

HOPE FOR TOMORROW

The Collective Approach for Transforming South Carolina's

BEHAVIORAL HEALTH SYSTEMS



South Carolina Institute of
Medicine & Public Health

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ABOUT THE SOUTH CAROLINA INSTITUTE OF MEDICINE & PUBLIC HEALTH (IMPH) BEHAVIORAL HEALTH TASKFORCE

Our **vision** is that South Carolina’s behavioral health system and its supports are accessible, comprehensive, cost-effective, integrated, built on science and evidence-based practice, focused on wellness and recovery and centered on people living with behavioral health illnesses and their families.

The taskforce **mission** is to create lasting improvements in our state’s system of behavioral health services and supports by developing and recommending cost-effective, actionable solutions to existing challenges.

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The South Carolina Institute of Medicine & Public Health (IMPH) is an independent entity serving as a neutral convener around the important health issues in our state. IMPH also serves as a provider of evidence-based information to inform health policy decisions.

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Many people contributed significant time and effort to the South Carolina Institute of Medicine & Public Health (IMPH) Behavioral Health Taskforce. The members of the steering committee were instrumental in framing the issues, leading the process and creating a vision for the future. They demonstrated extraordinary commitment to improving the health and quality of life of people in South Carolina with behavioral health illnesses. Together with the members of the taskforce, the taskforce chair, Mr. Kester Freeman, provided focused leadership to address the human suffering related to access barriers and determination to make actionable recommendations to improve access to a continuum of behavioral health services across South Carolina. The members of each of the committees supported the process through their expertise in specific areas of focus for the taskforce.

LETTER FROM THE CHAIR OF THE BEHAVIORAL HEALTH TASKFORCE

The following report reflects more than a year of work by dedicated behavioral health experts, researchers and advocates from across South Carolina in exploring ways to improve our state's behavioral health systems. As Chair of the Behavioral Health Taskforce, I believe this report represents the most comprehensive and thorough review of behavioral health care that has been produced in our state. The 20 actionable recommendations developed by the taskforce address serious challenges faced by those who are confronted by addiction and mental illness and provide a collective approach for transforming South Carolina's behavioral health systems.

The gaps and inadequacies in our current systems are serious and persist in spite of the laudable efforts of both public and private providers. Together, we must re-shape the way we approach behavioral health issues and services in our state. It is time to recognize the need for crisis care for behavioral health patients in a similar way to the care available for people experiencing a heart attack, stroke, trauma or other physical health crisis. Everyone in our state should have access to the type of care they need, when they need it—regardless of the health issue.

While addressing crisis care is vitally important, it is also essential to ensure that ongoing care is available for those living with chronic behavioral health conditions. Such ongoing care should include adequate outpatient and rehabilitative services, and any approach to supporting people in recovery should include a focus on critical needs such as housing, school-based supports and services for those in the justice system. South Carolina can become a national leader in improving and providing behavioral health care, and the time to act is now.

I would like to thank all of the taskforce members and the steering committee for their dedication to this effort. I want to also thank the Board of Directors of the South Carolina Institute of Medicine & Public Health for their support and endorsement of this report. Although this report represents the culmination of the work of the taskforce, its release marks the beginning of our broader, collective work in transforming South Carolina's behavioral health systems.

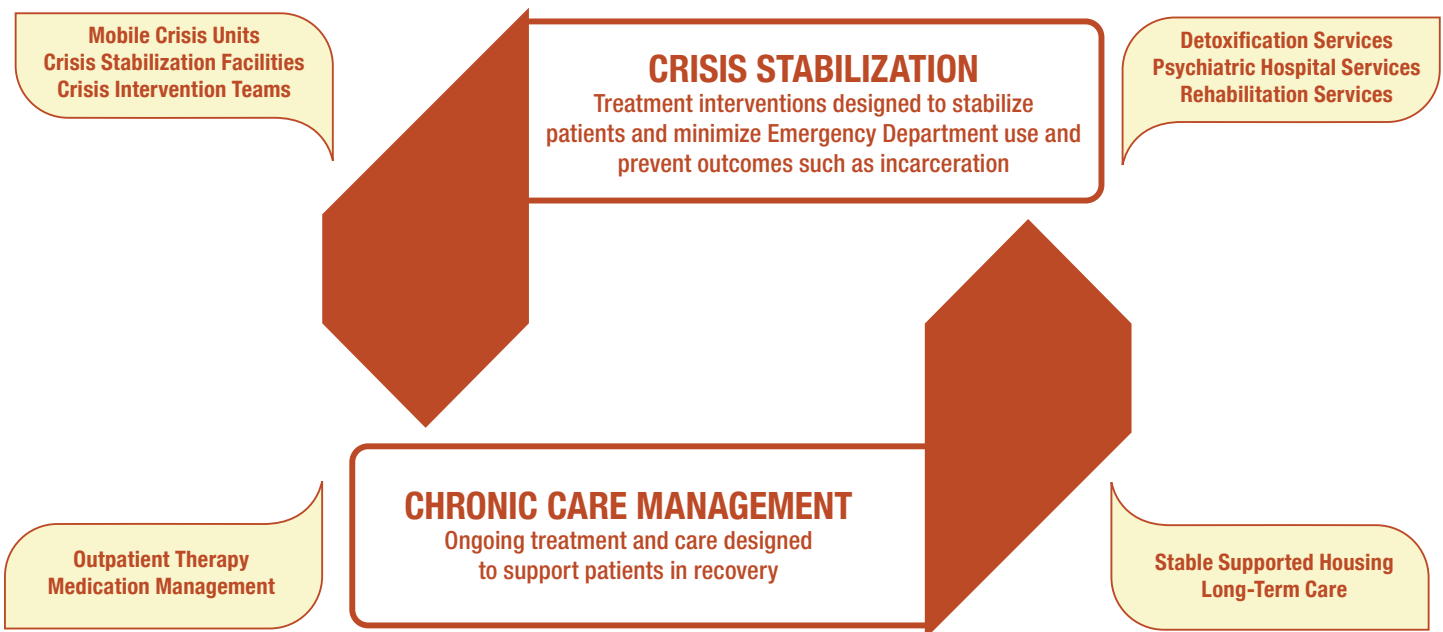


Kester S. Freeman, Jr.
Executive Director, South Carolina Institute of Medicine & Public Health

EXECUTIVE SUMMARY

From September of 2013 through December of 2014, the South Carolina Institute of Medicine & Public Health (IMPH) convened a taskforce of public and private behavioral health providers, researchers and advocates to address the complex challenges of people with behavioral health illnesses. The Behavioral Health Taskforce engaged experts from across our state in exploring critical issues and identifying solutions based on promising practices. The result of this process was the development of actionable recommendations that outline a collective approach for transforming South Carolina's behavioral health systems.

The taskforce created a bold vision for behavioral health in South Carolina based on two focal points: the need for *crisis stabilization services* and the need for a better, more accessible system of *chronic care management*. **This vision depicts a future in which all residents of South Carolina will have equal access to quality services for crisis stabilization and chronic care regardless of their individual means or where they live in the state.** The realization of this vision is essential in creating the continuum of care necessary to effectively treat and support patients with a behavioral health diagnosis. To improve behavioral health access and outcomes in our state, **nothing less than a system transformation is necessary.**



People who have a mental health illness or substance use disorder (SUD) are typically dealing with a chronic condition, and—like people with a chronic physical health illness—they need ongoing care and treatment in their community to regain health and maintain recovery. Patients in all parts of the state who experience a behavioral health crisis must have accessible services at all hours of the day and night. Crisis intervention services must be linked to stabilization services to allow patients experiencing a behavioral health emergency to be treated in an appropriate setting. Referrals and long-term treatment plans must be available to support patients as they leave the crisis care setting. Patients who need ongoing intensive supervision and care must have access to inpatient psychiatric hospital services, rehabilitation services and/or long-term care services. Patients ready and able to live in their community must have adequate supports that enable long-term success, including housing, accessible outpatient services, integrated clinical care and case management/care coordination.

The taskforce developed recommendations to improve the lives of individuals with behavioral health illnesses and their families by recognizing the need for expanded services and supports in a number of environments. This report outlines the status of different components of these systems and describes the recommendations of the taskforce. It is expected that the bulk of these recommendations will be implemented within five years, although some will be accomplished much more quickly while others may take more time. It is the intention of the taskforce and IMPH that lasting improvements to South Carolina's behavioral health systems are made as a result of these recommendations.

Recommendations:

1. Support the expansion of hours at outpatient behavioral health service sites around the state.
2. Increase the number of behavioral health professionals in all settings who are bilingual and can meet the needs of our non-English speaking population.
3. Develop a network of Mobile Crisis Units around the state.
4. Create short-stay crisis stabilization facilities across the state for patients experiencing a behavioral health emergency.
5. Increase the number of freestanding medical detoxification centers and beds to improve access for individuals withdrawing from the physical effects of alcohol and other drugs.
6. Increase bed capacity at existing psychiatric hospitals (both public and private).
7. Increase the capacity of Residential Treatment Centers to support people in their rehabilitation from drugs and alcohol.
8. Develop several small, highly supervised inpatient settings around the state to meet the needs of the small percentage of patients who require long-term care due to behavioral health illnesses that are not controlled and where the potential of violence may exist.
9. Change Certificate of Need (CON) requirements to allow hospitals to convert acute care beds to psychiatry beds without a CON under certain conditions.
10. Create a formal, neutral resource to support communities across South Carolina in defining their plan for care coordination among behavioral health providers and adoption of integrated behavioral and primary health care services.
11. Create a committee to determine how agencies providing behavioral health services can improve their coordination in order to provide more seamless services and maximize client outcomes.
12. Develop a statewide care coordination model for adults with serious behavioral health issues that offers home and community care options and minimizes unnecessary emergency room visits, law enforcement interventions and inpatient hospitalizations.
13. Develop permanent supportive housing units for persons with behavioral health illnesses and their families in integrated settings. In 2013, a target benchmark of 1,745 units was established. It is recommended that the need for this type of housing units be continuously monitored.
14. Secure funding for rental assistance and associated supportive services through rent guarantee contracts or leases with private landlords for persons with behavioral health illnesses and their families. In 2013, a target benchmark of 3,861 units was established. It is recommended that the need for this type of housing unit be continuously monitored.
15. Support an update to the enabling legislation of the South Carolina Housing Trust Fund that will provide more flexibility to state agencies in accessing funds needed to address the affordable housing needs of clients with a mental illness.
16. Create a new, separate taskforce to ensure adequate school-based behavioral health services are available in South Carolina schools.
17. Put into place a system whereby incarcerated adults have their Medicaid benefits suspended rather than eliminated.
18. Increase Crisis Intervention Team (CIT) training for law enforcement across the state.
19. Develop a formal discharge planning process with inmates who have a behavioral health illness.
20. Establish a South Carolina Behavioral Health Workforce Development Consortium to ensure a sufficient workforce of behavioral health professionals in order to support the vision of providing all-hours access to behavioral health services.

COLLECTIVELY, BEHAVIORAL HEALTH DISORDERS AFFECT MILLIONS OF AMERICANS EACH YEAR AND ARE CONSIDERED THE LEADING CAUSE OF DISABILITY IN THE UNITED STATES.¹

“...PEOPLE WITH SERIOUS MENTAL ILLNESS DIE UP TO 23 YEARS SOONER THAN OTHER AMERICANS, GIVING THEM A LIFE EXPECTANCY ON PAR WITH PEOPLE IN BANGLADESH.”⁵

INTRODUCTION

A system transformation is required in South Carolina in order to provide the services needed by people with behavioral health illnesses. A robust continuum of care is necessary to treat and support patients with a behavioral health diagnosis, and our current system is missing several critical elements. People experiencing a mental health or addiction emergency need access to crisis stabilization services such as mobile crisis units, crisis stabilization facilities and detoxification services. Some patients require inpatient psychiatric care or rehabilitation services as the next step toward recovery. Access to services such as outpatient therapy and medication management and/or supportive housing help individuals remain in recovery and prevent relapse into crisis. This service array will enable the behavioral health system to provide higher quality, more cost-effective care to patients.

Areas of focus of the Behavioral Health Taskforce include the need to provide crisis stabilization services and chronic care management and support in the context of:

- 1) Access to clinical services**
- 2) Integrated care**
- 3) Housing**
- 4) School-based services**
- 5) Services for justice-involved individuals**
- 6) Workforce development**

Collectively, behavioral health disorders affect millions of Americans each year and are considered **the leading cause** of disability in the United States.¹ In fact, these chronic diseases will eclipse physical diseases as the leading cause of disability worldwide by 2020.² The financial and human costs of these illnesses are enormous. Behavioral health care costs alone are \$57 billion per year in this country, about the same as cancer related treatment costs.³ The discrimination and stigma associated with these disorders is a barrier to improving systems of care and opening access to those systems; mental illness and substance use disorders (SUD) are not public health conditions that most people want to discuss. Individuals living with a behavioral health disorder often find it difficult to care for themselves or members of their family, complete daily activities, secure employment and manage relationships.⁴ Behavioral health disorders can take a significant toll on the lives of individuals and families and adversely impact communities.⁴

According to Dr. Thomas Insel, director of the National Institute of Mental Health, "...people with serious mental illness die up to 23 years sooner than other Americans, giving them a life expectancy on par with people in Bangladesh."⁵ Some are too sick to manage their behavioral health illness and often suffer with co-morbid physical health conditions. Risk factors for chronic medical conditions such as tobacco use, poor nutrition and sedentary lifestyles are more prevalent among people with a behavioral health illness as are the social conditions that often lead to poor health, such as homelessness and poverty. The current fragmented behavioral health care system and poor medication management are also to blame. People with a mental illness and/or a SUD often have limited access to primary care and are underdiagnosed and undertreated. Far too many end up in inappropriate settings such as hospital emergency departments, jails and prisons, homeless shelters or the street because of inadequate clinical services and community supports.

The Numbers: Mental Illness and Substance Use Disorders (SUD)

COSTS



\$57 BILLION
per year

BEHAVIORAL HEALTH CARE COSTS IN THE U.S.

[About the same as cancer-related treatment costs.^{3]}

MENTAL ILLNESS COSTS \$444 BILLION
per year



In medical care⁵



In societal costs such as lost productivity and disability payments⁵

44%

Of people receiving federal disability payments have a serious mental illness and are too sick to work⁹



INCREASES THE COST OF PHYSICAL HEALTH CARE

60% to 240%

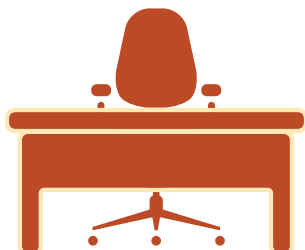
Having depression and a chronic physical health condition (such as hypertension, arthritis, diabetes, heart disease or asthma) increases the cost of care by 60 to 240% compared to costs associated with only the physical health condition.⁶

Adding alcoholism to one of these chronic physical health conditions increases costs by about 65 to 200%.⁶

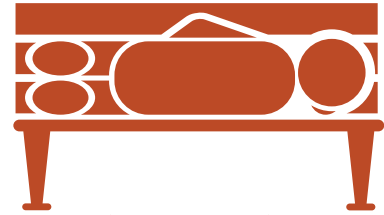
\$120 BILLION
per year

THE SOCIAL COSTS OF SUDs

This includes lost productivity, absenteeism, incarceration, drug-related illness and premature death.⁷



HOMELESS



HAVE AN UNTREATED MENTAL HEALTH ILLNESS



HAVE A SERIOUS MENTAL ILLNESS

Of the approximately 600,000 homeless persons in America, about one-third (200,000 people) have an untreated mental health illness.⁸ One-fifth have a serious mental illness.⁹



Approximately

50%
OF HOMELESS HAVE A SUD¹⁰

Approximately

70%
OF HOMELESS VETERANS HAVE A SUD¹⁰



INCARCERATION



56%

OF STATE PRISONERS
ACROSS THE COUNTRY

HAVE A MENTAL ILLNESS¹¹

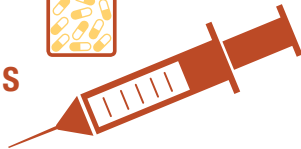
U.S. Bureau of Justice reported

16% OF THE TOTAL
JAIL AND PRISON
POPULATION IN THE
U.S. HAVE AN

**UNTREATED
MENTAL ILLNESS**

(about 300,000 people)⁸

65%
OF U.S. INMATES
HAVE A SUD



85% Are considered to be
SUBSTANCE INVOLVED*

*Ranges from having a diagnosable SUD, having committed a crime to acquire drugs or alcohol, being incarcerated for a drug or alcohol violation or being under the influence when committing the crime for which they were arrested.¹²

40%

**OF ADULTS WITH A SERIOUS
MENTAL ILLNESS ARE
ARRESTED AT SOME POINT**

...because of symptoms of their illness,
rather than an intent to harm.¹³

According to the National Alliance on Mental Illness.



EMERGENCY DEPARTMENTS



**12
million**

EMERGENCY DEPARTMENT VISITS

The Agency for Healthcare Research and Quality (AHRQ) reported that behavioral health diagnoses accounted for nearly 12 million Emergency Department (ED) visits in 2007, or 12.5% of the total ED visits in the U.S.¹⁴

OF THESE VISITS



due to
**MENTAL
ILLNESS**



due to a
SUD



due to
**CO-OCCURRING
DISORDERS¹⁴**

NATIONALLY

62%

of adults with a
**MENTAL HEALTH
CONDITION¹⁵**

90%

of people
WITH A SUD¹⁶

**DO NOT GET
TREATMENT**

Funding and utilization trends indicate the situation is even worse in South Carolina. Despite the efforts of many dedicated behavioral health professionals across South Carolina, treatment options and supportive services in this state are inadequate. Residents with a behavioral health illness need mechanisms to support early identification, crisis care, rehabilitation services and long-term chronic care management, therapy and treatment. A targeted focus on improving the system of crisis care services and long-term supportive services will serve to make this a reality.

NEARLY ONE IN FIVE AMERICANS HAVE A MENTAL ILLNESS. ONE IN TWELVE HAVE A SUBSTANCE USE DISORDER.¹⁸

BACKGROUND

In *Leading Change: A Plan for SAMHSA's Roles and Actions 2011–2014*, the Substance Abuse and Mental Health Services Administration (SAMHSA) defines behavioral health as “a state of mental/emotional being and/or choices and actions that affect wellness.”¹⁷ Behavioral health illnesses include both mental health illnesses and substance use disorders (SUD). Although these diseases are chronic and result in a range of problems, recovery is possible with appropriate treatment and support.¹⁷ The conditions and illnesses included under the behavioral health umbrella affect millions of Americans each year. In an effort to quantitatively identify the scope of behavioral health challenges in the U.S., SAMHSA administers the National Survey on Drug Use and Health (NSDUH), an annual survey of the civilian, non-institutionalized population of the United States aged 12 years old or older.¹⁸ Data gleaned from this survey provides critical information on mental health conditions, SUDs, illicit drug and alcohol use and co-occurring diseases.

According to the 2013 NSDUH, nearly one in five Americans (43.8 million people) reported having any mental illness in the past year.¹⁸ A person with any mental illness is defined as “any individual having any mental, behavioral or emotional disorder in the past year that met DSM-IV criteria (excluding developmental and substance use disorders).”¹⁸ Of the 43.8 million people with any mental illness, 10 million reported having a serious mental illness (SMI).¹⁸ Disorders included under the SMI category include major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic disorder, posttraumatic stress disorder (PTSD) and borderline personality disorder.¹⁹ NSDUH also found that one in twelve Americans have a SUD.¹⁸ A SUD is defined as dependence on or abuse of alcohol or illicit drugs (marijuana/hashish, cocaine, heroin, hallucinogens, inhalants or prescription-type psychotherapeutics [pain relievers, tranquilizers, stimulants and sedatives] used non-medically).¹⁸

Table 1 outlines the prevalence of SUDs and mental illness in the U.S. and in South Carolina.

Table 1: Substance Dependence or Abuse and Mental Health Disorders by Age Group in South Carolina and the United States

Percentages, Annual Averages Based on 2012 and 2013 NSDUHs

	12–17	18–25	18+
	%	%	%
Illicit Drug Dependence or Abuse (1)			
SC	3.85	7.34	2.80
US	3.76	7.59	2.60
Alcohol Dependence or Abuse			
SC	3.01	11.87	6.29
US	3.11	13.67	7.08
Had at Least One Major Depressive Episode (2)			
SC	9.44	8.05	6.46
US	9.86	8.81	6.77
Serious Mental Illness (3)			
SC		4.23	4.38
US		4.17	4.14
Any Mental Illness (4)			
SC		17.76	18.04
US		19.50	18.53
Had Serious Thoughts of Suicide			
SC		7.14	4.07
US		7.33	3.89

(1) Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants or prescription-type psychotherapeutics used non-medically. Illicit drugs other than marijuana include cocaine (including crack), heroin, hallucinogens, inhalants or prescription-type psychotherapeutics used non-medically. These estimates include data from original methamphetamine questions but do not include new methamphetamine items added in 2005 and 2006. See Section B.4.8 in Appendix B of the Results from the 2008 National Survey on Drug Use and Health: National Findings.

(2) Major depressive episode (MDE) is defined as in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), which specifies a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. There are minor wording differences in the questions in the adult and adolescent MDE modules. Therefore, data from youths aged 12 to 17 were not combined with data from persons aged 18 or older to produce an estimate for those aged 12 or older.

For details, see Section B of the “2011–2012 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology” at <http://www.samhsa.gov/data/NSDUH/2k-12State/NSDUHsae2012/Index.aspx>.

(3) SMI is defined as having a diagnosable mental, behavioral or emotional disorder, other than a developmental or substance use disorder, that met the criteria found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and resulted in serious functional impairment.

(4) Any mental illness (AMI) is defined as having a diagnosable mental, behavioral or emotional disorder, other than a developmental or substance use disorder, that met the criteria found in the 4th edition of the Diagnostic and Statistical Manual

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012–2013

Unfortunately, substance use and mental health disorders often do not occur independently of one another.

In fact, 7.7 million Americans have co-occurring disorders; the simultaneous occurrence of one or more substance use disorders and one or more mental illnesses.¹⁸ Although one disorder does not necessarily cause the other, it is important to consider the following: 1) mental illness can lead to the use and abuse of drugs as an attempt to self-medicate, 2) substance use and mental health disorders share many of the same root causes (genetics, brain deficiencies and environmental factors [i.e., early exposure to trauma]) and 3) illicit drug use can cause an individual to experience symptoms of a mental illness.²⁰ What is known with certainty is that people with a mental health disorder are at increased risk of developing a substance use disorder and vice versa.²⁰

Addressing the complexities of a co-occurring disorder can be an arduous undertaking, particularly when attempting to unravel the symptoms and determine an accurate diagnosis. Individuals with co-occurring disorders are often more likely to be non-compliant with treatment protocols and have poorer outcomes than individuals with only one mental illness or substance use disorder.²¹ Indicators of poor outcomes include increased rates of unemployment, arrests, emergency department visits and residential instability.¹⁹

In reviewing the myriad public health concerns in this state, the board of the South Carolina Institute of Medicine & Public Health (IMPH) endorsed developing a taskforce around the subject of behavioral health in 2013.

Because of the substantial numbers of individuals and families affected and the significant societal and health care costs, the IMPH board and leadership determined that behavioral health should be a priority for the organization. During the fall of 2013, IMPH convened the 20 member Behavioral Health Steering Committee to identify the specific topics requiring exploration and problem solving. At the beginning of 2014, a full taskforce comprised of more than 60 behavioral and mental health professionals and stakeholders from across South Carolina was convened to address a set of priority areas related to improving care and outcomes to better serve residents with behavioral health illnesses. Based on the priority areas identified by the steering committee in the fall of 2013, two committees were established (Community Resources and Integrated Care) to identify potential solutions by examining best and promising practices from South Carolina and other states.

The Community Resources Committee was co-chaired by Ms. Joy Jay (Director, Mental Health America of South Carolina) and Hon. Amy McCulloch (Judge, Richland County Mental Health Court and Co-Founder, Partners in Crisis). The aim of the committee was to establish recommendations related to the availability, integration and success of community resources for individuals and families needing behavioral health services. Housing, school-based services and services for justice-involved individuals were the primary focus areas. The Integrated Care Committee was co-chaired by Ms. Ann-Marie Dwyer (Director, Behavioral Health Services, South Carolina Department of Health and Human Services) and Dr. Ligia Latiff-Bolet (Director, Quality Management and Compliance, South Carolina Department of Mental Health). The aim of this committee was to establish recommendations related to care coordination and integration for individuals and families that need behavioral health services. The Integrated Care committee examined the issues of continuity of care amongst behavioral health providers and the need to better integrate behavioral health and primary care.

The steering committee oversaw the work of these two committees and considered the topics of access to clinical services and the behavioral health workforce. The Behavioral Health Taskforce is chaired by Mr. Kester Freeman, Jr., and the IMPH board liaison is Dr. Gerald Wilson. The recommendations provided in this report are a direct result of the work of the taskforce. The steering committee voted unanimously on all of these recommendations in December of 2014. Please see Appendix B for a full list of taskforce participants. Additionally, the minutes of each meeting for each committee of the taskforce are available at www.imph.org.

ACCESS TO CLINICAL SERVICES

It is the vision of the Behavioral Health Taskforce that we build upon current infrastructure to create a system that can provide all-hours access to clinical behavioral health services for every resident of South Carolina.

In recent years, states have stripped away both the community behavioral health services meant to keep people healthy and the hospital care needed to help them heal after a crisis.^{22,23} As states eliminate services for people with behavioral health illnesses, many of those individuals end up homeless or in emergency departments, jails and prisons.²⁴

The Behavioral Health Taskforce is recommending a transformation in the way that behavioral health services are provided in South Carolina. Systems and services must be in place that allow patients in crisis to easily access services through mobile crisis units, crisis stabilization facilities and detoxification centers. Inpatient psychiatric hospital and rehabilitation center capacity must be increased to care for patients whose needs exceed three to five days of inpatient care. Long-term care must be available for the small number of patients who may never be able to live independently. Finally, chronic care management must be available and readily accessible to all who need these services in order to help them gain or maintain success living independently in the community setting. This goal can be supported through improved access to outpatient services and community care such as supportive housing.

Background

The recent recession had a harmful impact on all aspects of health care, most notably the public behavioral health system. From 2009 to 2012, most states experienced significant cuts in non-Medicaid state mental health funds.²² States cut \$5 billion from mental health services during this time along with 10% of psychiatric hospital beds.¹³ South Carolina was no exception. Between 2008 and 2012, state appropriations for the South Carolina Department of Mental Health (DMH) were reduced by over \$86 million; a decrease of 39%.²³ In fact, South Carolina had the largest percentage of general fund public mental health budget cuts in the nation.²⁵ Similarly, the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) experienced a 51.2% decrease in state funding between 2008 and 2013, totaling approximately \$6.75 million.^{26,27} See Appendix A for detailed information about the budgets of the public mental health and substance abuse services systems in South Carolina.

The availability of funding impacts what services are offered and who is eligible to access these services. The severity of the recent funding cuts created a crisis in mental health care for many states. Vital services and supports such as community outpatient care, hospital-based psychiatric treatment, medication assistance and supportive housing were reduced or eliminated. Many clinical staff positions were also cut.²² As a result, countless people were not receiving the mental health services and supports they needed. Communities began to feel the impact of these limited services as homeless shelters, emergency departments and jails and prisons struggled to care for an increasing number of individuals living with a behavioral health illness.²⁵

In fiscal year (FY) 2012, DMH's operating revenue fell to its lowest level since FY 2005.²³ Funding trends began to change in 2013 when South Carolina experienced an increase in state mental health operating revenue.²³ Although an important step in the right direction, **more needs to be done to support our public systems of mental health and substance abuse services.** States—including South Carolina—face challenges as they work to establish and re-establish services and programs that focus on treatment during behavioral health crises and foster recovery and independence.

To understand the challenges confronting the current behavioral health delivery system, it is important to understand the history of mental health treatment in the U.S. and the factors that led to the deinstitutionalization movement.

During the late 19th and early 20th centuries, state asylums were considered the most appropriate setting for individuals with a serious, chronic mental illness. These institutions were the responsibility of cash-strapped local and state governments. Often, they were inadequately funded, understaffed and over-populated. In many instances, living conditions were poor and treatment of mentally ill patients was considered inhumane.²⁸

During the 1950s, several events marked the beginning of momentous change in the U.S. mental health system. Anti-psychotic drugs were introduced as a breakthrough in the treatment of mental illness. Symptoms of schizophrenia, bipolar disorder and psychosis could be diminished or controlled by medication, allowing many patients to be discharged from hospitals and monitored and treated in a community setting.²⁹ During this same time, several high profile reports, articles and exposés were published highlighting the sub-standard living conditions found in some state asylums. These reports began to focus the nation's attention on the serious problems confronting the U.S. mental health system.³⁰ Motivated by the promising results of anti-psychotic medications, damaging publicity and the potential of providing better and more cost-effective treatment through comprehensive community care, states began to move patients out of these state asylums.²⁸ In 1955, state mental hospitals housed 558,922 patients and by 1980, that number had fallen to 154,000.³¹

The evolution of federal mental health policy furthered the progression of deinstitutionalization. In 1946, President Truman signed into law the National Mental Health Act, which created the National Institute of Mental Health and provided federal funds for psychiatric education and research.²⁸ In 1963, the Mental Retardation Facilities and Community Mental Health Centers Construction Act (Public Law 88-164) was signed by President Kennedy.²⁹ This law represented a shift in federal policy from institution-based mental health treatment to a community-based system of care.³¹ The 1963 law provided federal funds to construct Community Mental Health Centers (CMHC) with additional funds allocated for staffing in 1965.²⁸ States continued to be responsible for funding and operating long-term institutional services.²⁹

Medicaid and Social Security Disability Income benefits also became significant drivers of deinstitutionalization. When the Medicaid program began to in 1965, coverage was extended to psychiatric services provided in general hospitals while simultaneously excluding coverage for psychiatric treatment in institutions of mental diseases (this rule still applies today).²⁹ Overall, this was viewed as a positive trend as general hospitals offered short-term treatment close to both the person's home and to subsequent outpatient treatment. Psychiatric care in general hospitals nearly doubled between 1955 and 1977, while state mental hospital usage declined by 30%.³² Medicaid rules also encouraged a transition for patients with a serious mental illness from state mental hospitals to nursing homes, which were viewed as a more humane and less costly treatment setting because of the federal match.³¹ In 1972, the Supplemental Security Income (SSI) disability benefits program began to provide direct financial support for housing and other living expenses for eligible individuals with disabling mental illness living in a community setting.²⁹

During the 1970s, legal action also influenced deinstitutionalization. Lawsuits were filed to address civil rights violations of persons with mental illnesses. Court rulings limited involuntary hospitalization, made states monetarily liable for inadequate care in state mental hospitals, established minimum requirements for care and treatment within state facilities and ordered care be provided in the least restrictive environment to meet individual needs.²⁹

Many people with mental illness successfully transitioned from institutional care to community-based support and treatment because of deinstitutionalization. However, problems arose when funding (state and federal) was not sufficient to provide the staff and services required to treat mental health needs through CMHCs.³¹ Community-based care fell short in providing necessary services and many individuals with mental illness found integration into the community to be a struggle. In addition, policymakers did not provide the array of services individuals with mental illness need to live successfully in the community setting because they did not understand those needs.³¹ Although health insurance policies and public programs provided some coverage of mental health services and treatment, that coverage was limited.³¹ The deinstitutionalization model was much more complex and costly to implement than the original supporters ever anticipated.

Throughout the 80s and 90s, a better understanding emerged regarding the services that are vital to the care of the mentally ill. Revisions and amendments to Medicaid, Medicare and SSI and the passage of the Americans with Disabilities Act and Fair Housing Act resulted in improved services and benefits to patients with a mental health illness.³³ However, a considerable amount of work still needs to be done if the vision of the Community Mental Health Act is to become a successful reality.

Access to Clinical Services in South Carolina

In South Carolina, access to behavioral health services appears to be even more difficult than national indicators reflect. One indicator of access is the “penetration rate”—the extent to which the public mental health system reaches people who need mental health services. As Table 2 demonstrates, South Carolina’s penetration rate is lower than the national average, and until 2013, was headed in the wrong direction.

Table 2: Public Mental Health Service Penetration Rates, South Carolina and U.S., 2010–2013

	2010	2011	2012	2013
South Carolina penetration rate per 1,000 population	19.52	17.06	16.36	16.79
United States penetration rate per 1,000 population	21.94	22.10	22.67	22.77

Source: Center for Mental Health Services Mental Health National Outcomes Measures (NOMS)

South Carolina also spends less on public mental health and substance use disorder services than national averages. In FY 2012, South Carolina spent \$57.07 per capita on public mental health expenditures, ranking 44th among states.ⁱ The national average that year was \$127.00 per capita.³⁴ In FY 2006, South Carolina spent \$1.39 per capita on substance abuse and addiction services, including prevention, treatment and research. This ranked the state 46th. The national per capita spending average that year was \$10.64.³⁵

Mental Health America recently reported that South Carolina ranks 43rd out of 51 states (the District of Columbia is included) in accessibility to mental health services.³⁶ This calculation includes access to insurance, access to treatment, quality and cost of insurance, access to special education and workforce availability. They also concluded that South Carolina ranks 48th in terms of the proportion of children who needed but did not get mental health services.³⁶

Improvements to the private system of behavioral health services are important, but strengthening public behavioral health systems is crucial to the treatment of individuals with behavioral health illnesses. People without private insurance or other ways to pay for care in the private sector rely on the public system. It must be ready to meet the needs of the population in an effective and efficient manner. As the following recommendations outline, this requires a significant re-investment into clinical services.

ⁱNote that each state’s mental health system is unique. While each state system may include components of inpatient and community mental health services, the infrastructures delivering those services often vary significantly. Such variances reduce the reliability of certain data and any corresponding comparisons, especially macro-level comparisons. For example, South Carolina is one of only a few integrated systems. Many other states have decentralized and privatized large components of their mental health delivery systems. Each of these differences in infrastructure allow for variations in reporting, which creates the possibility that submitted data may not accurately capture all mental health expenditures in a state, or may not allow for appropriate comparisons. Idiosyncratic to South Carolina: there are other state agencies that also provide mental health services whose data would not be captured by DMH as the State Mental Health Authority (SMHA); there are significant amounts of Medicaid expenditures associated with mental health services that do not flow through the SMHA; and, there are other large mental health service providers receiving both state appropriated funds and Medicaid funds that do not fall under the purview of the SMHA. Each of these instances affects the comprehensiveness of the reporting and validity of comparing state expenditures. Consequently, certain survey results could understate the mental health continuum in a state.

RECOMMENDATIONS RELATED TO ACCESS TO CLINICAL SERVICES

1. Support the expansion of hours at outpatient behavioral health service sites around the state.

The community utilization rate demonstrates how many people per 1,000 accessed public outpatient mental health services. The data in Table 3 indicate that South Carolina's utilization rate of community-based public mental health services falls below the U.S. average. The declining rate between 2010 and 2012 is likely a result of access barriers and parallels the chronology of the state mental health agency experiencing significant budget cuts.

Most people with a behavioral health illness need ongoing treatment, monitoring and counseling. It is important to make these services as accessible as possible in order to keep people healthy and able to live successfully in the community. One key aspect in providing accessible services is the hours of operation. Patients who are paid hourly and/or have little or no sick leave benefits often need after-hours services. Many individuals, especially the most vulnerable, have transportation and/or child care challenges and must work outpatient appointments into their schedule with a degree of flexibility.

Currently, very few community mental health clinics in South Carolina provide any care after 5:00 p.m. or on weekends. In fact, the CMHCs in Greenville, Columbia and Spartanburg—three of the largest communities in the state—operate Monday through Friday from 8:30 a.m. to 5:00 p.m. The Charleston/Dorchester Community Mental Health Centers are unique in their ability to provide evening and weekend hours and may serve as a viable service model for other centers in the state.

2. Increase the number of behavioral health professionals in all settings who are bilingual and can meet the needs of our non-English speaking population.

South Carolina's Latino population grew 154% between 2000 and 2011, the second fastest growth rate in the country.³⁷ Language and culture differences, along with fear brought on by public policies, can cause access barriers for this population to all types of social services, including public mental health services. There are few bilingual staff in the public behavioral health system, especially in the rural areas of South Carolina.³⁸

During 2014, DMH worked with PASOs—a statewide non-profit organization that helps the Latino community and service providers work together for strong and healthy families—and a group of over 25 advocates from around South Carolina worked to assess the needs of this population and strategize solutions. This coalition developed a Cultural and Linguistic Competence Strategic Plan for DMH. A key component of this plan is to implement special recruitment efforts to hire bilingual frontline staff and mental health professionals.

Efforts to train and recruit bilingual professionals into the behavioral health services system must continue to be a high priority.

3. Develop a network of Mobile Crisis Units around the state.

South Carolina's Emergency Departments (ED) experienced 41,333 discharges in 2003 for patients with a primary diagnosis of a behavioral health condition. This number rose to 63,482 in 2013 and 38% of these patients were self-pay/indigent.³⁹ This phenomenon has a significant impact on the operation of hospital EDs and significant cost implications for hospitals.

“Many people having behavioral health episodes also wind up in emergency departments because they either lack health insurance or can't afford primary physician care.”⁴⁰ Behavioral health crisis services should be available in every community. Instead of presenting in the ED of the closest hospital, behavioral health patients experiencing a crisis should be seen immediately by a behavioral health professional. Forty percent of people experiencing a behavioral health crisis do not need acute medical treatment.⁴⁰

A mobile crisis team has been operating in Charleston through DMH since the 90s, diverting about 2,080 visits from local EDs each year, avoiding a cost of \$1,500 or higher per visit. DMH estimates that they are able to bill Medicaid for 22% of the program costs. This program provides significant cost savings because patients are treated in a more appropriate, less expensive setting than the ED. It is recommended that this model be replicated around the state.

Table 3: Public Mental Health Service Community Utilization Rates, South Carolina and U.S., 2010–2013

	2010	2011	2012	2013
South Carolina utilization rate per 1,000 population	19.16	16.85	16.19	16.64
United States utilization rate per 1,000 population	20.86	21.17	21.67	22.09

Source: Center for Mental Health Services Mental Health National Outcomes Measures (NOMS)

The South Carolina Department of Health and Human Services (SC DHHS) is requesting \$3,648,000 in the state budget for FY 2016 to implement Community Crisis Response and Intervention (CCRI). If CCRI is approved in the final SC DHHS budget for FY16, SC DHHS would contract with DMH to stand up CCRI statewide by utilizing the DMH Community Mental Health Center (CMHC) infrastructure. These state funds would cover an estimated 78% of the costs. In the long-term, SC DHHS intends to file a Medicaid State Plan Amendment with the Centers for Medicaid and Medicare Services (CMS) under the 1915(i) option to cover this service. Since this program will cover all of the state’s residents regardless of insurance, ground floor funding will be essential in sustaining the CCRI long term.

4. Create short-stay crisis facilities across the state for patients experiencing a behavioral health emergency.

People experiencing a behavioral health crisis—who may be psychotic and/or suicidal—need somewhere to turn other than their local ED, since EDs are not typically staffed with behavioral health professionals and are not the appropriate setting for the care of these patients. For patients with needs beyond what the mobile crisis unit can provide, DMH previously ran a short-stay facility in Charleston from 1999 to 2009 with an average length of stay of 72 hours.⁴¹ The community is planning to re-open this facility pending licensure approval by the South Carolina Department of Health and Environmental Control (DHEC). This facility will help divert individuals needing crisis stabilization from EDs and those needing a step-down from the hospital setting. DMH’s CMHCs, local hospitals and other stakeholders must work together in other areas across the state to create a similar type of resource for their communities. A new licensure category should be created by DHEC to allow for a seamless process in getting authorization to open and operate such facilities, as they are a key component of the continuum of care that is needed to treat patients experiencing a behavioral health crisis.

5. Increase the number of freestanding medical detoxification centers and beds to improve access for individuals withdrawing from the physical effects of alcohol and other drugs.

DAODAS coordinates an array of community-based intervention and treatment services by subcontracting with 33 county alcohol and drug abuse authorities as well as other public and private service providers. Detoxification is one of the services offered as part of the DAODAS coordinated system of care.²⁶

Detoxification services assist an individual through the process of eliminating alcohol or other drugs from the body while minimizing physical and psychological risk.⁴² For many suffering from addiction, detoxification is the first stage of recovery and must be completed before a treatment or rehabilitation plan can begin.⁴³ The symptoms, risks and complications associated with detoxification can vary in severity and discomfort depending on the substance used. A range of detoxification services are needed in order to provide the appropriate level of care for those seeking help.

There are four freestanding medical detoxification facilities operating in South Carolina under the DAODAS umbrella with locations in Charleston, Greenville, Richland and York counties.⁴⁴ These short-term residential facilities provide 24-hour medical monitoring and support, structured counseling, medication management (if needed) and referral for rehabilitation/treatment.⁴² Under current federal law, the Institutions for Mental Disease (IMD) exclusion does not permit Medicaid reimbursement for services provided to adults (age 22 to 64) with a mental illness or a drug or alcohol addiction in facilities with 17 or more beds.⁴⁵ As a result, the bed count in each of the four freestanding medical detoxification facilities in South Carolina does not exceed 16. In total, there are 58 beds available in these four facilities.⁴⁴

Social detoxification facilities offer withdrawal support from alcohol and other drugs by providing 24-hour

Table 4: ED Visits for Alcohol and Drug Withdrawal by Payer Source

	Insurance		Medicaid		Medicare		Self-pay/Indigent		Total	
	Discharges	Charges	Discharges	Charges	Discharges	Charges	Discharges	Charges	Discharges	Charges
2007	566	\$1,140,278	306	\$573,088	446	\$899,363	969	\$1,917,810	2,287	\$4,530,540
2013	605	\$2,155,825	568	\$1,878,268	687	\$2,694,037	1,756	\$6,643,835	3,616	\$13,371,966

Source: South Carolina Revenue and Fiscal Affairs Office

observation, medical backup, structured counseling and referral to rehabilitation treatment. In contrast to medical detoxification, this process does not require direct medical supervision and does not involve a detox medical professional prescribing detoxification medications.⁴⁶ In the past, the DAODAS’s county alcohol and drug abuse authorities operated seven social detoxification centers. Since 2010, six of the seven have closed and the last will soon transition to a residential treatment facility. Change in Medicaid billing and reimbursement required by CMS was a significant factor in these closings. The detoxification centers in Charleston and York counties provide both medical and social detoxification services.

Options for detoxification services have decreased in recent years, particularly for the uninsured and those with limited income. Individuals have increasingly turned to hospitals as a safety net provider for assistance with withdrawal from alcohol and other drugs. For self-pay/indigent patients, ED visits for alcohol and drug withdrawal have almost doubled since 2007 and charges have more than tripled.⁴⁷

The need for comprehensive and accessible detoxification services is persistent and growing. According to the South Carolina State Health Plan: “A projected need for freestanding medical detoxification beds exists in almost every service area in the state. In addition, more facilities are needed for the services to be accessible within sixty (60) minutes travel time for the majority of state residents.”⁴⁶ As a critical part of the recovery process, these service needs must be addressed in order to achieve the best possible treatment outcomes for those struggling with addiction.

6. Increase bed capacity at existing psychiatric hospitals (both public and private).

Acute care for patients with a mental illness often must be addressed in a hospital setting. DMH inpatient facilities cannot utilize all the beds licensed to them due to limitations in staffing resources. The available beds are

operating at capacity, as are the psychiatric units of many private hospitals across the state.⁴⁶ Both public and private psychiatric hospitals have been reducing beds for decades across the country. In 1955, there was one psychiatric bed for every 3,000 Americans; but by 2005, there was one psychiatric bed for every 30,000 Americans.⁴⁸

The utilization rates of public mental health hospitals demonstrate a declining trend in South Carolina and nationally, and the rate of use in South Carolina is much lower than the national average. This is likely a result of access barriers caused by significant budget and human resource cuts and not a demonstration of less need for services.

The cost of operation and the historical lack of parity between physical health benefits and mental health benefits for the insured have been barriers to successfully operating psychiatric beds. There are a number of private and for-profit hospitals across South Carolina providing this service but uninsured patients typically rely on the public safety net of DMH facilities.

The availability of psychiatric beds in the publicly funded mental health system and in community hospitals needs to be increased to meet the needs of the adult population; children covered by Medicaid have access to Psychiatric Residential Treatment Facilities (PRTF). When a bed is not available, the person in need of this bed may be held in an ED for days and sometimes weeks. This setting is typically not conducive to the treatment of or recovery from a mental health crisis.

7. Increase the capacity of Residential Treatment Centers to support people in their rehabilitation from drugs and alcohol.

Although often an important first step in recovery, detoxification does not address the fundamental components of addiction or assist patients with developing skills needed to reintegrate into society without alcohol or drugs. These issues are addressed in rehabilitation

Table 5: Public Mental Health State Hospital Utilization Rates, South Carolina and U.S., 2010–2013

	2010	2011	2012	2013
South Carolina state hospital utilization rate per 1,000 population	.52	.58	.47	.39
United States state hospital utilization rate per 1,000 population	.51	.50	.48	.47

Source: Center for Mental Health Services Mental Health National Outcomes Measures (NOMS)

and treatment.⁴³ DAODAS, through its network of county authorities and providers, delivers residential treatment services as one of a range of options to address a client’s treatment and rehabilitation needs.⁴²

Residential treatment facilities offer 24-hour observation, monitoring and treatment in a stable and supportive environment. Clients have access to services that address specific medical and/or emotional problems and improve the client’s ability to organize and complete daily living tasks.⁴² Treatment plans are developed to support recovery and successful transition back to the community.⁴⁶ Individuals served in this setting require more intensive treatment than can be provided in outpatient care.⁴²

DAODAS and its county authorities support four residential treatment facilities for women and children in Greenville, Charleston, Colleton and Florence counties. These facilities are designed with special accommodations for mothers and a designated number of young children.⁴² Women often experience multiple barriers to accessing treatment and encounter these barriers more often than men. Economic concerns, family responsibilities and overcoming the stigma of substance use are the most significant access barriers that these specialized facilities attempt to mitigate.⁴⁹ There are also two residential treatment programs exclusively for women in Horry and York counties.⁴² All of these residential treatment facilities are subject to federal IMD exclusion laws and maintain a bed count of 16 beds or less to qualify for Medicaid reimbursement.⁴²

The National Survey of Substance Abuse Treatment Services (N-SSATS) reports the utilization rate for residential facilities in South Carolina was 97.9% in 2012, indicating these facilities are operating at capacity.⁵⁰ Bed availability and geographic location are both critical factors affecting access to residential treatment services in South Carolina.

Although women with young children have several residential treatment options around the state, there

are relatively few options available for men and women without young children. Morris Village (a DMH facility), Holmesview and Palmetto Center (both South Carolina Vocational Rehabilitation Department facilities) can provide residential treatment for men and women without young children; however, these facilities are subject to federal IMD exclusion laws and are not eligible for Medicaid reimbursement because they have more than 16 beds. Utilization is high in these facilities with Morris Village, which has 96 functional beds reporting an average daily census of 92.4 in 2014.²³ N-SSATS reported that the hospital inpatient utilization rate for facilities providing substance abuse treatment in South Carolina in 2012 was 100.4%. The N-SSATS hospital inpatient utilization rate was calculated using reports on clients served in substance abuse facilities on March 30, 2012. Based on these reports, there were 283 inpatient beds designated for substance abuse treatment and 284 substance abuse treatment clients.⁵⁰

Referral and placement in an appropriate treatment setting (whether outpatient, residential or inpatient) is key to successful recovery from substance use disorders. Residential treatment is an important component of the recovery plan for many suffering from addiction and should be an available option for those needing this level of care. When faced with limited access to needed services, many individuals are less likely to seek appropriate treatment. This contributes to poor outcomes, including relapse to substance use.⁴⁹

8. Develop several small, highly supervised inpatient settings around the state to meet the needs of the small percentage of patients who require long-term care due to behavioral health illnesses that are not controlled and where the potential of violence may exist.

It is estimated that up to 400 people in South Carolina need this type of supervised living arrangement due to severe behavioral health illnesses that are not well regulated with medication and other treatment. Some of these individuals

are veterans and have post-traumatic stress disorder. The South Carolina Veterans Administration reports serious difficulty in finding long-term placement for patients in this category.

9. Change Certificate of Need (CON) requirements to allow hospitals to convert acute care beds to psychiatry beds without a CON under certain conditions.

A change in the state's CON law will provide private and non-profit community hospitals the flexibility they need to meet the needs of people presenting in their EDs with a behavioral health crisis. A number of stakeholders support reform of the current CON program and are recommending that the General Assembly make changes that would enhance and streamline the current process. One key issue that needs to be addressed is hospitals across the state that hold psychiatric patients in their ED because there are not enough options available to place these patients in settings that are more suitable. Hospitals would be able to better address the behavioral health needs of their community and those patients seeking care in the ED for psychiatric and substance abuse services if, under certain conditions, the CON requirement could be waived for:

- An acute care hospital wanting to make a one-time conversion of a limited number of acute beds to psychiatry beds.
- An existing hospital that currently provides inpatient psychiatric services wanting to expand its existing inpatient psychiatric capacity.

INTEGRATED CARE

The Behavioral Health Taskforce envisions improved care and outcomes and reduced costs for patients with behavioral health illnesses through increased integration of behavioral health and primary care services and improved care coordination among behavioral health providers.

Behavioral health and physical health are not separate. Unfortunately, traditional systems of care act as though mental health illnesses and/or substance use disorders are independent of physical health and operate in silos. Behavioral health providers are working toward integrated behavioral and primary health care and improved care coordination to address this systemic challenge.

According to a national report from the Substance Abuse and Mental Health Services Administration (SAMHSA): "... individuals with both physical and behavioral health conditions are served by fragmented systems of care with little to no coordination across providers, and little to no coordination across systems. This fragmentation leads to poor quality, disparate financing and higher cost of care, as well as poor health, reduced productivity and higher costs for businesses and publicly funded systems such as justice, education and human services."⁵¹

There is considerable evidence that having two mostly independent systems of care leads to worse health outcomes and higher spending. A better understanding of the interrelatedness of emotional and physical health has served to increase efforts to provide integrated care that addresses physical health as well as behavioral health. **Integrated care produces better results, both in terms of health outcomes and patient satisfaction, for less cost than traditional care.**⁵² There are a number of evidence-based models of integrated care. On the national and state level, there is significant activity toward creating more integrated systems.

Challenges in transitioning to a more integrated care delivery system are numerous. The most significant, perhaps, is the existing financial framework of fee-for-service and volume-based reimbursement. Many of the functions of integrated care, such as case management, are typically non-reimbursable and providers must look to new financial and reimbursement frameworks such as Accountable Care Organizations. These offer incentives for comprehensively managing the health of individuals.^{52,53} Furthermore, integrated care settings require up-to-date health information technology systems to maximize efficiency and potential, which can be a barrier because of the significant upfront investment that is required.⁵³ Primary care providers and behavioral health professionals must overcome traditional cultural and practice differences in order to work together effectively.⁵⁴ Additionally, the need for information sharing often competes with the need for privacy.⁵³ Finally, there are many models of integrated care and providers must have the ability to work together to develop the model that works best for their community.

RECOMMENDATIONS RELATED TO INTEGRATED CARE

10. Create a formal, neutral resource to support communities across South Carolina in defining their plan for care coordination among behavioral health providers and adoption of integrated behavioral and primary health care services.

Because there are many ways to develop and implement an integrated care system, people in communities must work together to decide what system structure best meets their needs. A community-based approach increases community capacity and maximizes buy-in of key stakeholders. Existing infrastructures in South Carolina such as AccessHealth networks and Healthy Outcomes Plans at local hospitals could be utilized to operationalize the plan.

Key components to an integration plan would be decided by the respective communities and could include the following:

- **Develop Behavioral and Medical Health Homes:** Health homes can be operationalized through co-location or seamless communication and cross-trained staff. The focus is on patients with a behavioral health disorder and one or more chronic physical health conditions. Co-location can consist of placing behavioral health providers in primary care settings (such as Federally Qualified Health Clinics, Rural Health Clinics, primary care offices and hospitals) and/or placing primary care providers in behavioral health settings (such as Community Mental Health Centers). Health homes include comprehensive care management and coordination, health promotion, patient and family support and referrals to community social services as needed. Staff should be cross-trained in primary care, substance use disorders and mental health illness.
- **Telemedicine:** To ensure a more equitable distribution of limited human and financial resources, many providers utilize telemedicine and telepsychiatry (with both psychiatrists and advanced practice registered nurses) in locations where a lack of patient volume prohibits co-location and in emergency departments and primary care settings.
- **Common Screening Tools:** Primary care providersⁱⁱ can be incentivized to screen all patients for behavioral health conditions and behavioral health providers to screen all clients for medical health conditions. Standardized screening tools for the primary care setting (in addition to the primary health care screening) could include indicators for trauma, tobacco use, domestic violence, traumatic brain injuries, behavioral health disorders and history with law enforcement/incarceration. Standardized screening tools for the behavioral health care setting (in additional to the behavioral health screening) could include BMI, blood pressure and a physical health symptom checklist.
- **Health Information Technology and Integrated Medical Records:** Many providers are promoting the development of technologies and standards to enable interoperable exchange of behavioral health data while supporting privacy, security and confidentiality. Utilizing Electronic Medical Records (EMRs) that combine physical health and behavioral health records makes care coordination more efficient. Expanding access to health information through the utilization of Health Information Exchanges that can be used by health care providers as well as social service agencies also supports care coordination. It is important to find a method that allows various EMR systems to communicate. Communities may consider developing online registries that identify where there is capacity in specialized programming and/or inpatient psychiatric beds.

Community plans will rely on technical assistance and local leadership. Champions of the concepts of integrated care should be identified early on to ensure successful plan development and subsequent plan implementation. Integration plans should include an ongoing accountability and communication mechanism to ensure continuous and seamless collaboration and to track progress and outcomes. Demonstration projects from around the state serve to guide and inform community-based implementation strategies.

ⁱⁱTwo CPT codes are available to pediatricians through Medicaid to enable reimbursement of behavioral health screenings. Consider expanding this to all primary care providers (internists, geriatricians, general medicine, gynecologists, etc.) and to payors beyond Medicaid.

11. Create a committee to determine how agencies providing behavioral health services can improve their coordination in order to provide more seamless services and maximize client outcomes.

Currently, a number of state agencies deliver behavioral health services. The South Carolina Department of Mental Health (DMH) is devoted to public mental health services, the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) is devoted to substance use disorder services and Continuum of Care serves children with serious emotional or behavioral health diagnoses.

Patients with co-occurring disorders often face a fragmented system of care. Problems include different eligibility criteria, diverse funding mechanisms and sometimes a lack of appropriately trained staff. An examination of how agencies could provide more seamless services and care coordination could result in decreased costs and improve outcomes for people with a behavioral health illness.

12. Develop a statewide care coordination model for adults with serious behavioral health issues that offers home and community care options and minimizes unnecessary emergency room visits, law enforcement interventions and inpatient hospitalizations.

Systems of care have been developed across the country to provide highly coordinated and holistic care for children and youth who suffer from serious mental health illnesses. The systems include individualized treatment plans for each patient, coordinated service delivery, incorporation of the family in decision making and a focus on community-based treatment options.⁵⁵ Systems of care have become “a proven strategy to improve the lives of children and youth with serious mental health conditions and their families.”⁵⁵ Successful systems of care have been able to demonstrate significant return on investment through reduced utilization of inpatient and other types of intensive services.⁵⁶

Services provided through systems of care are termed ‘wraparound’ because they are highly individualized and coordinated. The Substance Abuse and Mental Health Services Administration (SAMHSA) has been focused on the expansion of systems of care for the last decade and has provided planning and implementation grants to

a number of states.⁵⁵ Overall, children and youth in the systems of care treatment model experience a reduction in suicidal thoughts, reduced contact with law enforcement and fewer days in hospital settings.⁵⁵

Because systems of care provide structures and processes for agencies to collaborate and coordinate service delivery, it has been suggested by behavioral health professionals as an approach in South Carolina for treating the adult population of individuals with the most intensive mental health needs. The system would utilize Assertive Community Treatment (ACT), an evidence-based approach to serving adults with multi-faceted behavioral health challenges. ACT integrates psychiatric, substance use and physical health services with vocational training and case management.

The South Carolina Department of Health and Human Services (SC DHHS) is pursuing state plan options under sections 1915c and 1915i. The state plan options will provide service authorities to support systems of care for youth aged 0 to 25 through what is known as the Palmetto Coordinated System of Care (PCSC). Since beneficiaries over age 25 would also benefit from 1915i service authorities, SC DHHS is considering creating a system of care for those 25 and older with the most intensive treatment needs.

Leadership for designing this model would consist of each state agency involved in the provision of behavioral health servicesⁱⁱⁱ as well as consumers, their family members and health care systems. As plans are developed for this adult-focused system, it is important to monitor the implementation of the PCSC, the system of care serving children and youth in South Carolina, to ensure the application of lessons learned during that process.

ⁱⁱⁱThe South Carolina Department of Mental Health (DMH), the South Carolina Department of Alcohol and Other Drug Abuse Service (DAODAS), the South Carolina Department of Disabilities and Special Needs (DDSN), the South Carolina Department of Corrections (SCDC) and the South Carolina Department of Health and Human Services (SC DHHS).

HOUSING

The vision of the Behavioral Health Taskforce is to ensure that every person with a behavioral health illness in South Carolina has the opportunity to live in safe, appropriate and affordable housing supported by comprehensive and coordinated services as needed to maintain residency in the community housing option of choice.

“Supportive housing is proven to improve housing stability, employment, mental and physical health, and school attendance; and to reduce active substance use. And supportive housing costs essentially the same amount as keeping people homeless and stuck in the revolving door of high-cost crisis care and emergency housing.”⁵⁷

Safe, secure and affordable housing is a necessary step to supporting the ongoing recovery of people with behavioral health illnesses. The current lack of housing options limits the potential for recovery for many individuals and families. It also provides a barrier to hospitals when discharging patients who have nowhere to go. Community supports such as behavioral and physical health care, pharmacy services, transportation and employment must also be accessible for residents of community-based housing.

Affordability of housing is a critical issue for people living with behavioral health conditions so severe that they cannot work. Supplemental Security Income (SSI) is the federal program that provides monthly income to aged, blind and persons with long-term disabilities who have no assets and limited income. With South Carolina’s federally defined housing market areas, the cost of a one-bedroom rental unit ranges from a low of 70% of SSI payments (which average \$698 per month) in the Sumter housing market to a high of 106% in the Charleston/North Charleston/Summerville housing market area (the state average is 88%).⁵⁸

In July of 2013, the Statewide Housing Taskforce developed a needs assessment to understand the demand for supported community housing options for people living with chronic behavioral and mental health conditions in South Carolina. Data from the South Carolina Department of Mental Health (DMH), the U.S. Department of Housing and Urban Development (HUD) and five private hospitals were analyzed to determine the unmet need for community-based housing options. Based on the results of the needs assessment, it was determined that there is a gap of 1,745 permanent housing units and 3,861 permanent rent-supported housing units. The Statewide Housing Taskforce is serving as the catalyst for developing housing units of different types across the state.

RECOMMENDATIONS RELATED TO HOUSING

13. Develop permanent supportive housing units for persons with behavioral health illnesses and their families in integrated settings. In 2013, a target benchmark of 1,745 units was established. It is recommended that the need for this type of housing units be continuously monitored.

One type of housing needed for people with behavioral health illnesses is permanent housing that is newly built or rehabilitated from older housing. These units will include community-based housing models to serve individuals with serious behavioral health illnesses who lack the daily living skills needed to maintain health and safety in the community. Units will be accessible to community amenities and have supportive services available at dedicated times as needed. Due to new federal guidelines, the proposed new housing units will be developed in integrated settings where persons with mental a health illness occupy no more than 25% of the units.

Partners in this endeavor include DMH, the South Carolina Department of Health and Human Services (SC DHHS) and local hospitals across the state. They are working to secure funding through all possible sources, including HUD, the State Housing Trust Fund and SC DHHS. SC DHHS is pursuing the 1915i state plan option, which will include supportive housing services and is currently seeking expert consultation on addressing housing needs of the mentally ill. The Behavioral Health Taskforce recommends that as DMH is able to invest more in community housing, the agency and its partners ensure a corresponding funding increase to provide behavioral health services to people living in the housing units.

14. Secure funding for rental assistance and associated supportive services through rent guarantee contracts or leases with private landlords for persons with behavioral health illnesses and their families. In 2013, a target benchmark of 3,861 units was established. It is recommended that the need for this type of housing unit be continuously monitored.

When searching for rental property, individuals with behavioral health illnesses can use subsidized or independent funds to help pay their rent. Section 8 of the Housing Act of 1937 provides rental housing assistance for low-income individuals and families. It is proposed that additional support is made available through proposed recurring rental assistance funds from the South Carolina Legislature as part of the DMH budget. As with the permanent housing model, a corresponding funding increase is needed to provide behavioral health services to people living in the housing units. As with the permanent housing model described above, no more than 25% of the units will be occupied by persons with mental health illnesses.

15. Support an update to the enabling legislation of the South Carolina Housing Trust Fund that will provide more flexibility to state agencies in accessing funds needed to address the affordable housing needs of clients with a mental illness.

The South Carolina Housing Trust Fund was created by the Legislature in 1992 and is administered by the South Carolina State Housing Finance and Development Authority. Deed stamp fees generate money for the fund, which currently totals about \$8 million per year. One of the challenges with the legislation is that only non-profit organizations are eligible to receive grants, which the Housing Authority interprets to mean that governmental entities are unable to receive grants but may receive loans. With input from business partners, the Housing Authority developed proposed updates to the current legislation, which includes expanding grant opportunities to governmental entities including state agencies (e.g., DMH, SC DHHS and the Department of Disabilities and Special Needs). Housing units funded through this mechanism will be built or rehabilitated in partnership with the Housing Authority and grantees who can in turn contract with either non-profit or private developers. Matching funds can be also used to further leverage grant funding.

SCHOOL-BASED SERVICES

The Behavioral Health Taskforce envisions that all children attending South Carolina schools will have access within their school to behavioral health services.

Issues such as school violence, bullying, emotional distress and substance abuse can affect children of all ages and prevent them from learning and achieving. Schools are in a unique position to support children with their behavioral health needs since children and youth spend the majority of their time away from home in the educational setting. Over the last decade, the number of school-based behavioral health programs has increased dramatically around the country.⁵⁹ Services typically include assessment, prevention and early intervention, treatment and case management, including referrals to other programs. Medicaid reimbursement is often a critical component to the financing of such programs.

School-based behavioral health services impact individual academic success, the school's learning environment, the ability of school professionals to respond to crises and the identification and treatment of youth with a behavioral health illness.⁵⁹ When implemented well, these programs can also help reduce barriers to receiving help for students and families and improve social, emotional/behavioral and academic outcomes.⁶⁰

As few as 16% of young people with a diagnosable behavioral health condition receive any treatment.^{61,62} Those who do often receive inadequate treatment.⁶¹ Improving access to behavioral health services through schools addresses some of the traditional barriers to care and helps to create healthier learners and youth that are more successful. In South Carolina, more than 727,000 children attend a public school in grades K–12.⁶² At least 9% of these youth have one or more behavioral health conditions.⁶¹

RECOMMENDATION RELATED TO SCHOOL-BASED SERVICES

16. Create a new, separate taskforce to ensure adequate school-based behavioral health services are available in South Carolina schools.

The South Carolina Department of Mental Health (DMH) provides professional services in nearly 500 public schools in the state (there are nearly 1,200 public schools). Some schools provide their own services or contract with private entities for mental health services. No comprehensive catalog of these services exists.

Future work includes a comprehensive assessment of the behavioral health services currently provided in South Carolina's schools and a plan to increase the number of schools that provide evidence-based behavioral health services. The proposed new taskforce will make recommendations about funding and delivery mechanisms to bring school-based behavioral health services to every school, what types of programming should be part of school-based services and how these services should be evaluated.

SERVICES FOR JUSTICE-INVOLVED INDIVIDUALS

It is the vision of the Behavioral Health Taskforce that we prevent unnecessary incarceration of persons with a behavioral health illness, provide appropriate care and treatment to individuals in detention centers and prisons who have a behavioral health illness and reduce recidivism by supporting ex-offenders with a behavioral health illness with reentry to the community through a formal discharge planning process.

The disproportionate number of people with behavioral health illnesses in correctional institutions and other stages in the criminal justice process is a consequence of limited access to behavioral health services and the stigmas that surround mental illness and substance use disorders.⁶³ **Nationally, there are more than three times as many people with serious mental illnesses in jails and prisons than in psychiatric hospitals.**⁶⁴ Forty percent of persons with a serious mental illness have been in jail or prison at some time in their life.⁶⁴

Table 6 outlines the proportion of the South Carolina prison population that has a mental health illness, a chemical dependency or a co-occurring disorder.

Evaluations for mental illness and chemical dependency are performed upon entry into the South Carolina Department of Corrections (SCDC) system. Of those identified with a mental health illness, 90% require medication while in prison and need medication management once released.⁶⁵

These numbers are dramatic but likely understate the situation. Statistics from the Bureau of Justice indicate that 56% of state prisoners across the nation have a mental health illness.¹¹ The National Center on Addiction and Substance Abuse at Columbia University estimates that 65% of prison inmates in this country have a substance use disorder and an additional 20% have problems with drugs or alcohol.¹²

The size and cost of America's prison system has increased tremendously over the past few decades, largely because of laws and policies that put more offenders behind bars and keep them there longer. In South Carolina, the average ex-offender released in 2009 was in prison for 2.3 years, 33% longer than the average ex-offender released in 1990.⁶⁷ This has a direct impact on the cost of running correctional institutions. The cost of supporting one inmate for one month in prison is \$1,909 in South Carolina.⁶⁶

Table 6: South Carolina Department of Corrections Inmates with Behavioral Health Illnesses (2014) *

	Male Population		Female Population		Total Population	
	Number	Percent	Number	Percent	Number	Percent
Total Population	20,488		1,416		21,904	
Mentally Ill	2,628	13%	473	33%	3,101	14%
Chemically Dependent	7,766	38%	773	55%	8,539	39%
Mentally Ill and Chemically Dependent	1,288	6%	269	19%	1,557	7%

* The numbers are not unduplicated, therefore may be indicated in more than one category.
Source: South Carolina Department of Corrections

The criminal justice setting is not prepared or resourced to care for people with a serious mental health illness.

This population is also a strain on the system: recidivism rates are high, the costs for treating these inmates is high, the average length of stay is longer, mentally ill inmates are more likely to commit suicide and they are sometimes abused or maltreated in the criminal justice setting.⁶⁴ For these reasons, it is imperative that behavioral health and criminal justice agencies and authorities work together in the care and treatment of inmates with behavioral health illnesses, both while the inmate is in jail or prison and once they have been released into the community.

In January 2014, State Circuit Judge Michael Baxley found SCDC at fault in its treatment and care of inmates with serious mental illness. The case was filed on behalf of approximately 3,500 inmates with serious mental health illnesses for system failures that resulted in a lack of medical treatment for many inmates with a mental illness as well as excessive use of force and isolation and appalling facility conditions.⁶⁷ The ruling made national news and drew attention to the inadequate human and financial resources at SCDC to treat this population appropriately.⁶⁸

With the appointment of Bryan Stirling as Director of SCDC, mediation in the case began, and in the fall of 2014, Mr. Stirling submitted the agency's proposed budget, which included the need for increased funding for the agency from the South Carolina legislature. In January 2015, the first results of the mediation were made public when a framework of a strategic plan for SCDC to improve care and treatment of mentally ill inmates was released. It includes plans for the development of a comprehensive mental health program and improved screening, evaluation, mental health record maintenance, administration of medication, suicide prevention and crisis intervention. It requires additional human and financial resources, facilities improvements and electronic medical records.⁶⁹

Meanwhile, a number of improvements have been made internally that are moving the agency forward in its ability to appropriately treat inmates with a serious mental illness. As of June 18, 2014, SCDC entered into a pre-release agreement with the Social Security Administration's (SSA) Disability Determination Services (DDS) which allows an offender housed in a SCDC facility to apply for Supplemental Security Income (SSI) and/or Social Security Disability Income (SSDI) up to 90 days before their anticipated release so that benefits can begin quickly after the inmate has been released. When an individual submits a SSI or SSDI application, they are automatically submitted for Medicaid benefits.

Because of improvements already made—also including the opening of a Self-Injurious Behavior Unit, enhancements to the licensing requirements of counselors⁷⁰ and the confidence in Mr. Stirling's leadership—the Behavioral Health Taskforce chose to focus its recommendations on the prevention of incarceration of people with a behavioral health illness, the need for inmates to maintain their Medicaid coverage when coming into the corrections system and the discharge planning process at correctional facilities.

RECOMMENDATIONS RELATED TO SERVICES FOR JUSTICE-INVOLVED INDIVIDUALS

17. Put into place a system whereby incarcerated adults have their Medicaid benefits suspended rather than eliminated.

The inmate exclusion rule is a federal law that prohibits the use of Medicaid dollars to pay for health care services for inmates in public institutions except for services lasting 24 hours or more, such as hospitalization.⁷¹ States often misinterpret the Centers for Medicaid and Medicare Services' (CMS) mandate to suspend Medicaid during incarceration and cancel their coverage instead.⁷¹

Currently, when an individual covered by Medicaid enters

a correctional facility in South Carolina, they lose their health care coverage. To regain coverage, they must reapply after they are released. This often causes a gap in coverage of at least 30 days. An ex-offender returning to the community faces many challenges, especially in the first few weeks.⁷² Lacking health care coverage during this time increases an individual's vulnerability and chances of reentry to the correctional setting.

Implementing the policy of suspension rather than termination of coverage in South Carolina would require a change to the information systems used by South Carolina Department of Health and Human Services (SC DHHS).

18. Increase Crisis Intervention Team (CIT) training for law enforcement across the state.

“Diversion and alternatives to incarceration for people with mental illness and addictions should become the overarching public health goals of a new, responsive mental health system.”⁷³ Just as the criminal justice system and the behavioral health services system must work together in the care and treatment of inmates and ex-offenders, they must also work together to prevent unnecessary incarceration.

During CIT trainings, law enforcement officers learn how to respond safely and quickly to people with serious mental health illness who are in crisis and link them to appropriate treatment. Officers learn to recognize the signs of psychiatric distress and how to de-escalate a crisis to avoid injuries or deaths of officers and community members. CIT is an evidence-based strategy for preventing unnecessary incarceration of people with a mental health illness and connecting them to appropriate mental health services.⁷⁴

The National Alliance for the Mentally Ill (NAMI) has a CIT Center, which promotes the expansion of crisis intervention teams nationwide and NAMI South Carolina (NAMI SC) provides CIT training across the state. The cost of the forty-hour course is \$750 per trainee and NAMI SC has one full-time and one part-time CIT trainer on staff. The Behavioral Health Taskforce will support the ongoing expansion of the program by identifying funding sources for the training of more law enforcement officers across the state.

SCDC has provided and will continue to provide CIT training to its correctional officers as part of a new partnership with the National Institute of Corrections. The training helps correctional officers identify situations that require specially trained crisis intervention officers as an effort to provide better mental health care for inmates and to make institutions safer for inmates and staff.⁷⁰

19. Develop a formal discharge planning process with inmates who have a behavioral health illness.

Although discharge planning is the norm for people leaving hospitals, people leaving correctional facilities are often left to fend for themselves in planning their continued care and treatment. Inmates with a behavioral health illness may not have the capacity or resources to plan their return to community life. They often need intensive case

management to ensure successful reentry to society.

Currently, when an adult inmate (>25 years of age) is released from a corrections facility in South Carolina, SCDC has no means to support or monitor what happens to this individual once they are in the community. SCDC and the South Carolina Department of Mental Health (DMH) are exploring a partnership to sustain a dedicated care coordinator for inmates with a serious mental health illness. An ideal discharge planning process would begin at least four months ahead of the scheduled release date. The care coordinator will meet with the inmate to assist with the development of a reentry plan. This would include plans for behavioral and physical health maintenance (including medication maintenance) and planning for housing and employment.

To support continuity of care and reduce recidivism, the same care coordinator will work with the ex-offender once they are released and support their successful reentry into the community by ensuring connections to appropriate resources. Appointments with behavioral health professionals will be coordinated and tracked and adequate amounts of medication will be provided. Currently, when inmates leave a SCDC facility, they are provided only five days of medication and a prescription for a 30-day refill. This can cause medication non-compliance. If the ex-offender runs out of medication and does not have the resources to get the prescription filled before their appointment with a behavioral health professional, they may experience a relapse. SCDC and DMH should develop a robust Memorandum of Understanding (MOU) and an evaluation plan of this new service to demonstrate its success and long-term cost savings.

An important part of collaboration between law enforcement and behavioral health is information sharing, particularly about the patient’s diagnosis (or diagnoses), medications, health status and treatment plan.⁷⁵ Because federal laws can limit what information is provided to probation and parole officers, creative solutions must be explored. SCDC and the South Carolina Department of Probation, Pardon and Parole (PPP) are investigating methods to support a warm hand-off for inmates being released on parole by improving information sharing to enable parole officers to anticipate the situation and needs of their clients. Parole officers should be trained to understand the needs of individuals with behavioral health illnesses and community resources that can help their clients with other social service needs.

Regarding the need for improved information sharing, a 2010 report from the Council of State Governments Justice Center states: “One approach many local jurisdictions have pursued is to have the court obtain the defendant’s permission for disclosure of health information as a condition of community supervision, or include a provision in the court order that permits the supervising officer to obtain health-related information when necessary to monitor compliance with the conditions of release. This facilitates the exchange of information between the covered entity that is providing treatment and the probation officer.”⁷⁶

PPP has a Reentry Program Services Division focused on promoting public safety and accountability through collaborative partnerships by implementing a seamless plan of services for the offender’s successful reentry and reintegration within their community. Currently, PPP staff meet with inmates 120 days prior to their release to determine service needs to support the transition back to

the community. However, there is limited communication between SCDC and PPP about the health information of inmates. With improved linkage and communication, both PPP and DMH could encourage and support ex-offenders in receiving the behavioral health services they need (for example, PPP officers could support follow-up if ex-offenders do not show up for an appointment with a behavioral health professional).

PPP works with about 60% of the 9,400 inmates released from SCDC each year (in addition to many others not coming out of SCDC). PPP staff supervise 32,000 individuals in the state and 12,000 out of state. Caseloads can range from 1:300 (Greenville) to 1:60 in less populous counties. These large caseloads present another barrier in supporting ex-offenders with behavioral health illnesses as they access the community services they need. PPP is requesting new funding from the legislature for the upcoming fiscal year to hire more parole agents and reduce their caseloads.⁷⁶

WORKFORCE DEVELOPMENT

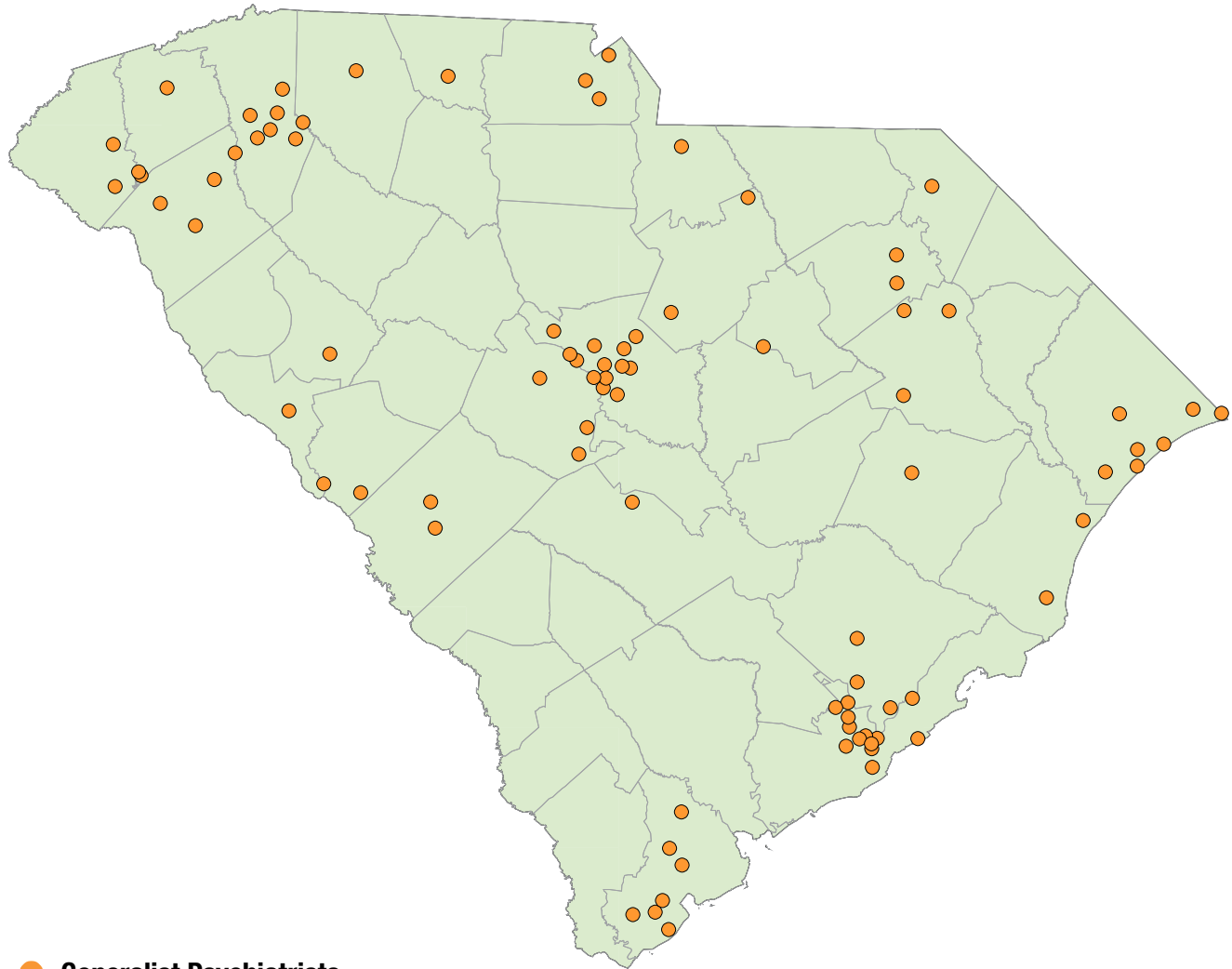
It is the vision of the Behavioral Health Taskforce that we support a comprehensive behavioral health system by creating and sustaining a stronger and larger behavioral health professional workforce.

A diverse array of professionals support behavioral health service provision including psychiatrists, psychologists, social workers, nurses, nurse practitioners, therapists and counselors. In 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) found that almost 91 million adults lived in areas that have a shortage of behavioral health professionals.⁷⁷ In a report to Congress, SAMHSA stated that 55% of the 3,100 counties nationwide do not have a practicing psychiatrist, psychologist or social worker who specializes in behavioral health issues.⁷⁷ **Currently, South Carolina ranks 38th in the availability of behavioral health providers with a 9,951 population-to-psychiatrist ratio.**³⁶ Between 2008 and 2013, when the U.S. general population grew by four percent, the number of psychiatrists in the U.S. actually dropped by four percent from 38,857 to 37,296.⁷⁸ In addition, approximately 57% of practicing psychiatrists are at least 55 years old. These professionals are well established in their career and often only accept private pay patients.⁷⁹ As more people in need of behavioral health services enter the coverage system through expansions available through the Affordable Care Act, many anticipate even greater difficulty accessing these professionals.⁷⁹

The South Carolina Area Health Education Consortium’s Office for Healthcare Workforce Analysis and Planning (OHW) provides information on the behavioral health workforce in South Carolina. The OHW developed capacity reports and service area maps at the request of the taskforce for three specific behavioral health specialties: psychiatrists, clinical nurse specialists and nurse practitioners. According to these reports, there were 504 licensed psychiatrists actively practicing in South Carolina in 2013, 410 of them in general practice. In 2012 there were 75 nurse practitioners and 28 clinical nurse specialists focused on mental health and actively practicing in South Carolina.⁸⁰ The following maps show the primary practice location for each of these disciplines and reveal that access to behavioral health providers is limited or non-existent in many counties and communities in the state.

MAP 1:

GENERALIST PSYCHIATRISTS IN SOUTH CAROLINA BY PRIMARY PRACTICE LOCATION IN 2013⁸¹



● **Generalist Psychiatrists**
N = 410

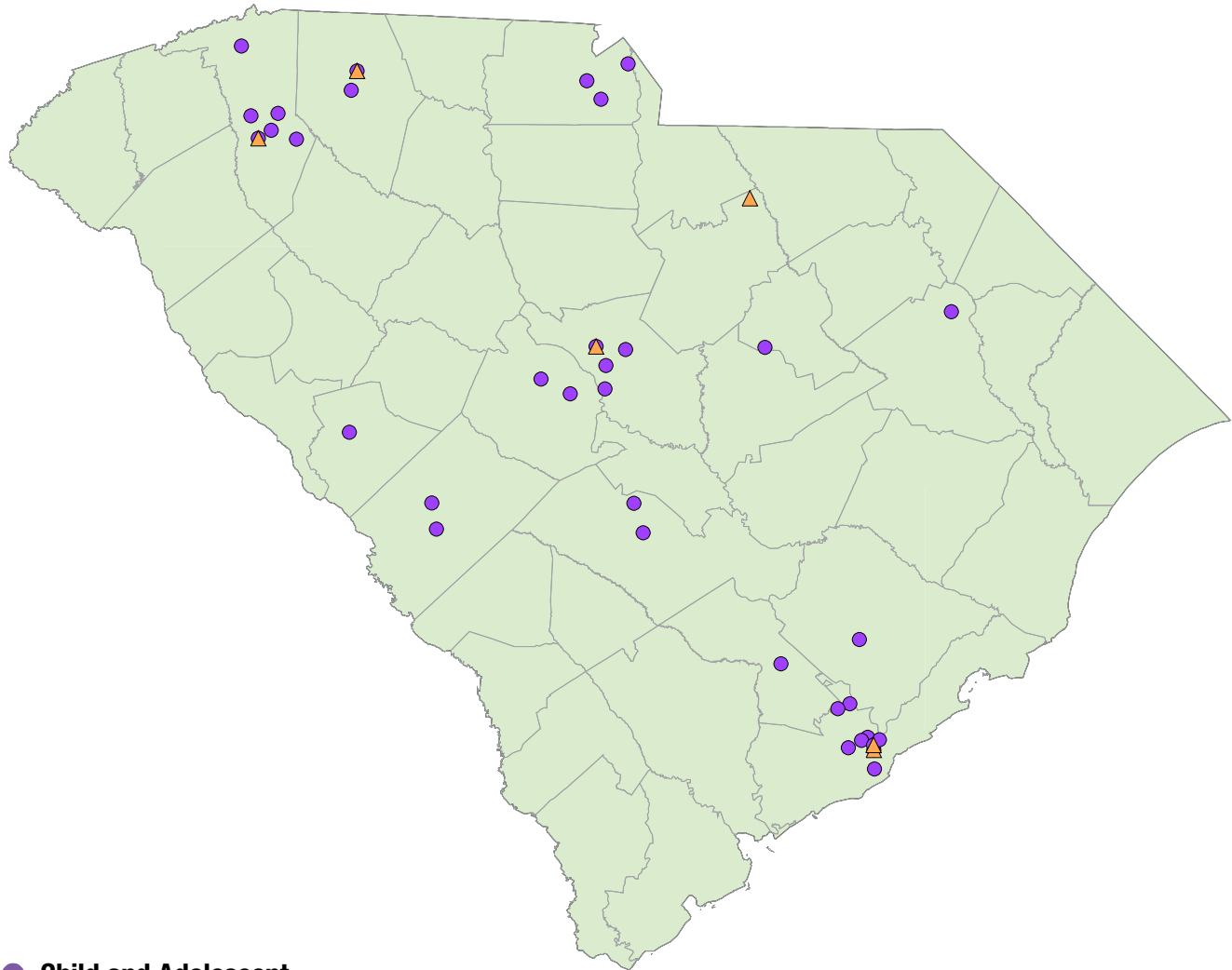
This information is based on physicians with an active license to practice and their primary practice location in South Carolina during the license renewal period ending June 30, 2013, and reported their dominant area of practice as Psychiatry. Primary practice locations are plotted within the practice zip code region and may not represent the street location of the practice. Physicians enrolled in residency training programs have been omitted from this map and the counts reported.

This map was created by the Office for Healthcare Workforce Analysis and Planning in the South Carolina AHEC program office, Sept. 5, 2014. Any questions should be directed to Linda M. Lacey at (843) 792-1655 or LaceyL@musc.edu



MAP 2:

SPECIALTY PSYCHIATRISTS IN SOUTH CAROLINA BY PRIMARY PRACTICE LOCATION IN 2013⁸²



● **Child and Adolescent Psychiatrist**
N = 72

▲ **Geriatrics Psychiatrists**
N = 11

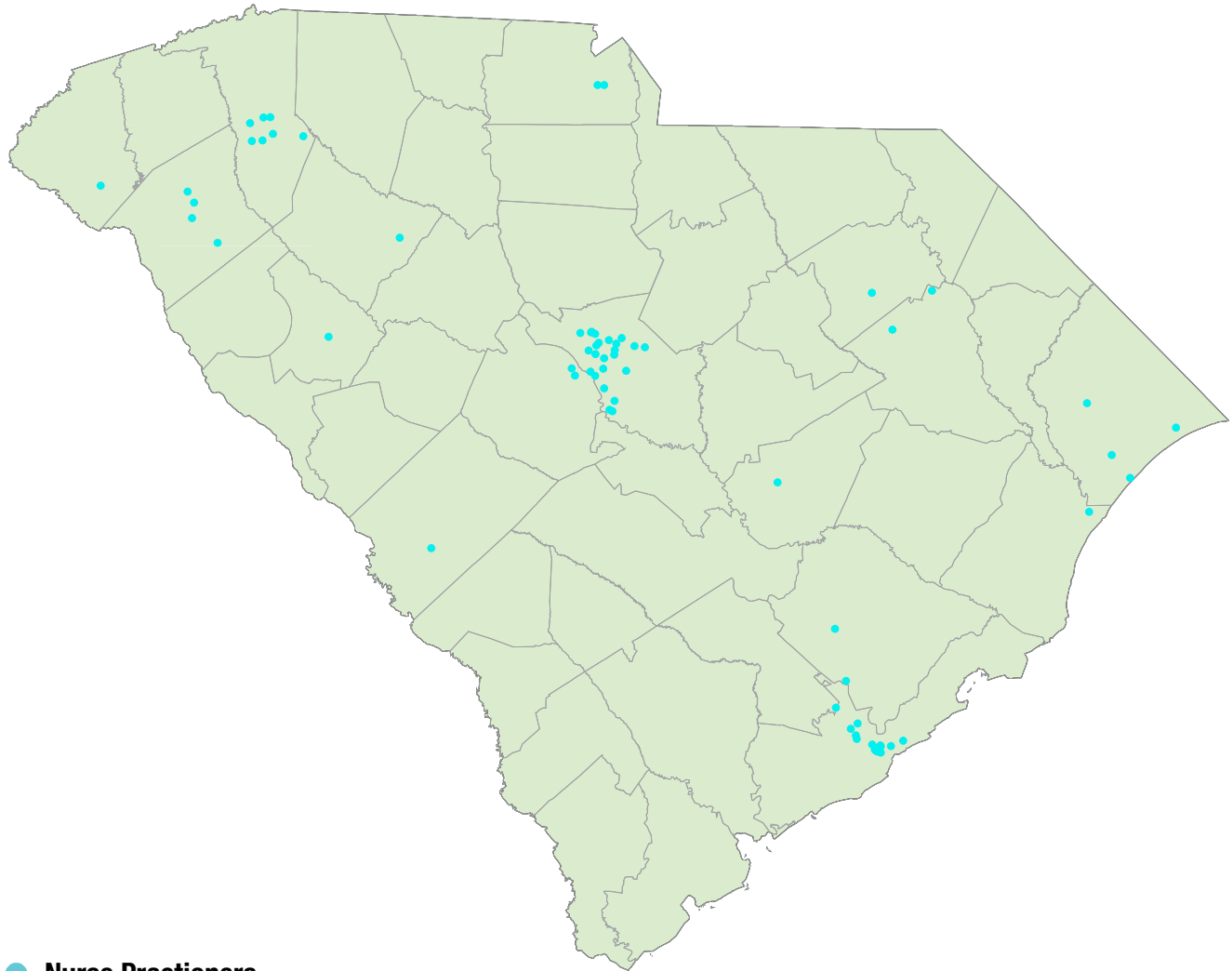
This information is based on physicians with an active license to practice and their primary practice location in South Carolina during the license renewal period ending June 30, 2013, and reported their dominant area of practice as Psychiatry with a specialization in either Geriatrics or Children and Adolescents. Primary practice locations are plotted within the practice zip code region and may not represent the street location of the practice. Physicians enrolled in residency training programs have been omitted from this map and the counts reported.

This map was created by the Office for Healthcare Workforce Analysis and Planning in the South Carolina AHEC program office, Sept. 5, 2014. Any questions should be directed to Linda M. Lacey at (843) 792-1655 or LaceyL@musc.edu



MAP 3:

PSYCH/MENTAL HEALTH NURSE PRACTITIONERS BY PRIMARY PRACTICE LOCATION IN 2012⁸³



● **Nurse Practitioners
specializing in Mental Health
Total N = 75**

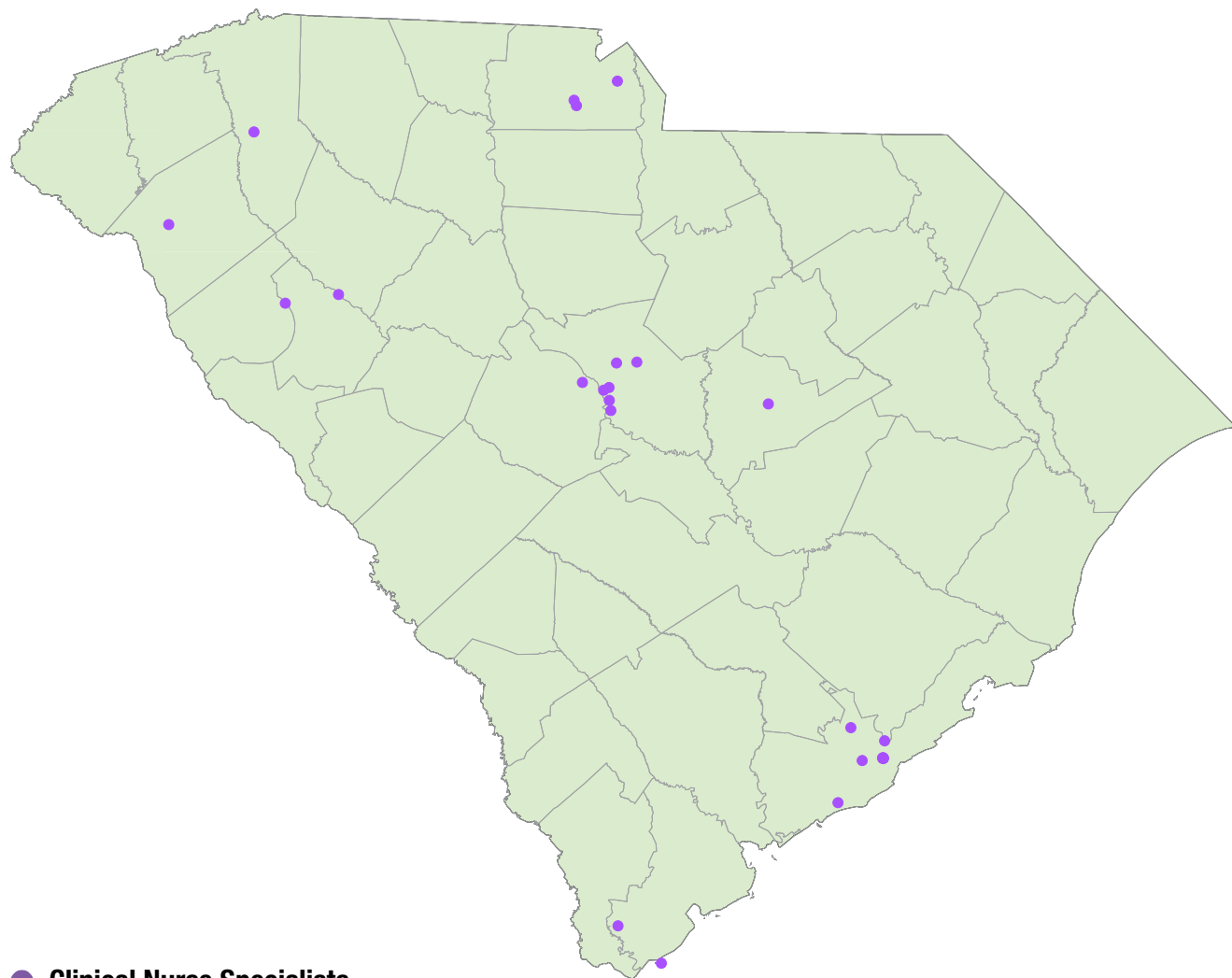
This information is based on Registered Nurses with an active license to practice and their primary practice location in South Carolina during the license renewal period ending April 30, 2012, who hold an approval to practice as a Nurse Practitioner and reported their dominant area of practice as Psych/Mental Health (n=71) or Developmental Disabilities (n=4). Locations plotted here are based on the zip code of the primary practice location. Dots are placed within the zip code region and may not represent the street location of the practice.

This map was created by the Office for Healthcare Workforce Analysis and Planning in the South Carolina AHEC program office, Sept. 12, 2014. Any questions should be directed to Linda M. Lacey at (843) 792-1655 or LaceyL@musc.edu



MAP 4:

PSYCH/MENTAL HEALTH CLINICAL NURSE SPECIALISTS BY PRIMARY PRACTICE LOCATION IN 2012⁸⁴



● **Clinical Nurse Specialists
specializing in Mental Health
N = 28**

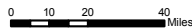
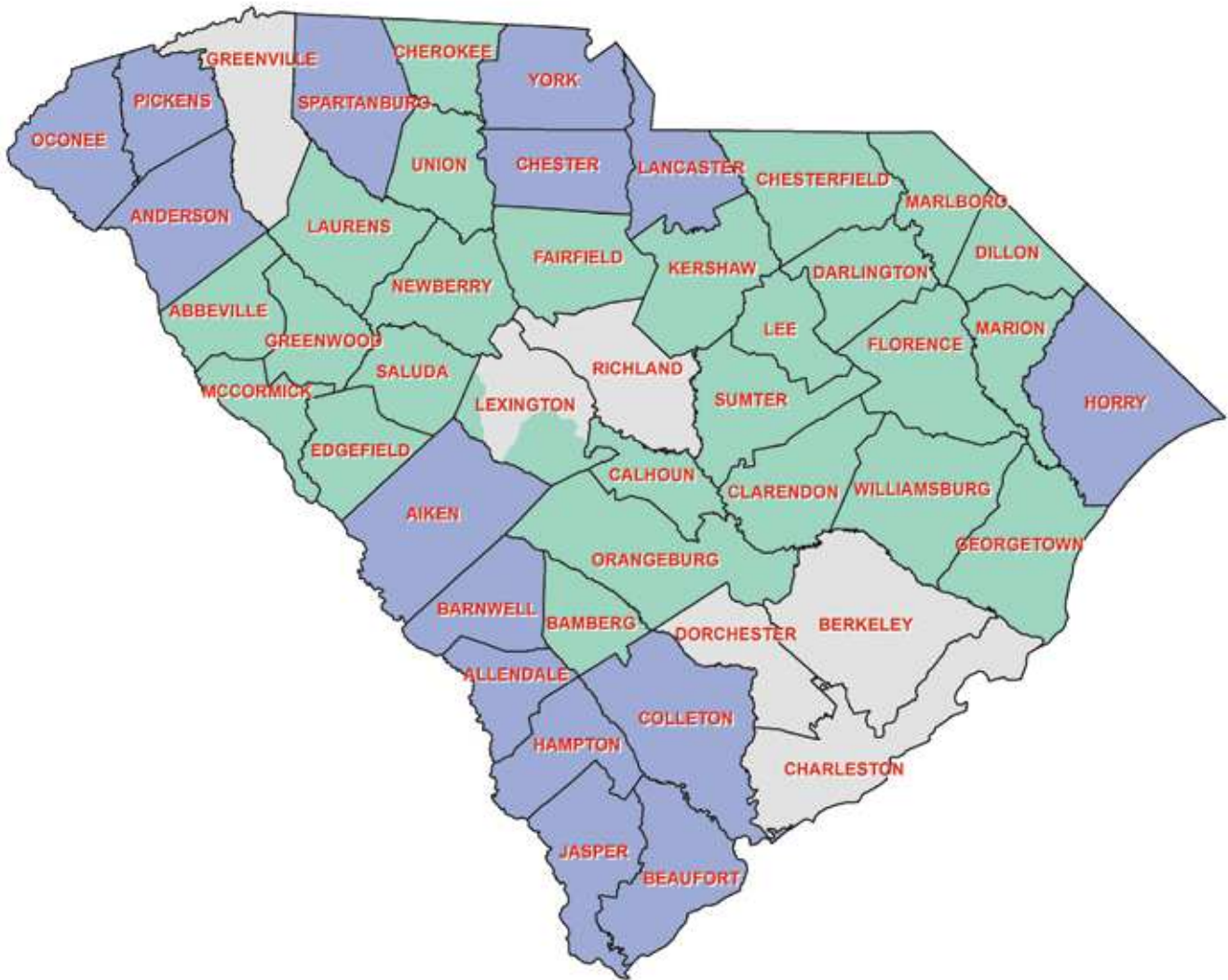
This information is based on Registered Nurses with an active license to practice and their primary practice location in South Carolina during the license renewal period ending April 30, 2012, who hold an approval to practice as a Clinical Nurse Specialists and reported their dominant area of practice as Psych/Mental Health. Locations plotted here are based on the zip code of the primary practice location. Dots are placed within the zip code region and may not represent the street location of the practice.

This map was created by the Office for Healthcare Workforce Analysis and Planning in the South Carolina AHEC program office, Sept. 12, 2014. Any questions should be directed to Linda M. Lacey at (843) 792-1655 or LaceyL@musc.edu



MAP 5:

SOUTH CAROLINA MENTAL HEALTH HEALTH PROFESSIONAL SHORTAGE AREAS (HSPA) BY TYPE⁸⁸



Legend

County Boundary

HSPA Type

- Geographic
- Low Income
- Not Designated

Data Source: U.S. Dept. of Health and Human Services
 Map Produced By: Division of Public Health Informatics, PHSIS, SC DHEC 8/19/2013 (S.J.K, W.A.)

Although the OHW provides information on workforce numbers and locations, this data is not intended to indicate whether the current workforce is adequate to meet the behavioral health needs of South Carolina residents. That information is provided by the Health Resources and Services Administration (HRSA). HRSA is responsible for the designation of Health Professional Shortage Areas (HPSA) for primary medical care, dentists and mental health providers in each state.⁸⁵ Shortage designations are based on a range of criteria that include population-to-provider ratios, income and poverty levels and levels of community need.⁸⁶ According to HRSA, the purpose of this designation is “to identify areas of unusually high need, to assure that mental health services are available and accessible to underserved communities and to assist with the retention and recruitment of providers into designated areas.”⁸⁷ **Map 5 shows that 41 of the 46 counties in South Carolina received HPSA designations based either on geographic or low-income criteria.**⁸⁸

An overlay of OHW and HRSA data presents a clear picture of the limited behavioral health workforce in South Carolina. Almost all of the counties in the state have some degree of a behavioral health provider shortage. In many rural areas, the shortages are particularly severe. Professional shortages result in barriers to care that include 1) extended travel time required to access the closest provider; 2) providers limit or stop taking new patients due to a high demand for their services and 3) private pay often replaces private insurance as the acceptable payment. When the barriers become too great and the search becomes too difficult, many individuals with a behavioral health illness stop looking for a provider. The result is that many do not receive the proper behavioral health treatment and support they need.⁷⁹

More psychiatrists, psychologists, social workers, nurses, nurse practitioners, licensed professional counselors and licensed marriage and family therapists are needed to meet the behavioral health needs of this state. Providers of behavioral health services across the state report it is difficult, if not impossible, to recruit behavioral health professionals to fill open positions. The University of South Carolina School of Nursing reported there were between 50 and 70 psychiatric mental health Nurse Practitioner vacancies posted in South Carolina in February 2014.⁸⁹ Some agencies are trying to address the workforce issue by dedicating funds to professional training and education programs. For instance, the South Carolina Department of Mental Health (DMH) supports graduate education for a Masters in Social Work. Other strategies that could support workforce development include the creation of psychiatry fellowships, loan forgiveness programs and a statewide agency pool.

RECOMMENDATION

The need for a significant increase in various behavioral health professionals across South Carolina and the complex solutions required to address the situation informs the Behavioral Health Taskforce’s recommendation related to the workforce.

20. Establish a South Carolina Behavioral Health Workforce Development Consortium to ensure a sufficient workforce of behavioral health professionals in order to support the vision of providing all-hours access to behavioral health services.

The Consortium will have stable and ongoing funding and permanent staff, and membership from key stakeholder agencies and educational institutions.

FOCUSING ON BEHAVIORAL HEALTH: A CASE STUDY OF SPARTANBURG, SOUTH CAROLINA

Case studies provide examples of steps taken, barriers encountered and solutions found in planning and implementing strategies to tackle problems and drive change. This case study reviews change in the behavioral health care delivery system in Spartanburg County. Components of this case can serve as models or blueprints for replication; however, the true intent of this case study is to inspire other communities to seek their own creative solutions to behavioral health access challenges in their local area.

Although the precipitating factors may vary, every community will soon discover (if it has not already done so) that it needs to expand access to behavioral health services. In a larger sense, the Wellstone Mental Health Act or the Affordable Care Act—both of which mandate that behavioral health and physical health issues must now be addressed comparably—might propel expansion. Locally, change may occur from the loss of an important community resource that provided both counseling and advocacy for mental health issues, as is the case in Spartanburg County, South Carolina.

While there are “macro” pieces to any community’s mosaic of services, such as hospital beds and professional counselors, most of the effective strategies to address unmet need must be local and preemptive in nature. In 2013, local funders in Spartanburg (United Way of the Piedmont, Mary Black Foundation, Spartanburg County Foundation and Spartanburg Regional Foundation), anticipated the forthcoming challenge and agreed to collectively fund a comprehensive report on the most critical behavioral health needs in Spartanburg County. With the assistance of an outside consultant, a steering committee was convened to help guide the work of an extensive needs assessment. The process was inclusive and transparent, bringing together individuals from a wide array of organizations that had first-hand experience and knowledge of local behavioral health resources and system limitations. Part of the assessment included a thorough data analysis and inventory of key strengths and weaknesses and revealed, among other points, the following significant findings:

- Behavioral Risk Factor Surveillance System (BRFSS) data show that Spartanburg County residents reported a slightly higher number of “mentally unhealthy” days than the state average—3.8 per month in Spartanburg County compared to 3.6 per month in South Carolina.
- Of the approximately 285,000 individuals living in Spartanburg County, roughly 72,000 were identified as “in need of behavioral health services.”
- Although 37% of BRFSS respondents indicated that mental health conditions interfered to some extent in normal activities in the past month, only 12% were receiving any treatment. Reasons for lack of treatment included too few access points, not enough providers, lack of knowledge of where to go and the stigma associated with behavioral health illnesses.
- The Health Resources and Services Administration (HRSA) designated Spartanburg County as a Mental Health Professional Shortage Area (HPSA), which indicates there are not enough mental health providers to serve the residents who need their services.
- When behavioral health systems are not adequate to address need, hospital Emergency Departments (ED) become default sources of behavioral health treatment. In 2009, there were 4,308 visits to Spartanburg County EDs for behavioral health issues, resulting in total charges of over \$21 million. That number climbed to 4,623 in 2011 with charges totaling \$22 million.
- An initial assessment found that the “Top 20” individuals with mental health issues who frequently bounce back and forth from the county detention center to the emergency department were costing these two systems over \$1 million annually.

Working with recommendations from the “Behavioral Health Needs Assessment: Spartanburg County, South Carolina,” the original steering committee was re-convened and charged with first designing a strategy and then a plan of action to address the community’s needs and circumvent predictable “taskforce hurdles.”

The Process

The Spartanburg County Behavioral Health Taskforce identified a five-component strategy for its first two years:

- (1) A **Working Taskforce** was created and populated with individuals from the original steering committee and with representatives from organizations that were significantly invested in expanding the community’s scope and range of behavioral health services. Their mission was comprehensive and intended to build partnerships among key stakeholders. From the beginning, taskforce membership was limited with new members added only as their unique skills were deemed necessary. To a great extent, this narrower committee membership design eliminated the usual backtracking of taskforces and, more important, seemed to foster a greater willingness to subordinate individual and organizational agendas.
- (2) The primary tool for specific actions was the use of **Ad Hoc Committees**. Each of these committees consisted of taskforce members based on their expressed interest and others from the community with demonstrated engagement and expertise. Each committee was convened around one strategy and was intended to either dissolve or spin off as a freestanding, self-sustaining entity upon completion of its assignment. This prevented the burnout often associated with comprehensive community initiatives. Ad Hoc Committees reported to the taskforce. The end products from this type of multitasking more than offset the challenges of scheduling and coordinating.
- (3) Recognizing that the most significant impact on the unmet need could be achieved by prevention, the taskforce committed itself to an **Upstream Strategy**—one that allows people to receive needed support and services before they reach the point of numerous ED visits, inpatient treatment or serving time in a detention center. Upstream solutions are often, if not always, more effective, cost-efficient and produce better outcomes.

- (4) **Sustainable Funding** (*community support vs. grant funding*): Experience has proven that it is often not feasible to pursue grant funding if the community cannot maintain a change once the grant funding cycle is complete. To ensure that systemic changes advocated by the taskforce are sustainable, the taskforce worked with key partners interested in taking ownership of initiatives that align with their own mission and goals.
- (5) **Evaluation**: Early on, the taskforce understood the importance of assessing and measuring outcomes and progress toward goals as a critical factor in establishing and maintaining the credibility of each program. An ad hoc committee of research professionals was established to select appropriate metrics to measure population impact and program success. This must be an ongoing effort and will warrant continuous monitoring by the full taskforce.

Achievements in 2014 (Year One)

The overarching goal of the taskforce has been to develop a comprehensive community plan that addresses the unmet behavioral health needs of the residents of Spartanburg County. This has been translated into a number of programs intended to expand access to services, to enhance awareness and expertise among professionals and laypersons and to reduce institutional challenges to providing behavioral health services.

In its inaugural program year the taskforce achieved the following primary accomplishments:

- **SBIRT (Screening, Brief Intervention, Referral to Treatment) Training**: SBIRT is an evidence-based practice used to identify and prevent problematic use and dependence on alcohol and other drugs. The SBIRT interview process is also adaptable for a range of other behavioral health challenges. In 2014, nearly 300 individuals in Spartanburg County participated in SBIRT training. It has become a standard part of the medical education for personnel at Spartanburg Regional Healthcare System (SRHS) and has been introduced throughout the guidance counselor system at Spartanburg County schools.
- **Mental Health America (MHA)**: Mental Health America re-established an affiliate in Spartanburg, which will lead coordination of education and public awareness efforts. The MHA staff is certified to

provide the Mental Health First Aid program and to train volunteers in the Community Mentor Program, including professionals in the behavioral health care field, local first responders as well as those providing safety net services.

- The **VISTA (Volunteers In Service to America) Program:** Since 2005, the United Way of the Piedmont has coordinated a VISTA program in which modestly subsidized volunteers perform community service. VISTAs have been a welcome addition to the work of the Spartanburg County Behavioral Health Taskforce by providing fresh, energetic ideas and perspective. In 2014, the Spartanburg program was restructured to provide both individual and collective service opportunities. Each VISTA is employed on a daily basis at a host organization whose direct or indirect mission impacts access to behavioral health services. In addition, the VISTAs are working as a team on supplemental projects that will have broader community impact on the behavioral health system. The Corporation for National and Community Service (CNCS), the funding body for the VISTA program, has identified Spartanburg as a national demonstration project. Over the next three years, CNCS will be reviewing the outcomes of Spartanburg's restructured VISTA program with the intent of using this model in other communities across the country.
- **Healthy Outcomes Project Spartanburg (HOPS):** Targeting 730 uninsured high frequency users of the ED, the Healthy Outcomes Program partners with a wide range of local safety net caregivers to identify and address health and behavioral health issues before they reach the crisis stage. There are currently 562 people enrolled in the Spartanburg program receiving intensive case management through a medical home to reduce their ED utilization and enable them to access no- or low-cost medications and appropriate referrals to other safety net providers.
- **ACT (Assertive Community Treatment):** ACT is a national, evidence-based treatment model that integrates psychiatric care, medication management, counseling and primary medical care. It is an intensive approach for community behavioral health service delivery and has been demonstrated to produce successful outcomes. VISTAs are in the process of developing an ACT pilot project in Spartanburg County, which will target the "Top 20" individuals who serve time in the detention center and who are high

frequency users of the ED.

- **Telepsychiatry Expansion Pilot:** Telepsychiatric and telemedicine services will be expanded to a maximum of ten community-based sites in 2015 (i.e., local Federally Qualified Health Centers [FQHCs and free clinics) and as many as 12 private physician offices. Telepsychiatry is currently utilized in SRHS's ED and has already demonstrated reduced lengths of stay in the ED and hospital. The ability to access a psychiatrist to provide diagnostic services and to develop a care plan assists in ensuring the patient access to more timely services.
- **Community Support Services:** A pilot program operated in partnership with the Spartanburg Housing Authority will be launched in the first quarter of 2015 utilizing professional and trained lay volunteers. It will provide a variety of behavioral health interventions and support services onsite at one of the Housing Authority locations for seniors and individuals with disabilities. Once successfully piloted, this model will expand to other vulnerable, at-risk segments of the community.
- **Directory of Services:** A robust directory of behavioral health services delineating eligibility criteria and fees is being developed as a web-based tool for community and medical providers to use as a referral and educational tool. Access will be available both online and through the 2-1-1 system.
- **Detention Center/Counseling Services Partnership:** Westgate Family Therapy, a local, non-profit entity providing individual and family therapy, has established a unique counseling partnership with the Spartanburg County Detention Center utilizing graduate students in need of clinical practicum experience. Having counseling services available onsite decreases the number of transports to the Community Mental Health Center and the ED, resulting in cost savings and a more efficient use of detention center staff. This partnership is being replicated at other community locations.
- **Detention Center/Emergency Department Partnership:** Many patients especially those receiving psychotropic medications—experience a medication change or interruption when they go to or from the detention center and the ED, causing symptoms of their mental illness to resurface. The sharing of medication formularies between the Spartanburg County Detention Center and the ED has resulted in improved

outcomes among inmates with significant behavioral health issues.

- **Improvements to the Emergency Department Facility:** Underwritten by a grant from the Spartanburg Regional Foundation, facility improvements have been made that enabled the ED at SRHS to redefine its role from a holding area for those in crisis to one that is equipped to provide “safe, compassionate and therapeutic care.”
- **Detoxification Services Re-establishment:** To replace the critically needed Ray Eubanks Detox Center, the taskforce, in partnership with the Spartanburg Alcohol and Drug Abuse Commission, under the direction of a VISTA team, is investigating the viability of implementing a medically assisted detox program. Currently, individuals detox in one of two places; the detention center or the hospital. The hospital does not admit patients for detox but often admits individuals suffering from the physical side effects of detox. Significant cost savings to the hospital system are anticipated through the implementation of a medically assisted, outpatient detox center that includes wraparound services and a community or peer mentor.
- **Crisis Intervention Team (CIT) Training:** Training for law enforcement and first responders, delivered by the local National Alliance on Mental Illness (NAMI) chapter, has been established as a protocol in the training of the Spartanburg County Sheriff’s Office field personnel. CIT training instructs officers on how to respond to people with a serious mental health illness, de-escalate crisis situations and link individuals with appropriate mental health services.
- **Emergency Hotline:** In partnership with the Spartanburg County Community Mental Health Center operated through the South Carolina Department of Mental Health (DMH), the taskforce is working to expand the current capacity of an emergency “hotline.” This new “warm line” would provide 24/7 support services to individuals at risk of developing a behavioral health crisis.

- **Upstate Warrior Solutions (UWS) Partnership:** In collaboration with UWS and the Spartanburg County Probation Department, the taskforce has located office space to house a local advocate who will provide outreach to veterans with behavioral health illnesses. The task force will also work closely with UWS to establish a support group for veterans at the Welcome Home Center, a homeless shelter for veterans.

Perspective and Next Steps

The taskforce began this effort knowing that there is a tremendous unmet need for behavioral health services in Spartanburg County. By law, mental health could no longer be treated as disconnected from physical health in practice and by insurance. The hospital ED was increasingly a holding area for individuals for whom the system had no alternatives. The taskforce realized leadership to expand community awareness and action was lacking.

The taskforce is making progress on many fronts and is capitalizing on an extraordinary willingness of agencies, caregivers, professionals and concerned citizens to be partners in a collaborative effort. It is important to note that the taskforce has received considerable recognition from state and national behavioral health professionals and organizations for their upstream and inclusive strategy. Spartanburg is often identified as a model community in this regard, which has, in turn, translated into significant outside sustainable support for some of the initiatives. Equally, it reflects the importance of cooperation among local service providers who have seen behavioral health as a community-wide issue not subject to mission and territorial limitations.

The most significant accomplishments so far are related to building institutional capacity and expanding access and expertise. If it is to be truly successful, it is expected that in 2015 the Spartanburg community will begin to realize that the work of this taskforce benefits them as individuals, as neighbors and as friends.

Many thanks to Tom Barnet, Chair of the Spartanburg Behavioral Health Taskforce and Heather Witt, Taskforce Coordinator, for their contributions to this case study. For more information on the Spartanburg Behavioral Health Initiative and the Taskforce, contact Ms. Heather Witt, Vice President of Community Impact at United Way of the Piedmont, Spartanburg, SC. (864) 582-7556 / hwitt@uwpiedmont.org / www.uwpiedmont.org

CONCLUSION

While it is clear that there are many challenges ahead in transforming South Carolina's behavioral health care systems, it is important to recognize the recent advances and innovations. South Carolina is a national leader in telepsychiatry.⁹⁰ Since 2009, a partnership between the South Carolina Department of Mental Health (DMH) and The Duke Endowment has provided telepsychiatry services in 20 emergency departments (EDs) across the state. An average of 400 consultations per month help hospitals shorten the length of time patients are held in the Emergency Department before being evaluated. Patients evaluated via telepsychiatry are twice as likely to appear for their follow-up appointment.⁹⁰ With new leadership at the South Carolina Department of Corrections (SCDC), significant improvements are being planned and implemented to enable the state's prison system to care for inmates with behavioral health illnesses. The creation and support of the Behavioral Health Taskforce has garnered significant attention, not only from participants, but from the broader public health and health care communities across the state.

To ensure that the recommendations of the taskforce are implemented and to harness the momentum created by the taskforce, the South Carolina Institute of Medicine & Public Health (IMPH) will continue to serve in a convening role on this topic. An implementation process will serve to track progress toward the established recommendations. The first step in this process is to prioritize the recommendations and determine timeframes and responsible parties for each step. Partnerships created through the taskforce's work will be critical to propel this work forward.

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Appendix A

Appendix A

South Carolina Department of Alcohol and Other Drug Abuse Services

Revenue

Fiscal Year	State	Federal *	Other	Restricted	Total
2000	12,883,578	25,857,655			38,741,233
2001	12,633,755	28,525,684			41,159,439
2002	11,770,049	30,029,970			41,800,019
2003	10,014,654	31,148,659			41,163,313
2004	8,654,022	28,292,532			36,946,554
2005	7,128,044	29,241,811			36,369,855
2006	8,479,878	25,771,816			34,251,694
2007*	17,135,070	27,767,572			44,902,642
2008	13,188,961	32,631,490			45,820,451
2009	11,542,520	25,042,001	4,625,327	350,000	41,559,848
2010	8,434,155	23,006,261	2,813,040	500,000	34,753,455
2011	6,540,829	24,851,677	2,056,504	250,000	33,699,010
2012	6,233,069	25,651,149	1,970,186	100,000	33,954,403
2013	6,436,817	24,957,124	2,304,438	50,000	33,748,379
2014*	7,689,155	26,523,528	4,730,526	123,985	39,067,194
2015 Budgeted*	8,393,707	29,898,624	5,183,457	223,985	43,699,773

Notes:

- * Federal funding for FY 2000-2008 includes Other and Restricted funding. Records have been archived and not easily accessible.
- * FY 2007 - Includes \$6.2 million pass-through to the Phoenix Center in Greenville to build an adolescent treatment facility
- * State Funding for FY 2014 includes non-recurring funds of \$1,150,000 allocated to Florence Circle Park (\$150,000) Tri-County - Dawn Center (\$250,000) and Keystone (\$750,000)
- * State Funding for FY 2015 includes non-recurring funds of \$1,700,000 allocated to Florence Circle Park (\$200,000), Keystone (\$750,000) and Phoenix Center (\$750,000)

Appendix A

South Carolina Department of Alcohol and Other Drug Abuse Services

Expenditures

Fiscal Year	State	Federal *	Other	Restricted	Total
2000	12,883,578	25,857,655			38,741,233
2001	12,633,755	28,525,684			41,159,439
2002	11,770,049	30,029,970			41,800,019
2003	10,014,654	31,148,659			41,163,313
2004	8,654,022	28,292,532			36,946,554
2005	7,128,044	29,241,811			36,369,855
2006	8,479,878	25,771,816			34,251,694
2007	17,135,070	27,767,572			44,902,642
2008	13,188,961	32,631,490			45,820,451
2009	9,040,495	24,827,220	3,830,428	248,838	37,946,981
2010	7,688,960	24,784,714	3,394,413	203,053	36,071,140
2011	6,540,829	24,538,956	1,456,101	90,387	32,626,273
2012	6,233,069	24,006,620	1,413,399	45,939	31,699,027
2013	6,436,817	25,305,981	2,302,791	48,945	34,094,534
2014	7,689,155	26,981,120	3,372,460	34,206	38,076,941
2015 Budgeted	8,393,707	29,898,624	5,183,457	223,985	43,699,773

* Federal funding for FY 2000-2008 includes Other and Restricted funding. Records have been archived and not easily accessible.

Appendix A

South Carolina Department of Mental Health

Revenue

Fiscal Year	State	Non-State*	Total
2000	197,488,816	153,016,897	350,505,713
2001	202,521,904	163,757,941	366,279,845
2002	176,212,176	164,137,677	340,349,853
2003	169,400,921	173,245,353	342,646,274
2004	171,640,733	173,099,725	344,740,458
2005	172,860,864	161,159,240	334,020,104
2006	180,644,048	159,581,196	340,225,244
2007	199,846,975	158,913,026	358,760,001
2008	219,344,083	163,229,390	382,573,473
2009	177,786,274	193,963,471	371,749,745
2010	161,432,734	197,864,487	359,297,221
2011	138,932,752	209,310,285	348,243,037
2012	132,968,384	202,048,123	335,016,507
2013	154,812,762	185,297,992	340,110,754
2014	176,508,067	185,281,681	361,789,748
2015 Projected	192,875,727	198,451,745	391,327,472

* "Non-state" consists of Medicaid reimbursement, disproportionate share, Veterans Administration, drug fines, county appropriations, block grant, etc.

Appendix A

South Carolina Department of Mental Health

Community and Inpatient Expenditures*

Fiscal Year	Community	Inpatient	Total
2000	146,516,154	114,074,967	260,591,121
2001	164,225,119	117,275,701	281,500,820
2002	157,803,709	103,203,179	261,006,888
2003	160,659,955	95,849,061	256,509,016
2004	170,942,952	94,599,054	265,542,006
2005	176,554,871	95,664,665	272,219,536
2006	175,461,298	95,388,674	270,849,972
2007	172,277,206	99,258,201	271,535,407
2008	170,485,059	106,343,458	276,828,517
2009	163,097,765	106,341,842	269,439,607
2010	153,999,692	103,186,211	257,185,903
2011	148,555,373	102,835,735	251,391,108
2012	143,442,218	101,387,503	244,829,721
2013	145,608,570	104,645,760	250,254,330
2014	150,455,527	110,515,823	260,971,350
2015 Projected	165,351,127	116,906,913	282,258,040

*Does not include Nursing Homes, Clinical Support Services, Administration and Public Safety.

Appendix B

Appendix B

Steering Committee

Mr. Kester Freeman, Jr., Chair

Executive Director
South Carolina Institute of Medicine & Public Health

Dr. Robert Bank

Executive Director
Columbia Area Mental Health Center
Deputy Director of Medical Affairs
South Carolina Department of Mental Health

Ms. Cheryl Johnson Benjamin

Senior Director, Health Council
United Way of the Midlands

Ms. Trina Cornelison

Executive Director
Continuum of Care
Office of the Governor

Ms. Ann-Marie Dwyer

Director, Behavioral Health
South Carolina Department of Health and Human Services

Dr. Alison Evans

Chair, South Carolina Mental Health Commission
South Carolina Department of Mental Health

Mr. Jim Head

Senior Vice President, Policy and Education
South Carolina Hospital Association

Mrs. Joy Jay

Director
Mental Health America of South Carolina

Mr. Thornton Kirby

President & CEO
South Carolina Hospital Association

Dr. Ligia Latiff-Bolet

Director, Quality Management and Compliance
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South Carolina Department of Health and Human Services

Mr. Bill Lindsey

Director
National Alliance on Mental Illness-South Carolina

Mr. John Magill

Director
South Carolina Department of Mental Health

Hon. Amy McCulloch

Judge, Richland County Mental Health Court
Co-Founder, Partners in Crisis

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Professor and Chair
University of South Carolina Department of
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Chair
Department of Psychiatry and Behavioral Medicine
Greenville Health System

Mr. Bryan Stirling

Director
South Carolina Department of Corrections

Mr. Bob Toomey

Director
South Carolina Department of Alcohol
and Other Drug Abuse Services

Dr. Thomas Uhde

Professor & Chair
Medical University of South Carolina Department
of Psychiatry and Behavioral Sciences

Ms. Lathran Woodard

Chief Executive Officer
South Carolina Primary Health Care Association

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Community Resources Committee

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Mental Health America of South Carolina

Hon. Amy McCulloch, Co-Chair

Judge, Richland County Mental Health Court Co-Founder,
Partners in Crisis

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Partner
Nelson Mullins

Mr. Mark W. Binkley

Deputy Director, Division of Administrative Services
South Carolina Department of Mental Health

Mr. Robert Carlton

State Social Work Consultant/Disaster
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Ms. Shirley Furtik

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Professor
Department of Psychology
Francis Marion University

Ms. Lisa Mustard

Director of Psychological Health
South Carolina Army National Guard

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Community Resources Committee, continued

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Ms. Helen Pridgen

South Carolina Area Director
American Foundation for Suicide Prevention

Ms. Carol Rice

Program Coordinator, Reentry Services
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Mr. Steve von Hollen

Director of Clinical Services
South Carolina Department of Disabilities and Special Needs

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South Carolina Primary Health Care Association

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Palmetto Health

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Project Director
Palmetto Coordinated System of Care
South Carolina Department of Health and Human Services

Ms. Stephanie Heckart

Vice President, Behavioral Health & Medical Management
Blue Cross Blue Shield of South Carolina

Ms. Leslie Wilson Hipp

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Spartanburg Regional Medical Center

Dr. Napoleon Wells

PACT/Behavioral Health, Team Lead
WJB Dorn Veteran's Administration Medical Center

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South Carolina Institute of Medicine & Public Health

Appendix C

Appendix C

Agencies, Organizations and Programs Addressing Behavioral Health at the State Level in South Carolina

1) Behavioral Health Council at the South Carolina Hospital Association

The South Carolina Hospital Association (SCHA) Behavioral Health Council serves as a networking forum for members to discuss challenges facing their organizations in the delivery of behavioral health services and to develop public policy recommendations on relevant issues.

2) Faces and Voices of Recovery–South Carolina (FAVOR SC)

FAVOR SC is a non-profit organization that promotes long-term recovery from substance use disorders through education, advocacy and recovery support services resulting in healthier individuals, families and communities. FAVOR SC has a board that consists of two representatives from each of the five chapters in South Carolina and several consultants. FAVOR SC receives part of its funding from the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS).

The core beliefs of FAVOR SC are:

- Recovery is a reality in the lives of millions
- There are many paths to recovery
- Recovery is a voluntary process
- Recovery flourishes in supportive communities
- Recovering people are part of the solution
- Recovery gives back what addiction has taken away

FAVOR SC supports the work of five chapters in South Carolina:

- FAVOR Greenville
- FAVOR Grand Strand
- FAVOR Midlands
- FAVOR Tri-County
- FAVOR Pee Dee

3) Federation of Families of South Carolina

The Federation of Families of South Carolina is a non-profit organization that serves families of children with any degree of emotional, behavioral or psychiatric disorder. The organization strives to provide leadership in the area of children's mental health through education, awareness, support and advocacy. The goals of the Federation of Families are to:

- Provide technical assistance and support when addressing the unique needs of children and youth and help them navigate the current mental health system and to advocate for an improved mental health system of care.
- Participate in prevention and intervention activities and promote community-based services.
- Facilitate a network of information to and from parents, youth and providers.
- Involve families and youth in policy and program development to ensure access to appropriate services.

Services include:

- Individual and group support networks
- Telephone and e-mail support
- Referrals
- Screening tool
- Youth Motivating Others through Voices of Experience (M.O.V.E.) (provides youth with the opportunity to come together in an effort to raise awareness around youth issues)
- Educational resources

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4) Governor's Council on Drug and Substance Abuse

In 2000, the federal Center for Substance Abuse Prevention awarded South Carolina a State Incentive Grant that sparked the formation of the Governor's Council on Substance Abuse Prevention (later adding "and Treatment" to its mission), involving numerous state agencies committed to addressing alcohol, tobacco and other drug (ATOD) abuse. The group has met quarterly since 2000, but its workgroups meet monthly to bi-monthly.

The Council's varied membership of state agencies and community and youth service organizations provides a mix of perspectives to effectively guide the state. Currently, the Council fulfills the following roles:

1. Serves as an advisory body to DAODAS on substance abuse prevention and treatment.
2. Tracks substance abuse funding streams and seeks to identify opportunities to coordinate, leverage, or redirect funding.
3. Promotes effective prevention strategies and processes and encourages their implementation in key organizations.
4. Addresses important issues through standing or ad hoc committees (i.e., Underage Drinking Action Group, State Epidemiological Outcomes Work Group, Fetal Alcohol Spectrum Disorders Collaborative and a Work Group on Evidence-Based Programs, Policies and Practices).
5. Advocates for prevention and treatment and their increased funding.
6. Oversees major initiatives such as serving as the advisory board for federal grants awarded to the state.
7. Informs members of ATOD information and important agency developments.

Governor's Council Member Agencies

- Department of Alcohol and Other Drug Abuse Services (DAODAS)
- Department of Public Safety
- Department of Juvenile Justice (DJJ)
- Department of Mental Health (DMH)
- Department of Health and Environmental Control (DHEC)
- Law Enforcement Division
- Vocational Rehabilitation Department
- Department of Disabilities and Special Needs (DDSN)
- Association of Prevention Professionals and Advocates
- Behavioral Health Services Association of South Carolina Inc.
- Army National Guard
- Mothers Against Drunk Driving (MADD)
- University of South Carolina (USC)
- Clemson University
- Center for Applied Prevention Technologies
- Southeast Addiction Technology Transfer Center
- Substance Abuse and Mental Health Services Administration (SAMHSA)

5) Joint Citizens and Legislative Committee on Children

The Joint Citizens and Legislative Committee on Children was created to research issues regarding the children of South Carolina and to offer policy and legislative recommendations to the Governor and Legislature. Membership of the Committee on Children is comprised of:

- Three Senators appointed by the President Pro Tempore of the Senate
- Three Representatives appointed by the Speaker of the House
- Three citizens appointed by the Governor
- The State Superintendent of Education
- Directors of the Departments of Mental Health, Social Services, Juvenile Justice and Disabilities and Special Needs

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The Committee on Children identifies and researches issues related to children, provides information and recommendations to the Governor and General Assembly, offers recommendations for policy and legislation and collaborates with state agencies that serve children. The Committee on Children publishes an annual report to the Governor and the General Assembly. Research and staff support for the Committee on Children is provided by the Children's Law Center at the University of South Carolina School of Law.

2013 Annual Report Topic Areas

- School Readiness
- Childhood Obesity
- Fatal and Non-fatal Injuries
- Immunizations
- Child Trauma

Several studies and initiatives sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) demonstrate positive, often dramatic, results for child trauma victims and their families when properly served with needed services and support systems provided by a network of pediatricians, mental health counselors and school personnel.

Within six months of treatment, many children exposed to traumatic events show improved symptoms and functioning at home, in school and in their communities. After 12 months, 44% of treated children experienced improved school attendance and grades, arrests of juveniles dropped by 36% and suicide attempts dropped by 64%.

These positive results suggest that early and effective interventions work to reduce or eliminate more serious health and behavioral concerns and avoid costly treatment of consequential disorders. The Committee on Children adopted trauma-informed practice as an initiative in 2012 and tasked the Joint Council on Children and Adolescents, comprised of state and local agencies, with leading this initiative. The Joint Council has worked to provide training to child-serving professionals.

The Joint Council's trauma-informed care workgroup has been led by DAODAS, the Department of Juvenile Justice, the Department of Mental Health, the South Carolina Chapter of the National Alliance on Mental Illness and Continuum of Care. This group has trained over 1,300 staff who work with children. As a consequence of these initiatives, identification and treatment for children experiencing trauma has improved in South Carolina. Testimony received at the Committee's 2012 Town Hall Meetings strongly supports the state's trauma-informed treatment training initiative and urged the continuation and expansion of evidence-based mental health treatment options for child trauma victims.

6) Joint Council on Children and Adolescents (JCCA)

The mission of the Joint Council on Children and Adolescents is to develop a coordinated system of care that promotes the efficient provision of effective services for children, adolescents and their families. To this end, the council strives to meet the changing needs of children, adolescents, and their families through a collaborative effort in the development of a system of care for the efficient delivery of services offered by government and private child-serving organizations. The Joint Council promotes a coordinated continuum of services, support, and policies that integrate planning and management based on meaningful partnerships with families and youth. Areas of interest include behavioral and physical health, mental health, substance abuse, developmental delays, child protection and welfare, and juvenile justice.

The council is made up of representatives from the following categories: Child-Serving State Agencies, Community and Other Organizations, and Youth and Family Advocates. Current council membership consists of the directors, or their designees, of the following agencies/organizations:

- Department of Mental Health (DMH)
- Department of Juvenile Justice (DJJ)
- Department of Social Services (DSS)

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- Department of Alcohol and Other Drug Abuse Services (DAODAS)
- Department of Disabilities and Special Needs (DDSN)
- Department of Education
- Department of Health and Environmental Control (DHEC)
- Department of Health and Human Services (DHHS)
- Continuum of Care (COC)
- Commission for Minority Affairs
- Behavioral Health Services Association of South Carolina, Inc.
- Children’s Law Center
- Faces and Voices of Recovery SC (FAVOR SC)
- Federation of Families
- National Alliance on Mental Illness–South Carolina (NAMI-SC)
- South Carolina Primary Health Care Association (SCPHCA)
- South Carolina Association of Children’s Homes & Family Services
- Children’s Trust of South Carolina
- University of South Carolina College of Social Work
- The Duke Endowment
- Family Connection of South Carolina

7) Mental Health America of South Carolina (MHA-SC)

MHA-SC has served the State of South Carolina since 1954 as a private, not-for-profit organization. Their mission is improving the lives of people with mental illness in South Carolina, promoting mental health, preventing mental disorders and achieving victory over mental illness through advocacy, education, research and service. MHA-SC assists individuals with mental illnesses and their families, provides community educational trainings and reaches out to the state through health fairs and advocacy activities. MHA-SC programs include:

- Housing
 - o MHA-SC created Turnkey Housing Corporation, which is an arm of the organization that develops housing. The housing staff work with local communities to design housing that best fits the needs of consumers and may use federal, state and private funding sources for construction.
 - o The KIVA Lodge (a group home for eight residents with persistent, severe mental illness) located in Blythewood, South Carolina. This group home provides structured, independent living with medication monitoring, group and individual therapy and ongoing support to ensure successful living in a community environment.
- Bridges Clubhouse
 - o A program, in partnership with the Lexington Mental Health Center, that offers an array of psychological, social and vocational programs, housing assistance and case management services in a family-oriented atmosphere to assist recovery.
- Our Place Clubhouse
 - o A day program in Charleston that helps people with mental illness to reach goals of independent living, developing new coping skills and continuation of recovery.
- Suicide Prevention
 - o Education related to suicide and the warning signs. Recommend using the QPR method, which stands for Question, Persuade and Refer—3 simple steps that anyone can learn to help save a life from suicide.
- Mental Health Screening
 - o Online screening tool available for community use.
- Don’t Duck Mental Health
 - o I.C. HOPE® “Don’t Duck Mental Health®” program is a public awareness and education campaign that dispels the negative perceptions and images associated with mental illness and mental health issues.
- Operation Santa
 - o An annual holiday event that ensures all patients in state facilities receive at least one present.

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MHA-SC also works on policies regarding South Carolina mental health clients and conducts public education campaigns through public appearances, media contacts, statewide speaking engagements, targeted workshops, legislative education days, special mailings, newsletters and community collaborations.

8) National Alliance on Mental Illness – South Carolina (NAMI - SC)

NAMI-SC, located in Columbia, SC, was founded in 1986 and has 18 affiliates around the state. The mission of NAMI-SC is to improve quality of life for individuals who live with mental illnesses and for their families by promoting the availability of effective services and resources through education, support and advocacy. NAMI-SC houses multiple programs related to mental health:

- For Families
 - o Family-to-Family (a course for family members of adult individuals experiencing symptoms of mental illness)
 - o NAMI Basics (for parents and other caregivers of children and adolescents experiencing symptoms of mental illness)
 - o Family Support Group (for family members of individuals experiencing symptoms of mental illness)
- For Consumers
 - o Peer-to-Peer (an experiential learning program for people experiencing symptoms of mental illness who are interested in establishing and maintaining their wellness and recovery)
 - o In Our Own Voice (a public education program presented by two trained consumer speakers experiencing symptoms of mental illness and achieving recovery)
 - o NAMI Connections (a weekly recovery support group lead by consumers in recovery for people experiencing symptoms of mental illness)
- For Schools
 - o Parents and Teachers as Allies (helps families and school professionals identify the key warning signs of early-onset mental illness in children and adolescents in our schools)
- For Professional Providers
 - o Provider Education (for line staff at public agencies who work directly with people who experience symptoms of severe and persistent mental illness)
- For Law Enforcement and EMS
 - o Crisis Intervention Training (CIT) (educates police officers about mental illness and how to apply their training in the field)

9) Palmetto Coordinated System of Care (PCSC)

It is the vision of the Palmetto Coordinated System of Care that the children and families of South Carolina shall receive services when needed that are designed to achieve safe, healthy and functional lives as successful, responsible, productive citizens.

It is the mission of the Palmetto Coordinated System of Care that the services provided by the agencies of the State of South Carolina to its citizens are thoughtfully planned and efficiently coordinated in a system of care and service delivery designed to respond to the needs of the child and family across agency lines of responsibility; the elimination of barriers to services; increased affordability and cost-effectiveness by the braiding of governmental funding and the appropriate involvement of families and local providers in decision-making for services.

The child-serving agency members:

- Department of Social Services (DSS)
- Department of Juvenile Justice (DJJ)
- Department of Mental Health (DMH)
- Department of Disabilities and Special Needs (DDSN)
- Department of Health and Human Services (DHHS)
- Department of Alcohol and Other Drug Abuse Services (DAODAS)
- Continuum of Care (COC)

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The leadership team directing the System of Care has the directors of the above eight agencies and three family member representatives.

10) Partners in Crisis

Co-Chaired by Judge Amy McCulloch and Sheriff Leon Lott

Partners in Crisis is a statewide coalition of stakeholders, including law enforcement officers, elected officials and mental health advocates that have come together to advocate for improvements in the state's mental health and substance abuse delivery system. Their mission is to promote access to quality services, treatment and support for children and adults that have a mental illness and/or substance use disorder. The goals for the group include:

- Promoting education and fostering awareness of mental health and/or substance abuse issues
- Advocating for appropriate resources for the prevention, care, treatment and follow-up services for individuals with a mental illness and/or substance use disorder
- Encouraging accountability of all community service providers and other activities or actions that will further the goals of promoting access, funding, education and advocacy for mental health and substance abuse services.

11) Protection & Advocacy for People with Disabilities, Inc.

Established in 1977, Protection & Advocacy for People with Disabilities, Inc. (P&A) is a statewide, non-profit organization that seeks to protect and advance the legal rights of people with disabilities. The P&A board of directors sets priorities annually under which P&A investigates reports of abuse and neglect. They also advocate for disability rights related to health care, education, employment and housing. Individuals of all ages and disabilities are served with no charges for service. Services include:

- Information and Referral
- Case Representation
- Systemic Advocacy
- Training and Education

12) South Carolina Continuum of Care

The Continuum of Care (COC) is a South Carolina state program that serves children with serious emotional or behavioral health diagnoses whose families need help keeping them in their home, school or community. The COC helps children and families using Wraparound care coordination, a team-based approach to caring for families with complicated needs. The mission of the COC is to ensure continuing development and delivery of appropriate services to those children with the most severe and complex emotional or behavioral health challenges whose needs are not being adequately met by existing services and programs. Through Wraparound services, our objective is to empower youth and families to help them realize their hopes and dreams, decrease out of home placements, improve school attendance and performance, decrease interactions with the legal system, and enhance the overall quality of life of the child.

The COC is primarily funded with state revenues and Medicaid funds and has an administrative state office in Columbia and four regional offices located in Columbia, North Charleston, Greenville and Florence that provide services.

COC's Principles

COCs Wraparound approach is based on ten guiding principles purposed to empower youth and their families and to help them reach their family vision and goals.

1. **Family Voice and Choice:** Family and youth/child perspectives are intentionally elicited and prioritized during all phases of the Wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.
2. **Team Based:** The Wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal and community support and service relationships.
3. **Natural Supports:** The team actively seeks out and encourages the full participation of team members drawn

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from family members' networks of interpersonal and community relationships. The Wraparound plan reflects activities and interventions that draw on sources of natural support.

4. **Collaboration:** Team members work cooperatively and share responsibility for developing, implementing, monitoring and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates and resources. The plan guides and coordinates each team member's work toward meeting the team's goals.
5. **Community-based:** The Wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible and least restrictive settings possible and that safely promote child and family integration into home and community life.
6. **Culturally Competent:** The Wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture and identity of the child/youth, family and their community.
7. **Individualized:** To achieve the goals laid out in the Wraparound plan, the team develops and implements a customized set of strategies, supports and services.
8. **Strengths Based:** The Wraparound process and the Wraparound plan identify, build on and enhance the capabilities, knowledge, skills and assets of the child and family, their community and other team members.
9. **Persistence:** Despite challenges, the team persists in working toward the goals included in the Wraparound plan until the team reaches agreement that a formal Wraparound process is no longer required.
10. **Outcome Based:** The team ties the goals and strategies of the Wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators and revises the plan accordingly.

13) South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS)

A cabinet-level agency, DAODAS oversees the state's public substance abuse system, which is made up of 33 county alcohol and drug abuse authorities. The 33 local agencies have offices in each of the state's 46 counties, thereby ensuring the availability of core substance abuse services to all South Carolina residents. These include a wide array of prevention, treatment and recovery-support services, each of which is driven by evidence-based practices and monitored by DAODAS for quality assurance. The primary source of funding for these programs is the Substance Abuse Prevention and Treatment Block Grant provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). This block grant currently provides almost 50 percent of the department's funding for direct services coordinated by the county alcohol and drug abuse authorities.

14) South Carolina Department of Health and Human Services (SC DHHS)

The South Carolina Department of Health and Human Services (SC DHHS) is a cabinet agency of the South Carolina Governor's Office. The SC DHHS is the single state agency designated to administer the South Carolina Medicaid program, called Healthy Connections, under Title XIX of the Social Security Act. The agency is responsible for determining Healthy Connections Medicaid eligibility for all coverage groups and paying claims on behalf of its members. Through Healthy Connections Medicaid, SC DHHS concentrates on better care, better value and better health for South Carolinians.

Healthy Connections Medicaid is a medical assistance program that helps pay for some or all medical bills for many people who may be unable to afford health services. The program also assists individuals who are over 65, or who have a disability, with the costs of nursing facility care and other medical expenses. Eligibility is usually based on applicants' income and assets.

The SC DHHS Division of Long Term Care and Behavioral Health is the agency's department that guides long-term care and behavioral health policies as SC DHHS transforms these critical services and explores ways to better integrate long-term care and behavioral health with primary care services.

Appendix C

15) South Carolina Department of Mental Health (DMH) Mental Health Commission

The South Carolina Mental Health Commission is the governing body of the South Carolina Department of Mental Health (DMH) and has jurisdiction over the state's public mental health system. The seven members are appointed for five-year terms by the Governor with advice and consent of the Senate. The Commission determines policies and promulgates regulations governing the operation of the department and the employment of professional and staff personnel.

DMH serves adults, children and their families affected by mental illness. DMH is committed to eliminating stigma and promoting the philosophy of recovery, to achieving its goals in collaboration with all stakeholders and to assuring the highest quality of culturally competent services possible. It operates on four core principles: respecting the individual, support for local care, a commitment to quality and improved public awareness and knowledge of mental health issues and services.

DMH operates 17 Community Mental Health Centers (CMHC) serving all 46 counties in South Carolina through four service regions. Each CMHC is responsible for providing outpatient, home-based, school-based and community-based programs to children, adults and their families. Services are provided in 485 schools around the state. DMH has long emphasized continuity of care for its patients, and each CMHC has one or more hospital liaisons assigned to follow its hospitalized patients, as well as to work with hospitals seeking to arrange aftercare for currently hospitalized patients. All of the CMHCs utilize a common Electronic Medical Record (EMR). Due to the absence of psychiatrists in many counties, DMH has been investing in additional technology to increase access to psychiatrists in rural clinics via telemedicine and is investing additional funds to recruit and contract with available psychiatrists. Telepsychiatry services are also provided in 20 hospital Emergency Departments (ED) around the state.

DMH also operates several community residential care facilities, which principally serve as step-down facilities for patients being discharged from the agency's forensic inpatient facility. DMH also operates four nursing homes, three of which are for state-qualified veterans. The agency currently operates four licensed state hospitals, of which one is dedicated to substance abuse treatment. Additionally, DMH operates the state's Sexually Violent Predator Treatment program.

In summary, each year, the DMH system provides services for approximately 100,000 patients, of which approximately 30,000 are children. In total, DMH has over 700 direct portals to services and more than 1,600 affiliates that have various working relationships with the agency.

16) SC SHARE

SC SHARE is a statewide non-profit organization that provides individuals with a mental illness tools for recovery, which they define as regaining meaning and purpose in their lives. The organization also established nine core values to aid in the recovery process:

- Education (develop and discover skills, knowledge and awareness)
- Choice (make responsible, informed decisions)
- Growth (growing and reaching your full potential)
- Hope (belief in the recovery process and expectations for change)
- Support (assist and encourage)
- Wellness (a positive state of recovery that leads to wholeness of mind, body and spirit)
- Community awareness and understanding (educating the community to improve perception of mental illness)
- Responsibility (taking ownership and accountability of yourself)
- Empowerment (having the tools, knowledge, skills and courage to grow, discover and proceed in recovery)

Appendix C

The concept of recovery is the foundation for all of their activities and resources. SC SHARE activities and resources include:

- Educational Workshops that:
 - o Increase understanding of mental illness
 - o Introduce individuals to new coping skills
 - o Give information about how to access new resources
 - o Helps individuals become fully engaged in their recovery
 - o Helps individuals become their own advocates
 - o Helps individuals to understand the need for partnership with their service providers
- Peer Support
- Recovery Resources
- Mentor Program

17) Statewide Housing Taskforce

The Statewide Housing Taskforce is comprised of representatives from DMH (central administration, community mental health centers and the inpatient system), private non-profit housing partner agencies, private for-profit entities, other state agencies and concerned citizens/client advocates. Chaired by Joy Jay, Executive Director of Mental Health America of South Carolina, the taskforce conducted a needs assessment in 2013 on available housing for mental health clients. Based on the information gathered by the taskforce, it was determined there is a gap between the total need of housing units and what is available. The largest gap is with “Apartments with Rent Supports with Mental Health Services Available.” As of July 2013 there was a need for 6,729 units but there were only 2,868 available units; therefore, there was a gap of 3,861. The next largest gap was with the “Apartments with On-Site or Scheduled Mental Health Staff Support,” which had a gap of 1,745 units. Other important information related to this taskforce includes:

- 5,000 people with mental illnesses in South Carolina are homeless, in sub-standard housing or in a hospital
- Mental Health America of South Carolina has 600 units with support services
- 27,000 individuals with a mental illness are living independently in South Carolina

18) Veterans' Policy Academy

The South Carolina Veterans' Policy Academy (VPA) is a consortium of federal, state and non-government agencies dedicated to providing services for veterans. The mission of the VPA is to develop a plan to identify needed services, make these services easily accessible and ultimately help South Carolina's veterans and their families return to healthy and successful lives.

Goals:

- Locate South Carolina veterans who served in the active guard and reserve forces and their respective families.
- Reduce intake points for triage of veterans and their families. An overabundance of entry points causes confusion among veterans, especially those with mental and/or physical limitations and/or substance abuse problems.
- Communicate among all stakeholders to identify and share information about resources to assist veterans and their families.
- Reduce duplication across state agencies with regard to their roles in assisting veterans and their families.
- Identify resources (federal, state or private) to assist and educate veterans and family members with problems.

Appendix D

Appendix D

National Behavioral Health Organizations

American Foundation for Suicide Prevention

<https://www.afsp.org/>

Faces and Voices of Recovery (FAVOR)

<http://www.facesandvoicesofrecovery.org/>

Mental Health America (MHA)

<http://www.mentalhealthamerica.net/>

Mental Health First Aid

<http://www.mentalhealthfirstaid.org/cs/>

National Alliance on Mental Illness (NAMI)

<http://www.nami.org/>

National Federation of Families for Children’s Mental Health

<https://www.ffcmh.org/>

National Institute of Mental Health

<http://www.nimh.nih.gov/index.shtml>

Substance Abuse and Mental Health Services Administration (SAMHSA)

<http://www.samhsa.gov/>

South Carolina Behavioral Health Organizations

Federation of Families of South Carolina

<http://fedfamsc.org/>

Mental Health America of South Carolina

<http://www.mha-sc.org/>

National Alliance on Mental Illness—South Carolina

<http://www.namisc.org/>

South Carolina Continuum of Care

<http://coc.sc.gov/>

South Carolina Faces and Voices of Recovery (SC FAVOR)

<http://favorsc.org/>

South Carolina Department of Alcohol and Other Drug Abuse Services

<http://www.daodas.state.sc.us/>

South Carolina Department of Mental Health

<http://www.state.sc.us/dmh/>

South Carolina SHARE

<http://www.scshare.com/>

The mission of the South Carolina Institute of Medicine & Public Health (IMPH) is to collectively inform policy to improve health and health care. IMPH seeks to achieve this mission by convening academic, governmental, organizational and community-based stakeholders around issues important to the health and well-being of all South Carolinians. In conducting this work, IMPH takes a comprehensive approach to advancing health issues through data analysis and translation and collaborative engagement. The work of IMPH is supported by a diverse array of public and private sources.

www.imph.org