis (i.e., Areas 2 and 3 in Figure 3). Within the dual diagnosis subpopulation there is also great variability in the magnitude of the impulse control deficit and attendant maladaptive behavior. For most of these individuals (i.e., Area 2), a significant deficit has required an increased level of behavior management, the technology of which reportedly needs to be developed in our service delivery system. For a very small percentage of cases (i.e., Area 3), behaviors related to this impulse control deficit are completely out of control. Such individuals could not be maintained in routine community and institutional programs without stabilization.

With the study completed, a meeting of the Assistant Commissioners for Mental Health Services, Mental Retardation Services, and Technical Services was convened to bring together the administrative perspectives needed to address the problems of dually diagnosed clients. At this time, the three Assistant Commissioners unanimously offer the following recommendations:

1. Rather than using the label dual diagnosis, service providers should deal with individuals in terms of their specific behaviors. The label of dual diagnosis provides too little information regarding treatment needs, whereas a more individualized behavior assessment can focus on the appropriate strategies for providing service.

2. Service providers (i.e., mental health, mental retardation, community, institution) must acknowledge that 1) routine management of behaviors based in impulse control deficits and 2) training/habilitation are simply part of the service array expected of them.

3. It would appear that the behavior of some retarded individuals occasionally will become so out of control that intensive stabilization services, beyond those typically offered by a community program or training center, are needed (i.e., Area 3 of Figure 3, in the text). If service providers are to face up to their responsibility to serve, some support systems must be made available to assist them during these difficult periods.

   Given the small numbers of such cases in individual agencies/facilities and the current economically constrained climate, extensive development (i.e., within individual agencies) of intensive stabilization services may be impractical. Rather, what is indicated is that the department take the lead by developing institutional capability for intensive stabilization services. Two settings are envisioned for such services:

   A. The Social Skills Center at Lynchburg Training School and Hospital, and

   B. Specialized stabilization units to be developed within the larger psychiatric facilities.

   Whereas the structure for the SSC program is already in place, programs in the psychiatric facilities would have to be developed. It is therefore proposed that a pilot program be created in one facility at this time. With refinement of the program during a trial period of operation, other units can be developed later. The issue of how to admit these individuals without violating their rights must, however, be explored before the implementation of any such program.

   While responsibility for these stabilization services has been placed on the institutions, communities should not be penalized or discouraged from starting discrete (i.e., freestanding or isolated) stabilization programs if it is felt to be a priority and need can be demonstrated.

4. Existing programs must develop their own internal capabilities to provide service and routine behavior management to individuals whose behavior problems relating to impulse control are significant, but not out of control.

These are the individuals in Area 2 of Figure 3. They show behavior problems, but not so severe as to require the stabilization services identified in Recommendation 3.

Programs need to access the combined behavior management/habilitation technology which facilitates working with these clients. A listing or library of programmatic resources should be maintained by the Department of Mental Health and Mental Retardation and available through community coordinators and/or a representative from the institutional services division.

The development of behavior management programming should be reinforced by bolstering community program certification standards regarding behavior management.

5. No beds in training centers that have been certified under ICF/MR regulations should be "decertified". Limitations on the use of behavior modification programs, physical restraint, and psychotropic medication, as specified in ICF/MR regulations are not felt to be so restrictive as to indicate the decertifying of some beds.

6. Mentally retarded individuals currently in psychiatric institutions who require no further psychiatric services should be identified as a priority for discharge or, as necessary, for transfer to a training center. Directors from psychiatric institutions should be charged with reviewing their rolls and developing a plan to move such individuals from their facilities. Such plans should include:

   A. A list of individuals suitable for discharge to the community and their aftercare needs.

   B. A list of individuals to be considered for transfer to a training center.

   C. A plan for serving those mentally retarded individuals awaiting transfer to a training center until such transfer is enacted.

   D. A timetable for completing discharge or transfer of these patients.

   Retarded individuals requiring the services available at a training center should be established as a priority for beds which open up in the training centers. An appropriate formula for accessing the beds should be negotiated with each training center director based on turnover from the facility and community demand for beds.

7. In conjunction with the Departments of Special Education, Social Services, and Health, community services boards should implement prevention programming aimed at the impulse control-related behaviors which have led to the dual diagnosis label. Development of problem-solving/behavior alternative skills, and coping abilities might be incorporated into the spectrum of community mental retardation services. Drop-in centers and community support systems could be developed. Such programming should acknowledge the psychological needs (as opposed to the behavioral problems) of the mentally retarded individual living in the community.

8. Those individuals who show significant behavior problems relating to impulse control should be a priority for case management.

9. A task force composed of institution directors, executive directors from community services boards, professional service staff, central office administration, members of the original task force, and other concerned parties should be convened. This task force would be charged with preparing for the Commissioner of the Department of Mental Health and Mental Retardation an implementation plan for the preceding recommendations.

I. Background

Although some efforts have been made in the State to serve dually diagnosed clients, the 1980 Report of the Commission on Mental Health and Mental Retardation identified this client population as one with unique problems and unmet service needs. The 1980 General Assembly adopted Senate Joint Resolution 8 which charged the Department of Mental Health and Mental Retardation with the responsibility of studying the dual diagnosis client, approximating the number of these clients, and recommending ways of assuring that dual diagnosis clients receive the services they need.

As mentioned earlier, the State has made several efforts in the past, through pilot projects, to serve dually diagnosed clients. Although these efforts, some of which have continued, are making a contribution to the delivery of services to this population, no adequate solution has been offered. The current study acknowledges and, to the extent possible, incorporates the approaches and recommendations of these previous studies and pilot efforts.

Following a review of existing literature and research on the dually diagnosed, a five facet approach was developed for the study of this population. These five components were:

1. An operational definition of dual diagnosis.

2. A major exploratory study of dual diagnosis to identify a) a typology of behavior profiles for this population, and b) dimensions underlying the amorphous concept of dual diagnosis.

3. An estimate of the number of dually diagnosed individuals in the State.

4. Open forums around the state to solicit input from mental health/mental retardation administrators and clinicians regarding ways of assuring service delivery to the dually diagnosed.

5. Synthesis.

To facilitate this process, the Department assembled a 15-member task force comprised of representatives of various geographic areas and service affiliations. A listing of task force members is provided in Appendix A.

With the completion of this process, a meeting of the Assistant Commissioners for Mental Health Services, Mental Retardation Services, and Technical Services was convened to bring together the three administrative perspectives which relate to the dual diagnosis problem. In turn, the three Assistant Commissioners developed a set of nine recommendations, presented in Component 6.

II. Introduction

Within the field of human services, a major concern has always been the person (or population) that falls between the cracks of various service delivery systems and, accordingly, does not receive needed services. The dual diagnosis client in particular has been the topic of extensive rhetoric bemoaning the systems' failure to squarely face the dilemma of the individual whose problems:

1. Embody both an emotional disturbance and mental retardation, but

2. Are not necessarily considered the exclusive domain of either the mental health or mental retardation service systems.

The needs of the dual diagnosis client seemingly place him/her between the two systems and perhaps in need of some combination of the two. Although some efforts have been made to address the needs of the dually diagnosed, to date, no clear cut answer has emerged.

Existing literature provides little insight into the problems of the dually diagnosed. Most glaring in this deficit is the ill-defined nature of dual diagnosis. Review of the literature shows numerous different and often conflicting definitions of dual diagnosis. This is further complicated by the fact that these definitions typically reflect the issue of primary treatment orientation (i.e., mental health-based vs. mental retardation-based), rather than the presenting problems/behaviors of the individual. Such an orientation puts the cart before the horse. Presumably, presenting problems rather than treatment needs determine a diagnosis. Some of these definitions are couched in the issue of differential diagnosis (i.e., mental retardation with a concomitant emotional disorder vs. an emotional disorder leading to functional retardation). Bottom line, however, translates into a question of which facility or service delivery system should serve a given dual diagnosis client.

At best, dual diagnosis is a catchall phrase which, appropriately or inappropriately, is affixed to any person who is not a clear cut case of mental retardation or an emotional disorder. Rather than the homogeneous population which some definitions bring to mind, dual diagnosis is a superordinate classification, the diversity of which perpetuates its own problems.

In view of this situation, what was indicated for this investigation was an exploratory study which identified the subgroups within this superordinate classification. This enabled the task force to map the domain of dual diagnosis and identify any underlying dimensions. For the purpose of such an investigation, the task force still had to generate a working or operational definition of dual diagnosis. This definition was not intended to perpetuate the controversy of who should or should not serve the dually diagnosed but rather to include the diverse subgroups which need to be examined.

COMPONENT 1: DEFINING DUAL DIAGNOSIS

In order to conduct the exploratory study presented in Component 2, it was necessary to develop a working definition of dual diagnosis which would determine what individuals to study. Therefore, for the sole purpose of sample selection (and not for diagnosis or treatment planning), a definition of dual diagnosis had to be developed.

An overwhelming problem in studies and services dealing with so-called dual diagnosis or mentally retarded/emotionally disturbed (MR/ED) clients has been arriving at a consensus about a definition of the population. The problem seems to arise where, at the outset of developing a definition, one looks beyond the behaviors and needs of the individual to the issue of service delivery, determining who does or does not serve these clients.

While the issue of who serves the client is indeed a valid consideration, it detracts from the crucial dimension of the client's problems and needs. Typically, this issue is voiced in terms of, which service delivery system is indicated (i.e., mental health vs. mental retardation). Clinically, however, the issue is perceived as one of differential diagnosis. To this end, the literature is replete with attempts to sort out the issues surrounding to what extent emotional disturbance and mental retardation can be treated as distinct entities, and to what extent they overlap. However, from the viewpoint of planning effective treatment/habilitation strategies, Bialer (1970) considers the controversy moot.

> " . . . . how crucial or useful is the diagnostic decision as to whether we have on hand a severely disturbed child whose emotional disorder has significantly depressed his behavioral efficiency so that his functional level has been assessed as falling within the range of mental retardation, as opposed to whether we are faced with a retarded child who shows a severe emotional problem? . . .
>
> ". . . Where the diagnostic label rather than the child's needs is the determining factor in his disposition, it may lead to that child's being tossed back and forth between a State school and a State hospital, or between agencies serving the disturbed and those serving the mentally retarded, each claiming the responsibility rests with the other." (pp. 72-74)

The sum of our knowledge (and consensus regarding dual diagnosis) is described by Benton (1964) who suggests that "all mental disorders (including mental retardation) represent, by definition, failure in adaptive behavior. In addition, there are some mental disorders (including mental retardation) which also involve intellectual impairment as a salient characteristic."

Attempting to develop a working definition of dual diagnosis for the current investigation, an important first step is to clarify the terms "mental retardation" and "emotional disturbance." The American Association on Mental Deficiency defines mental retardation as "subaverage general intellectual functioning which originates during the developmental period and is associated with impairment of adaptive behavior." On the other hand, Beier (1964) effectively describes the emotionally disturbed as "those whose adjustment patterns are such that they are in serious conflict with themselves, their families, or their community. Although not necessarily mentally retarded, they are persons whose effectiveness and efficiency are so impaired that they have varying degrees of difficulty dealing with emotional or stress situations, and they display various degrees of peculiarity in adaptive behavior."

Where, in its broadest sense, dual diagnosis can refer to anyone having both of these sets of characteristics (i.e., mental retardation and an emotional disturbance) regardless of cause or their relative intensities, an operational definition should be one which basically combines the two descriptions offered above. One deviation from the AAMD definition of mental retardation was, however, built in by the task force. Specifically, the reference to onset of mental retardation during the developmental period was dropped. The rationale was that, by leaving this phrase in, individuals who are functionally mentally retarded might be excluded from appropriate programs if their "retardation" did not originate during the developmental period.

Combining these definitons of mental retardation and emotional disturbance to reflect the overlap resulting in a "dual diagnosis" yields the following working definition, as adopted by the task force:

> Dual diagnosis refers to subaverage or seriously impaired general intellectual functioning in combination with dysfunctional adjustment patterns resulting in severe deficits in adaptive behavior.

It should again be noted that this definition is intended only for the investigation's sample selection and not for diagnostic or treatment planning purposes.

This broadening of the definition to include any segment of the population whose behavior evidences a degree of both mental retardation and an emotional disturbance was an important consideration. It appeared that many states opted to use a narrow definition for the purpose of designing programs for dual diagnosis clients. Such an orientation, while facilitating identification of potential clients, failed to capture the breadth of the population and service needs. In developing a broad definition of dual diagnosis, the task force wished to promote equal attention to both emotionally disturbed and mentally retarded individuals (i.e., those whose initial presenting problem was either an emotional disturbance or mental retardation, but who now may require a mix of similar services).

COMPONENT 2: CLUSTER ANALYTIC STUDY

In the hope of identifying subgroups within the super-ordinate classification of dual diagnosis, the following cluster analytic study was conducted.

Subjects. Two separate samples, one institutional and one community, were drawn for this investigation. An institutional sample of 788 dually diagnosed patients/residents was selected from the department's 15 psychiatric and mental retardation facilities. The second sample consisted of 583 dually diagnosed individuals selected from a variety of community based (i.e., non-institutional) settings.

In developing the institutional sample, each facility was asked to generate a list of all patients/residents whose behavior evidenced components of both mental retardation and an emotional disturbance. The lists were not limited to those individuals who carried both a psychiatric diagnosis and a mental retardation diagnosis. Rather, inclusion was more generally based upon the working definition of dual diagnosis:

1. Subaverage or seriously impaired general intellectual functioning, in combination with,
2. Dysfunctional adjustment patterns resulting in severe deficits in adapative behavior.

The resulting lists consisted of 375 patients from the psychiatric facilities and 413 residents from the mental retardation facilities. These 788 people composed the total population of dually diagnosed in the department's facilities during the period of this investigation.

A more involved sampling procedure was developed for the second sample in consideration of the large numbers of dually diagnosed individuals and service sites in the community. For the community sample, community service boards, private programs, correctional programs, and school systems had to be contacted. Using the same inclusion criterion employed for the institutional sample, programs were asked to estimate the number of dually diagnosed individuals they were serving. A program's dually diagnosed clients were included in the sample if five or more were identified and the program was amenable to participation in the study. Ultimately, a sample of 583 individuals from seven community mental health programs, seven community mental retardation programs, five private/contractual programs, six local school districts, and three correctional programs was obtained.

Although the procedure for the community sample could hardly be considered random, the method employed was certainly systemmatic and reasonable given the exploratory nature of the investigation. The sampling provided representation from all five Health Services Areas (HSA's) with respect to community service boards and private/contractual programs. In addition, school programs from four of the five HSA's were included in the community sample.

Instruments. Two instruments were used in this study: the Level of Care Survey (LOC) and the Behavior Development Survey (BDS). The LOC, developed by the New York State Office of Mental Hygiene, is a psychiatric evaluation research instrument used to identify a person's psychological and physical care needs. The BDS,

an adaptation of the AAMD Adaptive Behavior Scale, measures adaptive behaviors and training/habilitation needs of the mentally retarded. By combining a psychiatric survey with ratings of adaptive behaviors, a comprehensive profile of the dually diagnosed is obtained.

The LOC, a 91 item survey, is completed as a structured interview with a person's primary treatment worker or, in the case of school children, their teacher. Adaptive and maladaptive behavior subscales (i.e., self-initiative, sociability, orientation to environment, neatness, depression, inappropriate social behavior, antisocial behavior, impulse control deficits, and psychotic behavior) combine with information on recent dangerous behavior and need for behavior management to yield a global index of each person's indicated psychological level of care. Physical level of care is also computed from subscales on medical and skilled nursing care needs, activities of daily living, and potential for independent community living.

The BDS is composed of 54 items rating adaptive skills of the mentally retarded. The items group into major factors relating to various personal care and community living skills, training needs, social skills, self-sufficiency, and personal/social adaptation. Measuring clearly defined and observable behavior, the BDS is filled out by a person's primary treatment worker or teacher.

Procedure. Different procedures were established for the institutional and community samples. For the institutional sample, the major task of identifying the dually diagnosed patients/residents was usually handled by the facilities' clinical directors or their appointees. Beyond the identification of the dually diagnosed, the only data collection which was actually carried out as a part of this study was the completion of the BDS for patients in the psychaitric hospitals. All other data was retrieved from existing data files maintained by the Department of Mental Health and Mental Retardation.

A slightly different procedure had to be established for the community sample. Initially, dually diagnosed clients/students receiving services in the community programs had to be identified. Agency directors were asked to identify all of their dually diagnosed clients/students and to schedule on-site interviews with the primary treatment workers of the dually diagnosed. Prior to the on-site visit, the primary treatment workers were sent BDS forms and asked to complete one survey for each of their dually diagnosed clients/students. During the on-site visits, BDS forms were collected and then, using the LOC, primary treatment workers were interviewed individually regarding their dually diagnosed clients/students.

Results

Following the notion of two distinct samples (community and institutional), two separate analyses were performed. The method of analysis, however, was identical for the two samples. Specifically, data for a given sample was compiled using the technique of cluster analysis. This technique forms groups (or clusters) of individuals who are alike in some ways and different from individuals in all other identified groups. In creating the different groups, the technique of cluster analysis seeks to

1. Establish each group as maximally different from all other groups, and
2. Minimize the differences between individuals in a given group with respect to a key set of dimensions.

The technical aspects of this technique, which become involved because one has to deal with a large number of dimensions simultaneously, will not be discussed herein.

For these cluster analyses, the key set of dimensions are the subscales of the LOC and of the BDS. Subscales of the LOC are as follows:

1. Medical care needs
2. Skilled nursing care needs
3. Self care needs
4. Potential for independent living in the community
5. Personal neatness
6. Oriented/alert to one's environment
7. Self-initiative
8. Sociability
9. Depression
10. Inappropriate behaviors
11. Impulse control deficits
12. Psychotic symptoms
13. Recent dangerous behavior
14. Recent need for behavior control measures/behavior management
15. High risk for intensive care
16. Need for a secure environment
17. Antisocial behavior
18. Overall physical level of care
19. Overall psychological level of care

For the BDS, the following scales were used:

1. Personal self-sufficiency
2. Community self-sufficiency
3. Personal-social responsibility
4. Social adaptation
5. Personal adaptation
6. Economic skills
7. Language skills
8. Number and time skills
9. Domestic skills
10. Vocational skills
11. Self-directedness
12. Responsibility
13. Social skills
14. Overall adaptation

In trying to create groups that are maximally different, but that are internally homogeneous, these were the dimensions that were used.

A crucial issue in carrying out cluster analysis is deciding how many groups (i.e., clusters) to identify. The cluster analytic approach permits the researcher to set the number of groups that will be established by the analysis. Typically, this decision is based upon 1) a preconceived notion regarding the number of clusters that should exist, 2) a subjective assessment of the quality and utility of the solutions derived with different numbers of clusters, 3) a statistical ratio of within cluster variation to

between cluster variation, or 4) some combination of the preceeding three criteria.

In this case, there were no preconceived notions of how many clusters should be established. While the systematic, empirical orientation of this study might weigh in favor of the statistical ratio approach, there was a marked need to temper this drive in deference to maximizing the quality and clinical utility of the solution.

Using the statistical ratio approach, it was determined that between nine and 12 clusters should be extracted. Review of the solutions employing eight through 16 clusters indicated that clinical utility was maximized with 12 clusters. Given the concordance between the two criteria, it was decided to use a 12 cluster solution.

Community Sample. What follows are the clusters identified through the 12 cluster solution. In two cases, two clusters were basically similar, differing slightly on one minor dimension. In each case, it was decided to combine the groups into one cluster. The final product, therefore, was ten community clusters. For each of the final clusters, a narrative description of the group and a graphic profile is provided. For the graphic profile, only 13 of the 33 dimensions used in the analysis are presented. The number of dimensions included in these profiles was reduced to improve readability; only those dimensions which effectively differentiated between clusters were used for these profiles. It should, however, be noted that all 33 dimensions were used in the analysis which generated these clusters.

COMMUNITY CLUSTER 1: N = 5 The level of retardation of these individuals is borderline. They are independent with regard to self-care. They are alert to their environment and self directed.

The overwhelming clinical characteristic of this group of individuals is a high level of depression. They lack impulse control and require a secure environment. They are dangerous, probably to themselves. They do not exhibit much inappropriate or bizarre behavior. However, there is some attention-seeking and disruptive behavior. These individuals are at risk for running away.

There appears to be a high potential for community integration. These individuals are proficient in basic living skills such as money handling, language, telling time, domestic activities, vocational abilities, and social functioning.

COMMUNITY CLUSTER 2: N = 1 This individual is a moderately retarded child currently in the school system. This child requires supervision and some physical assistance with regard to self care. He accepts no responsibility for his appearance and is sloppy. This individual is alert to his environment and shows some self direction. He is very sociable but has a short attention span.

This individual behaves in an inappropriate or pesty manner. He is impulsive. This individual is neither dangerous nor bizarre.

This individual has language skills but cannot handle money or work with numbers. Generally, he requires a great deal of supervision with regard to the activities of daily living.

COMMUNITY CLUSTER 3: N = 9 The level of retardation of these individuals is moderate to severe. They require almost total supervision with regard to self-care. They have some medical needs. These individuals are only moderately aware of their environment and not very self-directed. They have significant deficits in their ability to socialize.

They are hostile and easily agitated. In addition, they display poor impulse control and are at risk for anti-social behavior. These individuals can show bizarre or stereotypic behavior. These individuals can be physically violent and probably require considerable physical control. They need a structured, secure environment.

These individuals are unlikely candidates for successful community integration. They are very low functioning in their performance of activities of daily living. Their verbal ability is low.

COMMUNITY CLUSTER 4: N = 147 The individuals in this cluster are mildly to moderately retarded. They are fairly independent in self-care but need minimal prompting or supervision. These individuals are alert to their environment and can attend to a task with some supervision.

These individuals are somewhat depressed. They are disruptive and have deficits in impulse control. They can be verbally abusive. Their behavior is occasionally bizarre and sometimes stereotypic.

These individuals can probably function in a group home with supervision. They have a moderate ability to perform activities of daily living. These individuals are at risk for institutionalization.

COMMUNITY CLUSTER 5: N = 310 These individuals are mildly retarded. They are completely independent with regard to self-care. They are neat and take responsibility for themselves and their possessions. They can function in the community. They are alert to their environment and self directed. They attend to tasks and have good social skills.

These individuals have a slight problem with impulse control, possibly becoming agitated or upset from time to time. They have a very high level of ability with regard to the activities of daily living, including language.

COMMUNITY CLUSTER 6: N = 25 These individuals are either borderline, mildly, or moderately retarded. They are independent with regard to self care and take responsibility for themselves and their belongings. They are self directed and have a good attention span. These individuals do moderately well with most of the activities of daily living, except money-handling.

These individuals are very disruptive. They are either dangerous or have a strong potential for becoming dangerous. They have no impulse control. They can display bizarre, stereotypic behavior.

COMMUNITY CLUSTER 7: N = 5 The level of retardation of these individuals is mild to moderate. The characteristics of the individuals in this cluster and cluster 5 are identical with one exception. The individuals in this cluster have some physical disabilities and require physical assistance with self care.

COMMUNITY CLUSTER 8: N = 76 The level of retardation of these individuals is moderate to severe. These individuals need moderate supervision and some physical assistance with self-care.

They are somewhat aware of their environment, but have little initiative. They have deficits in social skills. These individuals are disruptive, annoying, and slightly hyperactive. They display some bizarre and stereotypic behaviors. These individuals lack community living skills. Their language skills are rudimentary.

COMMUNITY CLUSTER 9: N = 3 These individuals are children currently in the school system. Their level of retardation is moderate to severe. These children need supervision and physical assistance with regard to self care. They accept some responsibility for themselves and their belongings.

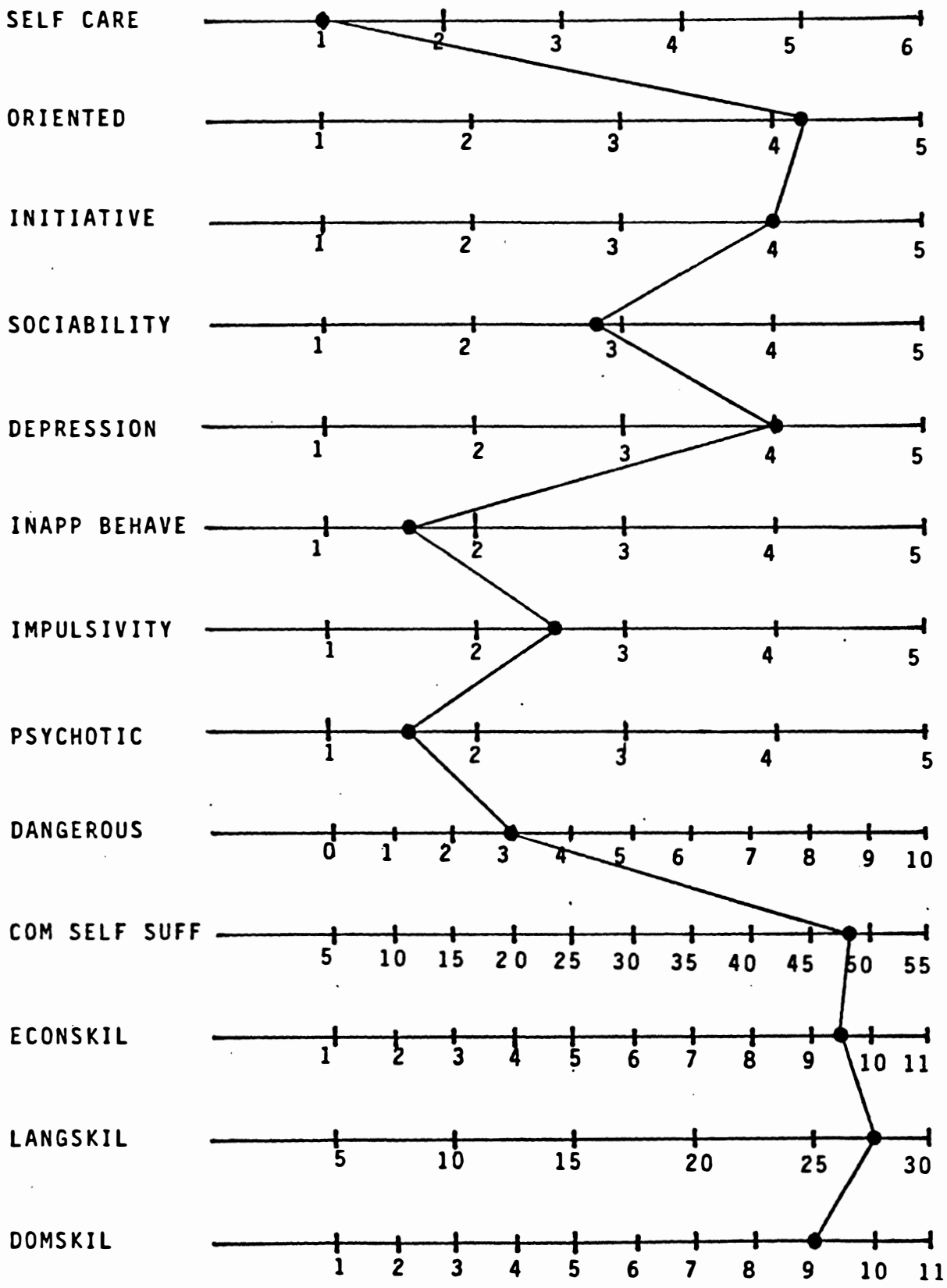
They are moderately oriented to their environment and they are moderately self directed. They can attend to tasks. Their social skills are adequate. These individuals have numerous annoying and inappropriate behaviors. In addition, psychotic symptoms are very much in evidence. They display no impulse control. These individuals are dangerous. They require behavior control and a secure environment.

They are poor candidates for integration into the community. They cannot perform many of the activities of daily living. They have some language skills.

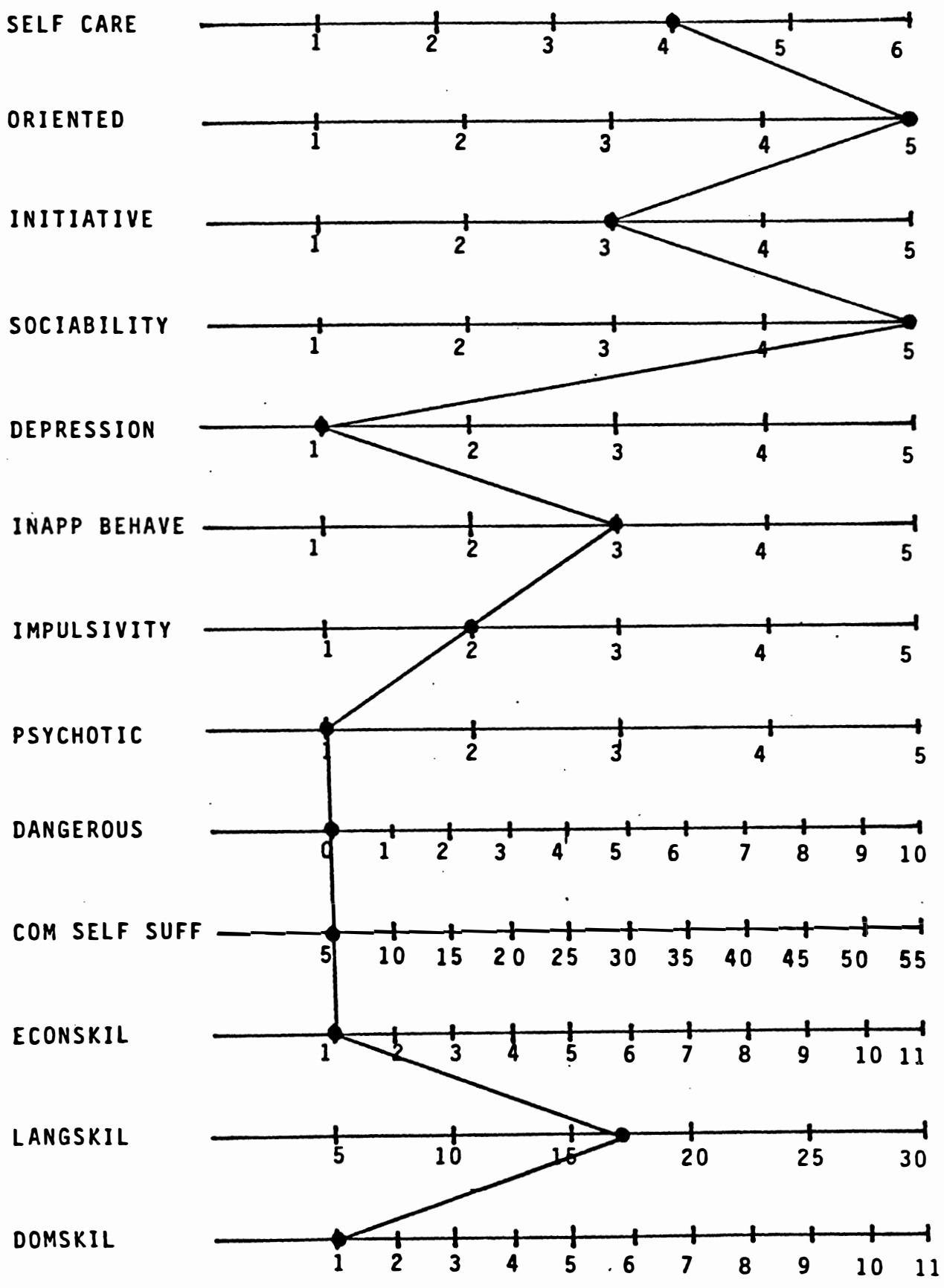
COMMUNITY CLUSTER 10: N = 2 The level of retardation of these individuals is mild. These individuals can care for themselves without supervision. However, they are not neat. They do maintain their possessions with some efficiency.

These individuals are aware of their environment and require minimal prompting to perform a task. They have some social skills. These individuals display some annoying and inappropriate behaviors. They also display bizarre and stereotypic behaviors. They are disruptive but not dangerous. They lack impulse control. These individuals have a low to moderate potential for successful community integration. They have a fair ability to perform the activities of daily living.

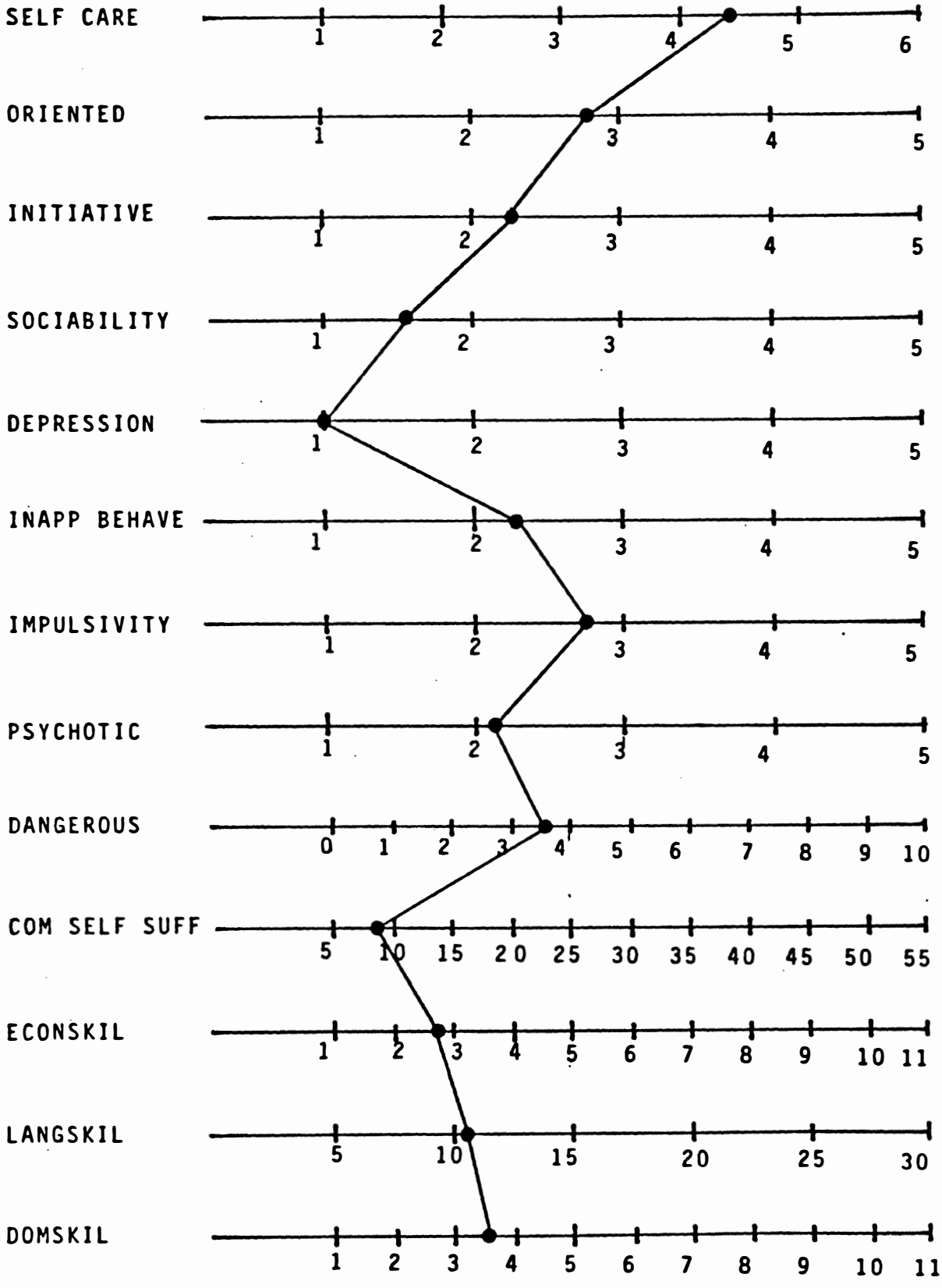
COMMUNITY CLUSTER 1: N = 5



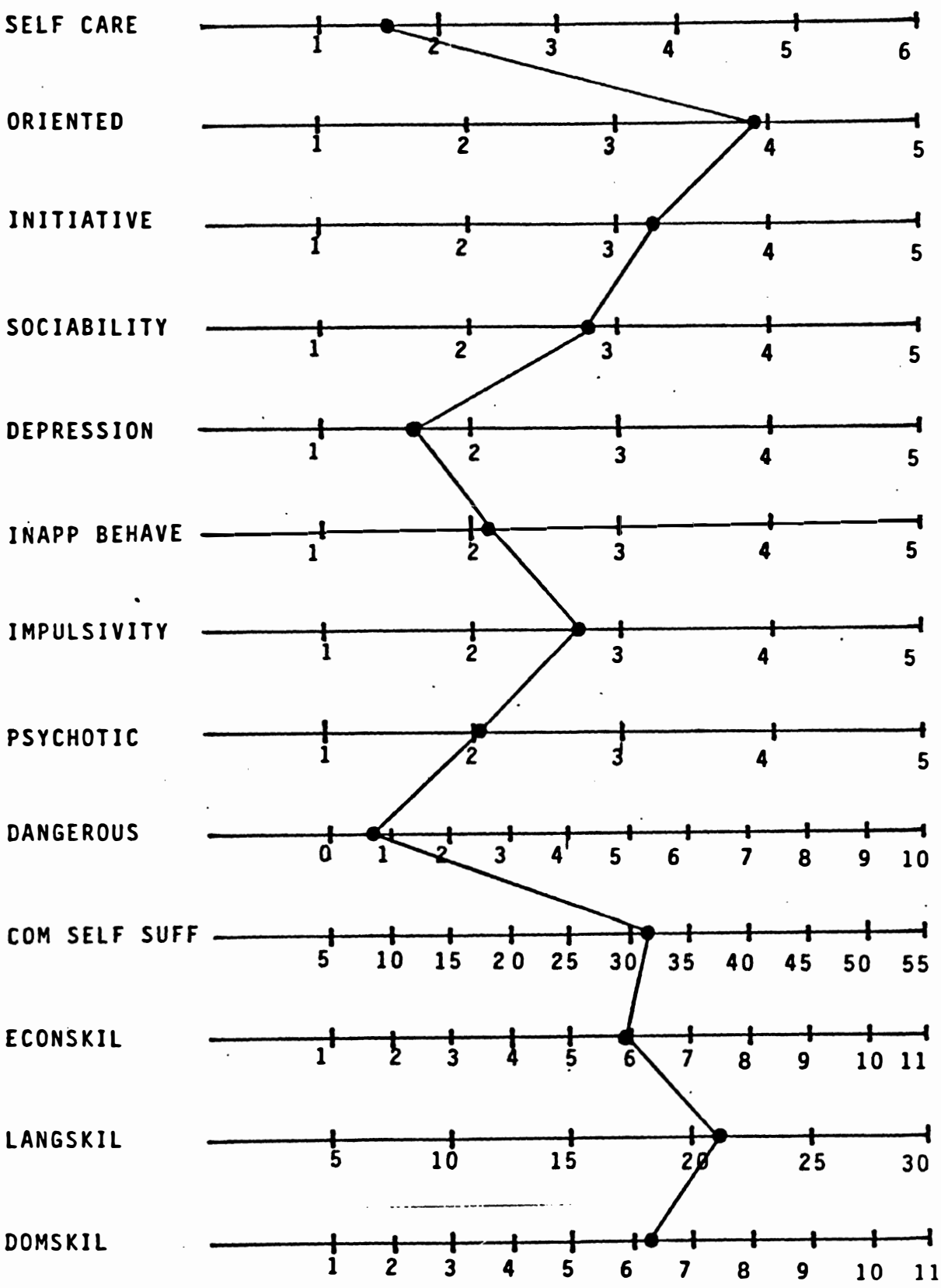
COMMUNITY CLUSTER 2: N = 1



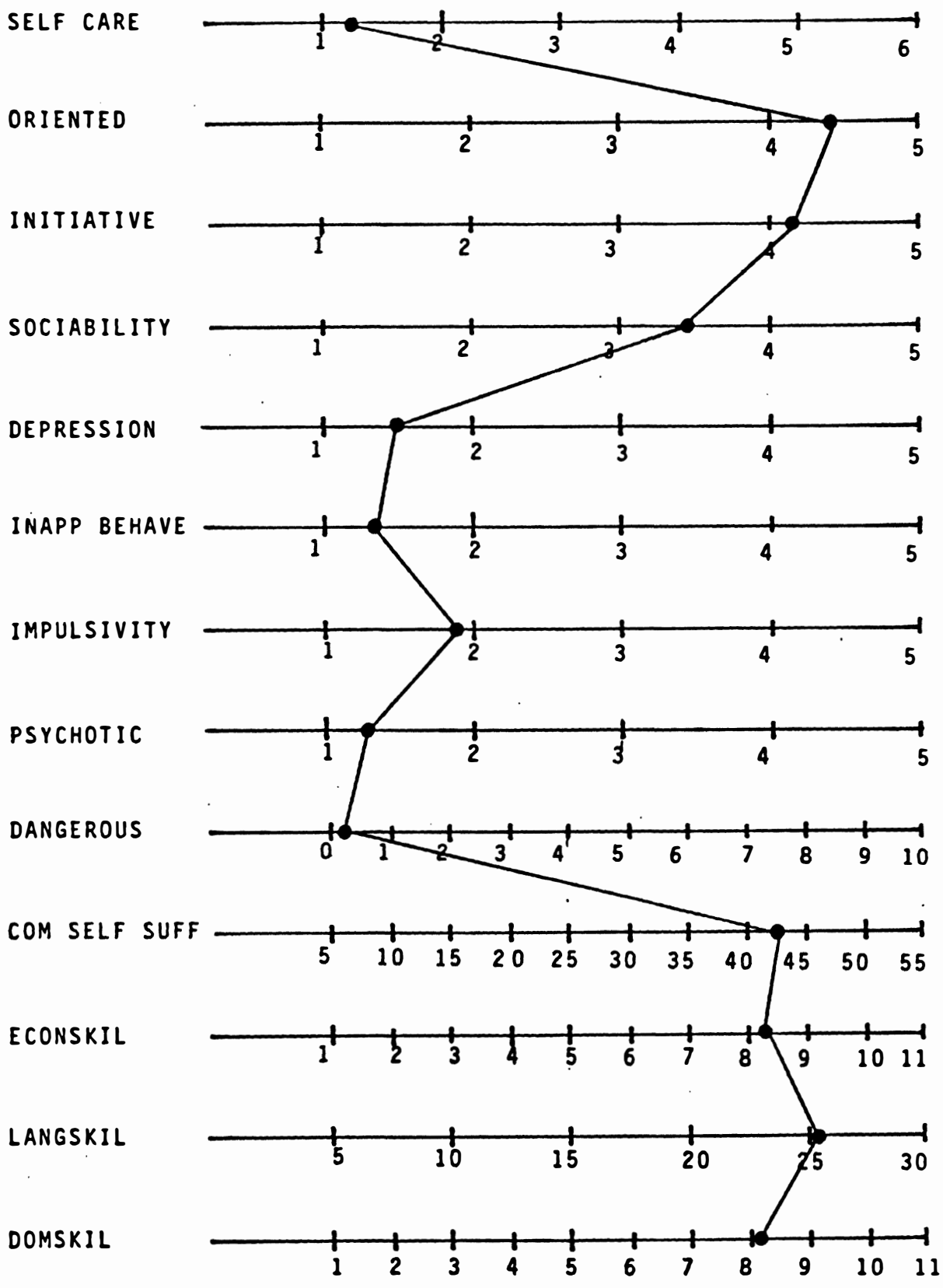
COMMUNITY CLUSTER 3: N = 9



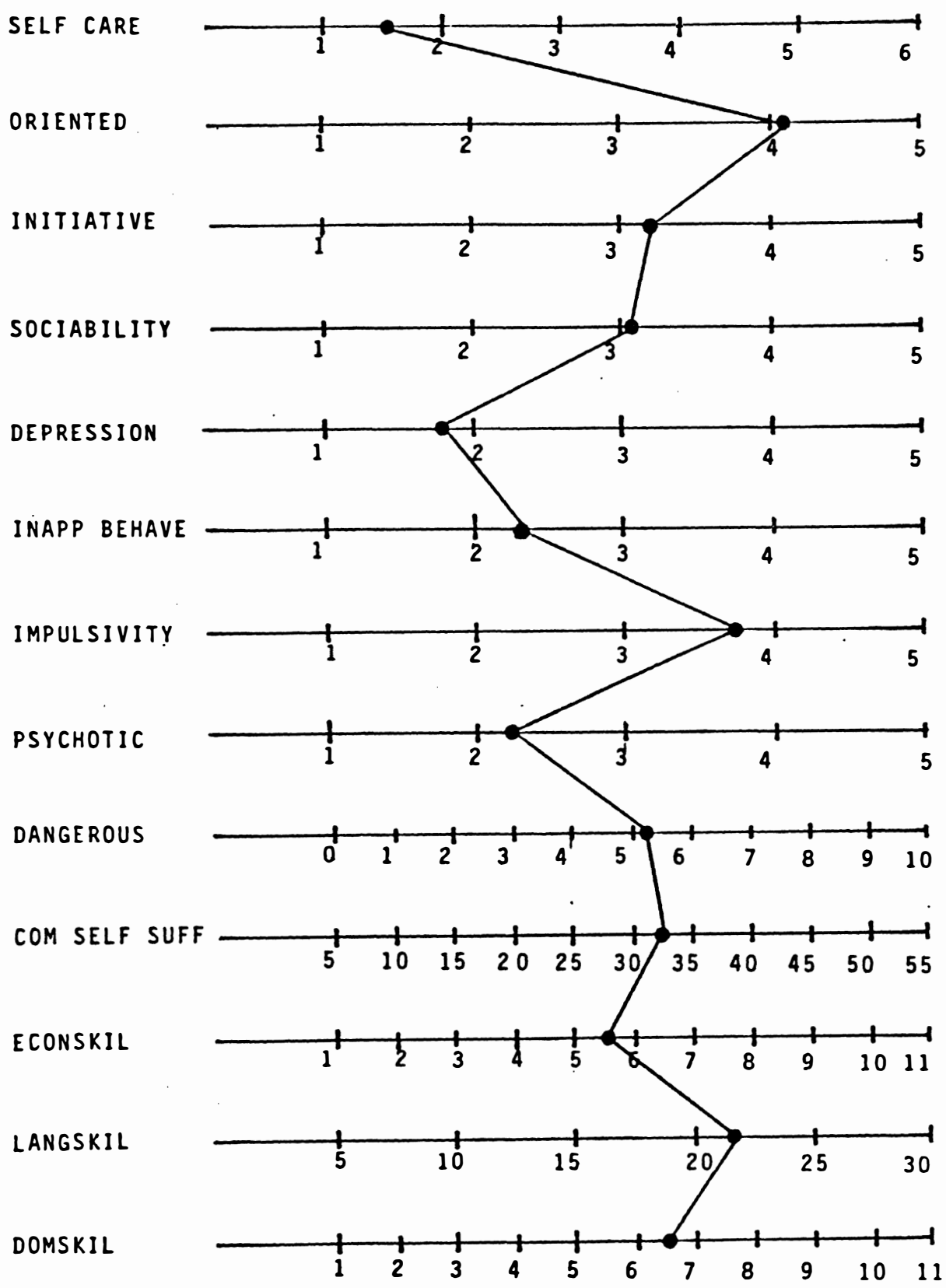
COMMUNITY CLUSTER 4: N = 147



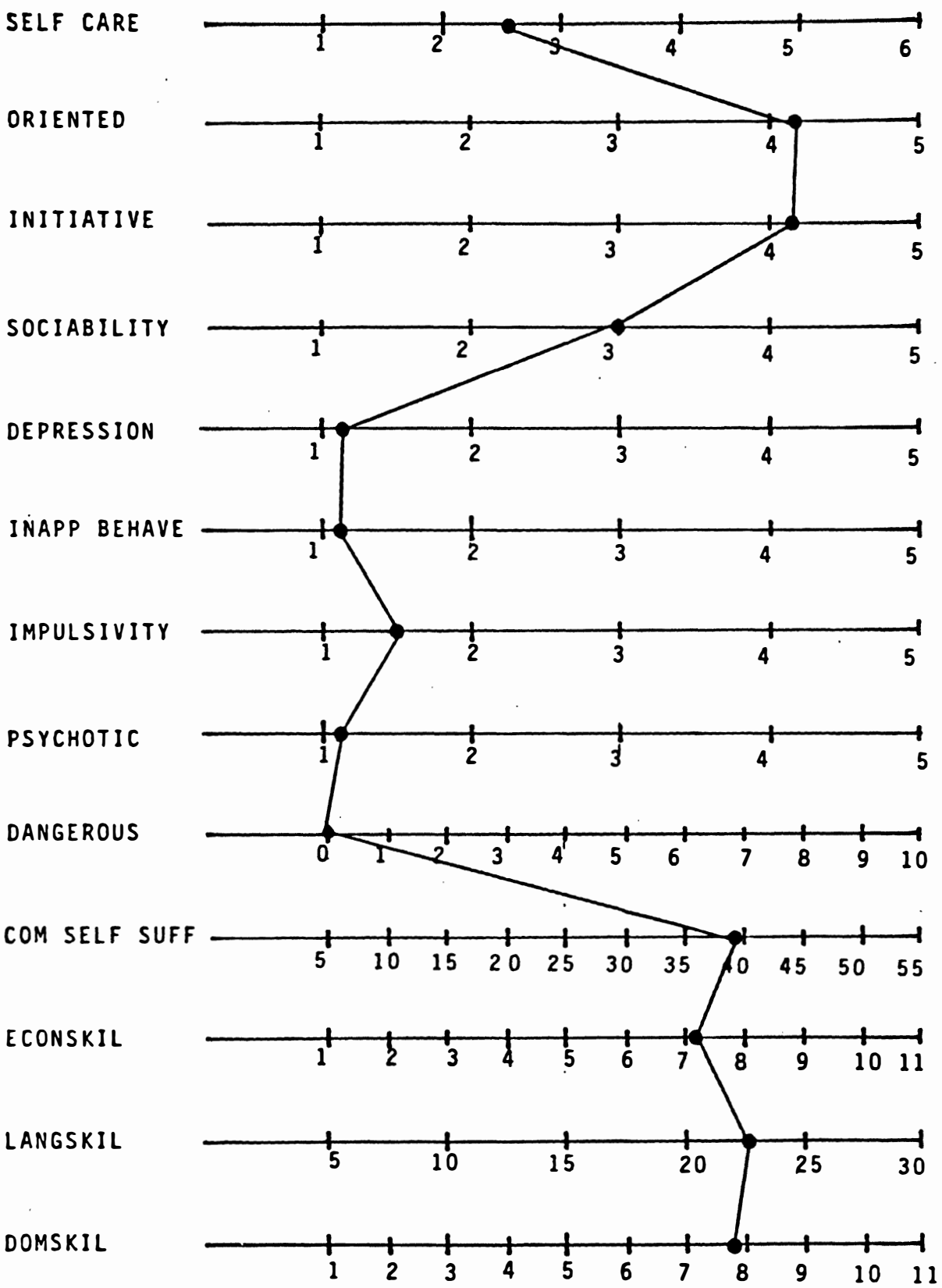
COMMUNITY CLUSTER 5: N = 310



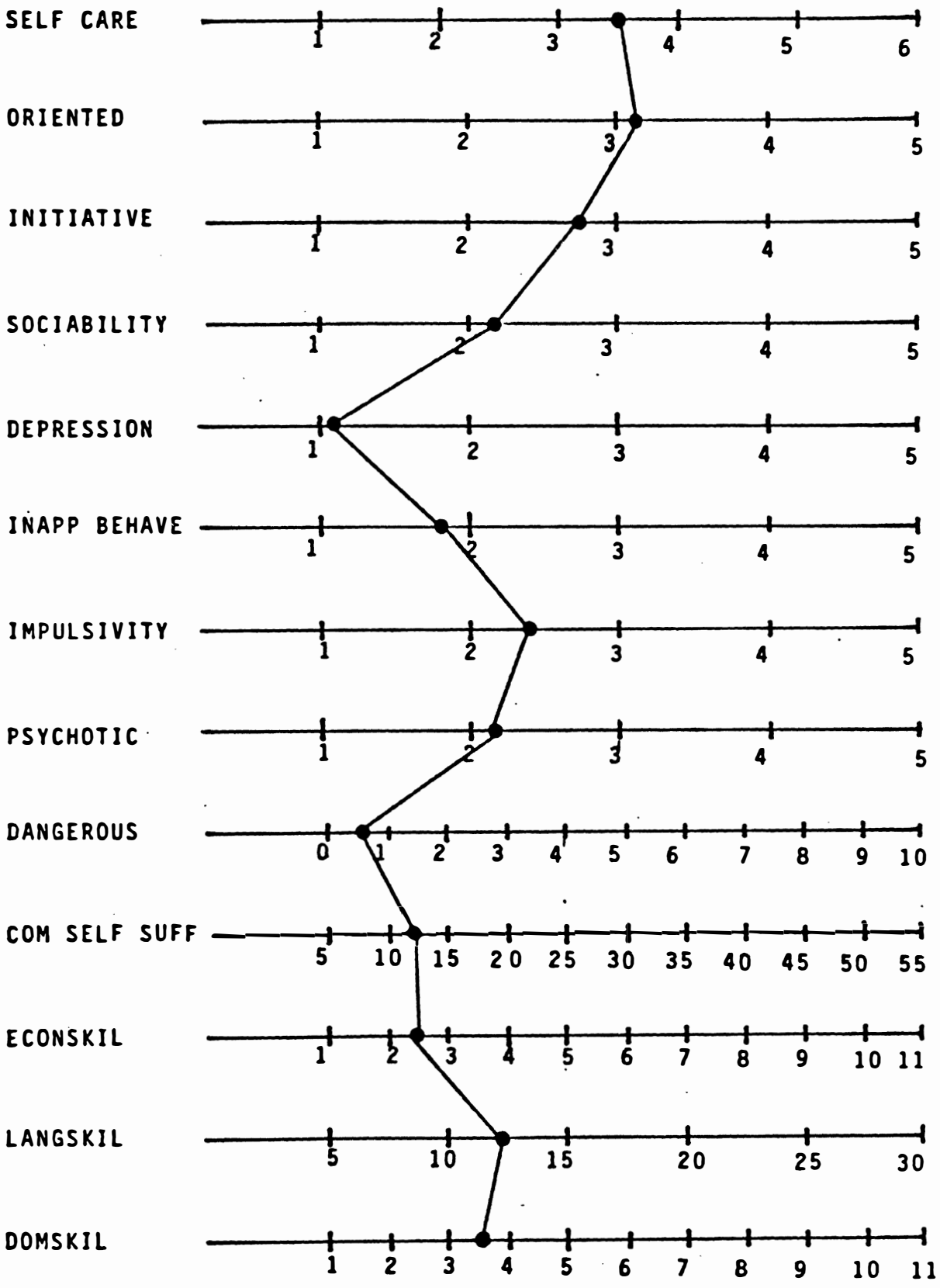
COMMUNITY CLUSTER 6: N = 25



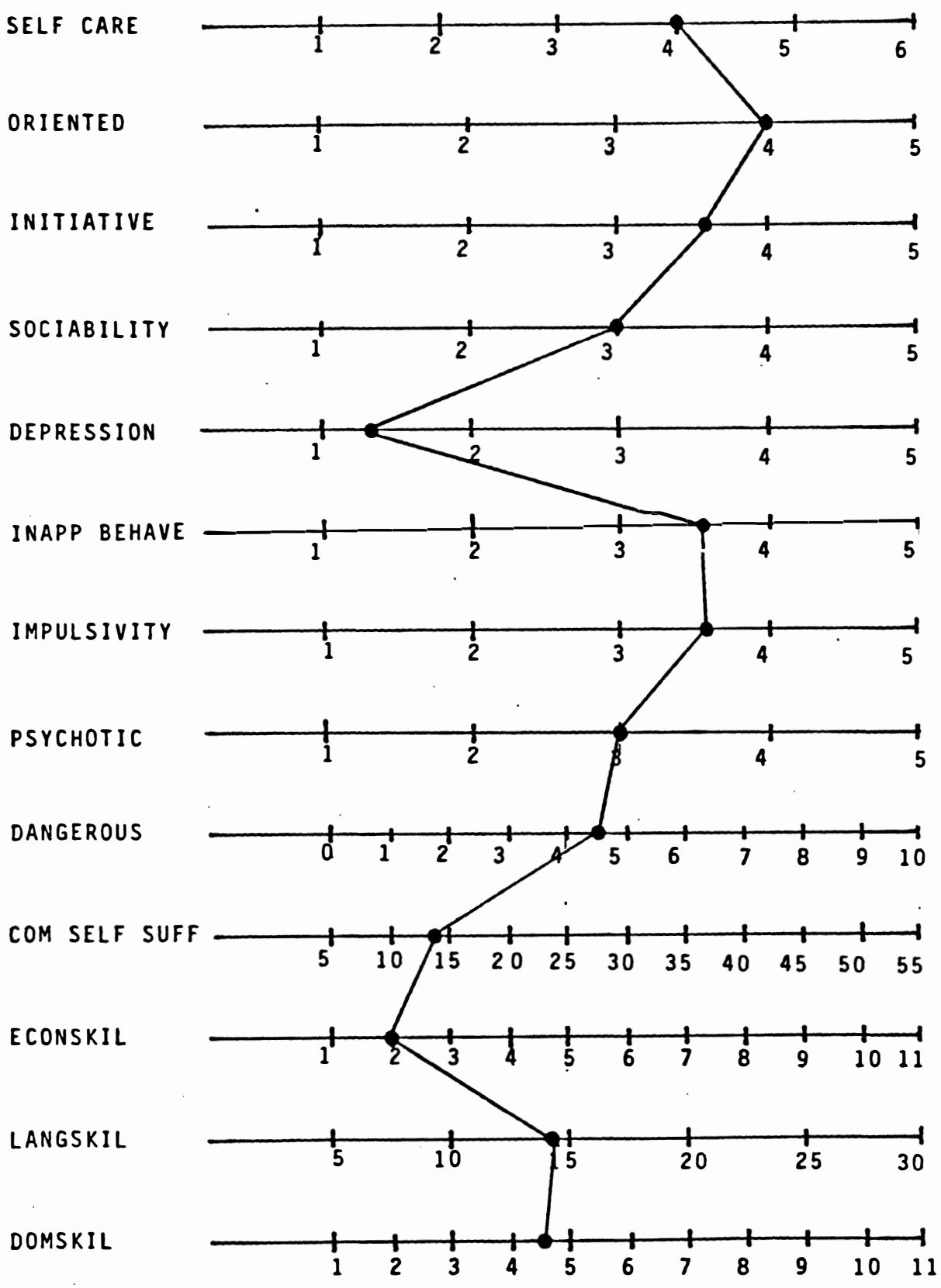
COMMUNITY CLUSTER 7: N = 5



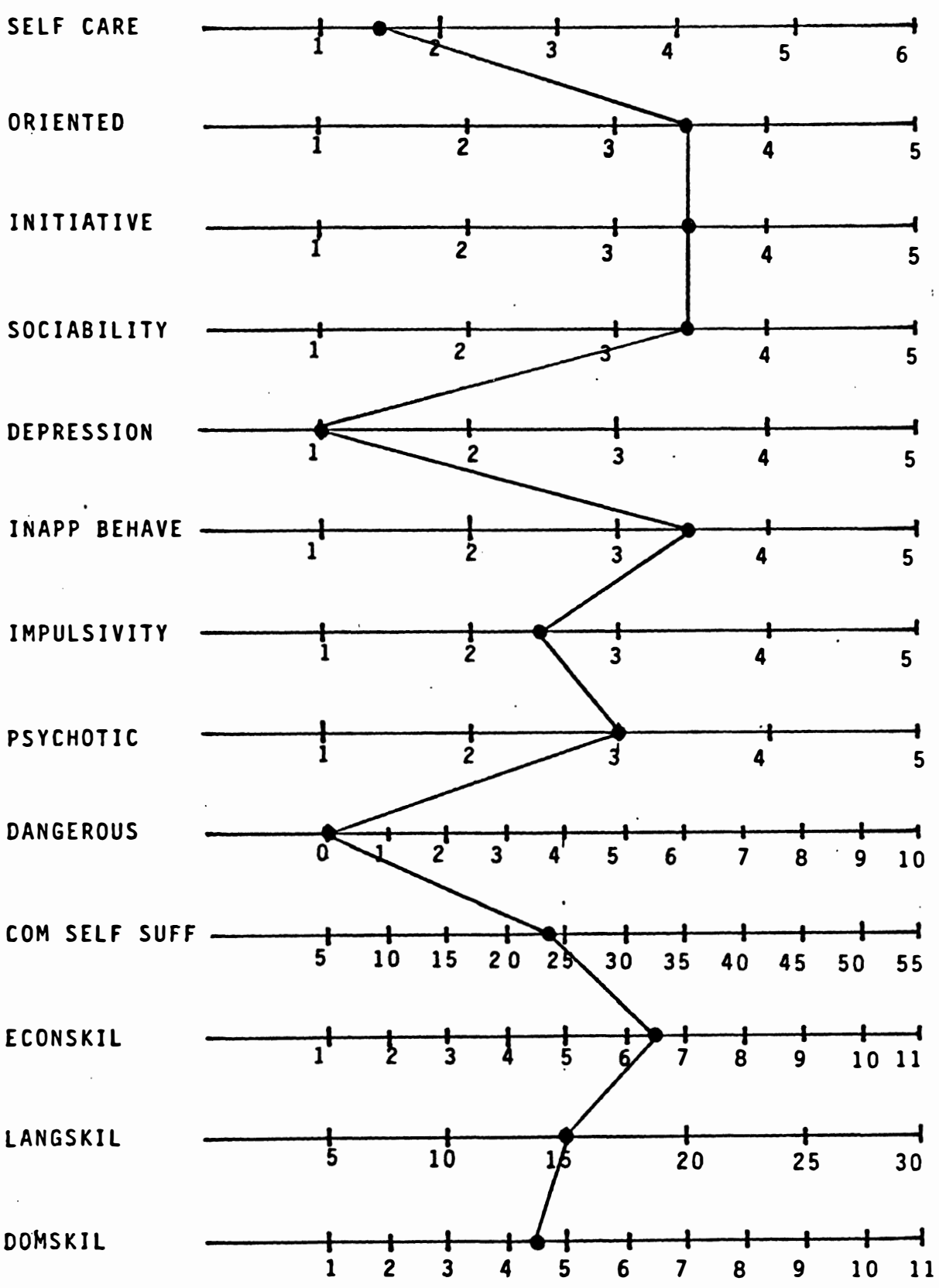
COMMUNITY CLUSTER 8: N = 76



COMMUNITY CLUSTER 9: N = 3



COMMUNITY CLUSTER 10: N = 2



Institutional Sample. What follows are the clusters identified through the 12 cluster solution using the 33 dimensions. Again, there were instances where similar clusters differed slightly on one minor dimension. Combining clusters in such cases, the final product is nine institutional clusters. For each cluster, the percentages of individuals in that cluster currently residing in psychiatric hospitals (i.e., M.H.) versus training centers (i.e., M.R.) are presented. As with the community sample, each cluster is described through a narrative and a graphic profile.

INSTITUTIONAL CLUSTER 1: N = 65, 60% M.H., 40% M.R. The individuals in this cluster are mildly to moderately retarded. They are independent with regard to self care. They are alert to their environment, self directed, and have social skills.

These individuals have problems with impulse control. They act inappropriately and are frequently verbally and physically abusive. Because they are dangerous, they need a secure environment. They also display some bizarre behavior. They are skilled in performing activities of daily living.

INSTITUTIONAL CLUSTER 2: N = 25, 44% M.H., 56% M.R. The individuals in this group are moderately to severely retarded. They require considerable supervision for self care. They are not well oriented to the environment and show little self initiative. They lack social skills.

These individuals have little impulse control and often display wild, inappropriate behaviors. They act bizarre. They are dangerous, assaultive, and require a great deal of behavior management. These individuals lack the skills necessary for community living.

INSTITUTIONAL CLUSTER 3: N = 146, 42% M.H., 58% M.R. These individuals are moderately to severely retarded. They require a modest degree of supervision for self care. They are not well oriented to their environment. They have little initiative and few social skills.

Impulse control is a problem for this group. There is some bizarre hyperactive, and antisocial behavior. They require behavior management and a secure environment.

These individuals do not have the skills necessary for community placement. They are unable to perform many of the activities of daily living.

INSTITUTIONAL CLUSTER 4: N = 110, 32% M.H., 68% M.R. These individuals are severely to profoundly retarded. They require supervision and physical assistance for self-care. They are not alert to their environment, nor are they self directed. They have no social skills.

These individuals are disruptive and dangerous. They require behavior management and a secure environment. No community living skills are present in this group.

INSTITUTIONAL CLUSTER 5: N = 171, 60% M.H., 40% M.R. These individuals are mildly or borderline retarded. Despite the fact that some of these individuals require skilled nursing care, they are independent with regard to self-care. They are alert to their environment, very self directed, and sociable.

There are no overwhelming negative clinical characteristics attributed to this group. They occasionally get agitated. These individuals have good community living skills.

INSTITUTIONAL CLUSTER 6: N = 142, 54% M.H., 46% M.R. These individuals are moderately to severely retarded. They require close supervision with regard to self care. They show little initiative and lack social skills. They have some impulse control problems and are not good candidates for community placement. Their language and community living skills are limited.

INSTITUTIONAL CLUSTER 7: N = 2, 100% M.H. These two individuals are moderately retarded. They are independent with regard to self-care. They are alert to their environment, but show little initiative.

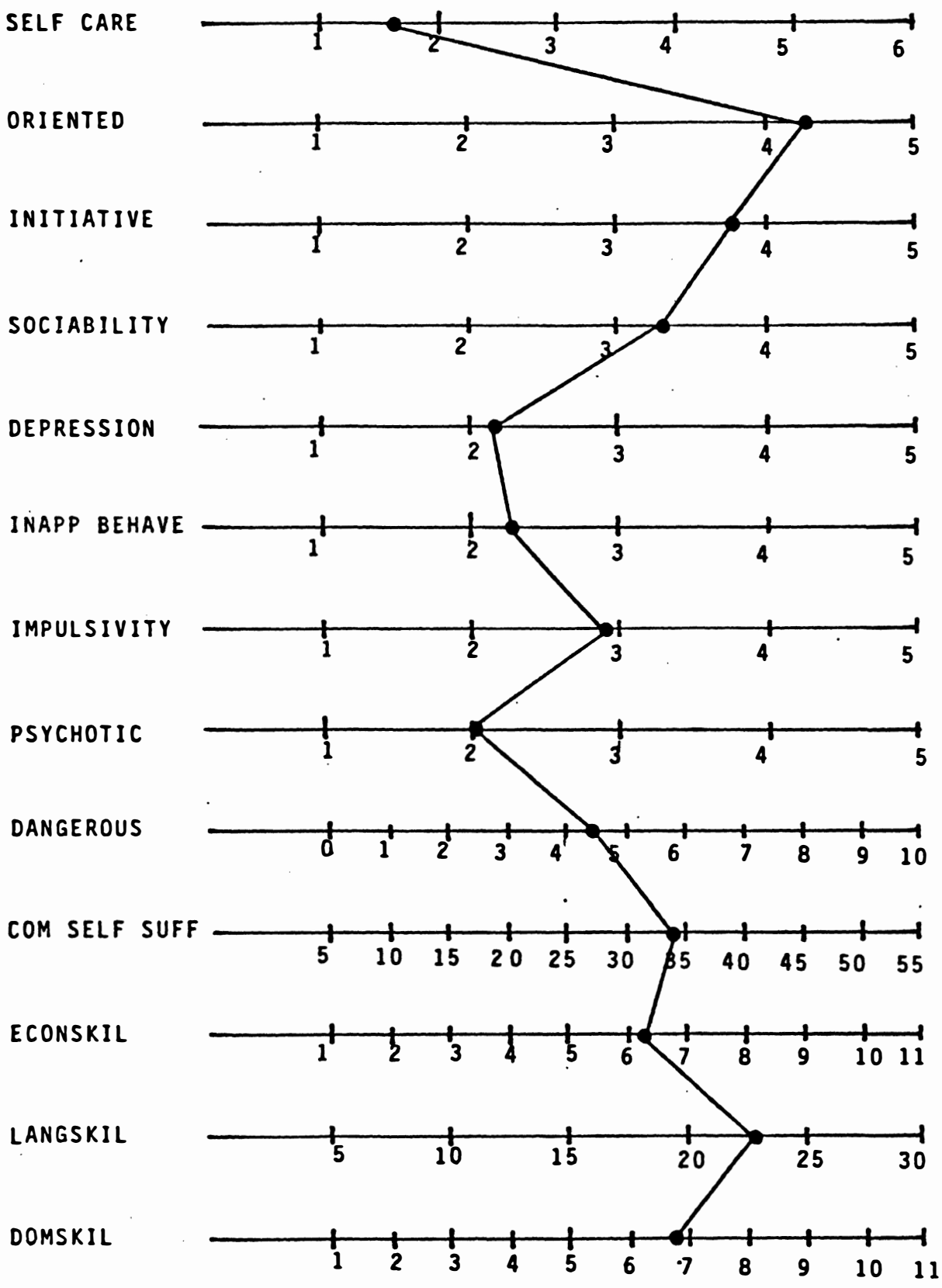
These individuals are acutely psychotic and dangerous. They are impulsive and require a secure environment. These individuals display low to moderate ability in the activities of daily living. They are poor candidates for community placement.

INSTITUTIONAL CLUSTER 8: N = 125, 38% M.H., 62% M.R. These individuals are severely to profoundly retarded. They require total care. They have no verbal communication skills and are minimally oriented to their environment.

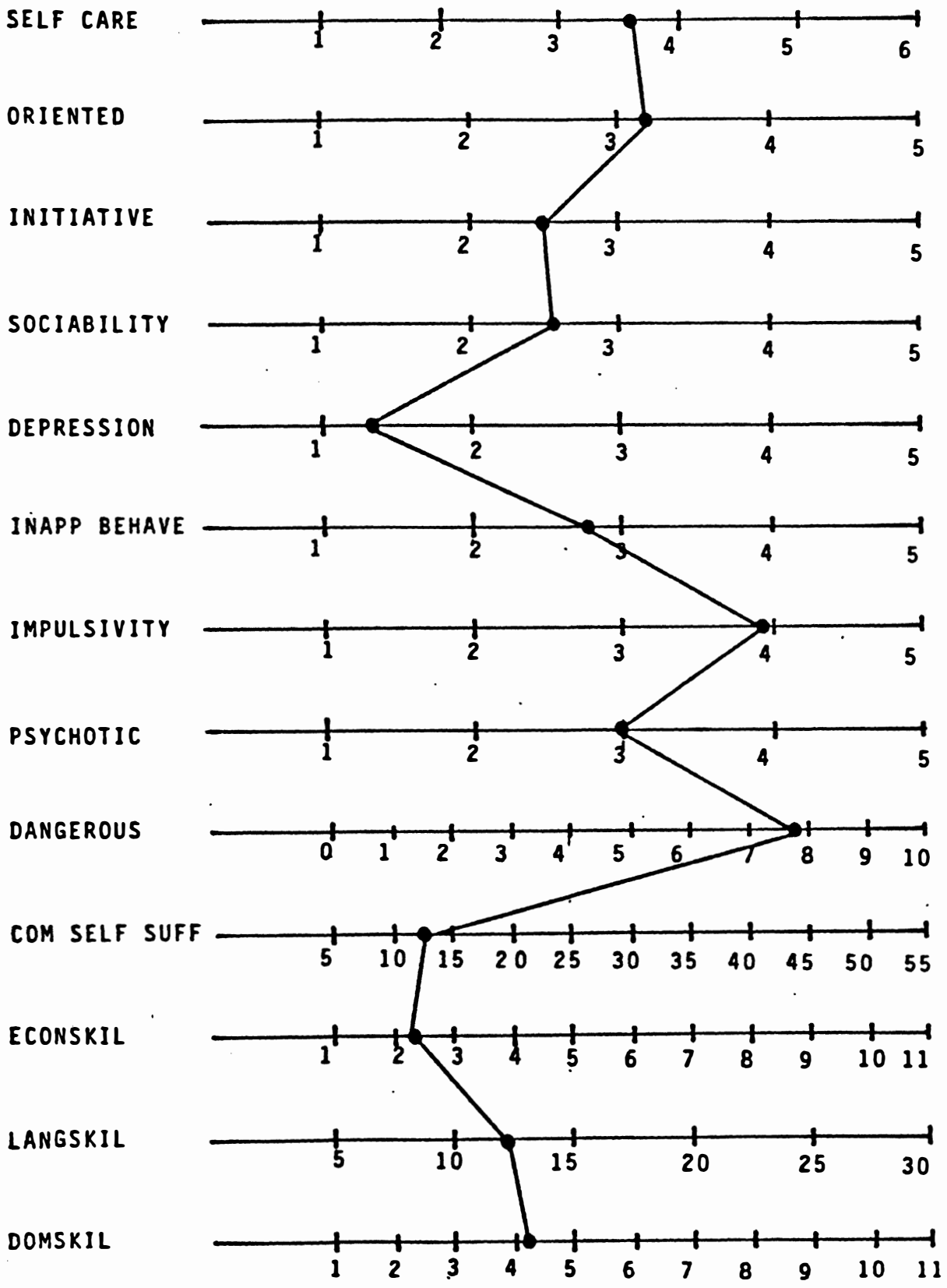
These individuals are easily agitated but not dangerous. They are unable to perform most of the activities of daily living and are unlikely candidates for community placement.

INSTITUTIONAL CLUSTER 9: N = 1, 100% M.R. This individual is moderately retarded. He can take care of himself with supervision. He is alert to his environment but has little initiative. This individual's behavior is extremely inappropriate, impulsive, and dangerous. Potential for community placement is very limited. Ability to perform the activities of daily living is variable.

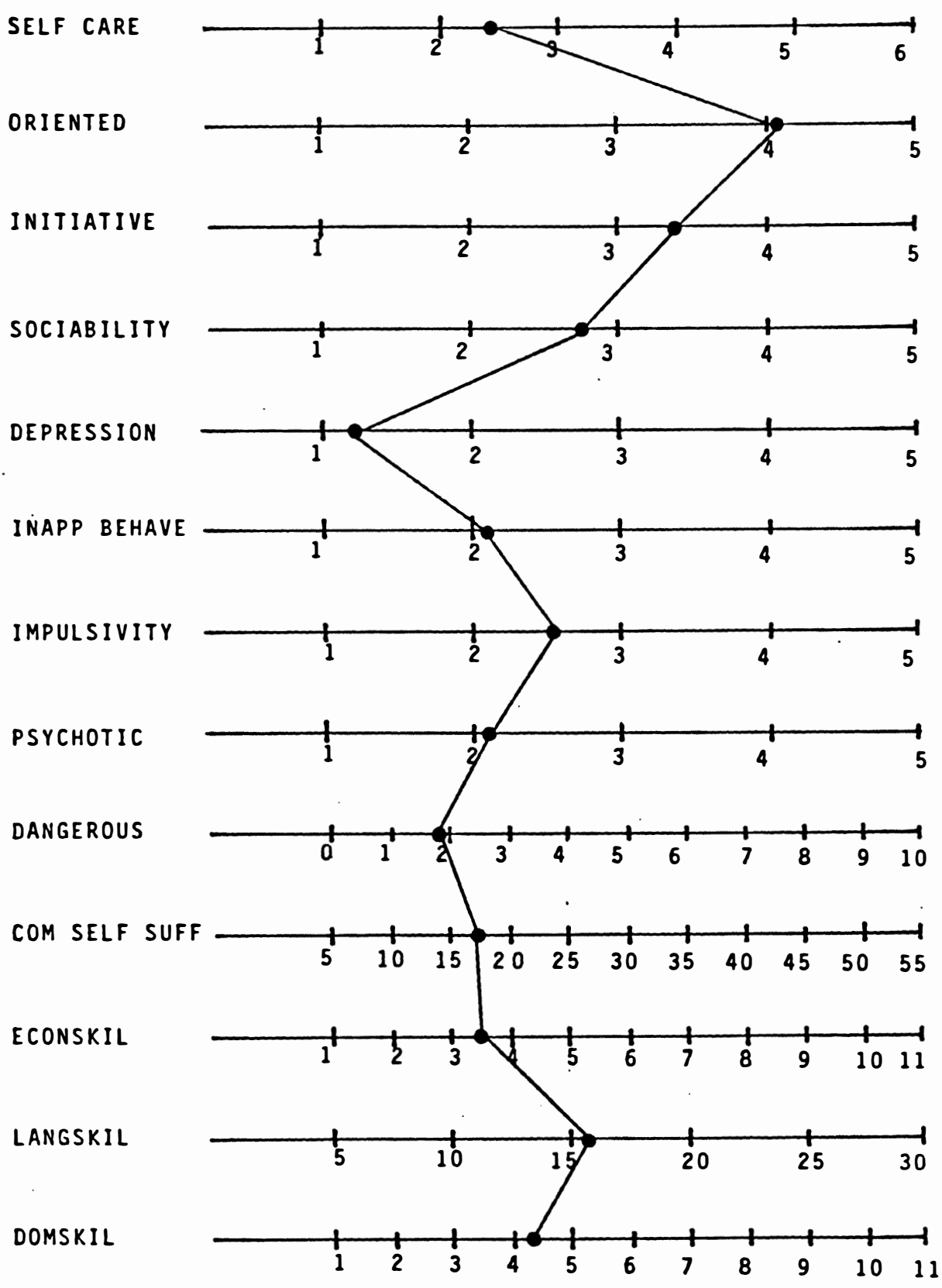
INSTITUTIONAL CLUSTER 1: N = 65; 60% MH, 40% MR



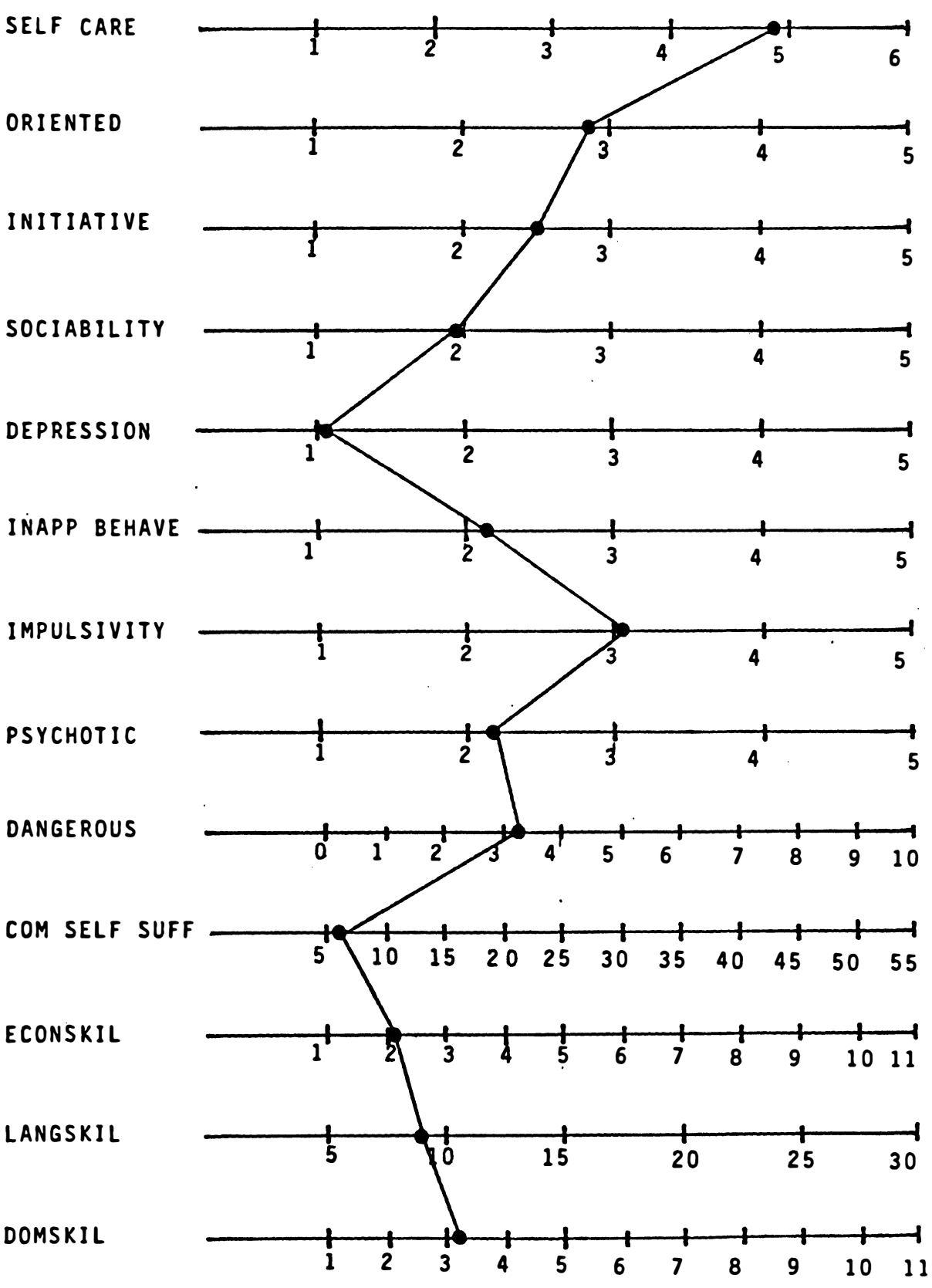
INSTITUTIONAL CLUSTER 2: N = 25; 44% MH, 56% MR



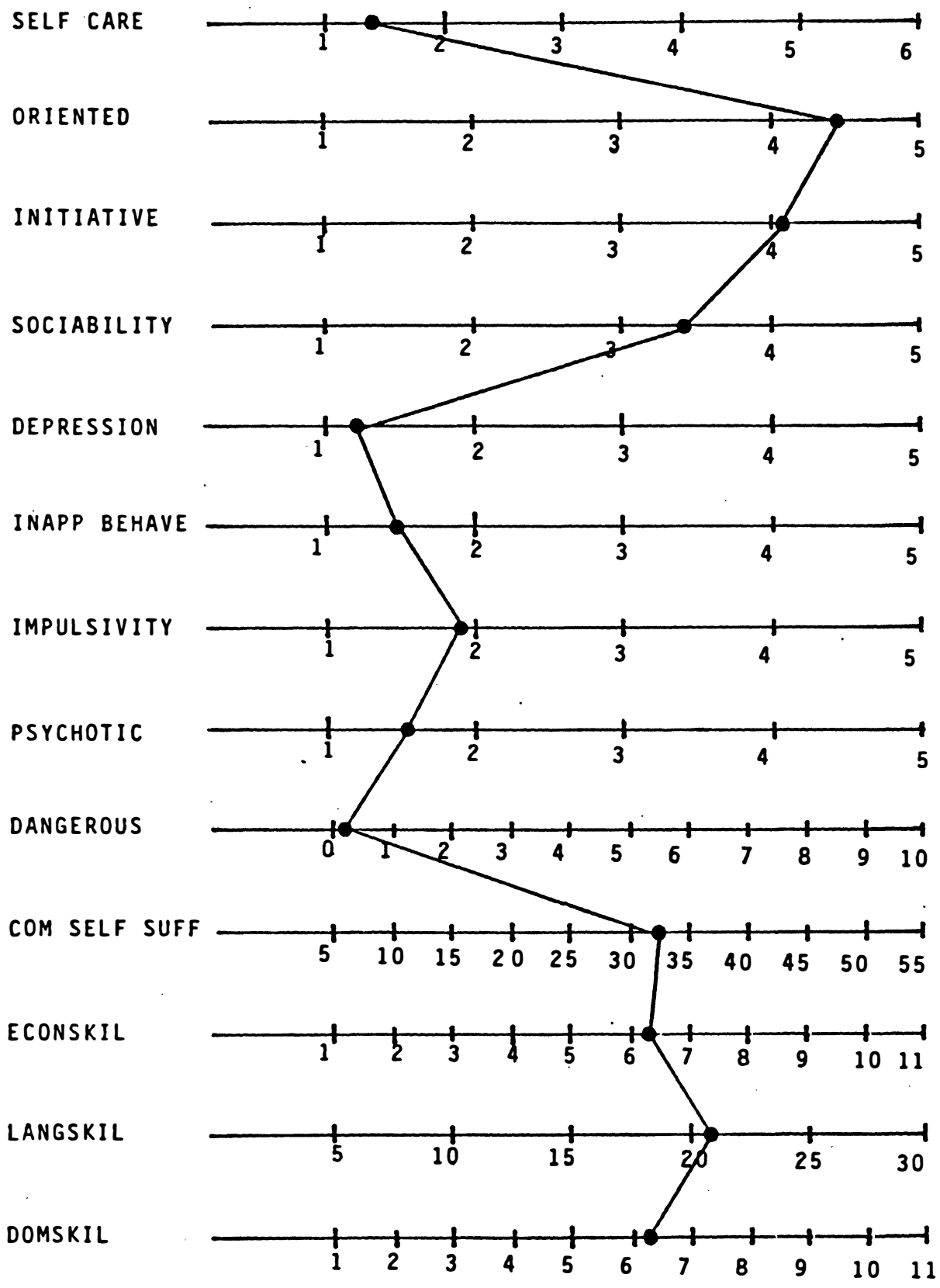
INSTITUTIONAL CLUSTER 3: N = 146; 42% MH, 58% MR



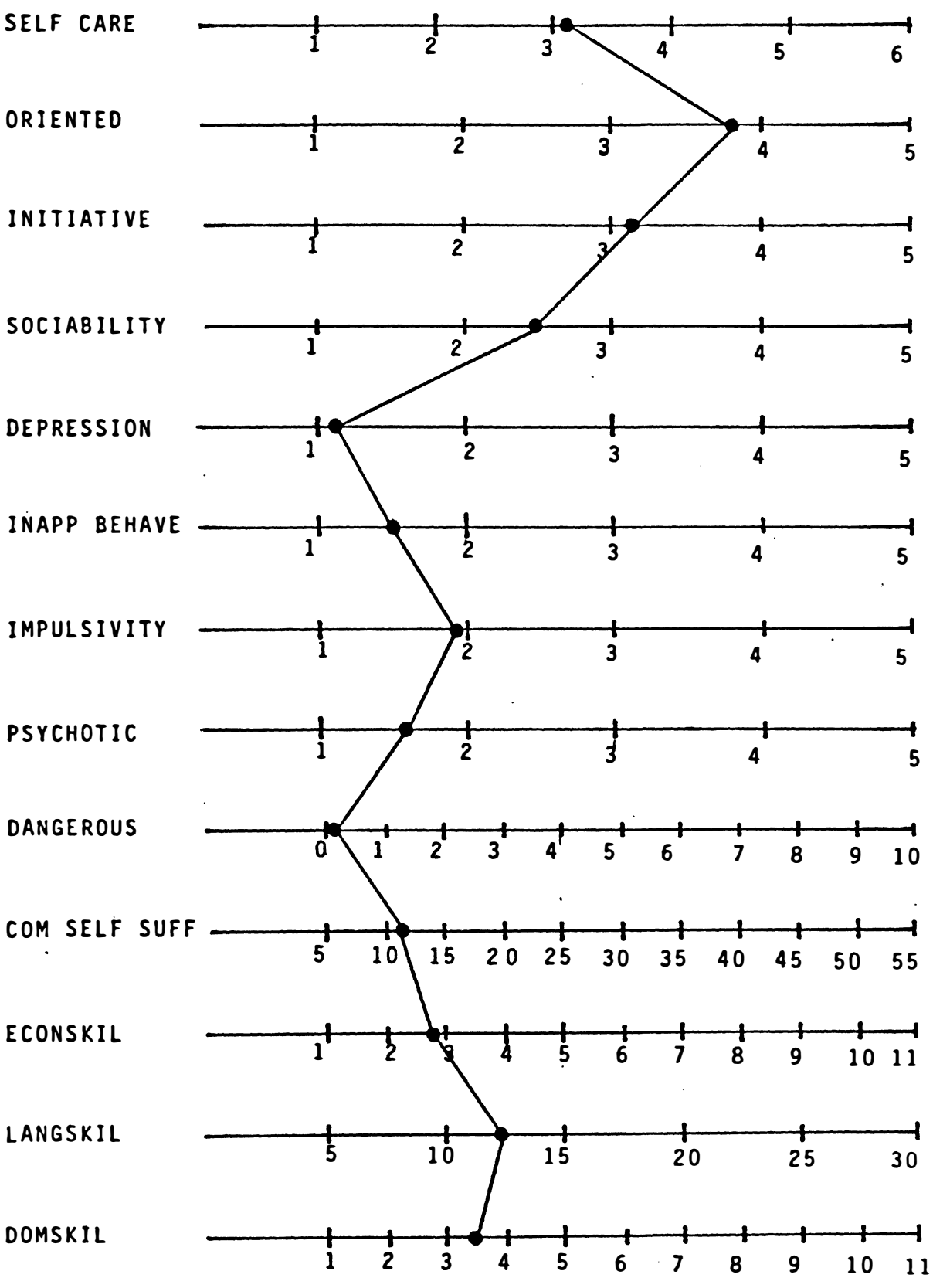
INSTITUTIONAL CLUSTER 4: N = 110; 32% MH, 68% MR



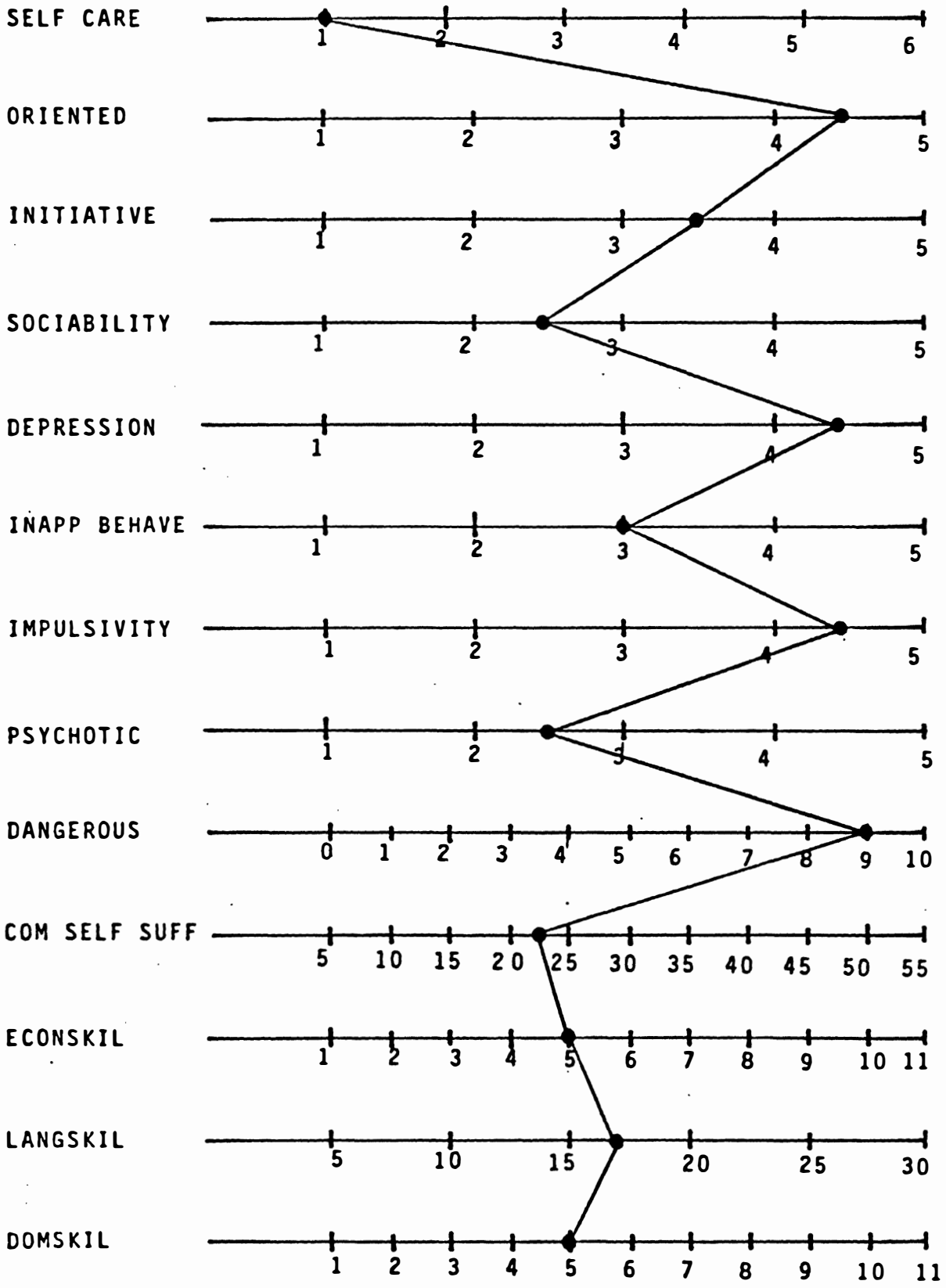
INSTITUTIONAL CLUSTER 5: N = 171; 60% MH, 40% MR



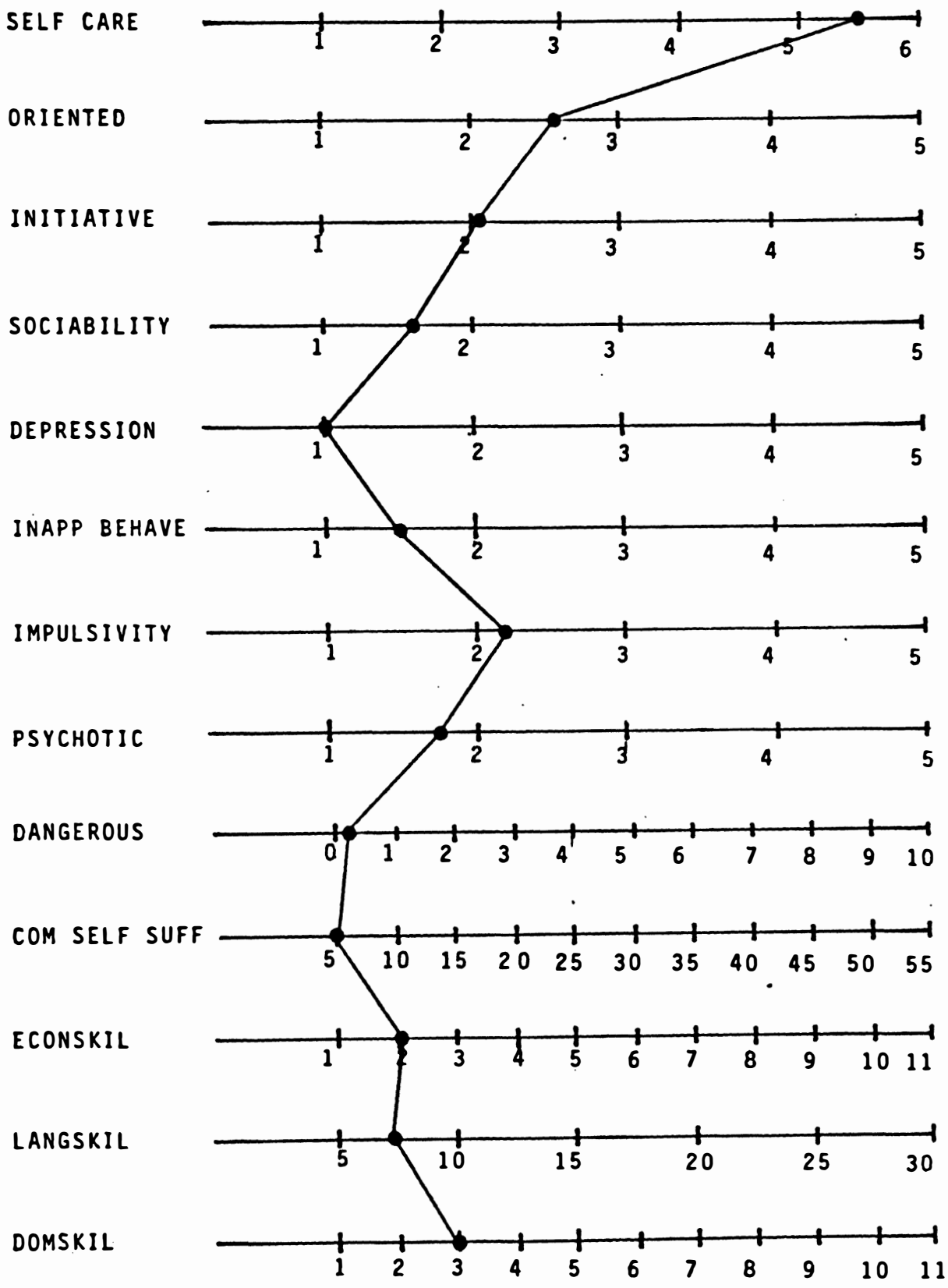
INSTITUTIONAL CLUSTER 6: N = 142; 54% MH, 46% MR



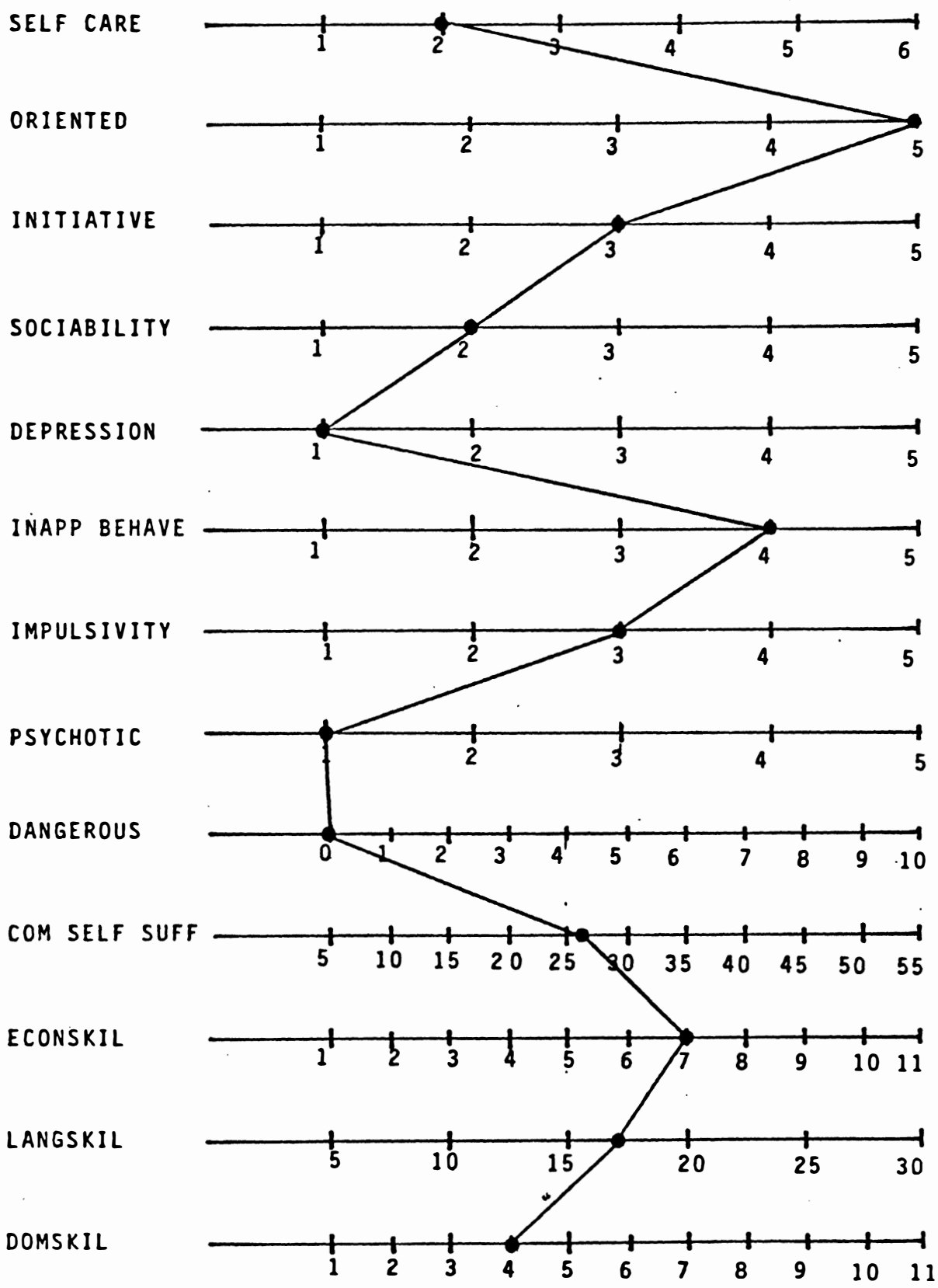
INSTITUTIONAL CLUSTER 7: N = 2; 100% MH



INSTITUTIONAL CLUSTER 8: N = 125; 38% MH,62% MR



INSTITUTIONAL CLUSTER 9: N = 1; 100% MR



Discussion

Through the technique of cluster analysis, ten clusters from the community sample and nine clusters from the institutional sample have been identified. Rather than discuss each separately, what is offered is a system which facilitates an understanding of all clusters from a given sample.

The 33 dimensions used in the preceeding cluster analyses can be collapsed into three principle domains:

1. Potential for community integration
2. Self-care skills
3. Behavior problems

Using these three domains, a multidimensional representation of the relationship between clusters can be created. Figures 1a and 1b present these multidimensional scalings for the community and institutional samples, respectively. In turn, the relationship between clusters can be analyzed by simultaneously examining clusters which converge on a particular set of self-care and community integration coordinates.

For the community sample, 320 (or 54.9% of the sample) demonstrate strong self-care skills as well as high potential for community integration. These individuals are from Clusters 1, 5, and 7. What differentiates Cluster 7 individuals from Cluster 5 is the presence of some physical disabilities in the former group, requiring a slightly higher level of physical care; otherwise, the two groups are virtually identical. In turn, Cluster 1 (N = 5) differs from the other two (Clusters 5 and 7; total N = 315) in terms of a markedly higher level of behavior problems. Whereas individuals from Clusters 5 or 7 might respond to everyday frustrations by becoming upset or occasionally agitated, individuals from Cluster 1 respond with an escape behavior, such as running away or attempting suicide.

Clusters 4, 6, and 10 all show strong self-care skills, but only a fair potential for community integration. For individuals in these clusters (total N = 174; 29.9% of the community sample), self-care skills are very much in evidence, but a higher level of behavior problems (compared to Clusters 5 and 7) shows them to have less potential for successful community integration. In terms of presenting problems, individuals in Cluster 4 (N = 147) show some bizarre or stereotypic behavior, but the primary problem appears to be a modest deficit in impulse control. The presence of bizarre behavior may in fact be a function of this impulse control deficit. In Clusters 6 and 10 (total N = 27), the behavior problems of Cluster 4 have become far more pronounced and urgent. Individuals in Cluster 6 (N = 25) show a dramatic lack of impulse control which, in combination with some bizarre behaviors, becomes most disruptive. For the two individuals in Cluster 10, impulse control is still a problem, but what has become most pronounced is the presence of psychotic symptoms.

Returning to the multidimensional scaling for the community sample, another set of coordinates around which clusters fell was "low self-care, low potential for community integration." Here, Clusters 2, 3, 8, and 9 (total N = 89) comprise 15.3% of the community sample. Individuals in Clusters 2 and 8 (total N = 77) show a moderate

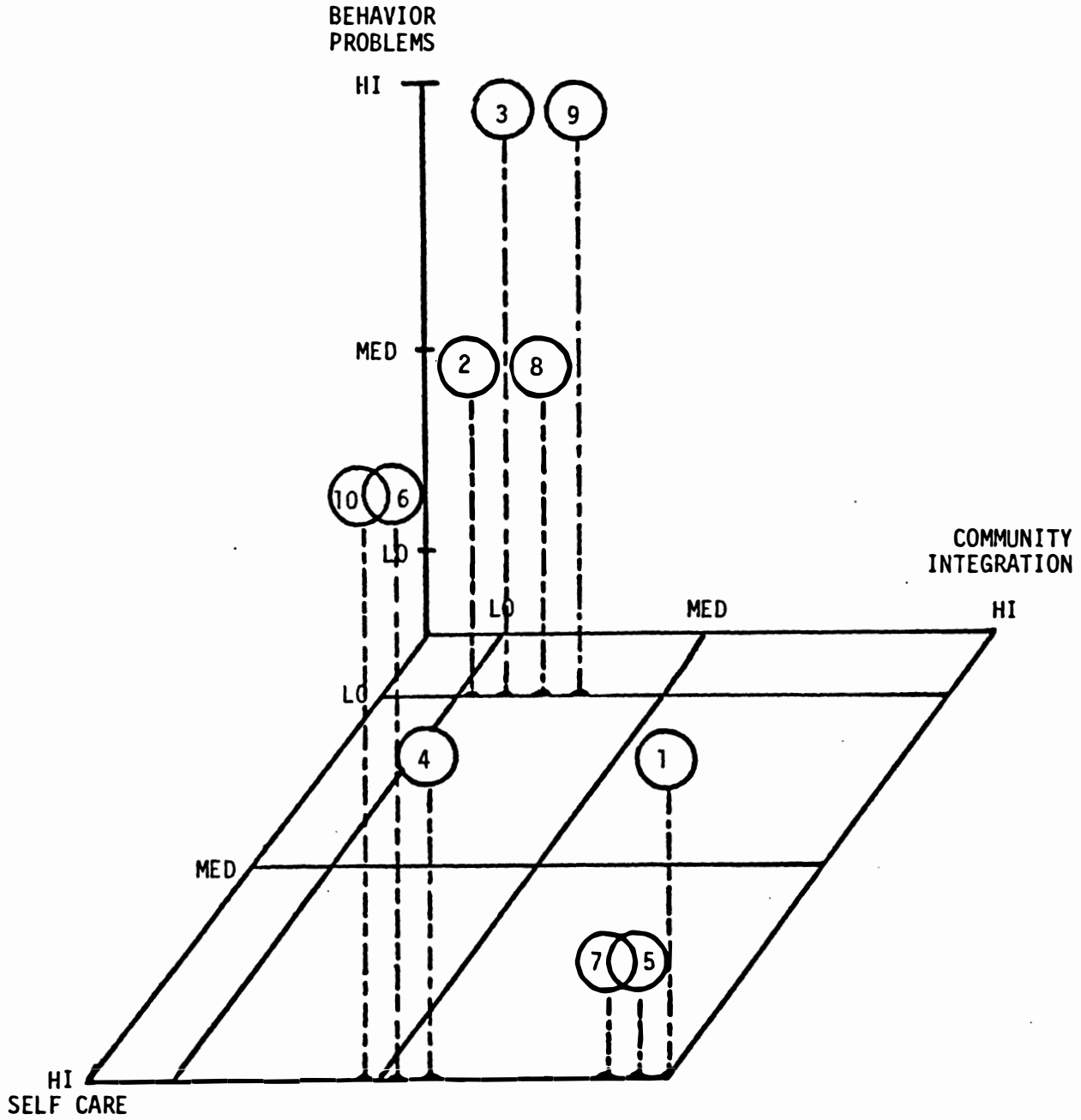


Figure 1a. Multidimensional representation of community clusters.

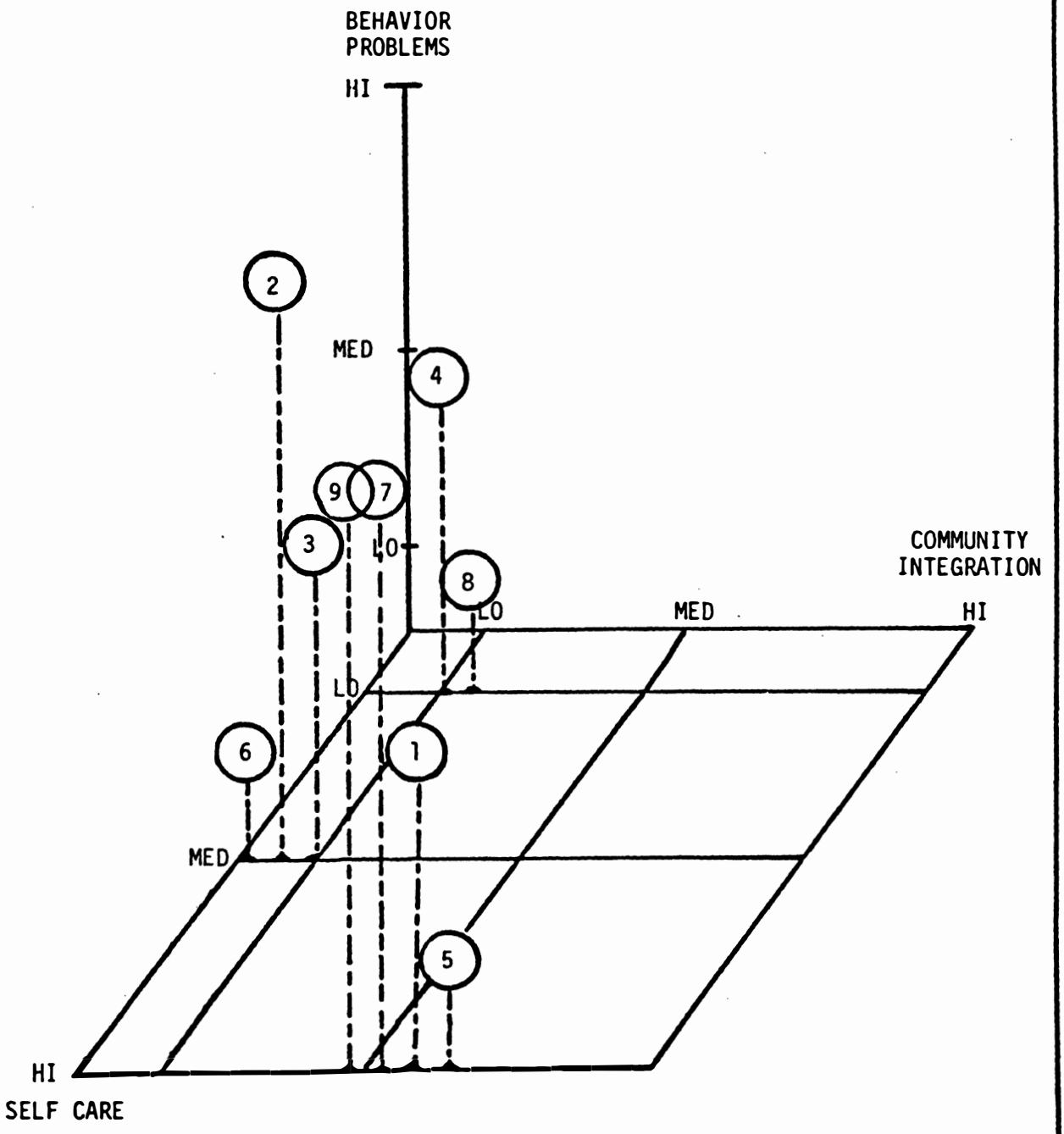


Figure 1b. Multidimensional representation of institutional clusters.

level impulse control deficit along with some disruptive or bizarre behavior. In Cluster 3 (N = 9), however, problems in impulse control have become overwhelming, with antisocial behavior and violence very much in evidence. In Cluster 9 (N = 3), on the other hand, both the impulse control problem and the bizarre behavior of Clusters 2 and 8 have intensified, yielding psychotic behavior and a total lack of impulse control.

What is most striking about the preceding analysis of these clusters is the apparent relationship between magnitude of the behavior problem and the size of the cluster. In each set of clusters discussed above, the behaviors of a large cluster become greatly amplified in a dramatically smaller cluster (or set of clusters). This relationship is presented pictorially in Figure 2a. Clusters converge around levels of retardation, but within a given level of retardation, behaviors seen in the larger cluster simply increase in intensity to yield another, but markedly smaller, cluster.

For all three levels of retardation, the majority of high intensity/small cluster individuals are showing increased deficits in impulse control (Clusters 1, 6, and 3; total N = 39). Only at the two lower levels of retardation does one see occassional bizarre behaviors of the larger group intensified to the level of predominantly psychotic behavior (Cluster 10 and 3; total N = 5). As percentages of the total community sample, high intensity impulse control problems are seen in 6.7% of the individuals, whereas extreme psychotic behavior is seen in only 0.9% of the individuals.

It would appear that for only a very small percentage of individuals in the community sample, one sees acute psychotic behavior in combination with mental retardation. However, for the majority of all cases in this sample, the issue of dual diagnosis can be reduced to magnitude of impulse control. A deficit in impulse control has long been recognized as a cardinal feature of retardation (both developmentally based and functional) and of mental illness. For those identified as dual diagnosis, however, deficits in impulse control (and the management of concomitant maladaptive behaviors) become an increasingly important concern.

To better understand this assessment, it may be useful to think in terms of a frequency distribution showing the prevalence of different levels of impulse control. Looking at the entire population of individuals within a given level of retardation (e.g. mild, moderate, severe), there is a continuum in this deficit that can be modeled as a statistically normal distribution (see Figure 3). With deficits in impulse control a cardinal feature of mental retardation, most retarded individuals show some degree of impulse control related problems. For the majority, these deficits have resulted in few, if any, behavior problems (i.e., Area 1 of Figure 3). If present, these behavior problems are easily handled or not if sufficient magnitude to be considered problemmatic. Beyond a certain level, however, these deficits in impulse control clearly result in a management problem for service providers; these individuals, seen in Areas 2 and 3 of Figure 3, come to be labeled as dually diagnosed.

Within this dual diagnosis subpopulation, there is great variability in the magnitude of the impulse control deficit and attendant maladaptive behavior. For most of these individuals (i.e., Area 2), a significant deficit has required an increased level of behavior management, the technology of which reportedly needs to be developed in our service delivery system. For a very small percentage of cases (i.e., Area 3), behaviors related to this impulse control deficit are out of control. Such individuals can not be maintained in routine community and institutional programs without stabilization.

FIGURE 2a

Relationship Between Community Clusters

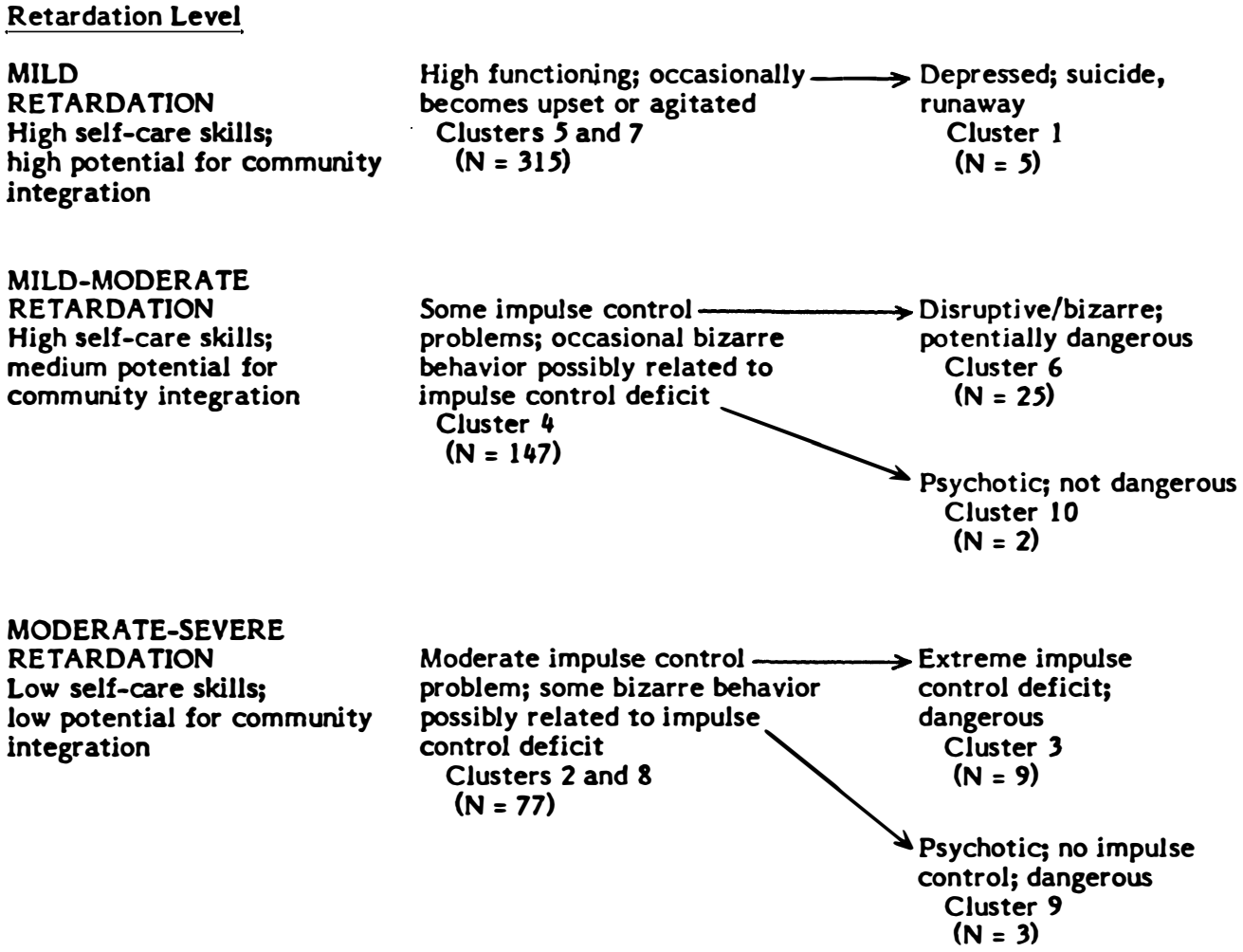


FIGURE 2b

Relationship between Institutional Clusters

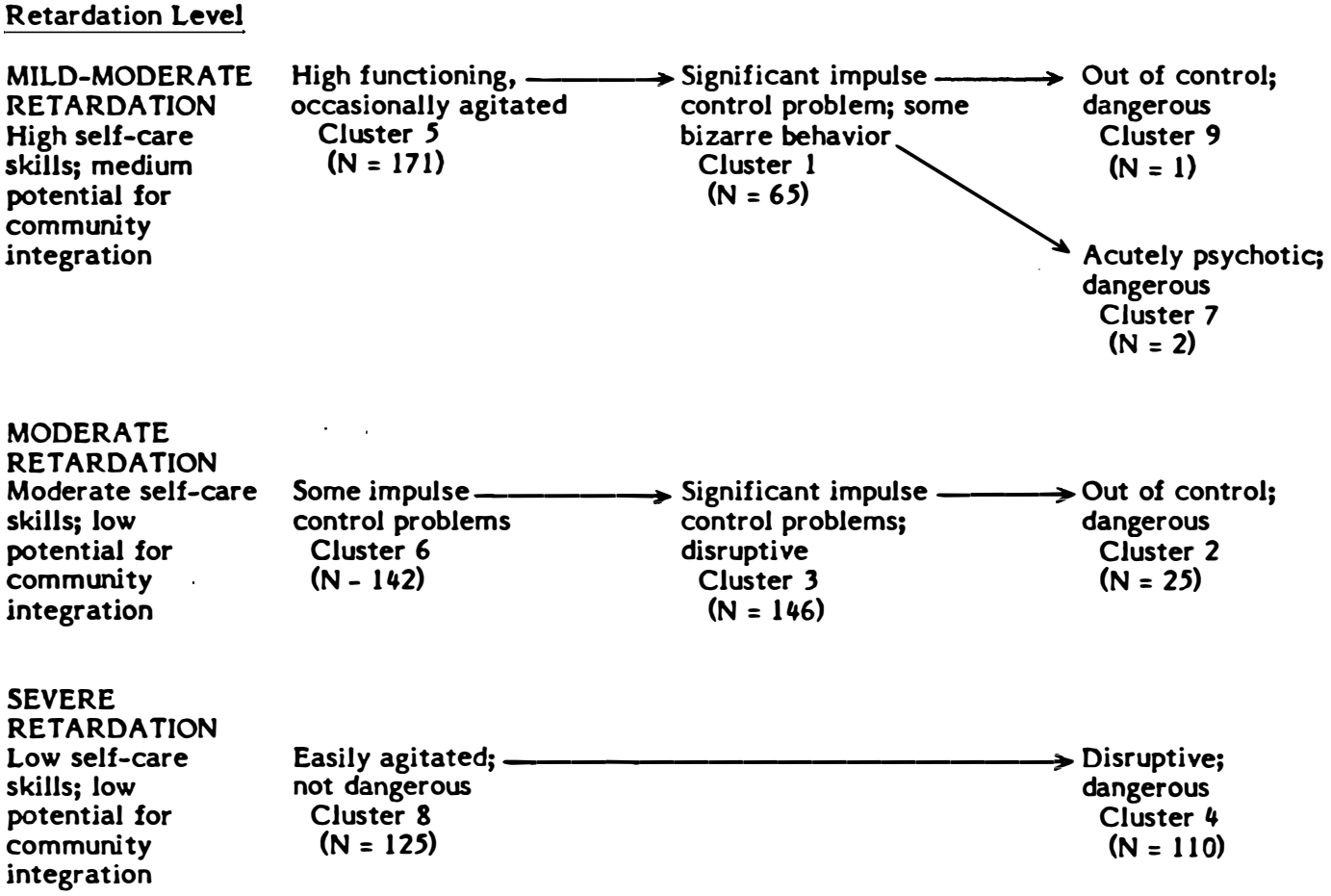
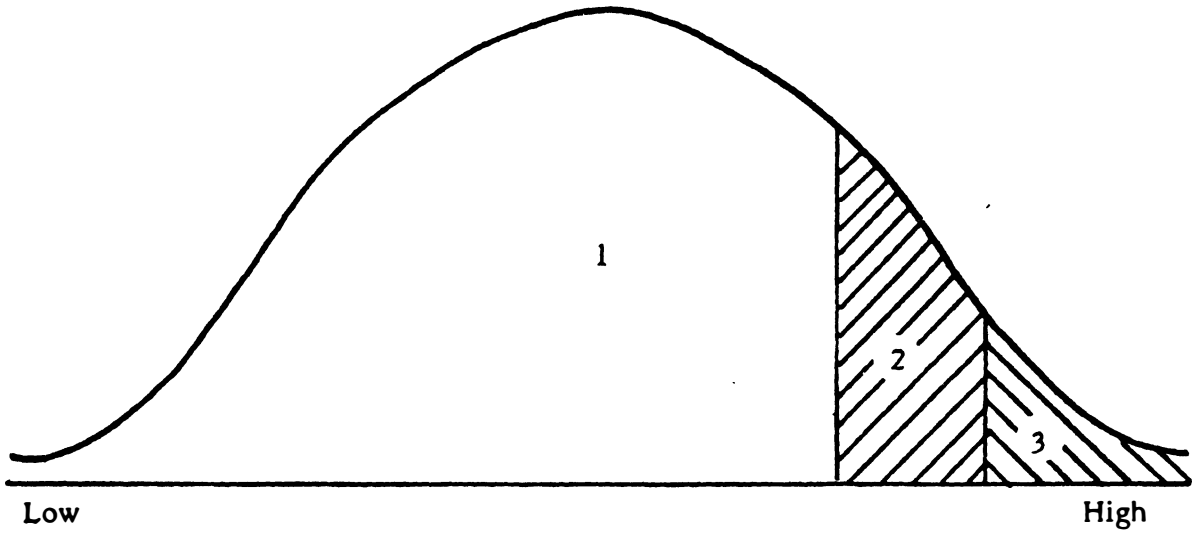


Figure 3



Magnitude of Impulse Control Deficit
And Concomitant Maladaptive Behavior

1 = Mentally retarded individuals whose behavior problems relating to impulse control are easily handled or not of sufficient magnitude to be considered problemmatic.

2 = Mentally retarded individuals who present significant maladaptive behaviors that can and should be routinely handled within existing programs. Without development of skills in routine behavior management, however, many staff may be unable to deal with these behavior problems. These individuals have previously been labeled as dually diagnosed. From the community sample, these individuals would be from Clusters 5 and 7, 4, or 2 and 8, depending on the level of retardation.

3 = Mentally retarded individuals whose behaviors are out of control and require intensive stabilization services. Such behaviors may include extreme hyperactivity resulting in constant disruptions and danger, physical violence to self, others, or property, firesetting, etc. From the community sample, these individuals would be from Clusters 1, 6, or 3, depending on the level of retardation.

Superimposing the information from clusters as displayed in Figure 2a onto the distribution in Figure 3, the individuals in clusters 5 and 7, 4, or 2 and 8 (depending on the level of retardation) from Area 2. They present significant maladaptive behaviors that, without development of skills in routine behavior management, many staff may be unable to deal with. Depending on their level of retardation, it would be individuals from Clusters 1, 6, or 3 that would be seen in Area 3. Individuals from Area 1 would be non-dually diagnosed, but retarded individuals served in the community.

With this in mind, let us turn to the institutional sample. Looking to Figure 1b, one sees that the clusters again converge around three sets of self-care and community integration coordinates. Except for Cluster 8, a group of two acutely psychotic dangerous individuals, clusters around a given set of coordinates again differ only on their levels of impulse control. While in some cases three levels of impulse control emerge, the overall pattern appears very much similar to that seen in the community sample. This relationship between clusters based on a level of impulse control is summarized in Figure 2b.

It is therefore felt that, with the exception of a small percentage of cases showing mental retardation in combination with acute psychosis, dual diagnosis in both the community and the institutions can be regarded as an issue of impulse control. Severity of maladaptive behaviors relating to impulse control consistently emerges as the dimension underlying an attribution of dual diagnosis.

In identifying deficits in impulse control as the dimension underlying dual diagnosis, it is, of course recognized that individuals identified as dually diagnosed display a wide variety of adaptive and maladaptive behaviors. The majority of these behaviors, though representative of an equally broad range of diagnostic groupings and etiologies, have simply been shown to have a common underlying dimension: deficits in impulse control.

COMPONENT 3: ENUMERATION

Using the estimates of dually diagnosed clients generated by agency directors when they were first contacted for the cluster analytic study, prevalence estimates can now be generated. In reviewing these figures, one must bear in mind that 1) they are indeed only estimates, based on counts which, from agency to agency, varied from informal estimates to formal review of every client served to computer-generated lists and 2) they are based on the broad working definition adopted by the task force.

There are an estimated 2790 non-institutionalized adults in the state who are mentally retarded and have an emotional disturbance. The actual number probably falls between 2500 and 3300. Adding in the 685 dually diagnosed adults in state institutions, this yields a prevalence rate between 0.086% and 0.108% for all adults in the State. For children and adolescents, an estimate of 1433 was generated, with the actual number probably falling within the range of 900 to 1700. Adding the 103 dually diagnosed children and adolescents currently in the state institutions, a prevalence rate between 0.061% and 0.109% is calculated.

COMPONENT 4: OPEN FORUMS FOR CLINICAL/ADMINISTRATIVE INPUT

Through the cluster analytic study a systematic and empirical perspective to the dual diagnosis issue was obtained. The structure of such a quantitative approach to the problem may have precluded incorporation of qualitative, clinical insights. Hence, the Dual Diagnosis Task Force held three open forums at different locations throughout the State. The purpose of these forums was to solicit input from interested consumers, professionals, and community and institutional representatives regarding services for the dually diagnosed.

The dates and locations of the open forums were:

April 21, 1981 - Southwestern State Hospital, Marion, Virginia
May 19, 1981 - Northern Virginia Mental Health Institute, Falls Church, Virginia
June 23, 1981 - Southeastern Virginia Training Center, Chesapeake, Virginia

The number of participants at each meeting ranged from ten to 30. Written testimony provided by the participants is included in Appendix B.

The following summary of comments reflects the nature of the presentations and exchanges which occurred at the meetings. The comments offered represent the opinions of the participants and should not necessarily be treated as valid conclusions.

-- There is a difference in admissions criteria of state psychiatric hospitals and training centers. Training centers have more restrictive admissions criteria; psychiatric hospitals have more leeway in admitting a wider variety of individuals to their facilities.

-- There does not exist in the State a program for behaviorally disordered mildly or moderately retarded persons.

-- A program for behaviorally disordered retarded individuals should be developed and the State should designate the responsibility for developing the program.

-- Given the current admissions criteria for mental retardation facilities, the elimination of ICF/MR standards would not make a significant difference in terms of the types of individuals who can be served in mental retardation facilities.

-- The problem of serving dually diagnosed clients is, at this time, an institutional rather than a community problem.

-- There is some question as to whether or not the technology exists for dealing with dual diagnosis clients.

-- Behavioral disorders are more difficult to deal with in the mentally retarded than classic psychiatric problems.

-- Psychiatric hospitals are developing concerns with respect to legal issues surrounding serving dual diagnosis clients.

-- There is a concern about the ramifications of defining a discrete new population--the dually diagnosed--as opposed to integrating services for these individuals into the existing services offered within the system.

-- The broad definition of dual diagnosis adopted by the task force could lead to the dumping of chronically emotionally disturbed individuals into mental retardation facilities.

-- Approved, scientific research in areas of therapeutic intervention for the dually diagnosed should be pursued.

-- It may be inappropriate for dually diagnosed individuals who function at a low level to be admitted on a voluntary basis to state facilities if they cannot understand admission procedures and release of information guidelines. These criteria may need to be revised.

-- Training centers are allowed to reject clients because they cannot meet the clients' needs. Psychiatric hospitals do not have this option.

-- The pre-screening forms of the Department of Mental Health and Mental Retardation are geared towards mental health facilities. Separate screening procedures may need to be developed for mentally retarded and dually diagnosed clients.

-- Dually diagnosed clients are disruptive in programs and require more care than is sometimes available. They do not seem to mix well with other patients in mental health facilities. Combining these patients with other patients seems to be dysfunctional for everyone.

-- Network planning for dually diagnosed clients is often difficult because of the different missions various agencies have.

-- Discharge planning for dually diagnosed clients seems to be difficult in that community programs and families do not appear to be reaccepting dually diagnosed patients. There is a scarcity of day programs for these patients.

-- Not enough services are offered by community mental health centers to dually diagnosed clients.

-- There is poor communication among community agencies and State facilities.

-- Psychiatric hospitals appear to be used as a waiting or holding placement for dually diagnosed clients awaiting long-term care. This does not fit the mission of the facilities.

-- Medicaid requirements present a problem in serving dual diagnosis clients in that they limit staff to using techniques which would be appropriate for working with aggressive clients.

-- From a parent's perspective, the service delivery system sets up catagories of diagnoses and services which some clients never fit into.

-- Several sections of the Code of Virginia present problems in working with incarcerated individuals who are dually diagnosed. Although these sections of the Code have been examined in the past by state agencies and legislators and continue to be studies, they still present ongoing problems for service providers, primarily in institutional settings.

-- Behavior Management Techniques seem to be the most effective method of working with dually diagnosed clients. Wider use of these techniques would assist in serving dually diagnosed clients. However, many of the techniques cannot be used because of ICF/MR restrictions.

-- Emphasis should be placed on describing the behavior and functional abilities of dual diagnosis clients.

-- A secure environment is needed for some dually diagnosed people.

The above comments do not reflect the entire discussion which took place, nor do they necessarily reflect a concensus on any of the points.

COMPONENT 5: SYNTHESIS

Across the state, there are an estimated 5000 individuals who are dually diagnosed, as defined by the task force. The actual number of dually diagnosed probably falls within the range of 4200 to 5800. Only a small percentage of these cases present severe behavior problems.

Of the estimated 5000 dually diagnosed, approximately 4200 are in community (i.e., non-institutional) settings. The remaining 800 can be found evenly split between the state's psychiatric hospitals and training centers for the mentally retarded. This represents 9.5% of the state institutions' patients/residents. While the number of dually diagnosis individuals does indeed seem to be large, it is not clear why the problems associated with serving this population have to be so great.

With the exception of a small percentage of cases showing acute psychotic behavior, dual diagnosis in both the community and the institutions can be regarded as an issue of impulse control and the management of concomitant maladaptive behaviors. Analysis of the clusters which emerged in the present study clearly indicates that dual diagnosis is predominantly a function of impulse control deficits.

Impulse control is and has always been a primary component of both mental retardation (i.e., developmentally based) and functional retardation. In a sense, then, dual diagnosis may be a misnomer. Excepting the small number of cases showing acute psychotic behavior in combination with mental retardation, there is nothing in the behavior patterns of these so-called dually diagnosed people to warrant their identification as a separate and unique population. Cases identified herein as dually diagnosed are, in large part, retarded individuals showing a significant impulse control deficit. In a few cases, the lack of impulse control is most difficult and potentially dangerous. The label of dual diagnosis functionally serves to exclude these difficult cases from one's target service population. A significant impulse control deficit or any other difficult behavior pattern is scarcely grounds to absolve a service delivery system of its responsibility.

Having labeled dual diagnosis as a misnomer should not be seen as an attempt by the task force to downplay or ignore the issue. The behaviors and problems that "dually diagnosed" individuals experience are indeed real. Similarly, as a feeling human being, mentally retarded individuals have psychological needs that must be addressed. However, where the majority of significant behaviors seen in dually diagnosed individuals can be accounted for as an impulse control deficit, it is not clear why a two-dimensional diagnosis must be imposed or how some service providers could perceive this population as outside their service domain. As such, labeling dual diagnosis as a misnomer is intended to highlight the problems that have become associated with serving this population.

COMPONENT 6: RECOMMENDATIONS

In order to assemble the administrative perspectives needed to address the problems of dually diagnosed clients, a meeting of the Assistant Commissioners for Mental Health Services, Mental Retardation Services, and Technical Services was convened. At this time, the three assistant commissioners unanimously offer the following recommendations:

1. Rather than using the label dual diagnosis, service providers should deal with individuals in terms of their specific behaviors. The label of dual diagnosis provides too little information regarding treatment needs, whereas a more individualized behavior assessment can focus on the appropriate strategies for providing service.

2. Service providers (i.e., mental health, mental retardation, community, institution) must acknowledge that 1) routine management of behaviors based in impulse control deficits and 2) training/habilitation are simply part of the service array expected of them. Mental retardation service providers must accept their responsibility to serve the mentally retarded individuals with a significant deficit in impulse control and recognize that impulse control problems may simply be part of the domain of mental retardation. Similarly, faced with a functionally retarded client, mental health service providers must acknowledge their responsibility to provide necessary services. The presence of functional retardation does not preclude the need for training/rehabilitation services.

   This recommendation cannot be benignly offered lest it be treated as a gratuitous platitude. It is felt that the Department of Mental Health and Mental Retardation must establish this recommendation as a programmatic philosophy and, in turn, restructure components of its service delivery system to support that philosophy. Such changes are discussed in the subsequent recommendations.

3. It would appear that the behavior of some retarded individuals occasionally will become so out of control that intensive stabilization services, beyond those typically offered by a community program or training center, are needed (i.e., Area 3 of Figure 3). If service providers are to face up to their responsibility to serve, some support systems must be made available to assist them during these difficult periods.

   Given the small numbers of such cases in individual agencies/facilities and the current economically constrained climate, extensive development (i.e., within individual agencies) of intensive stabilization services may be impractical. What is therefore indicated is that the department take the lead by developing institutional capability for intensive stabilization services. Two settings are envisioned for such stabilization services:

   A. The Social Skills Center at Lynchburg Training School and Hospital, and

B. Specialized stabilization units to be developed within the larger psychiatric facilities.

With changes recently proposed by LTS&H, the Social Skills Center (SSC) will become a 46-bed unit specialized in control of maladaptive behaviors and development of adaptive behaviors. This will be achieved through a combination of intensive staffing, behavioral programming, medication (as needed), and full spectrum training/habilitation.

Specialized stabilization units will also be developed within the larger psychiatric hospitals. Such units would be restricted to serving retarded individuals in need of these stabilization services. Programming similar to that of the Social Skills Center will be developed with consultation from Mr. Scott W. Carroll, director of the Social Skills Center.

Whereas the structure for the SSC program is already in place programs in the psychiatric facilities would have to be developed. It is therefore proposed that a pilot program be created in one facility at this time. With refinement of the program during a trial period of operation, other units can be developed later. Selection of a pilot site should be based on:

A. Availability of beds to be diverted to such a program.

B. Existing internal expertise in behavior analysis and management for the mentally retarded

C. Existing internal expertise in the use of psychotropic medications with the mentally retarded

D. Proximity to the consultative resources of a training center

E. A geographic assessment of program demand to minimize the distance between the placing agency and the institution and to maximize contact between the placing agency and the specialized program

F. The current number of retarded individuals within the psychiatric facility needing such stabilization services

The issue of how to admit these individuals without violating their rights must be explored before the implementation of any such program.

Use of this stabilization programming (in either site) should be carefully controlled through several procedural regulations:

A. Services should be time-limited and/or terminated upon goal attainment (i.e., extinction of the maladaptive behavior and development of adaptive behavior).

B. Frequent utilization reviews should be established.

C. No one should be admitted into these programs without firmly established and documented aftercare plans in hand at the time of admission.

D. Admission to these programs should be controlled by strict behaviorally-based criteria.

4. As a final note, responsibility for these stabilization services has been placed on the institutions. However, given that need can be demonstrated, communities should not be penalized or discouraged from starting discrete (i.e., freestanding or isolated) facilities providing such services. Existing programs must develop their own internal capabilities to provide service and routine behavior management to individuals whose behavior problems relating to impulse control are significant, but not out of control. These are the individuals in Area 2 of Figure 3. They show behavior problems, but not so severe as to require the stabilization services identified in Recommendation 3.

Programs need to access the combined behavior management/habilitation technology which facilitates working with these clients. Several agencies/facilities in this state have already incorporated this technology into their programs. Such programs include LTS&H's Social Skills Center, Southwestern State Hospital's Adult Development Center, Chesterfield's Home Intervention Program, Arlington's community mental health services and Mental Health Services of Roanoke Valley's Kiwanis Group Home for Boys. A listing or library of programmatic resources should be maintained by the Department of Mental Health and Mental Retardation and available through community coordinators and/or a representative from the institutional services division.

The development of behavior management programming should be reinforced by bolstering community program certification standards regarding behavior management. Such standards could require training of staff in appropriate behavior management strategies and the development of specialized in-house programming, aimed at "Area 2" individuals.

5. No beds in training centers that have been certified under ICF/MR regulations should be "decertified." During the open forums, there was frequent discussion of how ICF/MR regulations made it difficult to manage some residents. Review of these regulations (and AC MRDD regulations) show that use of behavior modification programs, physical restraint, and psychotropic medications are permissible and practical. There are certain limitations regarding their use, but none are felt to be so restrictive as to indicate the decertifying of some beds. This can be seen in ICF/MR Regulations 442.404 (f), 442.438, 442.439, 442.440, and 442.441. It may be useful for the department to initiate a meeting for training center executive directors and clinical directors to review the limits of behavior management under ICF/MR regulations. ICF/MR regulations are simply directed toward cautious use of behavioral, physical, and chemical restraint. Such programming should not be used as punishment or as a substitute for treatment.

6. Mentally retarded individuals currently in psychiatric institutions who require no further psychiatric services should be identified as a priority for discharge or, as necessary, for transfer to a training center. Directors from psychaitric institutions should be charged with reviewing their rolls and developing a plan to move such individuals from their facilities. Such plans should include:

A. A list of individuals suitable for discharge to the community and their aftercare needs.

B. A list of individuals to be considered for transfer to a training center.

C. A plan for serving those mentally retarded individuals awaiting transfer to a training center until such transfer is enacted.

D. A timetable for completing discharge or transfer of these patients.

Retarded individuals requiring the services available at a training center should be established as a priority for beds which open up in the training centers. An appropriate formula for accessing the beds should be negotiated with each training center director based on turnover from the facility and community demand for beds. Transfer to training centers could be handled through the Commissioner under Statute 37.1-48.

A major concern is ensuring that those mentally retarded individuals in the psychiatric institutions do in fact receive necessary services/training until such time as they are transferred or discharged. Such programming has been achieved at Southwestern State Hospital's Adult Development Center and it is recommended that other institutions review this program as a potential model for service delivery.

7. In conjunction with the Departments of Special Education, Social Services, and Health, community services boards should implement prevention programming aimed at the impulse control-related behaviors which have led to the dual diagnosis label. Development of problem-solving/behavior, alternative skills, and coping abilities might be incorporated into the spectrum of community mental retardation services. Drop-in centers and community support systems could be developed. Such programming should acknowledge the psychological needs (as opposed to the behavioral problems) of the mentally retarded individual living in the community.

8. Finally, those individuals who show significant behavior problems relating to impulse control should be identified as a priority for case management.

9. A task force composed of institution directors, executive directors from community services boards, central office administration, members of the original task force, and other concerned parties should be convened. This task force would be charged with preparing for the Commissioner of the Department of Mental Health and Mental Retardation an implementation plan for the preceeding recommendations.

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APPENDIX A

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APPENDIX B

Minutes and Written Statements from Open Forum Meetings

Available upon request from the Department of Mental Health and Mental Retardation