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Mental Health/Mental Illness

Dr. Matthew Stanley, Avera Medical Group University Psychiatry Associates, told the committee behavioral health is a broad topic encompassing a variety of conditions including mood disorders, psychotic disorders, and anxiety disorders, all of which he treats as an inpatient psychiatrist. While dementia is often cited as falling under behavioral health, it is a neurodegenerative disorder. Dr. Stanley clarified that individuals with dementia and autism spectrum disorder often end up on a "hold" (involuntary commitment) in a psychiatric facility not based solely on their confused state but because it may be combined with aggressive behavior. Depression can also be a factor in such diagnoses. Although these disorders are not a focus of the committee's study, he noted they do impact South Dakota's mental health system.

According to Dr. Stanley, several behavioral health crises exist in the state: opioid addiction, alcohol abuse, use of marijuana and methamphetamines, and suicide, which is a growing risk for females aged 10 to 14. He commented that suicide is likely beyond the scope of the study but by identifying people at risk earlier and getting them into treatment, individuals may not reach the point of committing suicide. Many South Dakota entities participate in the Zero Suicide program which offers specific tools and strategies health and behavioral health care systems can use to promote suicide prevention.
Referring to the 2015 Helmsley Trust study, Dr. Stanley noted that 17 percent of South Dakotans were identified as having depression episodes with 18 percent suffering from anxiety, making them the most common mental illnesses being treated in the state. Four percent of the state's population have chronic mental health issues while 60 to 80 percent of the inpatients being treated have co-occurring disorders.

Dr. Stanley stated that unlike other forms of illness, patients with behavioral health issues will walk into their doctor's office, tell the provider what is wrong, and then ask for help. Evidence-based monitoring is needed to determine what is working and what is not, and good data is necessary to make effective changes in mental health services and systems. He advised members that access to treatment will continue to be a problem on both a state and national level. Over 60 percent of psychiatrists are age 55 and older, which increases the risk of retiring more practitioners than are being created. New ideas like using telemedicine to communicate with patients in rural areas and developing a system of filters to identify people at risk and determine the appropriate level of care needed, could be endorsed to equalize care statewide.

Senator Soholt requested that the different forms of mental disorders be defined. Dr. Stanley offered the following clarifications:
• Mood disorders. The most common is depression for which there are 8 criteria: having depressed mood more days than not, loss of interest, loss of sleep, loss of energy, change in appetite, feelings of worthlessness or guilt, difficulty concentrating, and thoughts of suicide. To reach the level of diagnosis, the person must experience a disturbance of function, meaning they are unable to complete their duties at home or work and feel distressed.
• Mania. Bipolar disorder is in this category. Symptoms include decreased need for sleep, increased talkativeness, increased assertiveness, and grandiose sense of self. Manic people often do not recognize they are ill and may not follow treatment regimens because they miss getting manic.
• Psychosis. People with this disorder have lost touch with reality and experience hallucinations, delusions, and paranoia. It most typically occurs in the diagnosis of schizophrenia but can also be caused

by the use of stimulant drugs.
• Anxiety. It is the most commonly diagnosed category in behavioral health with generalized anxiety being the most often treated but also includes obsessive-compulsive disorder and panic disorder. Anxiety is recognized by discomfort with activities of daily living or being around others, overwhelming fear, and feelings of being out of control. It can be a common cause of substance abuse.

Dr. Stanley described how a person would move through the mental health system. Genetic, environmental, and supportive factors can contribute to mental disorders, which are primarily diagnosed in late adolescence or early adulthood. As the illness progresses and the person matures, social supports like family and work fall away – they are unable to keep a job, friends and family burn out on coping with the person, etc. Community mental health centers step in to offer case management and community support but the patient will feel increasingly alone. In some cases, it will lead to suicide. According to Dr. Stanley, many suicidal patients never make it to the attention of mental health specialists although 77 percent of people who commit suicide have seen a primary care physician within a year of the suicide and about 44 percent within 30 days of the act. Only 17 percent will have seen a mental health specialist within 30 days of their suicide. He said consistent mental health care from early initiation to illness resolution is needed, as is the recognition that mental illness is a medical illness.

Dr. Stanley specified that mental health and mental illness can co-exist but are not interchangeable terms. Mental health is to feel connected to others and have a sense of accomplishment. Mental illness is a clear medical category that fits specific criteria. Not everyone who is not conforming to societal norms is mentally ill.

Senator Kennedy wondered if mental health and behavioral health are the same. Dr. Stanley replied to the contrary, as behavioral health includes issues like autism that are not mental illnesses.

Responding to Representative Reed as to whether better training for law enforcement could help South Dakota's mental health system, Dr. Stanley conceded that while a lot of good things have been done in that area, more training could be beneficial not only for education but to change the culture in departments, too.

Representative Hunhoff asked for a definition of comorbidity. Dr. Stanley replied that co-occurring disorders is a case in which the patient has a mental illness and a chemical dependency disorder. Sixty to 80 percent of patients admitted to mental health facilities have substance issues as well as a mental illness.

Representative Otten wondered if those individuals who committed suicide and had seen a primary care physician in the previous year suffered from co-occurring disorders. Dr. Stanley did not believe primary care providers were missing signs of suicide in their patients but stressed that co-occurring illnesses such as substance use disorders elevate the risk of suicide. He said consistent screening and the discussion of mental illness during primary care may help to identify those risks earlier.

Dr. Stanley agreed with Senator Solano that improving engagement between primary care physicians and mental health specialists could result in clearer treatment paths for those with mental illness.

Representative Johns inquired if mental illness can run in families. Dr. Stanley responded that it is

difficult to interpret a genetic panel to determine risk but environmental factors can contribute to mental illness in families (depressed mother, alcoholism, physical violence, etc.).