South Carolina Institute of Medicine & Public Health

SCBHC
South Carolina Behavioral Health Coalition

MAY 2021

South Carolina Behavioral Health 2021 Progress Report:

Successes and Opportunities in Transforming Behavioral Health Care Systems across South Carolina

South Carolina Institute of Medicine & Public Health

SCBHC
South Carolina Behavioral Health Coalition

About the South Carolina Institute of Medicine and Public Health

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

About the South Carolina Behavioral Health Coalition

The South Carolina Behavioral Health Coalition (SCBHC) is an unprecedented statewide alliance between public and private organizations dedicated to improving access to a strong behavioral health care system.

Information

For questions or more information about this report, please email info@imph.org.

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Preface

The South Carolina Institute of Medicine and Public Health (IMPH) and the South Carolina Behavioral Health Coalition (SCBHC) wrote this collaborative report with the goal of celebrating significant improvements to our state's behavioral health system over the past five years.

In the introduction of this report, you will learn about South Carolina's behavioral health systems' response to needs related to the COVID-19 pandemic. We will outline the state of illnesses pre-pandemic and share what we know about what has happened since the onset of the public health emergency. The report highlights five successful interventions developed since the publication of the original *Hope for Tomorrow: The Collective Approach for Transforming South Carolina's Behavioral Health Systems* report published in May of 2015. These include (1) the South Carolina Mobile Crisis program, (2) the implementation of the Opioid Emergency Response Plan, (3) improved access to safety net outpatient mental health services, (4) expanded access to telebehavioral health services and (5) the effective integration of behavioral health specialists in community settings across the state.

Likewise, opportunities to further enhance the existing behavioral health care system across the state are assessed. These include (1) increasing the availability of mental health services in schools, (2) investing resources in crisis stabilization units, (3) encouraging jails and prisons to provide comprehensive discharge planning services, (4) shifting health care models to include integrated and collaborative care and (5) developing a more robust behavioral health workforce.

Furthermore, this report showcases three communities that have organized to address behavioral health concerns at the local level. These organizations are Healthy Tri-County, the Spartanburg County Behavioral Health Task Force and the Greenville County Behavioral Health Coalition.

In this report the term "behavioral health" includes both mental health illnesses and substance use disorders. As identified by the Substance Abuse and Mental Health Services Administration (SAMHSA), behavioral health is

> "the promotion of mental health resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities."[1]

We would like to thank the many state agencies, local partners, organizations and subject matter experts who dedicated their time to provide content and data to help shape the creation of this report.

Letter from Dr. Gerald Wilson, Chair of the South Carolina Behavioral Health Coalition

Seven years ago, IMPH recognized the need to examine our state's behavioral health infrastructure and service delivery system. Therefore, a taskforce was formed with the vision that South Carolina's behavioral health system and its supports be 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.

In 2015, IMPH released *Hope for Tomorrow: The Collective Approach for Transforming South Carolina's Behavioral Health Systems.* The report outlined 20 specific recommendations for bolstering our state's ability to care for people with mental illnesses and/or substance use disorders. The energy amongst stakeholders for action was unmistakable. This led to the formation of the South Carolina Behavioral Health Coalition (SCBHC) to provide a forum for collective action.[a] SCBHC is an unprecedented alliance of public and private agencies, organizations and health care providers collectively committed to improving the mental health and well-being of everyone in our state.[b]

I am proud to say that much has been accomplished over the last several years, and systems were positioned well to respond to the challenges created by the COVID-19 pandemic. This year's progress report focuses on five successes, where systems have been transformed to meet the needs of patients, and five opportunities for the next several years, where there is energy and interest to make investments and provide improved services.

To continue to make progress towards identified goals and objectives, we will continue to work collectively to address needs for all South Carolinians from cradle to grave. We recognize that this work takes collaboration and investment, and we are looking forward to the successes of the coming decade. We thank all the front-line behavioral health providers caring for our people and the leaders who lead through significant challenges and ever-changing circumstances.

Sincerely,

Gerald Wilson, MD

IMPH Behavioral Health Taskforce Board Liaison (2014-2015)
Chair, South Carolina Behavioral Health Coalition (2017-present)[c]
Surgeon (retired)

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[a] See Appendix A for the list of South Carolina Behavioral Health Coalition Participating Member Organizations
[b] See Appendix B for the South Carolina Behavioral Health Coalition Charter Highlights
[c] See Appendix C for the list of South Carolina Behavioral Health Coalition Core Leadership Team Members

Introduction

Background Data and Trends

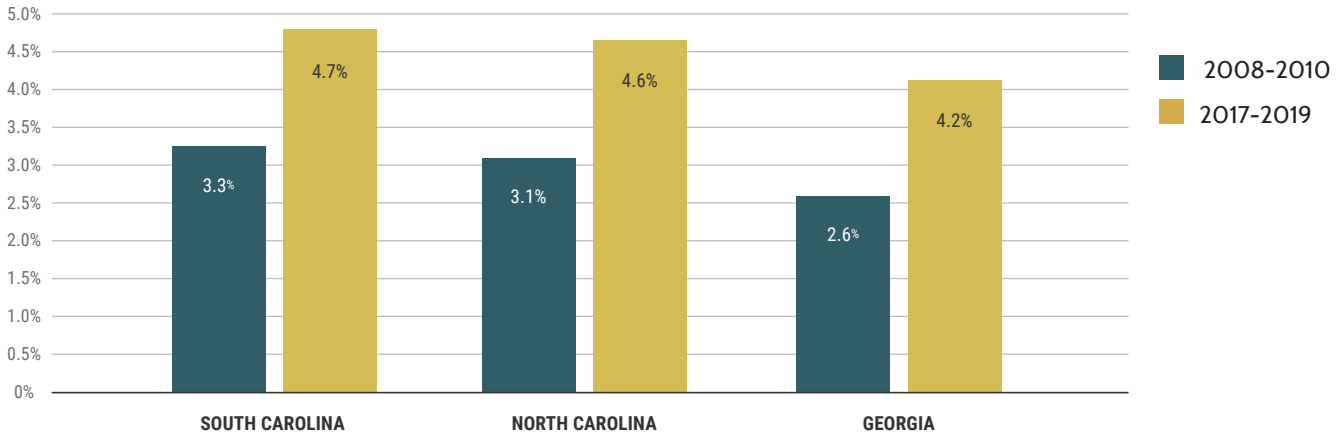
Behavioral health is influenced by complex patterns of social, economic and biological elements. Factors including traumatic life events, isolation and difficulty accessing care can accelerate serious mental illnesses or other behavioral health conditions.[2] Every year, an increasing number of Americans are diagnosed with behavioral health disorders, and the resulting burden of disease is consistently ranked among the highest of all illnesses in the United States.[3]

The disability adjusted life-year (DALY) is a measure of the total number of years lost to illness, disability or premature death in a population and is generally used to illustrate the burden of disability associated with a disease.[4] As of 2019, mental illness accounts for 6.6% of total DALYs across the country.[5] Substance use disorders (SUD) account for 6.7% of nationwide DALYs, which reflects a 144% increase between 1990 and 2019.[6] Major depressive disorder, anxiety disorders, drug use disorders, alcohol use disorders and schizophrenia account for the greatest amount of DALYs attributed to mental health and substance use disorders in the United States.[7]

Throughout the country there are more than 45 million Americans living with mental illness, including nearly a fifth of South Carolinians.[8] According to Mental Health America, 18.3% of South Carolinians reported a diagnosable mental, behavioral or emotional disorder in 2018 (illustrated in Graph 1 and Graph 2).[d,9] Between 2017 and 2019, the annual average prevalence of past-year serious mental illness in South Carolina was 4.7% (184,000 people).[14] The annual average prevalence for Georgia was 4.2% and North Carolina was 4.6%.[10,11]

GRAPH 1

Annual Prevalence of Past-Year Serious Mental Illness among Adults (18+) in South Carolina, North Carolina and Georgia, 2008-2010 and 2017-2019[12,13,14]



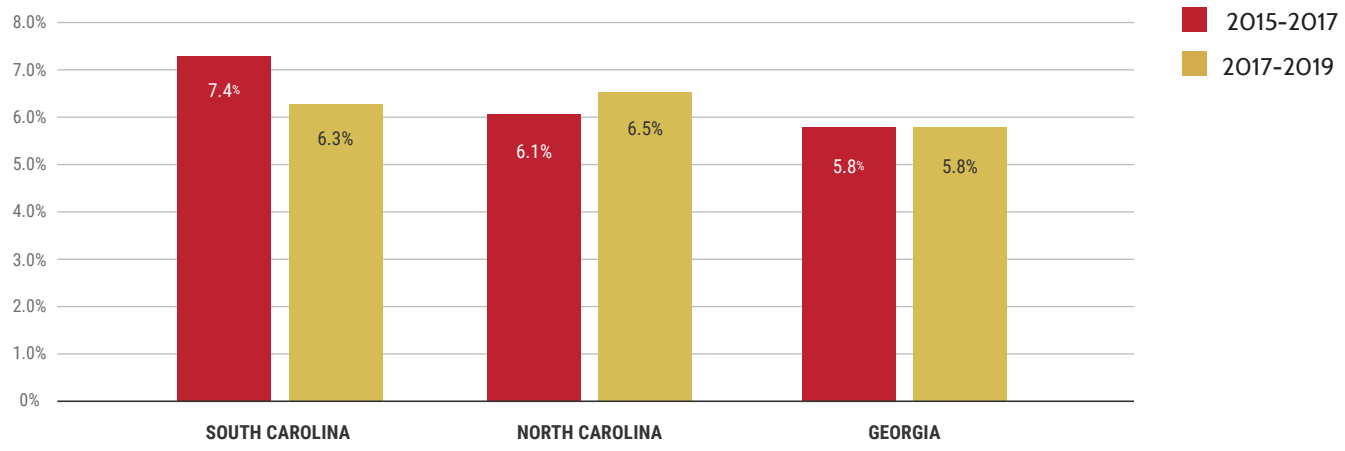
Source: Substance Abuse and Mental Health Services Administration, 2020

[d] See Appendix D for Mental Health America Rankings Methodology

The annual average prevalence of past-year SUDs among people aged 12 and older in South Carolina was 6.3% (268,000 people) between 2017 and 2019.[15] In terms of average prevalence of past-year substance use disorders, this places the Palmetto State below North Carolina but above Georgia.[16,17,18]

GRAPH 2

Annual Prevalence of Past-Year Substance Use Disorder among People Aged 12 and Older in South Carolina, North Carolina and Georgia, 2015-2017 and 2017-2019[19,20,21]



Source: Substance Abuse and Mental Health Services Administration, 2020

Deaths of Despair

Beginning in 2014, life expectancy in the United States began to decrease for the first time since 1979 due to deaths of despair.[22] "Deaths of despair" refers to deaths attributed to suicide, drug poisoning and alcoholic liver disease. These deaths are often the result of emotional, behavioral and biological factors manifested in feelings of hopelessness, defeat, guilt and loneliness.[23]

Concurrent to the observed decrease in life expectancy, morbidity and mortality associated with suicide, drug overdose and alcohol use disorders have steadily increased. In their book Tightrope (2020), authors Nicholas Kristof and Sheryl WuDunn explain,

> Life expectancy continues to rise in most of the rest of the industrialized world, but in the United States it has dropped for three years in a row—for the first time in a century. As we'll see, American kids today are 55% more likely to die by the age of nineteen than children in the other rich countries that are members of the Organization for Economic Co-Operation and Development, the club of industrialized nations. America now lags behind its peer countries in health care and high school graduation rates while suffering greater violence, poverty and addiction.[24]

Pointing to the correlation between poverty and deaths attributed to drugs, alcohol and suicide, authors and economists Anne Case and Angus Deaton attribute much of this challenge to the collapse of a strong middle class.[25,26] The relationships among unemployment, economic recession, isolation and deaths of despair are

complex. However, current trends in suicide, alcohol use disorders and drug overdoses paint a sobering picture of the depth of despair felt by communities.[27,28] As with deaths of despair, diseases of despair have also increased. Between 2009 and 2018, the national prevalence of alcohol-related diagnoses, substance-related diagnoses and suicide-related diagnoses increased by 68%.[29]

Addressing the mental and behavioral health disorders that lead to deaths of despair is a necessary component of reducing both morbidity and mortality. Research shows that mental and behavioral health disorders affect nearly one in four American adults, indicating a dramatic need across the country.[30]

Suicide

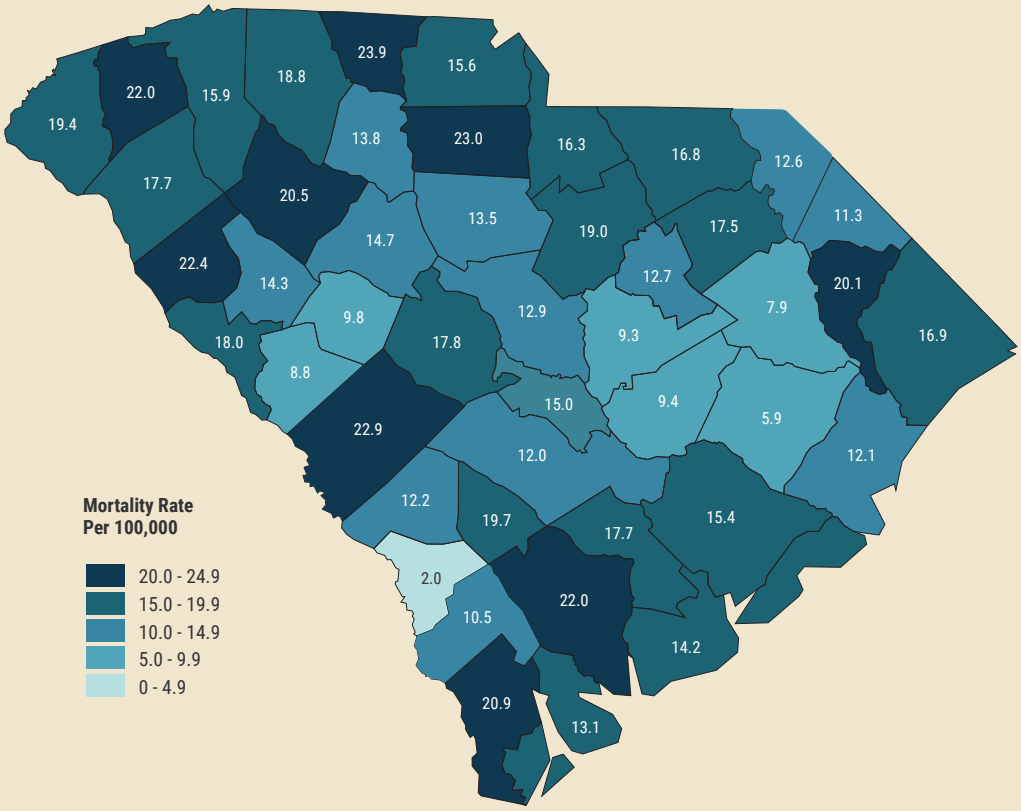
In 2019 alone, 47,511 lives were lost due to intentional self-harm in the United States.[31] In South Carolina, age-adjusted suicide rates have steadily increased over the past decade, from 13.5 deaths per 100,000 (637) in 2010 to 16.2 deaths per 100,000 (852) in 2019.[32,33]

Within South Carolina there are observable county-level differences in suicide deaths. Patterns in social fragmentation, social capital and socioeconomic status are often used to explore differences in suicide rates at the local level.[34] Data provided by the South Carolina Department of Health and Environmental Control (DHEC) illustrate that from 2016 to 2018 Cherokee, Chester, Aiken, Abbeville and Colleton Counties had the five highest three-year, age-adjusted suicide mortality rates per 100,000 in the state.[e,35] Map 1 below illustrates the differences in suicide mortality rates by county between 2016 and 2018.

MAP 1

Three-Year Age-Adjusted Suicide Mortality Rate per 100,000 in South Carolina by County 2016-2018[36]

Source: South Carolina Department of Health and Environmental Control, 2020

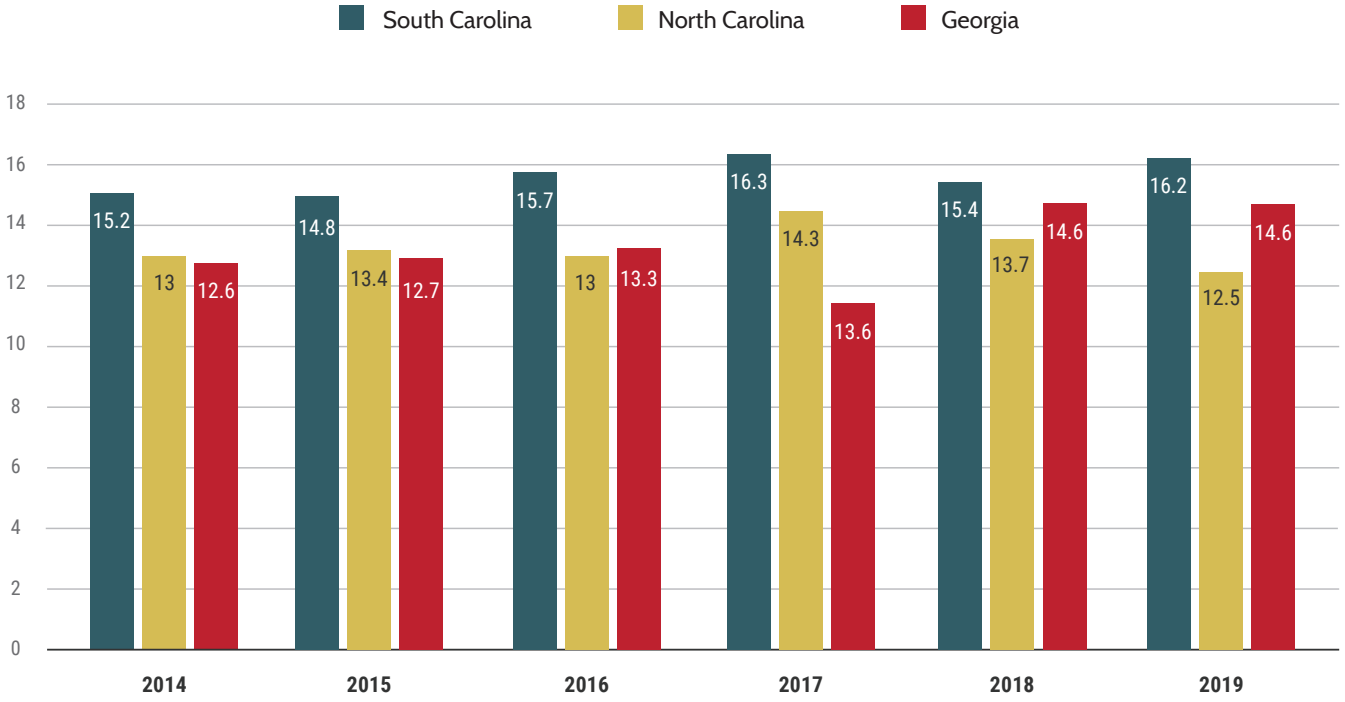


[e] See Appendix L for table illustrating county level, three-year age-adjusted mortality rate

Examining state-level differences in suicide rates is another valuable strategy. Suicide mortality in South Carolina has been consistently higher than immediate neighbors North Carolina and Georgia. Graph 3 below illustrates the adult suicide mortality rate in South Carolina, North Carolina and Georgia between 2014 and 2019.[37]

GRAPH 3

Five Year Age-Adjusted Suicide Rate per 100,000 in South Carolina, North Carolina and Georgia 2014-2019[38]



Source: National Center for Injury Prevention and Control, United States Centers for Disease Control and Prevention, 2020

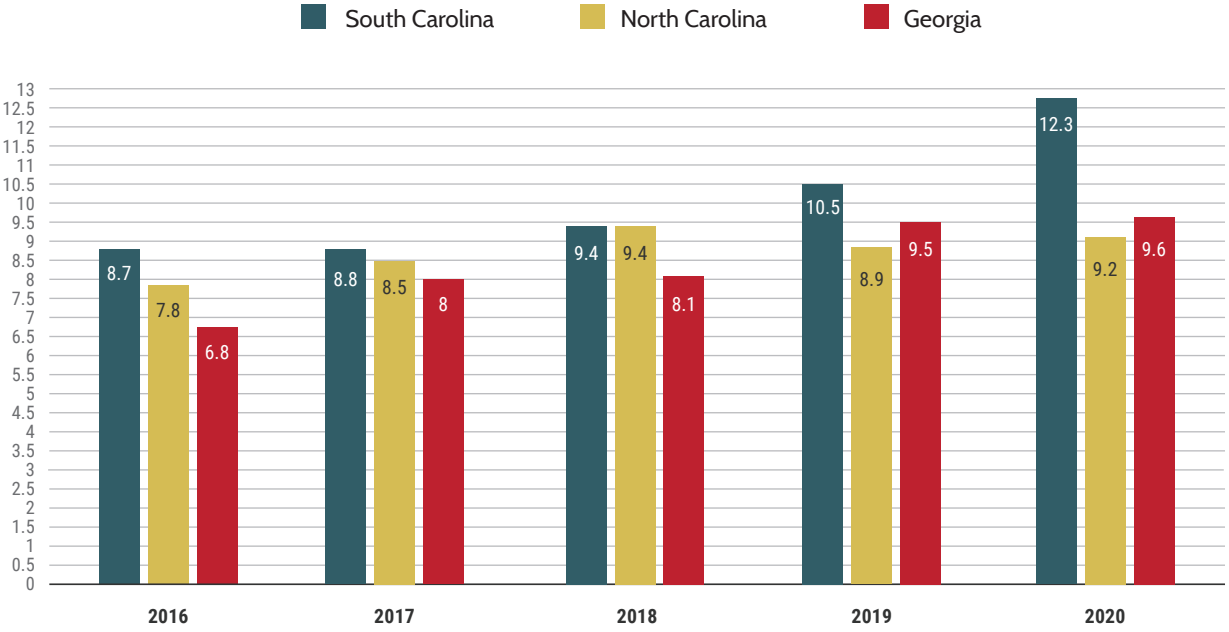
Children and youth are not exempt from the increase in behavioral health disorders. The National Survey of Children's Health reports that between 2018 and 2019, over eight million American children and adolescents were living with a diagnosed behavioral health condition.[f,39] Across the country, suicide is currently the second-leading cause of death among youth ages 14-18.[40] Between 2015 and 2019, suicide deaths increased 32% among adolescents aged 15-19 across the United States.[41]

In South Carolina, suicide is the third leading cause of death among youth age 10 to 24 and the eleventh leading cause of death across all age groups.[42] Compared to our closest neighbors, South Carolina has the highest youth suicide rate. Graph 4 below illustrates the number of deaths by suicide per 100,000 among adolescents between the ages of 15 and 19 in South Carolina, North Carolina and Georgia.[43]

[f] The National Survey of Children's Health (NSCH), funded and directed by the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB), provides information on the health and well-being of children ages 0-17 years in the United States. The NSCH is the largest national and state-level survey on the health and health care needs of children, their families and their communities.

GRAPH 4

Adolescent (Age 15 through 19) Suicide Mortality Rate per 100,000 in South Carolina, North Carolina and Georgia 2016-2020[44]



Source: National Center for Injury Prevention and Control, United States Centers for Disease Control and Prevention, 2021

Nationally, there are also notable gender and racial differences in adolescent suicide; for example, young men and young Indigenous American and Alaskan Natives are most likely to commit suicide.[45] However, the steepest increase in suicide rates in the past several years is found among young girls indicating that the gender gap in suicide mortality is shrinking.[46] In a longitudinal study occurring between 1975 and 2016, researchers found that suicide rates increased nearly 13% among young girls aged 10 to 14 between 2007 and 2016. During the same period, the suicide rate among young boys aged 10 to 14 rose by 7%.[47]

Understanding risk factors for youth suicide like behavioral health disorders, previous suicide attempts, impulsivity, challenging family dynamics, specific life events and the availability of means can provide meaningful insight into opportunities to diminish the feelings and opportunities which may lead to suicide.[48]

Drug Overdose Deaths

Concurrent to the rise in suicide deaths, there has also been an increase in deaths attributed to substance use disorders (SUD) over the past decade. The current epidemic of drug overdose deaths began during the 1990s because of the increase in natural and semi-synthetic prescription opioids for chronic pain.[49] In his book *Dreamland: The True Tale of America's Opiate Epidemic* (2015), Sam Quinones writes,

> In the United States, overdose deaths involving opiates rose from 10 a day in 1999 to one every half hour by 2012. Abuse of prescription painkillers was [the source of] 488,000 emergency room visits in 2011, almost triple the number of seven years before.[50]

Quinones goes on to explain that the average American is more likely to die from drug overdose than a motor vehicle accident.[51] The lifetime odds of dying from an opioid overdose for a person born in 2018 are one in 98, and the lifetime odds of dying from a motor vehicle accident for a person born in 2018 are one in 106.[52] These lifetime odds are approximated by dividing the one-year odds by the life expectancy of a person born in 2018 and reflect the likelihood of dying as a result of a specific accident.[53]

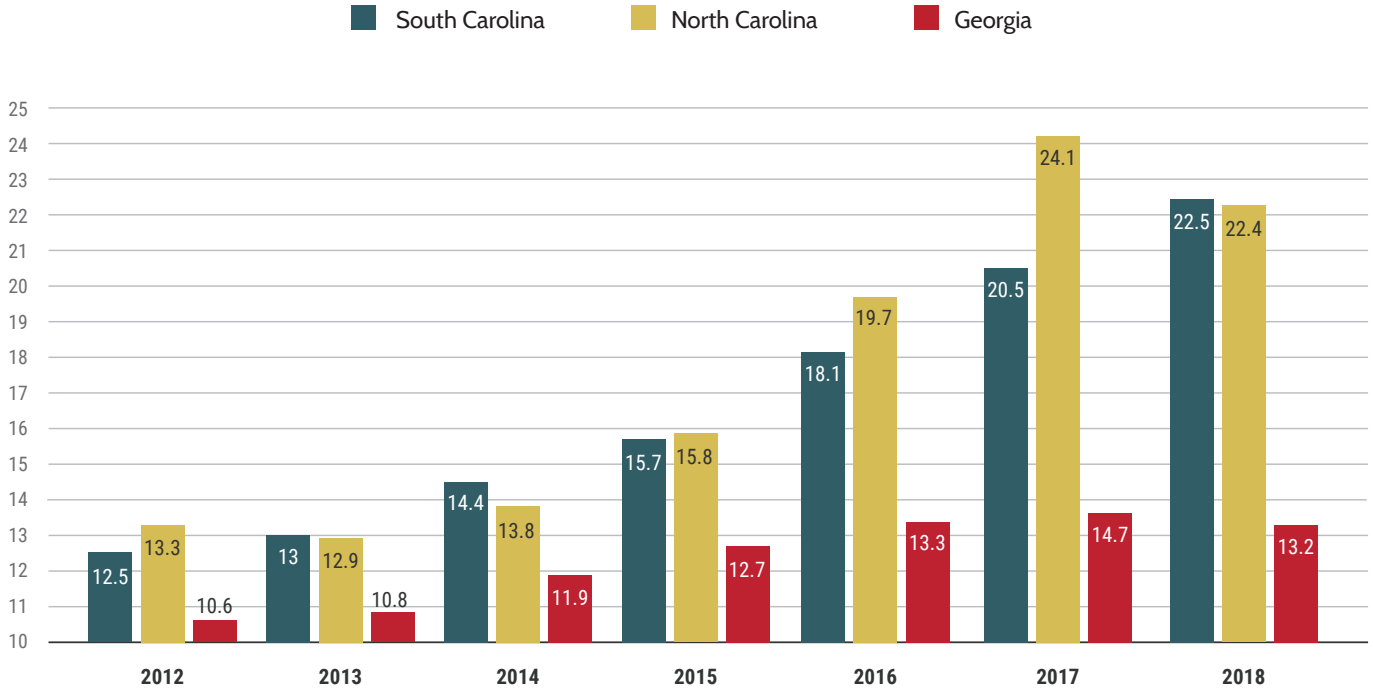
Nationally, the age-adjusted death rate attributed to opioid overdose is 14.6 per 100,000 as of 2019. In South Carolina, that number was 17.1 per 100,000 in the same year.[54]

Similarly, the age-adjusted death rate attributed to all drugs, which includes deaths from both intentional and unintentional overdose, has also increased in the past decade. The most recent data available as of January 2021 from the United States Centers for Disease Control and Prevention (CDC) reports that between 2012 and 2018 the rate of drug overdose deaths involving cocaine tripled, and the rate of deaths involving psychostimulants with misuse potential (i.e. methamphetamines) increased nearly five-fold.[55]

South Carolina recently witnessed a 10.2% single-year increase in the crude number of total drug overdose deaths across the state – from 1,001 deaths in 2017 to 1,103 deaths in 2018.[56] Graph 5 below illustrates the increase in drug overdose deaths between 2012 and 2018 in South Carolina, North Carolina and Georgia.[57]

GRAPH 5

Age-Adjusted Drug Overdose Death Rate per 100,00 in South Carolina, North Carolina and Georgia 2012-2018[58]



Source: United States Department of Health and Human Services. Centers for Disease Control and Prevention WONDER database, 2021

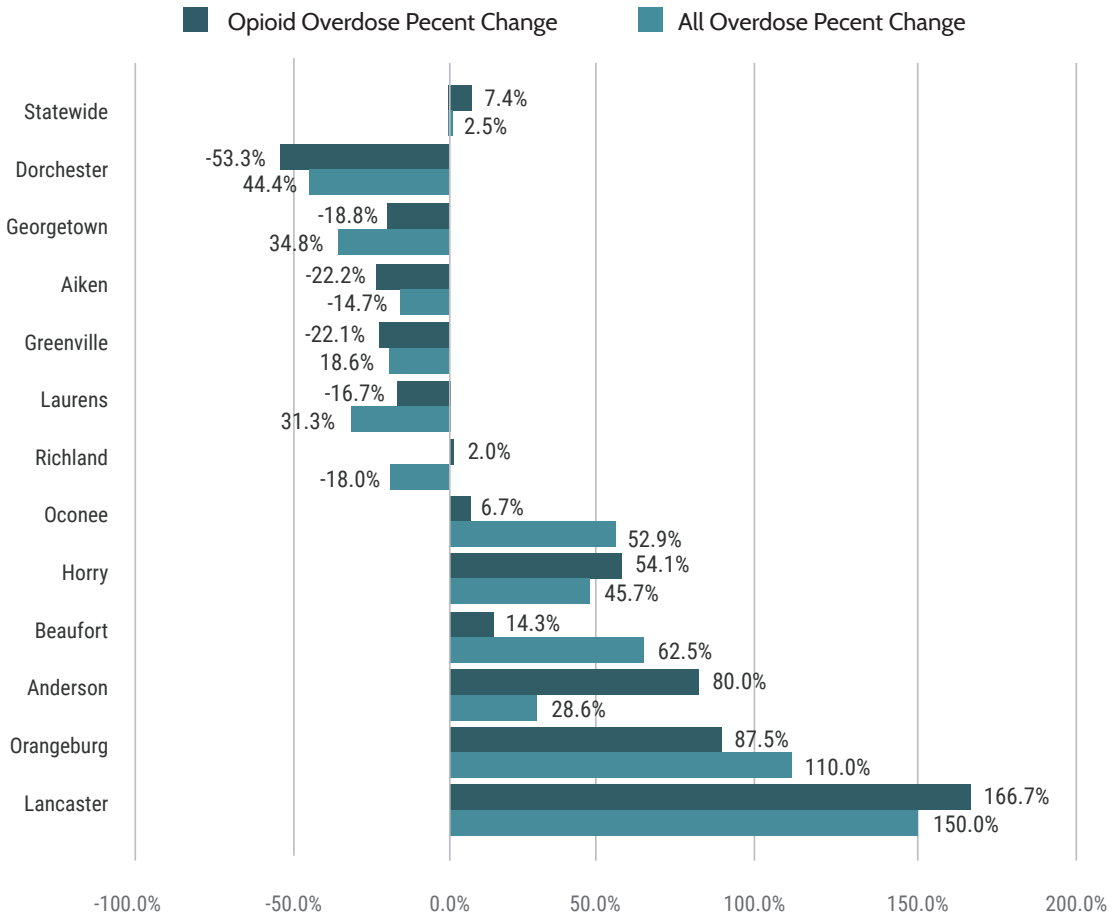
Across South Carolina, there are clear differences in drug overdose deaths by county and by drug. State agencies currently track overdose deaths attributed to prescription drugs, opioids, psychostimulants with misuse potential, fentanyl, heroin, methadone and cocaine. Excluding methadone, there has been an increase in drug overdose deaths attributed to each of these drugs between 2015 and 2019.[59]

Several counties had substantial increases in overdose mortality between 2018 and 2019. For example, Lancaster County witnessed a 167% increase in opioid related deaths between 2018 and 2019. Other large increases were seen in Orangeburg County (110% increase in total drug overdose deaths, 87.5% increase in opioid-related drug overdose deaths), Anderson County (28.6% increase in total drug overdose deaths, 80% increase in opioid-related overdose deaths) and Horry County (45.7% increase in total drug overdose deaths, 54.1% increase in opioid-related overdose deaths).[60]

The following graph shows the rates of change in selected counties between 2018 and 2019 in both nonspecific overdose deaths and overdose deaths attributable to opioids alone.[g,61]

GRAPH 6

Percent Change in Overdose Deaths in Selected Counties throughout South Carolina 2018-2019[62]

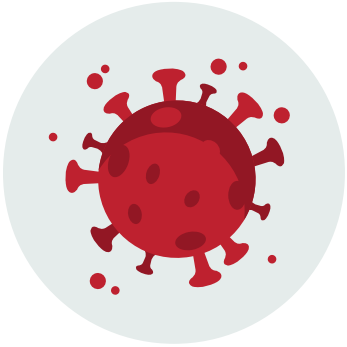


Source: South Carolina Department of Health and Environmental Control Vital Statistics, 2020

[g] See Appendix E for the Percent Change in Drug Overdose Deaths for all South Carolina Counties

Behavioral Health Impacts Attributed to the COVID-19 Pandemic

The increasing number of adults with a behavioral health disorder across South Carolina is alarming under any circumstance; however, with the arrival of COVID-19, the number of people suffering from serious mental illness and substance use disorders is expected to increase in response to isolation, uncertainty, stress and financial insecurity.[63]



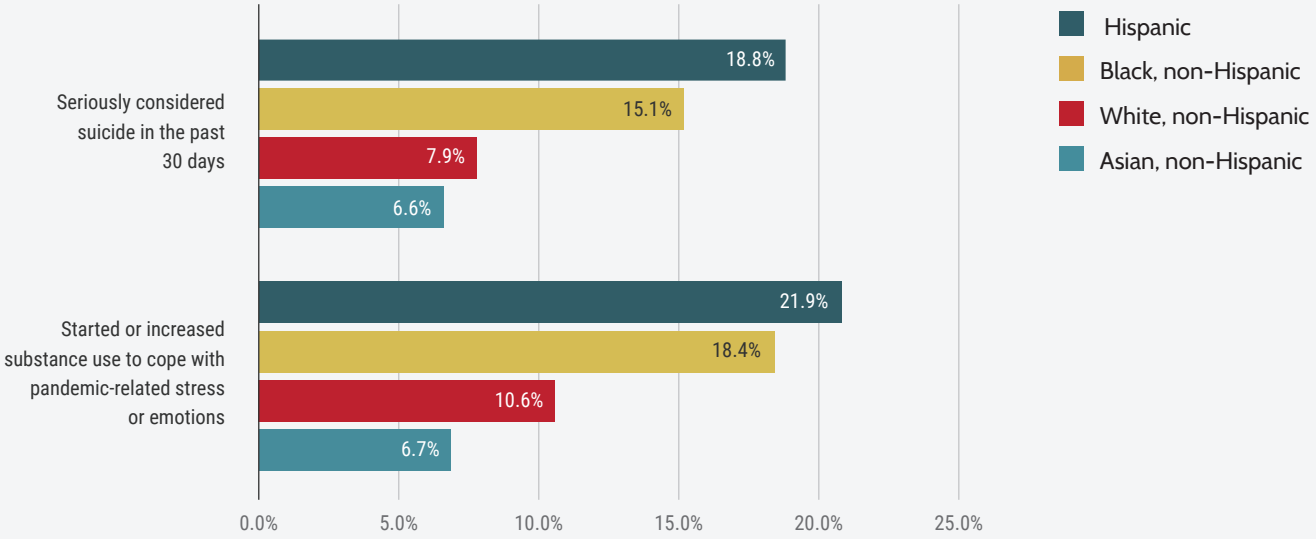
During the coronavirus pandemic, suicidal ideation, anxiety disorder and symptoms associated with major depression increased across the United States.[64] The result of a national, point-in-time survey administered between June 24 and June 30, 2020, indicates that 40.9% of adult participants reported an adverse mental or behavioral health outcome related to COVID-19.[65]

The survey results indicate that 13.3% of participants started or increased substance use to cope with pandemic-related stress.[66] The same survey found that 10.7% of participants seriously considered suicide in the month immediately prior.[67] This study found significant differences based on region, age, race and ethnicity, demonstrating that respondents from the South, young adults between 18 and 24 and Black and Hispanic participants are experiencing the most severe behavioral health impacts as a result of COVID-19.[68]

Survey results also showed that young adults aged 18 through 24 have suffered the most substantial negative mental health impacts due to the coronavirus.[69] Of the 731 survey participants between the ages of 18 and 24, 63% were symptomatic for generalized anxiety disorder and/or depressive disorder.[70] A global survey published in the journal *Progress in Neuro-Psychopharmacology and Biological Psychiatry* in 2020 reported that younger people are more vulnerable to stress, depression and anxiety symptoms associated with COVID-19.[71] The graphs below illustrates the responses described in the nationwide study discussed above.

GRAPH 7

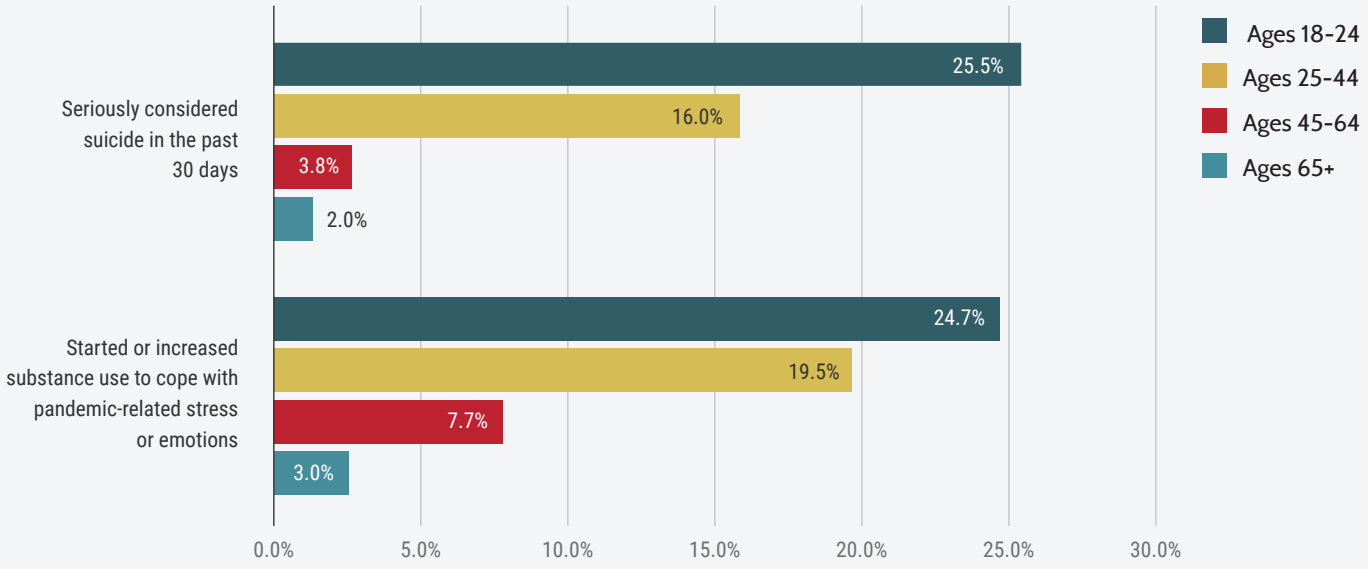
Adult Mental and Behavioral Health Outcomes during COVID-19 by Race/Ethnicity, the United States, June 24-30, 2020[72]



Source: Czeisler MÉ, Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, 2020

GRAPH 8

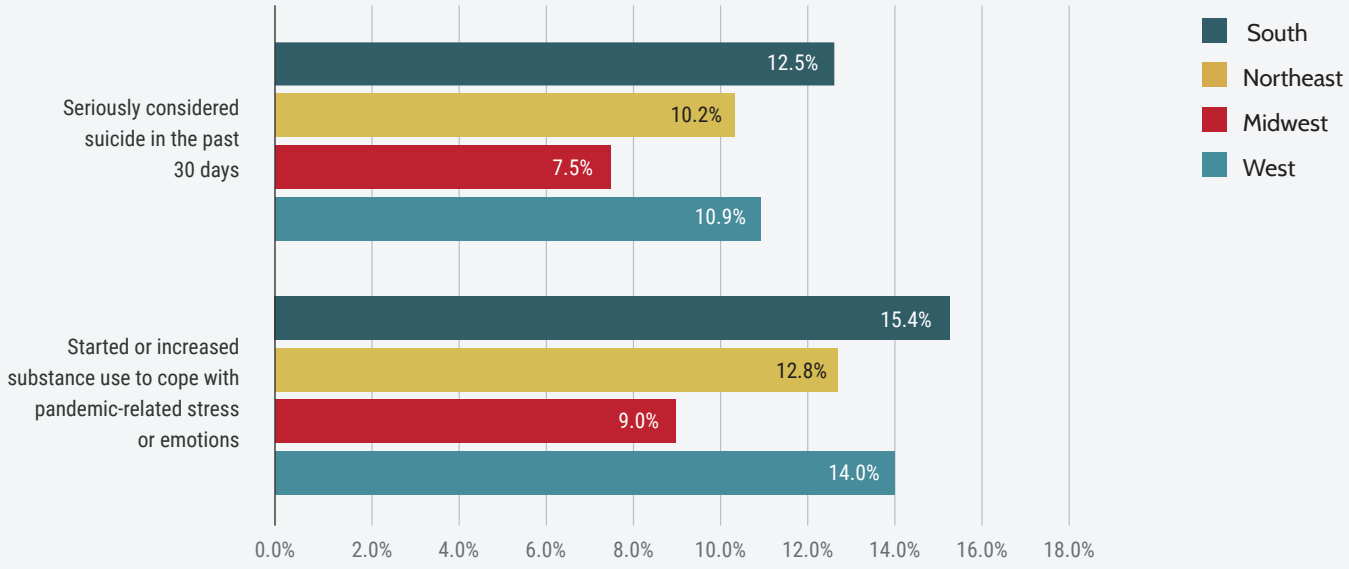
Adult Mental and Behavioral Health Outcomes during COVID-19 by Age, the United States, June 24-30, 2020[73]



Source: Czeisler MÉ, Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, 2020

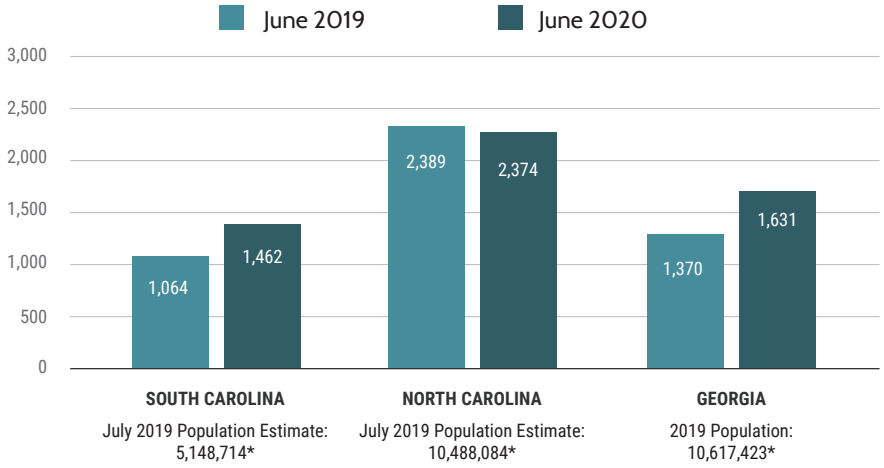
GRAPH 9

Adult Mental and Behavioral Health Outcomes during COVID-19 by Region, the United States, June 24-30, 2020[74]



Source: Czeisler MÉ, Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report, 2020

Provisional overdose data indicates that the United States had a 19.5% increase in drug overdose deaths between June 2019 and June 2020.[75] The national increase in suspected opioid overdoses is believed to be associated with the COVID-19 pandemic.[76] Stressors associated with isolation, financial insecurity and job losses resulting from the pandemic are believed to have increased the risk of relapse among people in recovery.[77] Graph 10 illustrates the raw number of provisional predicted overdose deaths in South Carolina, North Carolina and Georgia in June 2019 and in June 2020. This does not adjust for differences in population size, which partially explains the large differences among the states.



GRAPH 10

Provisional Predicted Overdose Deaths by State June 2019 and June 2020[78]

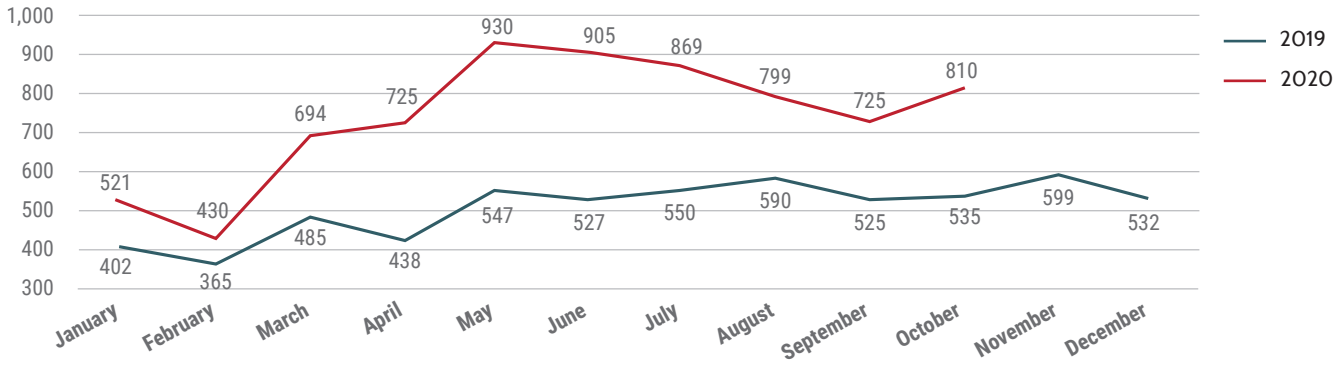
Source: National Center for Injury Prevention and Control, United States Centers for Disease Control and Prevention Vital Statistics Rapid Release Provisional Drug Overdose Death Counts, 2021

* Population gathered from the American community survey annual estimates, July 2019.[79]

In South Carolina, data from DHEC reflects what many subject matter experts cautioned at the beginning of the pandemic: morbidity and mortality rates related to opioid overdoses will rise in tandem with the viral spread.[80] Graph 11 below illustrates the increase in number of monthly suspected opioid overdoses and first responder naloxone administration between January 2019 and October 2020.[h,81]

GRAPH 11

South Carolina Suspected Opioid Overdose and First Responder Naloxone Administration, 2019 and 2020[82]



Source: Bureau of Emergency Medical Services and Trauma South Carolina Department of Health and Environmental Control, January 2019 – October 2020

Although pandemic-related statistics are troubling, COVID-19 has merely worsened an existing crisis. Recognizing the likely correlation between the coronavirus pandemic and the anticipated increase in suicide and opioid-related overdoses, suicide prevention and drug overdose prevention are essential components of a comprehensive pandemic response.[83,84]

[h] This data set includes all suspected opioid overdoses including those which did not result in death.

COVID-19 Pandemic Response

The coronavirus pandemic has illuminated our collective need for comprehensive response planning moving forward; specifically, we need a pandemic response plan that includes a robust behavioral health strategy.[85] On March 13, 2020, South Carolina Governor Henry McMaster declared a State of Emergency in response to the status of the coronavirus pandemic by implementing Executive Order 2020-08.[86] Since then, local and state agencies adjusted to respond to the State of Emergency while continuing to provide necessary behavioral health treatments and services to patients across the state. By March 31, 2020, there were an estimated 1,083 total confirmed cases of individuals infected with the virus across the state.[87]

As of February 17, 2021, South Carolina reported over 429,494 confirmed cases of COVID-19.[88] As cases continued to rise throughout 2020 and 2021, the need for behavioral health treatments and services increased as communities across the state faced significant mental health challenges due to social isolation, morbidity, bereavement, stress and anxiety.

The pandemic directly impacted the ability of patients to receive treatments and services through traditional in-person appointments. Between March 19, 2020 and April 16, 2020, the South Carolina Department of Health and Human Services (SCDHHS) issued seven Medicaid policy bulletins that extended the state's existing telehealth benefit and created new flexibilities to maintain access to care during the pandemic.[89] The South Carolina Behavioral Health Coalition (SCBHC) wrote to SCDHHS in early April to advocate for "the temporary approval of all community mental health services currently billable to Medicaid when delivered face-to-face to also be billable when delivered telephonically."[90] In the same letter, SCBHC voiced support for the adoption of telehealth services through local alcohol and drug abuse authorities.[i] In addition to the changes announced via Medicaid bulletins, on April 17, 2020, SCDHHS issued additional guidance clarifying the applicability of the Medicaid bulletins for local alcohol and drug abuse authorities.[91]

Additionally, on June 9, 2020, SCBHC wrote a letter to the Governor to provide information about the rising behavioral health needs across the state. This letter outlined potential COVID-19 policies including post-pandemic policy and funding approaches to improve access to behavioral health services in South Carolina. The SCBHC requested legislative support on COVID-19 Relief Funds & Extension of COVID-Related Policies including:

- Maintain and continue to expand telebehavioral health infrastructure across the state;
- Fund COVID-19 related eligible incurred and projected expenditures related to behavioral health services;
- Provide a minimum of $5 million in new funding to increase the number of psychiatric beds in response to anticipated increase in behavioral health crises;
- Increase funding for rental assistance to mitigate homelessness for mentally ill citizens;
- Provide funding to Mental Health America of South Carolina to secure 20 permanent housing units for people with serious mental illness; and
- Expand the digital infrastructure and broadband services to support behavioral health and other health care services in rural and remote areas of the state.[j,92]

Governor McMaster signed Act 142 on June 25, 2020, authorizing the expenditure of federal funds to be used

[i] See Appendix F for full letter to Director Baker, South Carolina Department of Health and Human Services
[j] See Appendix G for full letter to Governor McMaster, State of South Carolina

for the expansion of telehealth and broadband infrastructure across the state.[93] His endorsement of telehealth mirrored the Center for Medicaid and Medicare Services (CMS) strategy. In March of 2020, CMS expanded access to telebehavioral health through the national "Hospitals Without Walls" waiver.[94] Both of these actions provided additional flexibility to providers to be reimbursed for telephonic services.

On March 28, 2020, SCDHHS provided an update to COVID-19 telehealth policies in three sections: "The first explains SCDHHS' existing telemedicine benefit and flexibilities that were in-place prior to this bulletin. The second announces new and temporary flexibilities available to providers during the COVID-19 outbreak, which requires unprecedented social distancing. The third details guidelines to ensure quality of care."[95]

The additional flexibilities allowed providers to be reimbursed for individual psychotherapy, family psychotherapy, psychiatric diagnostic evaluations, behavior modification therapy, psychosocial rehabilitation services and remote family support services for the duration of the public health emergency.[96] Many other organizations and agencies have responded to behavioral health needs exacerbated by the coronavirus including the South Carolina Department of Mental Health (DMH), the Department of Alcohol and Other Drug Abuse Services (DAODAS) and the South Carolina Department of Health and Environmental Control (DHEC).

South Carolina Department of Mental Health's Response

In response to the pandemic, DMH increased the number of staff working remotely while continuing to provide services for community members. Leadership at the agency's treatment facilities, clinical programs and support services have worked to reduce the number of staff on-site while continuing to maintain productivity. DMH reports daily to the State Department of Administration the numbers of its employees who are physically on-the-job, working from home, on-leave or scheduled to be off and any whose absence is known to be the result of a COVID-19 infection or presumed infection.[97]

DMH clinical and administrative programs continue to address the challenges posed by the pandemic. As a health care provider, community mental health centers (CMHC) and clinics remain open with reduced staff to serve new patients and walk-ins with urgent circumstances.[98] All locations are equipped with an on-site nurse for patients who receive injectable medication. For patients who are still seen in a CMHC, the clinical setting is arranged to maintain a safe distance between the patient and provider.[99]

The coronavirus pandemic has also affected the way DMH delivers health care on a day-to-day basis. Some of the smaller clinics have reduced hours of operation, extending virtual care to most existing patients. Although all staff are considered essential employees, most of their clinical staff and support staff are equipped to work from home.[100]

While providing services virtually is proving to be successful for many patients and clinical staff, there are significant exceptions. Some patients are not able to be consistently and reliably reached by telephonic or telehealth means.[101] During this time, all centers remain open and are providing in-person services for emergent, urgent, new intakes or patients who need injections. All other services are delivered by telemedicine.[102]

Administration

Of the administrative staff who are still working in the building, a number are splitting time working virtually from home or staggering their hours to reduce the density of staff working in the building at any given time. Since unique issues related to the virus arise every day, senior management continues to meet daily. More than half of the senior staff are now participating in the meeting by phone or Skype. Policies, procedures or memoranda to address the issues raised are discussed, initiated and revised on a continuing basis as additional information and new guidance from public health and other governmental officials is received. The State Mental Health Commission's monthly meetings have been held via Zoom, which is expected to continue throughout the pandemic.[103]

Hospitals, Nursing Homes, Community Mental Health and Community Residential Care Facilities

DMH operates three licensed psychiatric hospitals and four nursing homes. Beginning March 13, 2020, DMH began limiting visitation at all inpatient psychiatric hospitals, nursing homes and community residential care facilities to limit risk of exposure to the virus.[104] Although visitation requirements vary by facility, DHEC provides guidelines for both indoor and outdoor visitation which include screening, face covering and social distancing requirements.[105] Observation and isolation areas were also established in each inpatient facility, and a negative COVID-19 test is required of all new residents before admission.[106]

To further limit exposure, DMH staff are screened prior to entry to the hospitals and nursing homes. Staff are asked a series of questions about their health and the health of those with whom they reside, and their temperature is taken.[107] If the employee appears ill, verbally indicates the likelihood of exposure or has a high temperature, they are sent home. The human resources department works with employees who are sent home regarding sick leave.[108]

One challenge for DMH inpatient hospitals and nursing homes, in common with hospitals and nursing homes throughout the nation, is having an adequate supply of personal protective equipment (PPE) consisting of masks, gloves, gowns and face shields.[109] According to a December 2020 national AARP analysis, 16.5% of nursing homes in South Carolina did not have a one-week supply of PPE.[110] Providing suitable PPE to staff and patients is necessary across the spectrum of health care settings, but there are unique challenges for infection control in the inpatient psychiatric setting.

Providing a safe, therapeutic treatment environment for patients with an infectious disease is a tremendous challenge for many psychiatric hospitals. Patients in DMH hospitals may sleep in a shared room and, with few exceptions, patients mingle throughout the day while attending therapy groups, participating in treatment teams and receiving medication.[111, 112]

By November 2020 over 10,000 coronavirus cases were traced to residential care facilities in South Carolina.[113] Although many of these cases occurred in private facilities, by December 2020 an excess of 250 cases had occurred at DMH nursing homes.[114] By mid-May 2021, nearly 12,500 resident cases had been reported in South Carolina nursing homes and residential care facilities, resulting in 1,935 resident deaths. Similarly, 7,732 staff cases have been reported as of May 19, 2021 and 29 staff have died as a result.[115]

DMH nursing homes include C.M. Tucker Stone Veterans Pavilion, C.M. Tucker Roddey Pavilion General Nursing Care Facility, Campbell Veterans Nursing Home and Victory House Veterans Nursing Home. Cumulatively, the four of these facilities have reported a total of 308 resident cases, 68 resident deaths, 234 staff cases and 3 staff deaths as of May 18, 2021.[116]

Community Mental Health Centers

DMH currently operates 16 CMHCs and 43 mental health clinics (MHC) across the state. The majority of CMHC and MHC staff are equipped to work from home, and as a result many existing patients are receiving services remotely.[117] Since providing therapy services virtually is a new experience for most staff, management is ensuring that staff working from home have continued access to supervision. CMHCs and MHCs are supporting clinical staff working remotely by having designated lead clinicians available for consultation throughout the day.[118]

Several CMHCs and MHCs remain open to see new patients, serve walk-ins with urgent circumstances and to provide injections when necessary. Some clinics placed tents in their parking lots for patients who need to be seen in person.[119] These tents are used to screen patients and staff before entering the building, and they enable patients needing injections to receive them without entering the facility. The in-house clinical settings for patients who are seen at a CMHCs or MHCs are arranged to maintain a safe distance between the therapist and patient.[120]

SC HOPES

DMH and DAODAS received an emergency COVID-19 grant from SAMHSA to develop a call center to manage the increase in community behavioral health needs resulting from the coronavirus pandemic.[121] The funds were used to create SC HOPES, which serves as a crisis counseling line for community members and health care workers.[122]

The SC HOPES line will be sustained until the fall of 2022 with funding from the Consolidated Appropriations Act of 2021 passed by the United States Congress.[123] DMH partnered with DAODAS in the development of the SC HOPES line to reach individuals who may be experiencing problems with substance misuse or who have both mental illness and substance use disorders and need assistance. DMH and DAODAS have a three-pronged approach to address the barriers to care via the following programs:

1. The Crisis Counseling Program telephone resource line, a clearinghouse for callers experiencing serious mental illness and/or substance use disorder to access brief telephonic intervention and to link to more intensive mental health services and care provided by DMH and/or DAODAS;
2. A Financial Assistance Program to cover fees for DMH services and assist with medication costs for (1) the justice-involved population with a serious mental illness or mental illness who are facing reentry into society, (2) those with mental illness and (3) health care workers affected by mental illness; and
3. The Healthcare Outreach Team, a program specifically designed to assist health care workers experiencing a mental illness due to COVID-19 by providing them with access to telehealth services. As part of the financial assistance element of this project, these workers, who are often underinsured or uninsured, will also be eligible for financial assistance to cover services and medication.[124]

Those taking calls on the SC HOPES line will not only be a sympathetic ear but will also be able to link callers to whatever level of behavioral health service they may need. Staff have the capacity to connect callers through to their nearest CMHC or to a substance use disorder treatment program. Those having a crisis will be connected to the DMH 24/7 Mobile Crisis Response program. DMH expanded the crisis line to include a Spanish-language number in late August 2020.[125] Between June 1, 2020, and January 21, 2021, the SC HOPES call center received a total of 1,462 unique calls.[126]

South Carolina Department of Alcohol and Other Drug Abuse Services Response to the Pandemic

DAODAS directs treatment and recovery services for South Carolinians in need. The agency has been instrumental in the design and implementation of the SC HOPES line and the companion website and continues to provide information online and through the media regarding harm reduction, naloxone distribution and overdoses.

DAODAS contracts with 32 separate local agencies throughout the state and over 50 direct treatment service providers, and reports that the coronavirus pandemic response has varied based on location and services being provided. While some treatment and prevention programs have moved to an in-person appointment only model, others are being offered online via Zoom or other video meeting software.

At the beginning of the pandemic, a considerable amount of attention was focused on access to medication-assisted treatment (MAT) for people who are in recovery. Community members who rely on these services are especially vulnerable to disruptions in their treatment plan and the traditional provision model, such as daily dosing in a public pharmacy, creates an environment in which pharmacists and patients are at an increased risk of contracting COVID-19.

Telebehavioral Health Service Expansion

The South Carolina Board of Medical Examiners (BOME) issued the Public Health State of Emergency Order 2020-BME-PH-05 on March 22, 2020. This order ensures that South Carolinians have quality services to prevent and reduce the consequences of substance misuse and addiction during the COVID-19 pandemic by providing guidance on the use of telemedicine for treating new and existing patients with MAT.[127] MAT is a combined treatment of behavioral therapy and medication for substance use disorders.[128] This form of treatment, primarily used for opioid disorders, provides long-lasting effects that help patients sustain recovery.[129]

On April 3, 2020, DAODAS issued a memorandum to all directors of County Alcohol and Drug Abuse Authorities regarding the delivery of MAT services via telemedicine. The memorandum advises practitioners who wanted to begin MAT with new patients via telemedicine to request that DAODAS petition the BOME for approval on their behalf.[k,130]

DAODAS further responded to the need for telehealth services by authorizing a $5,000 budget to county authorities for the acquisition and distribution of cellular telephones and pre-paid minutes to patients.[l] The distribution of personal devices ultimately increased the use of telehealth services and on April 17, 2020 SCDHHS further expanded reimbursements for telephonic services.[m,131]

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[k] See Appendix F for full letter to Director Baker, South Carolina Department of Health and Human Services
[l] See Appendix G for full letter to Governor McMaster, State of South Carolina
[m] See Appendix G for full letter to Governor McMaster, State of South Carolina

Treatment for Substance Use Disorder

The coronavirus pandemic has introduced a tremendous barrier in the provision of SUD prevention and management programs. Although South Carolina had an increase in opioid deaths for a fifth consecutive year in 2020, many prevention services have been moved online to accommodate social distancing guidelines.[132] Although services have been modified, no services have been entirely withdrawn.[133]

Naloxone Distribution

DAODAS spent more than $1.6 million to provide Narcan to South Carolinians during federal fiscal year 2020, which ran from October 1, 2019 through September 30, 2020.[134] During that period, the agency distributed a total of 18,160 naloxone kits to community distribution organizations across the state to include treatment service providers, recovery organizations, health care providers and state agencies. Partnering with the South Carolina Department of Health and Environmental Control Bureau of Emergency Medical Services and Trauma, DAODAS provided 4,379 naloxone kits to first responders.[135]

As of December 2020, DAODAS has also approved 62 community organizations as community distributors of naloxone.[136] As a result of the pandemic, DAODAS arranged to provide Narcan for all Opioid Treatment Programs (OTP) across the state to build their capacity to meet the needs of the growing number of patients. This program continued through September 30, 2020, and thereafter, all OTPs interested in obtaining additional Narcan for their patients were required to submit paperwork to join the Crisis Narcan Program and become designated as a community distributor. In the event of a future public health emergency or stay-at-home order due to a crisis, DAODAS will again ensure that Narcan is available to all OTPs to ensure the safety of patients.

South Carolina Law Enforcement Division Response to the Pandemic

The coronavirus pandemic has negatively impacted the way the South Carolina Law Enforcement Division (SLED) investigates drug trafficking organizations due to delays in court proceedings and engagement with witnesses and informants. In March 2020, SLED suspended Phase I of their reentry plan based on the Governor's Executive Order 2020-11, directing all non-essential employees to refrain from reporting to work physically or in-person until further notice.[137] The reentry plan was later amended to begin a phased approach allowing employees to return to work under safe conditions.

However, federal and state court systems have slowed or delayed in-person court trials. Since the pandemic, repeat offenders are continually being released through lower bonds before their scheduled trial date. Active investigations require agents to engage witnesses through interviews and undercover operations since the pandemic made the environment less safe for agents and witnesses, and cases were delayed as a result.[138,139]

Additionally, since the onset of the pandemic, the number of individuals with behavioral health illnesses who use illicit drugs has risen. As OERT and SLED monitored EMS and first responder response, suspected opioid overdoses were 51% higher as of October 2020 compared to October 2019.[140] As of July 1, 2020, fentanyl

accounted for 5.6% of all drug seizures, rising from 4.8% in 2019.[141] South Carolina does not have a Fentanyl Analogue Trafficking statute which would provide law enforcement with additional resources to combat the dangerous substance.[142]

To lessen the risk of exposure to COVID-19, alcohol enforcement agents stopped using underage informants when investigating cases that involve the sale of alcohol by businesses to individuals under the age of 21. As a result, the number of cases against these businesses has dropped. Alcohol agents are now tasked with enforcing the Governors Executive Order 2020-20[143] which requires officers to investigate businesses that have on-premises Alcohol Beverage Licenses and violate the safety requirements under the Executive Order. An increase in staffing and resources in responding to complaints against business violators has put a strain on SLED and reduced its ability to answer requests from other law enforcement agencies and the public in a timely manner.

Just Plain Killers and the Pandemic

In March 2020, the Just Plain Killers Education Campaign developed two new messages that targeted families quarantining at home during the statewide shutdown period. These messages focused on encouraging parents to explore methods for storing retail prescription drugs safely and to pause and talk to their children about the dangers of prescription drugs.[144]

The Pause to Talk campaign aired on both television and through social media between April 2020 and May 2020. These messages generated over one million video views through Facebook and YouTube.[145] The 1-2-Breathe campaign, which educated families on how to reverse an opioid overdose, aired four videos on Facebook and Hulu. The Facebook campaign aired between April 15, 2020, and May 31, 2020, and the Hulu campaign aired beginning June 29, 2020, through August 9, 2020.[146] The 15-second videos had combined impressions of 903,356 with a 53% video completion rate.[147]

Planning for continuous education and communication was already in progress at the onset of the pandemic which allowed DAODAS to successfully pivot to provide timely updates on the impact of COVID that reflected new strategies and adaptations. The immediate need for increased emergency planning called for crisis preparation for opioid treatment providers. The increase in emergency planning included the following:

1. Authorization of 14-day and 28-day take-home doses of methadone for approximately 7,000 patients;
2. Rapid Narcan distribution, which included nearly 6,500 boxes ordered and shipped for free distribution across the state;
3. Approval of reimbursement of Medicaid clinical telehealth services through SCDHHS and DAODAS for crisis management, individual psychotherapy, peer support, case management and/or any other behavioral health services provided via telehealth or telephone;
4. SC HOPES support line for 24/7 mental health and addiction support; and
5. Virtual recovery services and online mutual aid groups.[148]

Palmetto Care Connections and the Pandemic

Local county authorities were forced to adjust to delivering services in an unconventional manner due to the coronavirus pandemic. Although the adjustment period varied, most entities now have a pandemic response protocol on their websites; as of September 2020, most entities now offer both telehealth and in-person services.

With resources provided through Palmetto Care Connections for the Rural Health Network Development (RHND) Program, each county authority was successful in modifying methods in which they deliver services during COVID-19. Because each site was already equipped with telehealth carts and direct-to-consumer telehealth platforms, utilizing telehealth to serve patients during the pandemic was an uncomplicated transition. Between January 1, 2019, and May 19, 2020, members of the South Carolina Behavioral Health Telehealth Network provided almost 33,000 telehealth consults.

Since the onset of the pandemic, additional key successes implemented by Palmetto Care Connections to expand access to telehealth services include the following:

1. Creation of 500 accounts via the direct-to-consumer platform Vidyo;
2. Medicaid reimbursements for Medicaid members that receive one-on-one counseling services; and
3. Reimbursement for behavioral health telehealth visits for most payers.[149]

South Carolina Department of Health and Human Services Responds to Pandemic with Flexibility in Utilizing Telehealth

On March 28, 2020, the South Carolina Department of Health and Human Services (SCDHHS) issued Medicaid Bulletin 20-009, which clarified previously issued guidance on responding to the coronavirus and outlined the COVID-19 telehealth policy updates regarding temporary modifications to policies related to telehealth coverage.[150] The bulletin created temporary flexibilities for the delivery of behavioral health services throughout the duration of the federal public health emergency in addition to the Medicaid State Plan's existing telehealth benefit and other flexibilities announced by the agency during the pandemic.[151]

Exclusions that remain in place during the pandemic include:

1. Only individual services are eligible for telemedicine. Group or multi-family interventions are not reimbursable, nor are services with a staff-to-beneficiary ratio that is greater than one-to-one;
2. Providers may not conduct interventions remotely with more than one individual concurrently and must conclude any intervention or visit with one patient before commencing an intervention or visit with the next; and
3. Providers must still follow the course of therapy and limitations detailed in the beneficiary's IFSP or FSP.

School Mental Health Services during the COVID-19 Pandemic

In March 2020, South Carolina schools shut down as a result of the COVID-19 pandemic, and in a matter of weeks, therapists readjusted to provide virtual and telephonic services using software compliant with the Health Insurance Portability and Accountability Act.[152] Drop-in contact and services became available during this time, and mental health centers adapted to provide additional resources.[153] Family therapy sessions increased during the latter part of the school year and throughout the summer as students quarantined at home with their families.[154] From June 1, 2020, to June 30, 2020, 8,513 patients received school mental health services, an increase of about 15% from June 2019.[155]

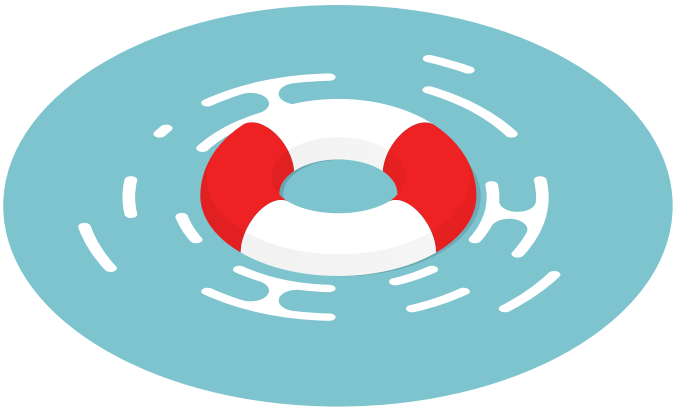
Youth in Crisis

Mental Health America of Greenville County (MHAGC) operate three crises support and intervention lines; The National Suicide Prevention Lifeline, CRISISline and TEENline. MHAGC responds to calls, texts and online chat requests 24 hours and seven days a week. Trained volunteers, AmeriCorps members and employees undergo over 60 hours of training before serving on the lines. For all three services, these trained adult and teen crisis intervention specialists provide confidential and non-judgmental active listening, information and referrals to resources and crisis intervention.

1. The National Suicide Prevention Lifeline (Phone and Chat Services 1-800-273-TALK/8255) was launched nationally in 2004. Multiple agencies in South Carolina have answered the line for certain regions in the state since that date. MHAGC has answered calls for the Lifeline for the Upstate region since 2007. Due to a lack of funding, the other agencies in the state have had to cease Lifeline operations. In early 2019. MHAGC was the only agency in the state answering Lifeline calls. It began answering calls for the entire state in September 2019, an opportunity made possible through two temporary national grants. MHAGC currently responds to Lifeline calls and online chat requests. The main grant supporting MHAGC answering Lifeline calls in South Carolina will end in September 2021, and no ongoing funding to continue this service has been secured.[156]

2. The CRISISline (Phone, Text and Chat Services 1-864-271-8888; Text-CRISISline to TEXTME/83983) has been operating since 1990 and currently provides telephonic, online chat and texting options. As of Fall 2020, MHAGC no longer has funding for this service and is, therefore, considering discontinuing its CRISISline telephonic operations.[157]

3. TEENline (Phone and Text Services 1-864-467-8336/TEEN; Text 1-864-77-TEENS/83367) was was launched in 1980 as a confidential hotline that provides peer-based support. TEENline teen volunteers complete the same rigorous training as the adult volunteers and they connect teens with peers who can empathize with their problems.[158]



According to MHAGC, there were 2,794 individuals across South Carolina between the ages of 11 and 24 who contacted their crisis support Lifeline, CRISISline and TEENline in 2019.[159] During this time, nine individuals were rescued. In 2020, 3,360 individuals across the state between the ages of nine and 24 contacted the MHAGC crisis support lines, an increase of about 20.3% from 2019. There were 76 individuals rescued in 2020.[160] Between January 2021 and April 9, 2021, 1,208 individuals between the ages of seven and 24 contacted one of the MHAGC crisis lines. As of April 9, 2021, there were 35 individuals rescued.

5 Successes in Transforming South Carolina's Behavioral Health Systems

1

South Carolina Mobile Crisis Program

To respond to the need for improved access to emergency mental health care, the Charleston Dorchester Mental Health Center created the first Mobile Crisis team in South Carolina in partnership with the Medical University of South Carolina (MUSC) in 1987.[161] The need for this type of service in other areas of the state was a highlight in the original IMPH report *Hope for Tomorrow: The Collective Approach for Transforming South Carolina's Behavioral Health Systems* (2015).[162] In FY 2016, the South Carolina Department of Health and Human Services (SCDHHS) requested and began receiving a recurring allocation of $3,648,000 in its budget from the General Assembly to support the South Carolina Department of Mental Health's (DMH) crisis response services. SCDHHS contracted with DMH to implement the South Carolina Mobile Crisis program statewide through the DMH Community Mental Health Center (CMHC) infrastructure. Through the program, all residents of South Carolina experiencing a psychiatric emergency are eligible to receive services regardless of insurance coverage. For patients covered by Medicaid, DMH can submit treatment expenses for reimbursement. In May of 2018, DMH began delivering emergency clinical screenings to adults and children in Berkeley County, the first county to implement the South Carolina Mobile Crisis program.[163] In FY 2019, the recurring allocation for SCDHHS increased to $3.8 million.[164] Roughly 85% of the funds are spent on personnel. In addition to the $3.8 million annual allocation, DMH contributes an additional $1.4 million each year for additional staffing, supervisory support, supplies and equipment needed for program use.[165]

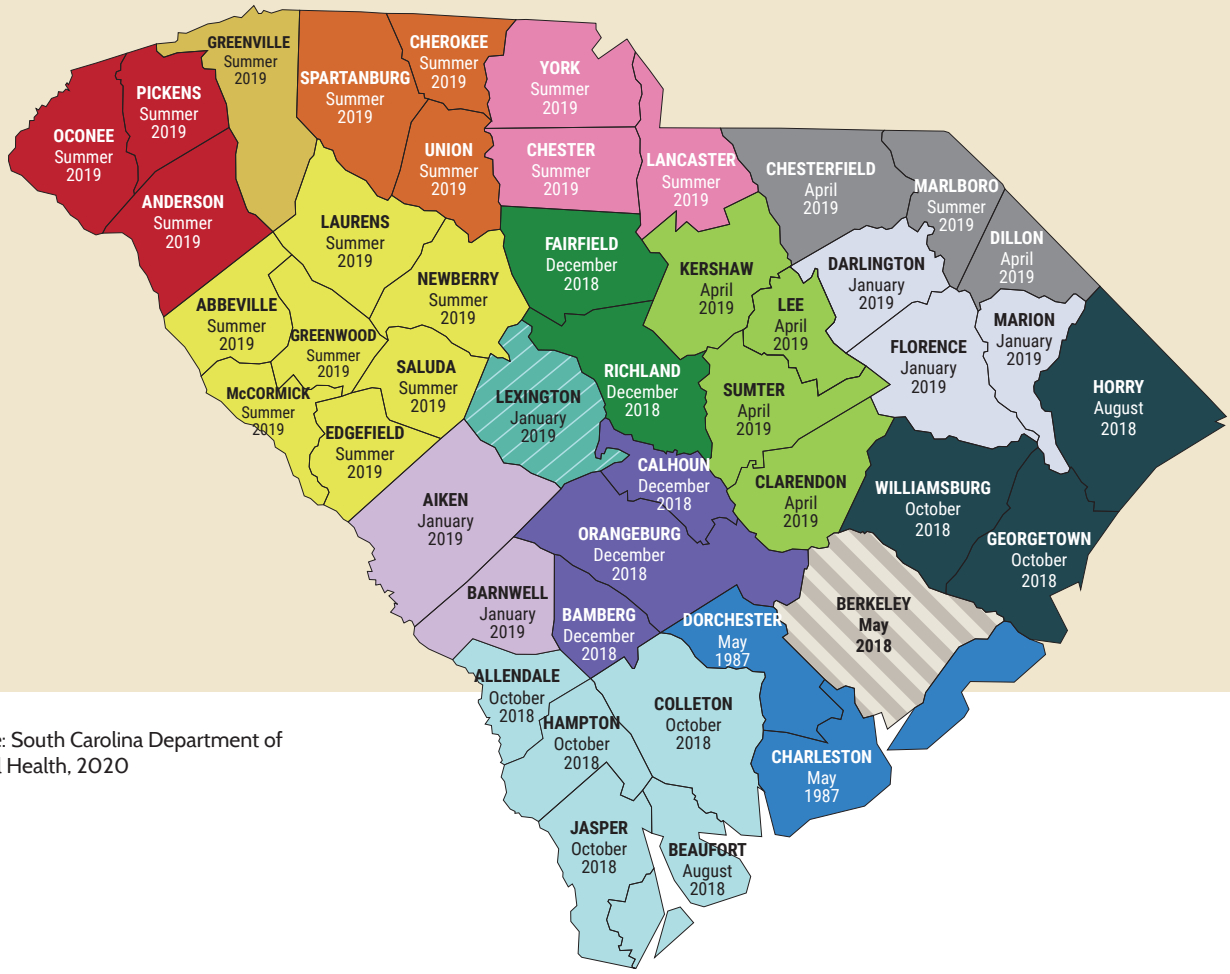
As of October 1, 2020, the Community Crisis Response and Intervention team (CCRI), first established with this funding, is now called the South Carolina Mobile Crisis program.

Placement of mobile teams within regions was established based upon a 60-minute response time from the point of origin. To respond to mental health emergencies within the 60-minute time frame, staff members cross regional lines to serve patients. The program staff consist of 48 full-time clinicians, 16 local area supervisors and over 200 dual clinicians who serve in various capacities at CMHCs during normal business hours, after hours, holidays and weekends. A 1-800 number was established to help residents access services, and calls are routed to the appropriate regional hub (1-833-DMH-CCRI or 1-833-364-2274). DMH now provides clinical screening services across South Carolina to anyone experiencing a mental health emergency through the South Carolina Mobile Crisis program. This program meets the immediate psychiatric needs of individuals and connects patients to proper long-term care, reduces unnecessary hospitalizations and emergency department visits and prevents patients from entering the law enforcement system.[166]

Map 2 details the timeframe of implementation of the South Carolina Mobile Crisis program in each of South Carolina's 46 counties. The program became statewide in the summer of 2019.

MAP 2

South Carolina Department of Mental Health Mobile Crisis Program Rollout Dates by County[167]



Source: South Carolina Department of Mental Health, 2020

In response to the developing psychiatric crises in South Carolina communities caused by a lack of access to mental health services, this program provides individuals with an assessment and referral process that accelerate access to treatment services. The South Carolina Mobile Crisis program serves as an extension of local mental health services. Central Office Mobile Crisis staff provide administrative support, streamlined data collection, contract monitoring, community engagement and marketing as well as training for clinicians and quality maintenance for the program.[168]

The South Carolina Mobile Crisis program assigns mental health professionals to mobile crisis service teams based on demand and population.[169] At the end of the first quarter, May 2018 through July 2018, 173 individuals were served, and within the first year, over 1,800 individuals received treatment. As of June 2020, over 8,000 individuals have been served through the South Carolina Mobile Crisis program since May 2018.[169]

Table 1 identifies the volume of patients and their outcomes from April 2020 through September 2020. During this time frame, there were over 5,000 individuals who experienced a mental health crisis and sought treatment through the program. More than 7,000 services were provided to those individuals during the same time frame.

TABLE 1

South Carolina Department of Mental Health Mobile Crisis Program Patients Seen and Services Provided April 2020 - September 2020[170]

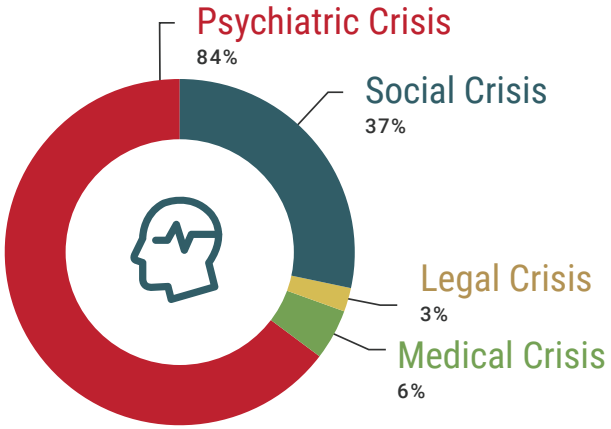
Patient Status	On-site or Call Disposition			
	APRIL 2020-JUNE 2020		JULY 2020-SEPTEMBER 2020	
	#	%	#	%
Went to ED	374	13%	335	14%
Went to Hospital	168	6%	122	5%
Went to Jail	31	1%	26	1%
Stayed in Community	1,917	68%	1,722	70%
Other	325	12%	264	11%
TOTAL	2,815	100%	2,469	100%

Source: South Carolina Department of Mental Health, 2020

From April through June 2020, during the first few months of the coronavirus pandemic, 84% of patients who sought treatment and services through the South Carolina Mobile Crisis program reported having a psychiatric crisis.[171] Major crisis types included in the psychiatric crisis category include psychosis, depression, suicidal ideation, anxiety and alcohol and drug use. At the same time, 37% of patients reported having a social crisis.[172] Major crisis types include relationship issues and housing. Many of the psychiatric and social crisis (893 or 37%) patients seen from April 2020 through June 2020 were between the ages of 26 and 44. The second largest (645 or 27%) age range of patients seen during that time frame was ages 45 through 64.

GRAPH 12

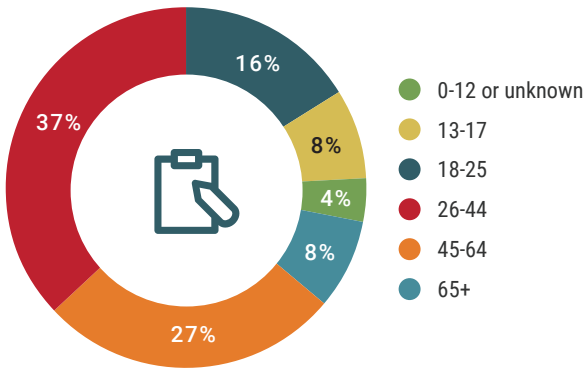
South Carolina Department of Mental Health Mobile Crisis Program Psychiatric and Social Patient Crisis Types April 2020 - June 2020[173]



Source: South Carolina Department of Mental Health, 2020

GRAPH 13

South Carolina Department of Mental Health Mobile Crisis Program Patient Age Groups April 2020 - June 2020[174]



Source: South Carolina Department of Mental Health, 2020

To measure the impact of the South Carolina Mobile Crisis program, DMH submits quarterly reports to SCDHHS.[175] Data in the submitted reports are categorized by region and track incoming crisis calls, patient demographics, crisis categories, the type of response provided and outcomes of on-site services (i.e., intervention and referral, intervention and went to emergency department and intervention and went to jail) and telephonic services (i.e., informational and referral, brief counseling, etc.).

The South Carolina Mobile Crisis program staff also train law enforcement and first responders in evidence-based practices for crisis intervention and conduct stakeholder meetings to identify strengths and areas of improvement for program operations.[176]

2

Opioid Emergency Response Plan and Team

The opioid epidemic remains a public health emergency in South Carolina and across the country. The South Carolina Opioid Emergency Response Team (OERT) was created in 2017 as a result of Governor Henry McMaster declaring a statewide public health emergency.[177] In June of 2018, the South Carolina Opioid Emergency Response Plan (OERP) was published by the Response Team to address the ongoing epidemic by providing strategies, recommendations and best practices to ensure coordinated efforts between stakeholders, private sector partners and federal, state and local agencies.[178] Supporting the OERT and OERP is a focus of the South Carolina Behavioral Health Coalition.

South Carolina's OERP has four focus areas:

Educate and Communicate

Prevent and Respond

Treat and Recover

Coordinate Law Enforcement Strategies

To monitor and respond to opioid misuse and overdoses in South Carolina, the OERT developed the Overdose Action Protocol which is designed to:

1. Reduce injury and death by identifying geographical high-burden areas within the state and targeting strategies that prevent overdose deaths; and
2. Synchronize response efforts across state stakeholders and mobilizing local partners to deploy resources that limit the effects of suspected drugs.[179]

Overdose Action Protocol implementation is a combined effort of multi-agency partners, designed to engage individuals before, during and after an overdose. It includes an outlined and tiered approach for routine monitoring effects, enhanced investigations and rapid response.[180] The following pages provide a high-level overview of the four focus areas included in the OERP and outlines the actions taken to address each one.

Focus Area 1: Educate and Communicate

Just Plain Killers Public Education Campaign

The South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS), along with Chernoff Newman, a marketing and communications agency in South Carolina, launched the *Just Plain Killers* campaign in January 2018.[181] The statewide campaign, implemented in phases, is a cohesive effort to address and reduce the negative effects of opioid misuse and abuse around the state through education. The key messages of the campaign emphasize the dangers of misusing and abusing prescription opioids while providing statewide resources for those impacted by opioid use disorder.

Key messages implemented:

1. From January 2018 through June 2018, the campaign depicted the widespread availability of prescription opioids, explained the magnitude of the opioid epidemic in South Carolina and illustrated how easily addiction can develop from prescription opioid misuse;
2. From July 2018 through June 2019, the campaign provided statewide resources for individuals affected by opioid use disorder and explored alternatives to opioids when seeking relief from pain; and
3. From July 2019 through September 2020, the campaign shared the unpleasant side effects of prescription opioids. During the pandemic specifically, the campaign enforced the importance of taking the time to have meaningful conversations with children surrounding the dangers of prescription drugs.[182]

Since the start of the campaign in January 2018, a $1 million yearly funding package has come from three sources; State Targeted Response to the Opioid Crisis Federal Grant, State Opioid Response Federal Grant and State Opioid Response Supplement Federal Grant.

Throughout the duration of the campaign, various media outlets were used to disseminate information. Examples of communication strategies included press conferences with Governor Henry McMaster, traditional paid media on television and social media content placement via Facebook, Instagram and Twitter. During the first year of the campaign, there were a total of 433 social media posts with over 2.5 million impressions, 13,689 engagements, 905 link clicks and 4,087 fans.[183] In year three of the campaign, platforms expanded to include paid advertising on Hulu and statewide message placement on video displays in physician waiting rooms.[184] As of June 2019, a total of 791 messages were posted on social media platforms with over 3.9 million impressions, 34,331 engagements, 23,769 link clicks and an additional 5,504 fans.[185]

As a result of the coronavirus (COVID-19) pandemic, plans to host live promotional events in 2020 were put on hold.[186]

Opioid Risk Prevention Partnership Campaign for Prescribers and Clinical Care Teams

The Opioid Risk Prevention Partnership (ORPP) was established in 2018 to advance the conversation among South Carolina hospitals, providers, patients and the public on the management of pain.[187] A joint venture with BlueCross® BlueShield® of South Carolina (BCBSSC), the South Carolina Hospital Association (SCHA) and the South Carolina Medical Association (SCMA), the partnership endeavors to share resources

that support physicians and clinical care teams in facilitating discussions about pain and the appropriate use of alternatives to opioids in pain management.[188]

A cycle of educational campaigns were introduced through the partnership to create an awareness of the opioid crisis in South Carolina, reintroduce ORPP efforts and focus on resource and content development to continue to address acute pain, chronic pain and addiction.[189]

The Teaser Campaign ran in September 2018 and October 2018 and was centered on providing resources for clinicians and patients.[190] Specific clinician resources on acute pain, chronic pain and addiction were designed to build clinician knowledge on addressing pain and addiction with patients as well as facilitate patient-provider conversations.[191] The campaign yielded 30,244 successful email deliveries and 5,456 individuals were reached via social media.[192]

The full campaign ran from December 2018 through December 2019 with an emphasis on:

1. Continuing Medical Education (CME) development and implementation;
2. Development of campaign materials on video;
3. Clinician resource and message development and dissemination; and
4. Monitoring and reporting of campaign results.[193]

In addition to the Teaser Campaign, the South Carolina Department of Health and Human Services' (SCDHHS) Pharmacy Lock-In Program is designed to identify recipients who are using Medicaid pharmacy services at a frequency or amount that is not medically necessary. The program includes a set of 21 criteria identified through behaviors common with fraud, waste and abuse, and has contributed to an opioid prescribing rate for Medicaid members that is significantly below the statewide average. Through the Pharmacy Lock-In program, Medicaid members are given a score based on the set criteria and those whose score qualifies them for the Pharmacy Lock-In Program are restricted to a single pharmacy to fill their Medicaid-paid prescriptions for a two-year period.

Continuing Medical Education Courses

Development and implementation of two ORPP CME courses entitled Effective Pain Management for a Healthier South Carolina: A CME on Acute Pain, Chronic Pain, and Opioid Misuse/Opioid Use Disorder includes a combination of current evidence and application of real-life cases.[194] As of December 2019, 202 clinicians completed these CME courses and 59% of those individuals were motivated to perform further research on acute pain, chronic pain and opioid misuse/opioid use disorder.[195]

The establishment of these CME courses provided a foundation for the development of 10 quick reference resources that were released every month throughout the campaign with brief actionable tips based on topics addressed in the CME courses. The CME curriculum also produced a series of videos entitled Perspectives on Opioids that were used to further enhance messaging by featuring personal testimonials from a physician, a first responder and an individual in recovery.[196] The results of the full campaign included 64,806 successful emails delivered, 161,000 views of the videos with 95% positive reactions and 9,837 individuals reached via social media.[197]

Future direction of the campaign includes exploring options for continued collaboration within other clinical disciplines, providing direct support to providers in clinical settings and implementing guidance within existing clinician resources.[198]

Collaborative Effort for State Rapid Response

In addition to OERP's four ongoing focus areas, the South Carolina Department of Health and Environmental Control (DHEC) has been working with state partners to improve the identification of overdose hotspots and mobilize resources to prevent overdose deaths in targeted geographic areas. Plans for improved surveillance were in progress prior to the pandemic and implementation was well-timed to respond to the ripple effects of the pandemic on substance misuse. In April 2020, a core group of stakeholders from the OERT initiated weekly phone calls to monitor data from the Bureau of Emergency Medical Services (EMS) and Trauma on suspected opioid overdoses across the state.[199]

Weekly phone calls enabled state-level staff to reach out to county-level counterparts in high-burden areas to encourage targeted response efforts. Within one month of implementation of this partnership, OERT improved the ability of state and local partners to identify local hotspots. Local treatment centers initiated drive-thru distribution events in areas with clusters of overdoses specifically for Deterra, a disposal system for unused medication and Narcan.[200] The initiative also inspired more safety agencies to register for the Overdose Detection Mapping Application Program (ODMAP), an open source overdose mapping tool, so data is collected real-time at the local level.[201]

Naloxone Access

Naloxone, most commonly known as Narcan, is a liquid medication designed to rapidly counteract the life-threatening effects of an opioid overdose.[202] The medication is an immediate but temporary relief treatment to restore breathing that has slowed or stopped as a result of overdosing with opioids such as heroin, morphine, oxycodone or other prescription pain medications.[203]

The endowment of the State Opioid Response (SOR) grant is administered by DAODAS and the funding source for this initiative is provided by the Center for Substance Abuse Treatment (CSAT) and Substance Abuse and Mental Health Services Administration (SAMHSA). The funding stream allowed for the development of the Community Distribution Naloxone Program for the 32 local alcohol and drug treatment programs across the state.

In South Carolina, designated community distributors provide naloxone to patients, caregivers and concerned community members to prevent overdose deaths.[204] State law defines a community distributor as "an organization, either public or private, which provides substance use disorder assistance and services, such as counseling, homeless services, advocacy, harm reduction, alcohol and drug screening and treatment to individuals at risk of experiencing an opioid-related overdose."[205]

DAODAS provides naloxone for the community distributors as defined by state law. Community distributors are required to use the training materials provided by DAODAS that explain the requirements of the law and are provided to each recipient of naloxone.[206]

From October 2019 through July 31, 2020, DAODAS spent $547,500 on 7,300 doses of Narcan for the Community Distribution Naloxone Program, and community distributors provided 5,527 doses of naloxone during that time.[207] This SOR grant also funded distribution of naloxone to approved community distributors in each of the seven high-burden counties beyond the 32 county alcohol and drug treatment agencies. Approved community distributors (excluding the county alcohol and drug abuse authorities) were eligible to apply for naloxone in the following high-burden counties:

1. Charleston
2. Greenville
3. Horry
4. Lexington
5. Richland
6. Spartanburg
7. York

Grantees placed orders of up to $25,000 of naloxone through the Narcan Direct portal as needed throughout the grant period to maintain the required minimum of 12 packs on-hand; once the $25,000 cap was reached, the applicant was able to request an increase in its cap and secure additional funding based on usage reports, distribution and the availability of federal funds.[208]

As a result of the coronavirus pandemic, DAODAS arranged to provide crisis Narcan for all Opioid Treatment Programs (OTP) across the state to build their capacity to meet the needs of the growing number of patients. This program continued through September 30, 2020 and thereafter all OTPs interested in obtaining additional Narcan for their patients are required to submit paperwork to join the Crisis Narcan program and become designated as a community distributor. In the event of a future public health emergency or stay-at-home order due to a crisis, DAODAS will again ensure that Narcan is available to OTPs to ensure the safety of patients. As of December 2020, there are 15 organizations receiving Narcan through this initiative.[209]

South Carolina Overdose Prevention Project

The South Carolina Overdose Prevention Project is a $3.2 million, five-year joint effort between DAODAS and DHEC, funded through a 2016 federal SAMHSA Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO) grant. The Overdose Prevention Project was created as a result of the 2015 South Carolina Overdose Prevention Act.[210] The Act seeks to grant immunity from both civil and criminal prosecution to doctors, first responders, pharmacists and caregivers who are engaged in the prescription, dispensation and administration of naloxone in a suspected opioid overdose case.[211] Providing access to naloxone regardless of the ability to pay for the medication is crucial to first responders, patients, their families and caregivers.

The purpose of this initiative is to teach law enforcement officers, fire fighters, opioid use disorder patients and their caregivers how to identify an opioid overdose, how to correctly administer naloxone to the overdosing individual and how to provide them with naloxone. The goals of the five-year grant are to:

1. Reduce the number of opioid overdose related deaths in South Carolina;
2. Reduce the rate of intentional, unintentional and undetermined opioid overdoses in South Carolina;
3. Increase the number of opioid overdose reversals in South Carolina;
4. Increase the number of referrals to substance abuse treatment services in South Carolina for opioid use disorders; and
5. Increase the number of naloxone kits and trainings provided to first responders, patients and caregivers throughout South Carolina.[212]

Between 2013 and 2018, there was a 110% increase in the amount of naloxone administered by EMS personnel in South Carolina.[213] DHEC continues to monitor and respond to trends in suspected overdoses in South Carolina and OERT partners continually work to ensure access to prevention, treatment and recovery.

Four medically monitored withdrawal management sites throughout the state provide Narcan to patients and their caregivers.[214] These withdrawal management sites are located in Charleston, Greenville, Richland and York counties. In addition to the withdrawal management sites, the Law Enforcement Officer Naloxone (LEON) program and the Reducing Opioid Loss of Life (ROLL) programs were created in an effort to decrease future opioid crises across South Carolina.

The LEON program was created in the fall of 2016 by DHEC's Bureau of Emergency Medical Services to train South Carolina law enforcement personnel on identifying, treating and reporting drug overdoses attributed to opioids.[215] Between it's inception and October 2020, LEON has trained and equipped an excess of 10,000 police officers and 228 organizations across the state to administer Naloxone.[216]

The ROLL program was created after the LEON program in 2018 by DHEC's Bureau of EMS to train South Carolina fire departments on identifying, treating and reporting drug overdoses.[216] The ROLL program has successfully trained 1,831 firefighters from 113 fire departments since September 2018. There have been 1,820 dispenses through LEON and 289 dispenses through ROLL as of November 15, 2020.[217] Narcan doses administered by first responders participating in the LEON and ROLL programs were successful in reversing 95% of encountered overdoses as of August 31, 2020.[218]

DAODAS does not collect data on the use of rescue kits by patients and their families, so no data is available on the total number of overdoses prevented through access to naloxone.[219]

As of August 17, 2020, opioid emergency planning resulted in:

63 hospitals integrating a prescription drug monitoring program (PDMP) into their electronic health records (EHR) system

5 Medical University of South Carolina distribution of Narcan kits to at-risk patients across five emergency departments (ED)

437 pharmacies across South Carolina notified the State Board of Pharmacy that they are voluntarily dispensing naloxone[220]

56 organizations designated as community distributors of naloxone

277 providers across 25 counties engaged in outreach education developed by Prisma Health

Focus Area 3: Treat and Recover

Medication-Assisted Treatment Capacity and Subsidies for Treatment

Currently, there are three safe and effective medications approved by the Federal Drug Administration (FDA) for the treatment of opioid addiction: buprenorphine, methadone and naltrexone.[221] The FDA recommends that these medications are used in combination with counseling and psychosocial support.[222] Alcohol and drug authorities and opioid treatment programs in South Carolina have adopted this evidence-based model of care delivery.

In September 2016, DAODAS received the State Targeted Response (STR) grant from SAMHSA to begin planning and implementing MAT services with county alcohol and drug authorities. In 2018 they were awarded the SOR federal grant to continue combating opioid misuse in South Carolina.[223] DAODAS expanded the funding coverage with the SOR grant to include Recovery Community Organizations (RCO), OTPs and community distribution of Narcan.

Five South Carolina hospitals provide buprenorphine stabilization in EDs with referrals for continued care.[224] Since 2016, over 15,000 patients have been treated with this model through STR and SOR grant funding as well as funding from SCDHHS.[225]

With state funding, the Medical University of South Carolina began the MAT ED project to expand MAT services in South Carolina in December 2017.[226] In the first year of the ED Project, 5,044 patients were screened for substance misuse, and 132 Narcan kits were distributed to at-risk patients in EDs.[227] As of December 31, 2020, the ED Project had screened 23,653 patients for substance misuse and distributed 1,246 Narcan kits to at-risk patients in EDs.[228] As of February 22, 2021, the ED Project exists in six locations:

1. MUSC Health University Medical Center Charleston;
2. Tidelands-Waccamaw Community Hospital;
3. Grand Strand Medical Center;
4. Spartanburg Medical Center with live support at main campus and virtual services at the Mary Black Campus of the Spartanburg Regional Health Center;
5. Prisma Health-Upstate; and
6. Tidelands Georgetown Memorial Hospital.[229]

Short term goals of the ED Project include expanding services to the McLeod Regional Medical Center and Circle Park Behavioral Health Services in Florence.

Peer Support Services and Recovery Services across South Carolina

Peer support services (PSS) are an innovative practice focused on improving the way patients with substance use disorders (SUD) receive access to mental health and recovery services from providers who are survivors, consumers, current patients and former patients.[230] Peers with lived experiences are essential to the recovery process as they can provide unique support to patients that clinicians without lived experiences may not provide. Benefits of PSS include engagement through shared experience, support in the path to recovery, thorough comprehension of recovery plans and a level of trust that may result in better adherence to follow-up treatments and fewer unnecessary hospitalizations.[231]

Since 2014, SCDHHS has reimbursed local county substance use disorder treatment providers for PSS to better serve Medicaid members who face substance use challenges.[232]

There are several outlets of PSS settings including recovery centers and churches. Core values shared by the recovery community include support for all paths to recovery, cultural diversity and inclusion, leadership development, keeping recovery first, participatory processes and authenticity of peers helping peers.[233] From 2017 through 2020, there were roughly 8,178 patients who utilized peer support services through DAODAS-funded authorities in South Carolina.[234]

More than 25,000 individuals were provided recovery treatments and services through South Carolina's seven recovery community organizations (RCO) from 2016 through July 2020. This includes over 70 Oxford Houses recovery residences, the South Carolina Alliance of Recovery Residences and a wide variety of peer support specialists working in jails, prisons and hospitals.[235]

For the project period September 2018 through September 2020, DAODAS awarded sub-grants to two new emerging RCOs and provided sub-grants for year one of the SOR.[236] These awards supported the RCOs in their development as a non-profit, community-based recovery support center.[237] All RCOs provide "All Recovery" meetings, Self-Management and Recovery Training (SMART) meetings, recovery coaching and family support services. Two of the RCOs, one centrally located and one in the Lowcountry, focus on engaging youth in recovery and supporting families that have lost a loved one due to an overdose.[238]

From October 2017 through July 2020, five of the RCOs trained and certified 148 peer support specialists.[239] The Recovery Training Academies, which provide Trainings of Excellence to individuals interested in becoming a Certified Peer Support Specialist, are held at the Midlands Recovery Center, FAVOR Greenville and FAVOR Piedmont.[240]

SCDHHS added Opioid Treatment Program Services to the Medicaid State Plan in January 2019. The benefit included reimbursement for Medication Assisted Treatment (MAT) for methadone and buprenorphine which included a comprehensive supportive service array.[241] In July 2019 this service was added to the managed care benefit to ensure it was available to every Medicaid member in the state. In July 2020 SCDHHS added coverage of naltrexone to the opioid treatment program benefit and provided additional flexibilities regarding administration methods for treatment of opioid use disorder (ex. additional coverage of long-acting injectable medications).[242] Additionally, SCDHHS reimburses for long-acting injectable medications indicated for the treatment of opioid use disorder, including naltrexone for extended-release injectable suspension and buprenorphine extended-release, outside of the encounter rate for Federally Qualified Health Centers and Rural Health Clinics.[243]

DAODAS and the South Carolina Department of Corrections (SCDC) have a Memorandum of Agreement that provides funding and services through SOR.[244] This partnership provides treatment transition and coverage for opioid use disorder patients who are reentering communities from state prisons.[245] The program offers peer support services to assist with the transition from the state prison system to the community and provides inmates with resources to support their recovery efforts. For example, the program provides Vivitrol®, an FDA-approved medication that blocks the effects of opioids and alcohol on the brain which, used in conjunction with counseling, reduces the chances of recurring opioid dependency.[246] This initiative provided MAT and transition services to 689 inmates with an SUD and an additional 80 inmates with an opioid use disorder from November 2017 to July 2020.[247]

In addition to providing services for inmates with opioid use disorders, the SOR MAT program will double its efforts in providing services to inmates with drug use disorders, including a warm hand-off to alcohol and other drug abuse county authorities. This program will also demonstrate the effectiveness of training inmates to train other inmates as it relates to keeping offenders engaged and connected to services.

A highlight of the partnership between DAODAS and SCDC, of the 54 inmates who enrolled in the MAT project, only one returned to prison for any amount of time.[248] This is noteworthy as the average recidivism rate in South Carolina is 22.3%.[249]

Focus Area 4: Coordinated Law Enforcement Strategies

In alignment with the Opioid Emergency Response Plan, the South Carolina Law Enforcement Division (SLED), with the support of many state agencies and local law enforcement departments across the state, identified six goals in February 2020 to improve the effectiveness of law enforcement strategies for combatting the opioid crisis in South Carolina.[250] The six goals are grouped under Focus Area 4 where SLED serves as the coordinating agency to employ coordinated law enforcement strategies between state agencies and stakeholders. The six goals of Focus Area 4 are to:

1. Help support and expand prescription drug disposal programs to reduce the number of unused medications. Focus Area 4 promotes the Drug Enforcement Administration's (DEA) National Prescription Drug Take Back Day through law enforcement agency websites and social media. Information and resources about environmentally friendly methods of disposal of controlled substances are also shared. Focus Area 4 also helps to promote take back sites that are available in communities year-round and will encourage the establishment of new sites at law enforcement facilities throughout the state;

2. Increase resources to combat illicit opioid supply chains. This is achieved by improving intelligence and law enforcement focus in areas of highly concentrated use and overdose. Resources are allocated to enforce existing policies that ban transportation of opioids through major interstates, commercial parcel carriers and other transportation methods;

3. Reduce the number of fatal opioid overdoses through education, training and funding. Law enforcement agencies are encouraged to participate in the existing LEON grant program. Collaboration with DAODAS is crucial to seeking funding and sustainability of the program once the LEON grant period has ended. Training is available to educate community distributors on the use of naloxone and other opioid overdose reversal medications;

4. Expand treatment options for individuals with opioid use disorders and assist in facilitating access to care in lieu of incarceration. Recommendations and support for programs like drug courts are encouraged;

5. Improve the Driving Under the Influence of Drugs Detection (DUID) program and track statistics from DUID cases throughout the state; and

6. Enhance and expand current data sharing efforts between state agencies and stakeholders, encouraging the exchange of pertinent information to assist with intelligence for officers and public health coordinators. Hot spots for opioid use are identified and data-driven decisions improve targets to specific vicinities to concentrate resources on community education and prevention measures.[251]

Expanding Incineration of Unused Medication

Laws established by the United States Environmental Protection Agency (EPA) prohibit local sites in South Carolina, and other states, from having portable incinerators for the purpose of destroying unused prescription medication.[252] SLED drives the collection of unused medication through drop boxes and local take back days where the medications are taken to Alabama for incineration two to four times a year.[253]

The Law Enforcement Take Back Program began in February 2019 and as of February 2020, 11,684 pounds of pills have been received in drop boxes and incinerated.[254] As of August 2020, this program involves agencies from 20 counties. The biannual take-back program was initiated to encourage more law enforcement agencies to register to collect unused pharmaceutical-controlled substances from users. This program complements the DEA's Disposal of Controlled Substance program through the Diversion Control Division of the United States Department of Justice and the *Secure and Responsible Drug Disposal Act of 2010*.[255,256]

Implementation of South Carolina Interdiction Teams

In June 2018, the OERP acknowledged SLED as the Secondary Lead Coordinator for the OERT Joint Information System to utilize and encourage use of materials developed as part of the statewide public education and outreach campaign. The goal of this campaign is to address and reduce the negative effects of opioid misuse and abuse around the state.[257] Other responsibilities of the SLED agency include the following:

1. Sharing information and resources related to the opioid crisis and stakeholder partnerships;
2. Serving as the primary liaison with local law enforcement opioid community relations endeavors;
3. Developing relationships with appropriate local, state and federal partners interested in public education and outreach; and
4. Developing opportunities to collaborate on producing outreach materials that educate the public on the negative effects of opioid misuse and abuse around South Carolina.[258]

The South Carolina Highway Patrol (SCHP) Criminal Interdiction Unit personnel are assigned to regional Troop Commanders to lead field operations and remain actively engaged in the interdiction mission. Troop Commanders are assigned to the Columbia, Greenwood, Greenville, Rock Hill, Florence, Myrtle Beach, Charleston and Orangeburg areas.

In 2019, the SLED Interdiction Team and SCHP, in collaboration with Homeland Security Investigations (HIS) of the United States Department of Homeland Security, the United State Postal Service (USPS) and the DEA, seized over 20 pounds of heroin, about one pound of fentanyl and roughly one pound of opioid pills.[259] As of July 2020, the team seized over 24 pounds of fentanyl tablets, over three pounds of heroin and dismantled about 30 heroin/fentanyl/opiate supply chains.[260]

3

Improved Access to Safety Net Outpatient Mental Health Services

There has long been a need to increase access to outpatient mental health services in South Carolina, particularly for the uninsured and underinsured. Reducing barriers and providing access to services are essential for individuals and families seeking care. South Carolinians should understand how to navigate the mental health system and obtain quality care when needed. It is important that evidence-based best practices be implemented and that the standard of care be improved across the country to provide a stable process for individuals seeking behavioral health care.[261] Recent examples of efforts to improve access to outpatient safety net mental health services throughout South Carolina over the last few years include the following:

The Future is Now

In August of 2012, the Future is Now (FIN) initiative began to support rapid response and appointments at the South Carolina Department of Mental Health's (DMH) 16 community mental health centers (CMHC).[262] FIN serves as the blueprint for all DMH CMHCs to ensure that patients are receiving the outpatient mental health services they need in a timely manner through the public safety net system.[263] Since inception, the FIN initiative has accomplished the following:

1. Increased productivity within all 16 CMHCs;
2. Compiled accurate cost data to identify efficient practices within all CMHCs;
3. Provided 95% of all requests for services within the established guidelines (1 day for emergent, 2 days for urgent and 7 days for routine appointments);
4. Reduced the caseload size for staff;
5. Refined and implemented the Levels of Care system to provide appropriate treatment and services to patients with the most severe needs; and
6. Administered training in trauma-focused services and evidence-based treatments for clinical supervisors and clinicians.[264]

Recreational Vehicles Delivering Mental Health Services

DMH now owns five recreational vehicles (RV) that are designed to expand services into rural communities and to provide assessment, case management, individual and family therapy, medication management and support crisis response.[265] The Charleston-Dorchester, Spartanburg, Beckman, Santee-Wateree and Columbia Area CMHCs own and operate RVs in this manner. Of the five centers that own RVs, the Spartanburg Area Mental Health Center is the only center currently operational and providing services during the pandemic.[266]

The Spartanburg Area Mental Health Center purchased their RV in February 2020 and immediately deployed it in response to the outbreak of the coronavirus pandemic to serve individuals who did not have access to the clinic due to COVID-19 restrictions. As of September 30th, 2020, 1,500 patients had been served across three counties.[267] In the future, DMH plans to refocus the priorities of the Spartanburg Area Mental Health Center RV to operate as a mobile clinic, offering a wide range of services to about 2,000 patient visits per year.[268]

Mental Health Law Enforcement Alliance Project

In September 2020, DMH introduced the Mental Health Law Enforcement Alliance Project (Alliance) through their Office of Emergency Services.[269] The Alliance initiative is a three-year project designed to strengthen mental health and law enforcement collaborations and to provide proper care and preventative mental health treatment to children, adults and families who experience trauma, and expand the reach of mental health services statewide.[270] The project uses a Community Support Unit (CSU) RV that can travel throughout South Carolina to respond to mental health crises and participate in community outreach efforts.[271]

Alliance teams, consisting of law enforcement officers trained in crisis intervention and DMH clinicians, travel statewide and respond to police calls involving children or adults experiencing trauma, disaster or crisis within 24 hours of the emergency and provide them with trauma-sensitive care.[272] Immediate support and short-term evaluations allow the patient to connect to their local CMHC for additional support and resources.[273]

The CSU RV provides a confidential space for individuals suffering traumatic experiences by conducting visits to the individual's home, school and other places in the community.[274] Initiating home, school and community visits allows Alliance team members to identify high-risk patients, establish case reviews, monitor progress and coordinate follow-ups and referrals for treatment and recovery.[275] The Rapid CSU RV response will also help place clinicians effectively in communities of need and promote educational tools and resources for understanding and identifying trauma and the recovery process.[276] DMH's three-year plan for Alliance include the following:

1. Developing protocols for deployment of trained clinicians;
2. Providing proper tools and technology needed to perform evaluations; and
3. Ensuring CSU RV availability for travel and use.[277]

4

Expanded Access to Telebehavioral Health Services

Telehealth is a valuable tool for expanding the accessibility of behavioral health services. By using digital and web-based methods to reach patients, providers can extend services to clients who otherwise may not have access to behavioral health services due to barriers such as transportation and childcare. Additionally, telehealth services allow providers to see a different perspective of the mental and emotional state of their patients that they would not necessarily see during an in-person visit.[278]

South Carolina Department of Mental Health Services

The South Carolina Department of Mental Health (DMH) has been a champion of telemental health services and now has efforts that focus on providers who deliver telehealth services to patients. DMH has been a provider of telemental health programs since 1996, beginning with the Deaf Services Program, by providing frequency and flexibility to patients who require specialized skills and prefer not to have an interpreter.[279] As of October 2020, DMH had provided over 636,500 patient interfaces via telemedicine; 346,100 of

those interfaces were between April 2020 and October 2020 alone.[280] Prior to the coronavirus pandemic, telemental health encounters averaged 3,000 encounters per month, and since the onset of the pandemic, telemental health encounters average 15,700 per month for DMH patients.[281]

DMH Telepsychiatry Programs have expanded to include the Emergency Department Telepsychiatry Program, Community Telepsychiatry Program, Emergency Medical Service Telehealth Pilot Project and Inpatient Services Telepsychiatry Program.[282]

Telepsychiatry in Emergency Preparedness

The DMH Emergency Department Telepsychiatry program was launched in 2007 with funding from the Duke Endowment. In 2019, the DMH Emergency Department Telepsychiatry Program conducted 8,986 assessments in 23 emergency departments across the state.[283,284,285] The assessments assist with triage and individualized treatment plans for patients experiencing a psychiatric crisis. This program has been evaluated by the University of South Carolina School of Medicine and has been proven to:

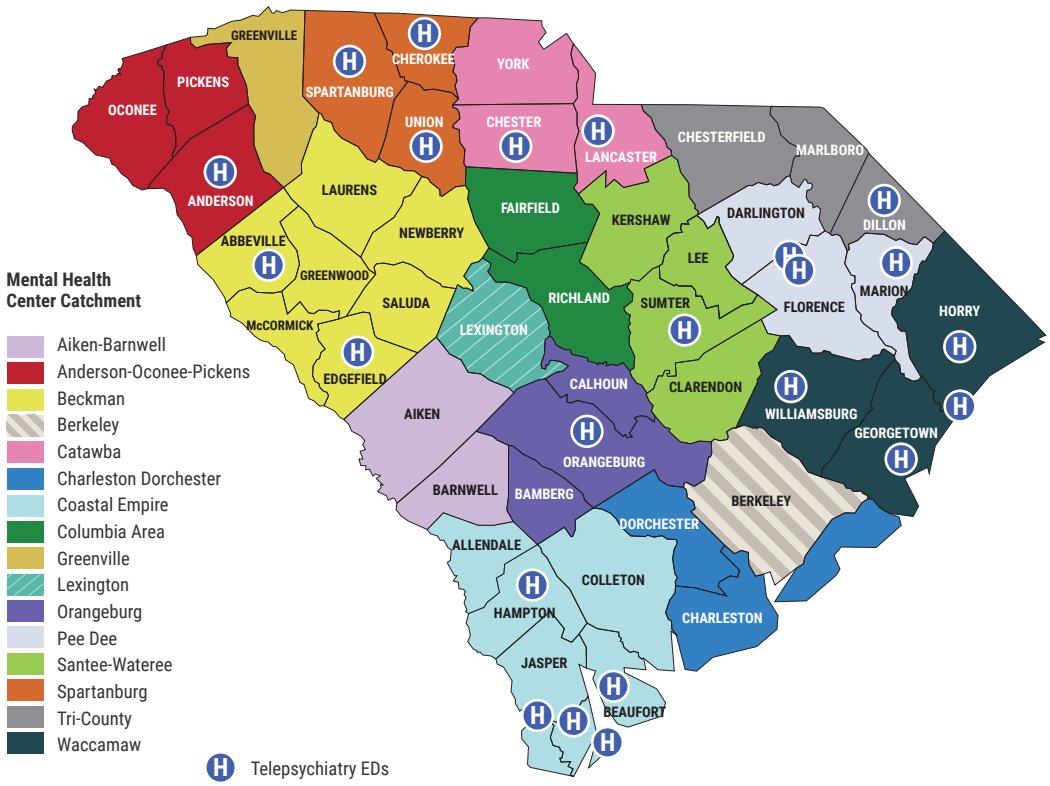
1. Provide patients with a quality psychiatric assessment as soon as possible;
2. Assist in initiation of medication and/or other treatments as prescribed;
3. Reduce the length of stay in the hospital;
4. Save an average of $2,434 for the hospital per ED visit; and
5. Facilitate comprehensive planning for continuity of care upon discharge.

As of July 2020, there were 23 community hospital EDs across the state that directly link their patients to a DMH psychiatrist for face-to-face health assessments using video technology.[285] Prior to the coronavirus pandemic, the DMH Emergency Department Telepsychiatry Program and the DMH Community Telepsychiatry Program provided an averaged 2,750 of telemental health services per month.[286]

MAP 3

Community Hospital Emergency Departments with South Carolina Department of Mental Health Telepsychiatry Programs as of August 2020[287]

Source: South Carolina Department of Mental Health, 2020



Telepsychiatry in Schools

Since 2019, telepsychiatry has placed a direct line between the student and physician in 135 schools, eliminating the immediate need for a student to visit a mental health center (MHC).[288]

Telepsychiatry in Nursing Homes

The DMH Telepsychiatry department, DMH Information Technology division and the E. Roy Stone, Jr. Veterans Home Pavilion deployed telepsychiatry services in the summer of 2019 via a Telehealth Cart at the patient's bedside.[289] Clinicians have the ability to make diagnoses, transfer patient data and improve treatments.

Community Telepsychiatry Program

The DMH Community Telepsychiatry Program launched in 2013 and provided services to children, adolescents and adults at all 16 community mental health centers (CMHC) and 43 MHCs in South Carolina.[290] As of July 2020, the program provided over 149,200 telepsychiatry treatment services to patients at CMHCs and MHCs.[291]

DMH and the Medical University of South Carolina Inpatient Telepsychiatry Program

The Medical University of South Carolina (MUSC) partnered with DMH and five other hospitals to create the MUSC Inpatient Telepsychiatry program in 2019.[292] As of November 2020, this program was in Tidelands Georgetown Memorial Hospital, Tidelands Waccamaw Community Hospital, Prisma Health Toumey Hospital, MUSC Health Florence Medical Center, MUSC Health Marion Medical Center and Spartanburg Regional Healthcare System Pelham Medical Center. The program provides scheduled consultative care on psychiatric evaluations and medication management for inpatient medical, obstetric and surgical units before a patient is physically transferred to a psychiatric hospital.[293]

The program provides the following:

1. Scheduled consultations within 24 hours, Monday through Friday;
2. Diagnosis and treatment of patients with delirium and dementia;
3. Management of substance use disorders, detoxification and withdrawal;
4. Safety and risk assessments for agitated, violent or suicidal patients;
5. Medication recommendations; and
6. Diagnosis and treatment of chronic mental health conditions.

From January 2020 through October 2020, a total of 402 inpatient telepsychiatry visits were conducted through this program.[294]

Telebehavioral Health beyond DMH

Emergency Medical Services Telehealth Pilot Project

The Telehealth Pilot Project, funded by an MUSC telehealth grant, commenced in 2017 with the vision of adequately diverting behavioral health patients from local EDs and hospitals. The pilot program uses telehealth technology to pre-assess patients experiencing a psychiatric crisis identified on 911 calls. The pre-assessment has significantly decreased the amount of time needed to complete intervention.[295]

Local County Substance Use Disorder Treatment Centers

In 2018, the South Carolina Department of Health and Human Services added Act 301 Behavioral Health Centers as approved referring sites for telemedicine visits.[296] A referring site is where the Medicaid member is physically located at the time the service is being delivered via a telecommunication system. Services that are eligible for reimbursement include consultation, office visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examinations and testing delivered via a telecommunication system.[297]

Expanding into Rural Areas

In 2018, the Greenville Health System, now Prisma Health, launched a series of telehealth initiatives with a vision to transform health care for South Carolina communities.[298] Prisma Health Children's Hospital school-based health centers program was established through the Bradshaw Institute for Community Child Health & Advocacy, in partnership with United Way of Greenville. The purpose of the Children's Hospital school-based health centers is to reduce absenteeism by increasing access to health care for middle school students in underserved communities.[299] This partnership spans five centers and carries the expertise of physicians and specialists using video technology to places that often do not have access to specific medical specialties.

South Carolina Telehealth Alliance

The South Carolina Telehealth Alliance (SCTA) is a collaboration of partners working to expand telehealth services across the state through administrative functions of programs and services, telehealth equipment and maintenance, technical support and security as well as other initiatives determined through annual strategic planning.[300] The SCTA is administered out of the Center for Telehealth at MUSC, which serves as its fiscal agent. The SCTA receives guidance and strategic oversight from its SCTA Advisory Council and is funded by the South Carolina State Legislature.[301]

The SCTA Statewide Strategic Plan for telehealth includes broadening mental health and related telehealth clinical services and programs that increase access to quality behavioral health care by:

1. Supporting hospitals with behavioral health related clinical services and programs;
2. Supporting primary care and related-care providers with efficient access to mental health and related clinical services and programs;
3. Supporting additional DMH locations with telemental health services and programs; and
4. Extending care to non-traditional settings to improve access to mental health and related clinical services and programs.[302]

South Carolina was projected to conduct nearly 2 million telehealth interactions in 2020 - a nearly 500% increase from the previous year. The South Carolina Telehealth Alliance partners with nearly 450 sites and an excess of 40 state and nonprofit organizations to offer the demanded telehealth services. As of January 2021, SCTA partners have conducted nearly 80,000 unique telehealth sessions.[303]

Palmetto Care Connections

In 2010, Palmetto Care Connections (PCC) was formed to provide continuous telehealth support services to health care providers in rural and underserved communities across South Carolina. PCC is a non-profit telehealth network that partners with 16 organizations to assist health care providers in connecting rural and underserved South Carolinians to quality health care services through broadband, technology and telehealth programs.[304]

In 2017, the Health Resources & Services Administration (HRSA) deployed the Rural Health Network

Development (RHND) Program grant through PCC. This grant allowed behavioral health sites in South Carolina to implement telehealth services that improved access to care for their patients and increased access to Medication-Assisted Treatment (MAT) services.[305] The RHND Program also works to:

1. Improve health care access and coordination for rural residents in South Carolina;
2. Reduce the prevalence of opioid addiction; and
3. Improve population health especially as it relates to chronic disease including mental health disorders.[306]

As outlined in Table 2, the three-year, grant-supported program has 17 partners within South Carolina's 46 counties and focuses on addressing physical health and mental health care needs in rural communities. The program works to:

1. Create and disseminate universal policies and procedures for telehealth while focusing on care coordination;
2. Expand network membership and informal partnerships to increase integrated care options;
3. Connect participating sites to exchange patient information;
4. Link 50 sites to a telehealth network through technology expansion;
5. Provide telehealth presenter training to each participating site;
6. Assist providers with billing and reimbursement information; and
7. Support members in providing telehealth consults.[307]

TABLE 2

Palmetto Care Connections South Carolina Rural Health Network Partners[308]

Partner Organization	Type of Organization	Location
Allendale County Hospital	Critical Access Hospital	Allendale County
Bamberg Family Practice	Rural Health Clinic	Bamberg County
Behavioral Health Services	Association of Alcohol and Drug Centers	Statewide
BlueCross® BlueShield® of South Carolina	Insurance Organization	Richland County
Family Health Center	Federally Qualified Health Center	Orangeburg/Calhoun/Bamberg Counties
Hampton Regional Medical Center	Non Profit Rural Community Hospital	Hampton County
Medical University of South Carolina	Non Profit Health System and Academic Teaching Center	Charleston County
McLeod Regional Medical Center	Non Profit Health System	Pee Dee Region
Prisma Health	Non Profit Health System and Academic Teaching Center	Upstate and Midlands
South Carolina Area Health Education Consortium	Health Education Agency	Charleston County
South Carolina Department of Health & Human Services	State Medicaid Agency	Richland County
South Carolina Department of Mental Health	State Mental Health Agency	Richland County
South Carolina Hospital Association	Association of South Carolina Hospitals	Richland County
South Carolina Office of Rural Health	State Office of Rural Health	Lexington County
South Carolina Primary Health Care Association	Association of Community Health Centers	Richland County
Tri-County Commission on Alcohol & Drug Abuse	Alcohol and Drug Abuse Center	Orangeburg/Bamberg Counties
University of South Carolina School of Medicine	State University - Hospital	Columbia/Richland County

Source: Palmetto Care Connections, 2020

Palmetto Care Connections will continue to support all elements of the Rural Health Network Development Program long-term including technical support to each county alcohol and drug authority site. PCC will provide on-site visits, training, planning, development and implementation of additional telehealth services and maintenance costs for telehealth carts.

The Behavioral Health Services Association of South Carolina, Inc.

The Behavioral Health Services Association of South Carolina, Inc. (BHSA) is comprised of the state's 32 substance use disorder prevention, treatment and recovery authorities that provide services to the state's 46 counties.[309] Each of these local entities contract with the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) to deliver a wide range of prevention, treatment, recovery and intervention services through funding from the Substance Abuse Mental Health Services Administration federal block grant and other funding streams.[310]

BHSA provides several member benefits to assist agencies with the delivery of behavioral health services and works closely with DAODAS to ensure quality outcomes. BHSA manages the Electronic Health Records system, a statewide online management system and technical assistance for continuum of services with the provider system, all of which support the implementation of telehealth as a service delivery model.[311]

As a result of the established partnerships listed in Table 2, each of the 32 local county alcohol and drug authorities has a telehealth cart in its facility and is equipped with direct-to-consumer platforms. The direct-to-consumer platform is used for peer counseling services, one-on-one counseling services and tele-MAT services.

Successful telehealth initiatives implemented by BHSA include the following:

- Telehealth service delivery since the onset of the COVID-19 pandemic; and
- Implementation of group telehealth services to maintain patient engagement.[312]

5

Behavioral Health Specialists in Communities and Community-Based Organizations

In 2018, 51.4% of adults in South Carolina who experienced a mental illness did not receive the treatment that they needed.[313] During the same year, 68% of youth ages 12 to 17 who needed treatment did not receive any mental health treatment, and only 28.3% of the youth who sought treatment received consistent services.[314] South Carolina ranked 40 out of 50 states and the District of Columbia in 2018 for its mental health provider-to-patient ratio with a ratio of 570 to one.[n,315] This ratio, as outlined in the Workforce section of this report, has improved since the 2017 Mental Health America Report ranking, but there is still a need for behavioral health providers, such as psychiatrists, psychologists, licensed clinical social workers (LCSW), counselors, marriage and family therapists, advanced practice registered nurses and nurse practitioners specializing in mental health care across the state.[316]

[n] According to Mental Health America, mental health workforce availability is the ratio of the county population to the number of mental health providers including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental health care.

Embedding different types of behavioral health specialists in communities is an integral part of improving outcomes for behavioral health patients and addressing barriers patients face when accessing care. Traditionally, community behavioral health specialists have been overlooked when care teams are developed. However, including these individuals within the network of services at different levels and in different care settings when managing the health needs of a community provides balance, efficient delivery of care, improved mental health outcomes and overall improved patient satisfaction.[317]

Mental Health Clinicians in Community Settings

School Mental Health Services

Embedding mental health professionals in schools provides accessibility as well as opportunities to increase mental health awareness and prevention. As outlined in the School Mental Health Services section of this report, the South Carolina Department of Mental Health (DMH) has substantially increased the number of mental health clinicians in schools across the Palmetto State since 2018 through the School Mental Health Services (SMHS) program. SMHS mental health professionals (MHP) specialize in providing mental health care in schools across South Carolina, engaging in universal prevention activities in group, classroom, grade and school settings. MHPs are trained in clinical assessments, evidence-based evaluations and interventions, facilitating psychiatric evaluations and consultation along with crisis interventions.[318] DMH MHPs are integrated into 843 school communities across the state providing access to care and ensuring an appropriate and timely intervention for students by connecting students to psychiatric treatment and evaluation when necessary.[319] Working alongside school staff members, MHPs provide support, streamline referral criteria and establish protocols and referral systems with outside agencies. Additionally, MHPs work to provide parent and teacher trainings and develop individualized student treatment plans in partnership with the student and their family.[320]

Embedding Mental Health Professionals in Emergency Departments

DMH embeds MHPs in hospital emergency departments (ED). As of December 2020, eight Community Mental Health Centers (CMHC) embedded 12 therapists within hospital EDs through a 50-50 cost share agreement.[321] MHPs provide consultative services to patients experiencing psychiatric emergencies in EDs and facilitate connections to appropriate resources. In September of 2015, DMH received the Garrett Lee Smith Memorial Suicide Prevention grant in the amount of $736,000 per year for five years. Part of this funding supported efforts that placed MHPs in hospital EDs to meet the needs of psychiatric patients.[322]

Embedding Clinicians in Child Advocacy Centers

As of December 2020, nine of DMH's CMHCs have clinicians embedded within or working closely with child advocacy centers through a Memorandum of Agreement (MOA) or contractual agreement.[323] These staff manage mental health care for children who have been victims of abuse or neglect. Participating CMHCs include Aiken-Barnwell, Anderson-Oconee-Pickens, Beckman Center for Mental Health Services, Berkeley, Charleston Dorchester, Columbia Area, Greenville Area, Pee Dee and Tri-County CMHC.[324] Ten staff members from five of the centers are embedded in child advocacy centers, and the remaining four centers coordinate resources with advocacy centers through an MOA or contract.

Embedding Clinicians in Law Enforcement Agencies

Currently, there are two grant initiatives supporting the practice and priority of embedding behavioral health clinicians in law enforcement agencies: the Mental Health/Law Enforcement Alliance Initiative and the Victims of Crime Act (VOCA). Both initiatives are designed to strengthen resources by integrating mental health and law enforcement initiatives to expand the reach of mental health services across South Carolina. MHPs work to enhance services for individuals within the criminal justice system.

Mental Health/Law Enforcement Alliance Initiative

The Mental Health/Law Enforcement Alliance Initiative began in 2019 and is funded by BlueCross® BlueShield® of South Carolina Foundation.[325] This initiative is a three-year effort that aims to embed mental health clinicians within law enforcement agencies in five communities to respond to the needs of communities, families and children faced with trauma, allowing for early intervention and mitigation of longer-term mental health issues. The five counties with MHPs embedded in law enforcement agencies include Lexington, Newberry, Berkeley, Dorchester and Richland. The coronavirus pandemic has put limitations on properly implementing and tracking the growth of this initiative.[326]

The Victims of Crime Act

The Victims of Crime Act (VOCA) began funding master's level therapists embedded in local law enforcement agencies in July 2017. These therapists respond to crime scenes with law enforcement to provide support and immediate connection to a therapeutic resource for victims. Currently, four VOCA clinicians are embedded in six law enforcement agencies to provide direct services to victims of crimes.[327] The six law enforcement agencies with embedded clinicians include Charleston County Sheriff's Office, North Charleston Police Department (PD), Mt. Pleasant PD, Summerville PD, Charleston City PD and Dorchester County Sheriff's Office. VOCA clinicians provide the following resources to law enforcement officers:

- Crime scene support and immediate support or treatment to victims;
- Assessment of individual needs in the community and identification of appropriate resources;
- Mental health trainings to officers;
- Partnerships with officers at community events; and
- Reviews of daily PD incident reports and facilitation of mental health services to individuals listed on the report.[328]

From October 2019 through September 2020, VOCA provided treatments and services to 966 individuals.[329] During that time, domestic family violence was the most reported type of incident experienced by individuals who received treatments and services from VOCA.[330] Top services received were information and referrals along with emotional support.[331] The total direct cost for the VOCA program for the year was $405,591.[332]

Embedding Clinicians in the South Carolina Department of Corrections

The South Carolina Department of Corrections' (SCDC) Division of Behavioral Health and Substance Abuse Services is designed to maintain the health and well-being of all offenders incarcerated in the agency. The intent of the division is to provide a continuum of services to address the behavioral health needs of incarcerated individuals as well as reintegration planning.

Objectives include the following:

1. Provide varying levels of substance abuse prevention, intervention and treatment services that are individual and collectively appropriate;
2. Provide programming and continuum of care guidance for offenders that will increase the opportunities for successful community re-integration;
3. Maintain and increase the quality and quantity of behavioral health and substance use disorder services with effective quality assurance and research efforts; and
4. Continuously provide training and staff development opportunities for employees and evaluate the effectiveness and appropriateness of services rendered.[333]

The division has four programs across the state that identify, assess and provide substance abuse educational opportunities and therapies for offenders incarcerated within SCDC. As of November 2020, there were 14 behavioral health specialists embedded in SCDC to deliver treatments and services.[334] These clinicians support the following programs:

1. The Screening, Identification & Orientation Program aimed to screen offenders using the Texas Christian University Drug Dependency Screen and identify newly admitted offenders for potential behavioral health needs. All participants receive the *Agency Policies and Procedures* overview prior to assignment along with behavioral health substance abuse services at SCDCs Reception & Evaluation sites around Columbia.
2. Female Substance Abuse Programs:
    a. The Camille Graham Addiction Treatment Unit is designed to provide female offenders with a six-month program structure specific to age and gender. This 48-bed residential program uses a Therapeutic Community Model treatment approach;[o] and
    b. The Goodman Addiction Treatment Unit is a 48-bed residential program designed to provide female and youth offenders with a six-month program structure using a Therapeutic Community Model treatment approach.
3. Adult Male Substance Abuse Programs are provided through the Horizon Addiction Treatment Unit, a 256-bed residential program, located at Lee Correctional Institution in Bishopville. This program addresses substance use disorders, arrestable behaviors, criminal thinking and other life issues of male offenders using a Therapeutic Community Model treatment approach for six months. Individuals who are court ordered or who have been conditionally paroled with identified substance use disorder program needs, as well as those with active, acute substance use are assigned priority admission status.
4. Male Youthful Offender Substance Abuse Programs are housed across South Carolina at the Turbeville Correctional Institution, Trenton Correctional Institution and Wateree Correctional Institution. The programs offer a six to nine-month structured program. These institutions offer a total of 272 beds using a Therapeutic Community Model treatment approach.[335]

Program participants are admitted based on prerequisites designed for each specific program. Embedding behavioral health specialists within SCDC is an evolving intervention that ensures coordinated behavioral health care and relevant services for inmates.

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[o] According to the National Center for Biotechnology Information at the United States Library of Medicine, therapeutic community (TC) treatment is an intensive and comprehensive addiction treatment approach for adults. TC treatment promotes a holistic lifestyle and identifies social, psychological and emotional behaviors that lead to substance use.

Innovations at Community-Based Organizations

Faces and Voices of Recovery Greenville

Faces and Voices of Recovery (FAVOR) Greenville is a recovery community organization (RCO) dedicated to providing intervention and recovery support services at no cost.[336] FAVOR Greenville serves the entire Upstate Region of South Carolina with locations in Greenville, Spartanburg, Anderson, Pickens and Oconee Counties. A member of the national recovery advocacy movement, FAVOR Greenville provides immediate access to intervention services and long-term recovery support offering innovative programs, services and approaches to individuals and families suffering with substance use disorders.

Innovations in recovery support offered by FAVOR Greenville include the following:

1. FAVOR Overdose Recovery Coaching Evaluation (FORCE) is a research project launched in January of 2018 that connects overdose survivors in Prisma Upstate EDs with a FAVOR Recovery Coach who will meet the participant bedside to provide ongoing support and implement a long-term recovery plan after discharge. The FAVOR Recovery Coach remains connected to the survivor through the critical first months of recovery to prevent a future overdose. This program was developed in collaboration with the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS).

2. Linking Inpatient to Recovery is a separate inpatient program and partnership with Clemson University and Prisma Health. The program is a randomized control trial which began in April 2018 and has demonstrated the effectiveness of peer recovery support. Individuals with a FAVOR Greenville recovery coach completed treatment/recovery programming at an 84% success rate compared to 36% of patients treated without a recovery coach.[337]

3. Doctors Who Coach is a partnership between FAVOR Greenville, Prisma Health-Upstate and the University of South Carolina (USC) School of Medicine Greenville with a focus on training medical students to be recovery coaches. This joint venture prepares medical students to assist patients affected by addiction.

4. Operation Rescue is a hotline providing free and confidential support for individuals and families dealing with addiction. The call/text hotline is open 24 hours a day and seven days a week.

5. Assertive Community Engagement (ACE) is a creative method used by specially trained recovery coaches to reach individuals and their families with home visits, parental engagement, community visits and technology.

6. In partnership with Nicholtown Missionary Baptist Church, FAVOR Greenville provides recovery treatment services to underserved communities, including one-on-one coaching and an annual Rally for Recovery.[338]

COVID-19 has triggered a significant increase in community need for recovery services. While operating at maximum capacity, FAVOR Greenville has also been able to shift to online meetings and a telehealth support model which has evolved into a hybrid model. In addition, FAVOR Greenville is providing small face-to-face groups and individual sessions supplemented by online meetings and telehealth.[339]

5 Opportunities for the Future Transformation of South Carolina's Behavioral Health Systems

1

School Mental Health Services

Common behavioral health issues such as bullying, family challenges, emotional distress and substance misuse can affect children of all ages and prevent them from learning and achieving. Schools are a natural setting for providing services to children with behavioral health needs, and the initial symptoms and signs of a behavioral health illness are often first observed in the school setting.[340] While there are significant unmet needs and limited resources to address behavioral health concerns in schools, confronting behavioral health issues and providing resources to children where they are comfortable is critical to their success in school and overall development of essential life skills.[341] Essential mental health services provided in schools typically include assessment, prevention and early intervention as well as treatment and case management, including referrals to other programs.

In some rural areas, school-based services are the only access to behavioral health treatment and resources that the child has.[342] Results from the 2019 National Survey of Children's Health indicates that an excess of 236,700 children aged three to 17 in South Carolina reported a mental, emotional, developmental or behavioral health problem.[343] Out of those children and teens with a treatable mental illness, 68% did not receive needed treatment or services from a mental health professional.[344] According to Mental Health America's report, *The State of Mental Health in America 2021*, South Carolina ranks 48 out of 50 states and the District of Columbia for prevalence of youth with untreated major depression.[p,345] Access to providers is essential to receiving adequate treatment.

Medicaid reimbursement is often a critical component to the financing of programs and services as the majority of school-based services are reimbursed by Medicaid.[346] Students who receive school-based behavioral health interventions demonstrate greater motivation, confidence, commitment to school and the ability to adapt when transitioning between grades, which leads to better time management, goal setting, problem solving skills, grades and reduced truancy.[347] Schools report less violence, bullying and conflict between students when these services are provided.[348]

Call to Action: South Carolina Safe School Environment

The Core Leadership Team of the South Carolina Behavioral Health Coalition (SCBHC) developed a vision for safe schools and formally adopted the South Carolina Safe School Environment Call to Action in March of 2018.[q,349] The South Carolina Department of Education (SCDE) convened

[p] See Appendix D to read the Mental Health America Rankings methodology for the Youth with a Major Depression Episode Who Did Not Receive Mental Health Services
[q] See Appendix K to read the full Call to Action – South Carolina Safe School Environment

with the SCBHC, the South Carolina Law Enforcement Division (SLED) and the South Carolina Department of Mental Health (DMH) to discuss the national gun violence epidemic, develop specific recommendations to prioritize the safety of students and a concrete timeline for achieving the vision for safe schools.[350] The Core Leadership Team of the SCBHC developed the Call to Action with the belief that:

1. Violence is not naturally a product of mental illness; most people who suffer from mental illness are not violent, and most people who act out violently are not mentally ill;
2. The most effective way to address behavioral health issues in the school setting is through prevention, education and early intervention;
3. School violence prevention and preparedness programs should be implemented and that these programs should be non-stigmatizing in nature;
4. Continued support and removal of any barriers to research into the contributing factors behind gun violence is critical, so that evidence-based prevention and intervention strategies in school and community settings can be developed;
5. Policies should be established to reduce access to firearms by troubled youth or those who are of immediate danger to themselves or others;
6. All students should have direct and timely access to school mental health counselors;
7. Every effort should be made to increase the number of mental health professionals available to youth in the school and community setting; and
8. Public and private payers and employers should provide coverage for school mental health counseling and treatment.

Call to Action: South Carolina Safe School Environment was originally outlined to be implemented within three years beginning March 2018. The following list outlines the 2018-2019 immediate goals:

2018-2019 Achieved Goals:

1. SCDE worked with law enforcement and mental health experts to develop virtual training modules for students, teachers, staff, parents and community members to identify characteristics of potentially dangerous behavior and the importance of reporting this potentially dangerous behavior;
2. The comprehensive district safety plan was developed and is practiced yearly with local law enforcement. This plan includes intruder/lockdown drills; and
3. SCDE worked with SLED to review all statutes and regulations regarding school safety requirements in schools and updated/implemented these regulations for the 2018-2019 school year.

Since adoption of the Call to Action, DMH has added over 85 school mental health positions in over 115 schools and all 2018-2019 immediate goals previously mentioned were accomplished as of March 2021.[351] During the 2019-2020 school year, SCDE completed the following:

2019-2020 Achieved Goals:

1. Allocated funds to local law enforcement agencies to sustain and place full-time School Resource Officers (SRO) in approximately 205 schools across the state that did not have an SRO prior to receiving state funds;
2. Supported DMH in offering the Signs Matter: Early Detection suicide prevention and awareness training statewide to over 2,000 administrators, educators and other school staff;
3. Collaborated with SLED to conduct exterior security assessments in 10 public schools;
4. Hired 10 additional DMH mental health counselors during the 2018-2019 school year for schools in Anderson School District 2, Florence School District 1 and Sumter School District as a result of the Project AWARE grant;
5. Coordinated five School-Based Behavioral Threat Assessment and Management trainings for school personnel statewide; and
6. Coordinated two train-the-trainer School-Based Behavioral Threat Assessment and Management trainings with 50 individuals.[352]

The substantial increase in school mental health clinicians and schools served by DMH denotes a sign of growth towards the 2022 goal to provide access to school-based mental health counselors in every school.

To help school districts across South Carolina provide standardized and effective plans to prevent school violence, SCDE released a training in February 2019 entitled School-Based Behavioral Threat Assessment and Management: Best Practices Guide for South Carolina K–12 Schools. The goal of the training is to help school staff and administration identify and respond to potentially violent and dangerous situations. The guide was developed with input from SLED and identifies school safety requirements provided in state statutes and regulations including South Carolina law S.C. Code Ann. § 59-63-910, which requires all public schools to conduct active shooter/intruder drills at least twice a year.[353] Additionally, the plan recommends that school boards adopt a threat assessment policy that requires training and reporting procedures.

SCDE is currently implementing all of the following 2020-2021 goals:

1. Continuing to offer the Signs Matter: Early Detection suicide prevention and awareness training statewide to administrators, educators and other school staff;
2. Growing the number of SCDE and district staff certified by the National Council of Behavioral Health as Adult Mental Health First Aiders and/or Youth Mental Health First Aiders;
3. Promoting mental health awareness by facilitating Mental Health First Aid training sessions for administrators, educators and other school staff;
4. Providing additional funding to local law enforcement agencies to sustain or place a full-time SRO in schools statewide that did not have an SRO prior to receiving state funds;
5. Improving educators' access to Social Emotional Learning (SEL) resources through the development of an SCDE website dedicated to SEL; and
6. Growing the number of school-based mental health counselors financed by the Project AWARE grant, serving in Anderson School District 2, Florence School District 1 and Sumter School District.[354]

Support for Expanding and Improving School Mental Health Services

Since 2014, school mental health services and funding allocation from the General Assembly has steadily grown. In FY 2017, DMH received $500,000 in new recurring state dollars to support their school-based programming. Of the $500,000, $100,000 of the school mental health funding from the General Assembly was designated by DMH to fund salaries for school mental health clinician positions in alternative school programs. In FY 2020, DMH received an additional $2.2 million in new recurring state dollars.[355]

TABLE 3

New Recurring State Funding for the South Carolina Department of Mental Health School Services Fiscal Years 2014-2020[356]

Source: South Carolina Department of Mental Health, 2020

Fiscal Year	State Funding	Number of Schools Served
2014	$1,000,000	460
2015	$2,000,000	480
2016	$2,500,000	519
2017	$3,000,000	540
2018	$3,500,000	653
2019	$4,000,000	740
2020	$6,200,000	843

DMH continues to blend funding streams that build long-term sustainability for school mental health positions after their first year. By funding positions with state appropriations, center funding, financial support from school districts and revenue from reimbursable services, school mental health positions are more likely to have a steadfast presence within schools. Blended funding also helps maintain positions if there is ever a decrease in one funding stream.

Through funding from the BlueCross® BlueShield® of South Carolina Foundation, 10 DMH clinician roles and two care coordinator roles have been added in targeted rural communities covering 12 elementary schools in the Pee Dee region. The service model in these communities focuses on prevention and early identification of mental health illnesses.

In the spring of 2019, telepsychiatry was rolled out in schools in the Pee Dee region. School mental health clinicians facilitate psychiatric consultations with students via secure telehealth connections. As of March 2021, telepsychiatry has expanded into 135 schools across 10 school districts in South Carolina.[357] DMH will develop best practices for the provision of school mental health services with the eventual 2022 goal of moving telepsychiatry into other elementary schools where they provide services.[358]

Due to COVID-19, South Carolina schools opened in August 2020 with in-person and virtual learning options. Upon reopening, schools contracted with DMH were physically staffed with therapists whether students were presently in school or opted for virtual learning.[359] Therapists are needed in the building not only to improve access for students but to give faculty and administration access and support.[360]

The South Carolina State Legislature provided $2.2 million for additional school mental health staff in FY20. Prior to the coronavirus pandemic, $600,000 of additional funding was requested for FY21 to expand school mental health services. All efforts are being made to reach the 2022 goal to provide access to school-based mental health counselors in every school.[361]

South Carolina Department of Mental Health School-Based Services

DMH has a long tradition of providing school-based mental health services in schools across the state and currently serves 843 schools.[362] DMH has contracts with all but four school districts in the state. The consistent growth in the number of DMH clinicians in schools since 2014 demonstrates the demand for services. Services provided within schools include intervention and diagnostic services with a range of treatments and programs that incorporate individual, group and family therapy.[363]

A key to providing mental health care to students in need across South Carolina is accessibility. The presence of mental health clinicians in schools can also provide opportunities to increase mental health awareness and prevention. School mental health clinicians are often the main point of contact for mental health-related issues among students as school settings allow for easier access when families are faced with transportation and scheduling issues. Services are most easily accessible when school districts provide private spaces on school campuses for clinicians to meet with students and families in a familiar and convenient location.

When students, teachers and parents see that the school administration places a high value on mental health care, not only does the stigma around mental health services decrease but working parents or those with transportation challenges face fewer disruptions when school children receive therapy at school. Additionally, when students receive appropriate mental health services, both their educational outcomes and school climate improve.[364]

Embedding mental health clinicians who speak Spanish and other languages is primarily helpful to the schools that they serve on a full-time basis. However, clinicians who speak multiple languages can assist other clinicians when needed, thus extending bilingual services to other schools. All mental health professionals at DMH have access to a Language Line, which can be used to assist in translation services for multiple languages, including Spanish.[365] The Language Line provides an interpreter over speaker phone, so a clinician can meet with child and/or family when an in-person interpreter is unable to be scheduled.[366] Decreasing the language barrier increases access to quality school mental health services and treatments for students.

DMH serves deaf and hard-of-hearing patients through the Office of Deaf Services. The Office of Deaf Services at DMH provides mental health services in American Sign Language and has school mental health clinicians.[367]

Some schools across the state provide their own mental health services or contract with private entities for mental health services. No comprehensive catalog of school mental health services across South Carolina exists.

Increased access to school-based mental health services, treatment options and support programs are important to the development of positive social-emotional learning, mental wellness and positive connections within the child's environment and their family.[368,369]

South Carolina Multi-Tiered System of Supports

In 2015, DMH contracted with the University of South Carolina School of Behavioral Health Team to create the John H. Magill School Mental Health Certificate Program, which provides guidance and assistance in the ongoing evaluation, quality assessment and improvement of school mental health services provided by DMH.[370] A separate, independent advisory committee was created to examine and provide specific recommendations to improve DMH's school-based services.

On May 18, 2018, South Carolina law 59-33-510 on Special Education for Handicapped Children was amended to include Act 213 on Dyslexia Screenings, which instructs school districts statewide to implement the Multi-Tiered System of Supports (MTSS) approach for the 2019-2020 school year.[r,371,372] The Act also includes a dedicated mental health professional who works closely with the school nurse, teachers, school administrators and safety and support teams. Through funding by the BlueCross® BlueShield® of South Carolina Foundation, DMH will increase the number of mental health clinicians in schools.[373,374] As of December 2020, DMH was working with SCDE to develop a goal for school mental health clinician-to-student ratio. The clinician-to-student ratio will be informed by national recommendations as well as the demonstrated needs and resources in our state.[375] Beyond early intervention for every student who struggles to attain or maintain grade-level performance by effectively utilizing evidence-based instructional model, the goal of this programming is to increase student resiliency and parent and community engagement.[376]

The offices of Student Intervention Services and Medicaid Services at SCDE are working to increase student access to counselors, social workers and mental health professionals who support the whole child and promote students' ability to learn. SCDE provides various trainings including technical assistance and professional development opportunities to school districts. These resources enable the school districts to provide support to students who need behavioral health services and to serve as a medical provider with the ability to bill Medicaid.

Project AWARE

In 2018, the Project AWARE (Advancing Wellness and Resiliency in Education) State Education Agency Grant, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), was developed to build and expand the capacity of state educational agencies in partnership with state mental health agencies. The expectation in South Carolina is that programs will work with state and local systems to achieve goals such as:

1. Providing increased awareness of mental health services to students, staff and families that address issues affecting school-aged youth;
2. Providing training for school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues; and
3. Connecting school-aged youth who may have behavioral issues and their families to needed services.[377]

SCDE was awarded $1,511,545 in FY 2018 and $1,760,408 in FY 2019 to implement South Carolina AWARE: Advancing Wellness and Resilience in Education (SCA) as a result of the Project AWARE grant.[378] The purpose of SCA was to build the state's capacity to increase awareness of school mental health services statewide; provide a multi-tiered system of supports to address mental and behavioral issues within the partnering local education agencies and their schools; provide evidence-based best practices; and train and assist with appropriate response to students, families and caregivers.[379] The Project AWARE grant also funded DMH School Mental Health positions.

As of May 2020, Project AWARE served 56 schools in Anderson School District 2, Florence School District 1 and Sumter School Districts and provided treatment for over 78,000 individuals and families.[380] A major objective included providing mental health treatment to 575,000 students, family members and community members through outreach efforts and awareness marketing.[381] Short-term goals included the following:

[r] According to the South Carolina Department of Education, a multi-tiered system of supports (MTSS) is a multi-disciplinary approach that uses data to identify students in need of early intervention, treatment and ongoing support.

1. Increased access to culturally competent and developmentally appropriate school and community-based mental health services for children and youth with severe emotional disturbances or serious mental illness;
2. School-based mental health programs that addressed any ongoing mental health needs of children with symptoms consistent with a mental disorder;
3. Immediate responses to the needs of students who may have exhibited severe behavioral or psychological signs indicating the need for clinical intervention; and
4. A developed infrastructure that sustained and expanded mental health and behavioral health services and supports for school-aged youth beyond federal funding.[382]

DMH Community Mental Health Centers (CMHC) deliver the telepsychiatry services administered through the grant. Project AWARE includes funding for telepsychiatry equipment in the three Project AWARE school districts. In addition, the grant funds a School Mental Health Telepsychiatry Coordinator who provides support and technical assistance for school districts' IT departments.

South Carolina Youth Suicide Prevention Initiative

The most recent data available indicates that the suicide rate in South Carolina increased 56% for youth and young adults (YYA), ages 10 through 24 between the years 2007 through 2009 and 2016 through 2018. The majority of those YYAs were white males between the ages of 20 and 24.[383,384] Top circumstances that lead to suicide deaths and attempts included intimate partner problems and mental health illnesses such as depression.[385]

The South Carolina Youth Suicide Prevention Initiative (SCYSPI) is housed within the DMH Office of Suicide Prevention and is funded by the 5-year Garrett Lee Smith Memorial Suicide Prevention (GLS) grant though SAMHSA.[386] The $736,000 yearly grant works to reduce suicide deaths and attempts for South Carolina YYAs ages 10 through 24.[387] SCYSPI aims to share evidence-based suicide prevention strategies, as reflected in the goals and objectives.

Current goals and objectives of SCYSPI include:

1. Strengthening statewide infrastructure to improve behavioral health services to potentially suicidal YYAs;
2. Implementing evidence-based prevention and intervention strategies to increase screening and access to services for YYAs at risk of suicide;
3. Developing an interagency response protocol to use when a YYA is determined to be at risk of suicide; and
4. Raising awareness and educating parents, teachers and other caring adults on depression, other mental health issues, suicidal ideation and suicide attempts in YYAs and how to respond.[388]

In schools, SCYSPI provides training on awareness, prevention, intervention and postvention (interventions implemented after a suicide or suicide attempt). To sustain the protocol, school district personnel are invited to ongoing virtual and in-person train-the-trainer events so they can provide internal trainings once the grant has ended. In April 2020, DMH and SCDE created a partnership that grants 10,000 teachers, district employees and school staff across the state of South Carolina the opportunity to take a free, self-paced course titled Signs Matter: Early Detection. This two-hour training is a suicide awareness and prevention online course that gives faculty and other school staff the ability to learn about warning signs and how they may present themselves at different age levels as well as how and when to express concern and refer students to counseling staff or administration.[389]

The Signs Matter: Early Detection training includes the following:

- A close look at the most common mental health problems and how they typically appear in a school setting;
- Real-world scenarios in an elementary, middle and high school setting to aid in identifying students in need of assistance;
- An online evidence-based assessment tool to ensure that all participants have gained an understanding of the material covered;
- Resources for understanding a school's role in suicide prevention; and
- A review of related legal requirements for schools.[390]

As of June 2020, DMH continues to provide postvention support to students in response to any sudden deaths, specifically suicide deaths and consultation to schools regarding training needs and policy change.[391] As of October 2020, 80 schools and districts have received training and 2,072 school personnel completed and passed the Signs Matter: Early Detection training.[392] An additional 1,242 school personnel were trained in various suicide prevention, intervention and postvention trainings. In addition, students and faculty throughout 58 colleges and universities in South Carolina watched It's Real: College Students and Mental Health, a film produced by the American Foundation for Suicide Prevention, a college-level suicide awareness and prevention initiative intended to highlight mental health issues commonly experienced by students.[393]

2

Crisis Stabilization Units

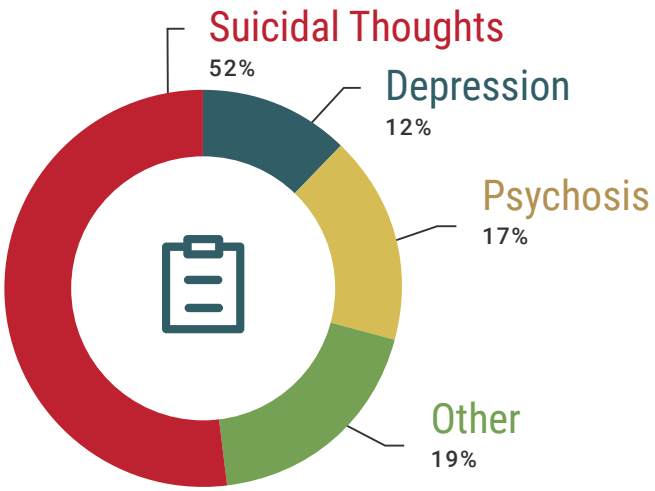
Crisis stabilization units (CSU) are small inpatient treatment facilities designed to stabilize patients, minimize emergency department (ED) visits and prevent incarceration for individuals who have a mental illness or substance use disorder (SUD).[394]

Patients who experience a behavioral health crisis must have access to behavioral health services at all times. Individuals who have a mental illness or an SUD need easily accessible, ongoing care and treatment to gain and maintain health and recovery. Chronic care management and crisis stabilization must be available and accessible.

Tri-County Crisis Stabilization Center

The Tri-County Crisis Stabilization Center (TCSC) in Charleston reopened in October 2017 and is open 24 hours, seven days a week, all year long. This adult crisis unit provides treatment options for individuals experiencing emergency psychiatric symptoms.[395] The objective of the TCSC is to divert individuals from unnecessary ED visits with voluntary short-term treatment options. TCSC is a 10-bed facility with an average length of stay of less than three and a half days.

Graph 14 illustrates the most common diagnoses treated at TCSC.



GRAPH 14

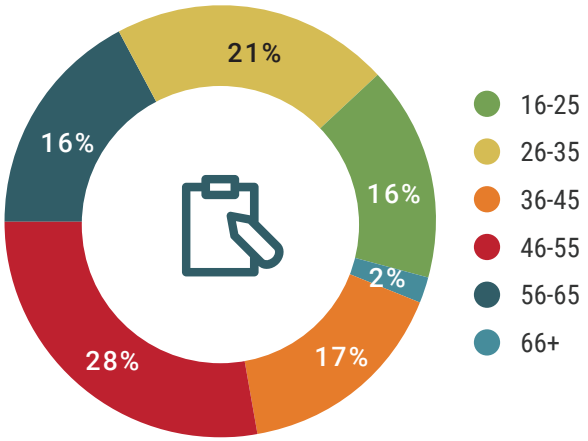
Tri-County Crisis Stabilization Center Most Commonly Treated Patient Diagnoses July 2019-April 2020[396]

Source: South Carolina Department of Mental Health, 2020

The Eubanks Center

The Eubanks Center – Peer Support Living Room opened in October of 2018 as an alternative safe space to the ED for individuals living with mental health illnesses experiencing a crisis. The Eubanks Center operates the Peer-Support Living Room in partnership with United Way of the Piedmont and Spartanburg Regional Healthcare System to provide individuals with a means to seek out support and resources in order to prevent a crisis.[397] The services are provided in an unconventional setting, similar to a traditional living room in a home, to reduce the stigma of receiving mental health treatment.[398] Treatment and services are accessible Monday through Friday, from 1:00 p.m. until 9:00 p.m. for individuals ages 16 and older. The program is staffed with peer support specialists, mental health clinicians and a case manager who assist with employment search, utility assistance and dental care.[399]

From July 2019 until April 2020, the Eubanks Center served almost 250 individuals with over 500 visits, preventing more than 100 hospitalizations or emergency room visits.[400] Like the Tri-County Crisis Stabilization Center, the Eubanks Center serves a variety of individuals with different diagnoses, the most common of which is anxiety. It also serves individuals who are leaving the hospital or ED but are not ready to be at home or work full time. Graph 15 illustrates the percentage of individuals served at the Eubanks Center by age.



GRAPH 15

Eubanks Center Individuals Served by Age July 2019-April 2020[401]

Source: Spartanburg Area Mental Health Center, 2020

Prior to the outbreak of the coronavirus pandemic, discussions and plans were underway for CSUs in Orangeburg, Columbia, Central or Anderson and Greenville. The planning for the units in Orangeburg and Central were well-developed, and those communities were close to action for implementation. As a result of the pandemic, all plans for developing additional facilities have been suspended for the foreseeable future. DMH will revisit these plans in the future.[402]

A future in which all South Carolinians have equal access to quality services in order to stabilize during a crisis, detoxify and/or receive chronic care management regardless of where they reside or their personal financial status is a necessary step to create an equitable continuum of care that effectively treats and supports patients with behavioral health diagnoses.

3

Discharge and Reentry Planning South Carolina Department of Corrections

Preparing to properly discharge inmates with behavioral health illnesses at the end of their sentence should be a pre-developed process based on the assessed needs of the individual.[403] The initial *Hope for Tomorrow: The Collective Approach for Transforming South Carolina's Behavioral Health Systems* report published in 2015 by the South Carolina Institute of Medicine and Public Health outlined the vision to prevent unnecessary incarceration for 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.[404]

Adequate treatment options are often not available to the justice-involved population, and many individuals who live with mental health illnesses and/or substance use disorders (SUD) reenter communities that cannot sufficiently support their behavioral health treatment needs.[405] A proposed solution, aimed at reducing recidivism and providing ongoing and appropriate care and treatment to justice-involved individuals who have behavioral health illnesses is to begin discharge planning upon the offenders initial incarceration.[406]

Ex-offenders often face significant challenges upon reentry to the community setting.[407] Lacking health care coverage, for example, increases an individual's vulnerability and chances of recidivism.[408,409]

A reduction of state spending is possible when justice-involved individuals who are eligible for Medicaid are enrolled and provided access to adequate behavioral and physical health services and support resources upon release, keeping them healthy and preventing recidivism.[410]

Services within the South Carolina Department of Corrections

In-House Recovery Resources

In-house recovery resources are provided by the South Carolina Department of Corrections (SCDC) and through a contract with the Department of Alcohol and Other Drug Abuse Services (DAODAS). Certified peer support specialists within SCDC are employed by DAODAS and provide treatments using a combination of supports and medication-assisted treatment (MAT) when appropriate. MAT aids social, behavioral and supportive treatments and services that support inmates in achieving successful integration into society, while effectively managing their lifelong recovery process.[411]

The purpose of the SCDC's Behavioral Health Services – MAT Program Delivery Protocol is to:

1. Provide MAT education to an inmate prior to his/her release in an effort to reduce recidivism, and to increase treatment retention and improved outcomes;
2. Empower inmates with evidence-based recovery tools necessary to recover from alcohol and opioid use disorders;
3. Assist inmates who have opioid and alcohol use disorders in achieving recovery and long-term abstinence by managing cravings and blocking the effects of ingested opioids and alcohol with the use of naltrexone, the generic version of Vivitrol®; and
4. Improve outcomes for offenders enrolled in the MAT program, facilitate the coordination of services and increase communication and collaboration with community stakeholders.[412]

Under contract with DAODAS, SCDC works collaboratively to provide peer support training to inmates. The initiative is renewed annually and allows up to 150 inmates to be trained.[413] This training and certification include both male and female populations, long-term inmates and inmates who will soon be released.[414] The goal of the Peer Support Training program is to provide inmate-certified peer support specialists to assist with the SCDC addiction treatment services and to increase the number of inmates served with recovery programming.[415]

Reentry Planning

Reentry planning within SCDC is managed by the Office of Programs, Reentry and Rehabilitative Services (OPRRS) where formal reentry planning for inmates begins six months before their anticipated release date. Through this new initiative, the OPRRS division provides opportunities to assist inmates in all facets of rehabilitation where they can learn new job skills, obtain their GED, earn vocational certificates, learn about how crimes affect victims and assist in teaching youth in the community about life in prison.[416] OPRRS also works closely with staff from the Office of Behavioral Health who are involved with discharge planning for those with serious mental illnesses. As of March 2021, there were over 4,700 individuals incarcerated in South Carolina's prison system who suffered from a mental illness.[417] This number represents over 27% of the population within the institutions, and this percentage continues to grow.[418] A consistent community-based behavioral health response in South Carolina will continue to reduce costs to both the criminal justice and health care systems and to reduce recidivism among those with behavioral health illnesses.

Bryan Stirling, director of SCDC has recently created a Difficult Reentry Placements position to manage complex mental health and medical reentry placements.[419] The purpose of this initiative is to collaborate internally with OPRRS, the Office of Behavioral Health, the Office of Medical Services and the Office of Operations in the community placement of these complex returning individuals.[420]

The new position focuses on discharge planning for complex medical and mental health inmates with special placement needs when returning to the community and acts as a liaison with Program Services on all reentry initiatives at the facility level.[421] There was a request in the fiscal year 2020 state budget to fund an initiative including five to eight internal discharge planning positions and 30 days of post-release medication support.[422] However, given the delays in the states budgeting process due to the coronavirus pandemic, any budget requests for increased resources for discharge planning will be deferred to fiscal year 2022.[423]

Collaborative Efforts

In addition to the internal initiative to create the position of Difficult Reentry Placements within SCDC, the South Carolina Department of Probation, Parole and Pardon Services (SCDPPP) identified the need for SCDC to create a multiagency workgroup to focus on the community placements of inmates with complex mental health and medical reentry needs.[424] Under the direction and leadership of SCDC, a workgroup has now been developed to include SCDPPP, the South Carolina Department of Social Services (DSS), the South Carolina Department of Disabilities and Special Needs (DDSN), the South Carolina Department of Mental Health (DMH) and the South Carolina Department of Health and Human Services (SCDHHS).[425]

The workgroup meets monthly to review inmate cases with identified challenges, such as those needing residential mental health or inpatient care, long-term care at the skilled level, sex offenders who are homeless with mental health challenges or other similarly complex needs. Other members of the group include the South Carolina Hospital Association, the South Carolina Health Care Association (to represent nursing homes) and both the Eastern Carolina Homelessness Organization and the Interagency Council on Homelessness. The goal of the workgroup is to review cases of incarcerated individuals in need of specialized placement assistance in advance of their release to ensure an approved location and services at the time of release. This group will also develop long-term planning for multiple agencies and develop coordinated budget requests.

SCDHHS allows inmates who are in the custody of SCDC and in need of Medicaid long-term care (LTC) benefits for nursing home placement to apply for Medicaid benefits or services while awaiting discharge.[426] Inmates who have been hospitalized for more than 24 hours and had Medicaid approved for that hospitalization are approved for conversion to an LTC facility. Inmates are also entitled to apply for conversion or initiation of other types of Medicaid, such as Community Choices for in-home care or the Optional State Supplementation Program for individuals who will be placed in a Community Residential Care Facility upon release.[427]

Inmates who are awaiting release and are likely to become eligible for Medicaid upon release can apply for deferred Medicaid benefits, without having their application fully processed until their release. One of the suggested recommendations in the initial *Hope for Tomorrow: The Collective Approach for Transforming South Carolina's Behavioral Health Systems* report was to,

> "put into place a system whereby incarcerated adults have their Medicaid benefits suspended rather than eliminated."[428]

As of June 2016, inmates who have Medicaid coverage upon incarceration can have their benefits suspended rather than terminated while incarcerated, which reduces their wait time upon release to connect with

providers. These approaches lessen the ongoing concern of ex-offenders not having access to health coverage once they are released from prison.[429]

In 2019, over 7,500 inmates were released from SCDC, and 24% of those individuals were assigned a mental health classification at the time of release.[430,431] When nearing discharge, services like Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), housing, employment matching, social security benefits and Medicaid are coordinated in partnership with SC Thrive through the Good Grid Benefits Bank, an internal resource platform.[432] SCDC utilizes the Good Grid Benefits Bank platform to submit applications on behalf of inmates. Many inmates are provided behavioral health appointments after their release date, but attendance record for these appointments is unknown or not tracked at this time.[433] SCDC does not follow inmates after they have completed their sentence and have been released.[434]

Discharge planning services coordinated between SCDC, DMH and SCDPPP will ensure continuity of care and long-term improvements of coordination of interagency referrals for offenders being released into communities. SCDPPP has intensive supervision officers who work with reentering individuals with the most significant mental illnesses to maintain their appointment adherence. While efforts are made to track referrals, SCDPPP does not currently track referrals through the Good Grid Benefits Bank nor does SCDPPP track every referral for released inmates on parole.[435]

Community Recovery Resources

DMH provides community care to newly released inmates but does not deliver in-house resources to SCDC.[436] DMH provides support to prisons, jails and detention centers by receiving newly released inmates in their Community Mental Health Centers (CMHC). CMHCs require mental health assessments of newly released inmates before providing care.[437] Each CMHC communicates with SCDC through a clinician or supervisor who serves as a Justice-Involved Programming Liaison to coordinate appointments for patients before their release.[438] These liaisons are a point of contact that help to facilitate the needs of the justice-involved population with partnering agencies.[439] This includes routing referrals and directing justice-involved individuals to the appropriate internal resource.[440]

The growth of inmate discharge planning services between SCDC, DMH and SCDPPP is now underway to ensure continuity of care and long-term improvements of coordination of interagency referrals of offenders being released into local communities.

Emerging Partnership in Spartanburg

In November of 2020, SCDC and DMH launched an ongoing partnership to help female offenders break the cycles of violence, trauma, substance use and incarceration by creating a safe environment for themselves and their family.[441] By providing outpatient treatment for trauma, teaching parenting skills and enhancing family connections while incarcerated, this program aims to enhance resilience, protective factors and positive relationship skills. This 12-month program begins six months pre-release and continues six months after an inmate has been released. The participants begin working with the outpatient team prior to their release, reducing the gap and connection to services during their time of release from prison and return to the outside world. Participants with trauma, mental illnesses and/or SUDs engage in gender specific treatment for trauma as well as treatment to improve family relationships. SCDC collaborates with the Spartanburg Area Mental Health Center to provide care. Community SUD counselors are provided on an as-needed basis for 12 months.[442] Upon program implementation, the partnership served three cohorts of 20 females each.[443]

4

Integration and Collaborative Care

As the United States focuses on a value-based health care system, South Carolina has moved forward with implementing value-based strategies for purchasing, payment and reimbursement of services.[444]

The initial *Hope for Tomorrow: The Collective Approach for Transforming South Carolina's Behavioral Health Systems* (2015) report outlined its vision as the improvement of "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."[445]

Although value-based care is often used interchangeably with quality improvement and cost reduction, the three are not synonymous. Instead, quality improvement and cost-saving measures are individual components of value-based care, which focus on measured improvements in health outcomes.[446] Value-based care considers the patient's goals and incentivizes effective integrated care to ensure improved health across the lifespan of the individual.[447]

Under a value-based care model, improvement of health care services cannot progress without the integration of behavioral and physical health care. The integration of both services reduces stigma related to mental health, improves patient outcomes and reduces overall costs.[448] A best practice used for reducing barriers and increasing a cohesive structure of care for patients and health care providers is to align the physical and behavioral health provider systems.[449]

South Carolina Department of Mental Health Efforts to Provide Integrated Care

The clinical staff employed by the South Carolina Department of Mental Health (DMH) provide a variety of mental health treatments and services for children, adolescents, adults and families through outpatient Community Mental Health Centers (CMHC) and clinics across the state.[450] Clinical Care Coordinators also provide targeted case management services through the 16 CMHCs and satellite offices, resulting in a network of outpatient facilities in every county. CMHCs utilize a common electronic medical record (EMR) system and the DMH central office provides oversight of the centers. Each center determines how it will meet the agency's strategic goals, and seven of the centers use various collaborative and co-located models of care. The seven CMHCs with integrated care models are as follows:

1. Aiken-Barnwell Mental Health Center (ABMHC)

An ABMHC mental health professional (MHP) provides care at the Wagener Medical Center two days a week, and a psychiatrist provides telebehavioral health to the medical center as needed. As of September 2020, the staff serves 23 patients at this location.[451]

2. Beckman Center for Mental Health Services (BCMHS)

BCMHS has maintained a contract with Carolina Health Centers, a Federally Qualified Health Center (FQHC), for 14 years and provides four mental health professionals to serve patients in six of their 11 locations. In addition, mental health services are provided at the Transitional Care Clinic, Peachtree Medical and Clinica Gratis by mental health staff. BCMHS psychiatrists are also available to provide consultation to medical staff at these sites.

3. Berkeley Community Mental Health Center (BCMHC)

BCMHC partners with Fetter Healthcare Network, an FQHC, to provide physical health care in the mental health center one half-day per week.

4. Catawba Community Mental Health Center (CCMHC)

In 2019, CCMHC opened Synergy Health and Wellness, a primary care practice in its adult-serving York County clinic that allows patients to see their mental health clinician, psychiatrist and/or primary care provider at the same facility on the same day.[452] Synergy's funding included a federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant that ended March of 2020. Funding was used to hire staff including a nurse practitioner and medical technician.[453]

Physical health services are provided three days a week in CCMHCs York County Clinic and one day per week each in Lancaster and Chester County Clinics as of June 2020.[454] The grant also supported a peer support specialist to deliver interventions and wellness activities such as diabetes education, weight management, stress control and smoking cessation.[455] Outcomes attributed to the project include the following:

a. Decreased emergency department visits;
b. Improvements in overall health of patients;
c. Lower blood pressure and blood sugar (A1C) and cholesterol;
d. Weight loss; and
e. Higher levels of patient satisfaction.

5. Charleston Dorchester Mental Health Center (CDMHC)

CDMHC has partnered with the Fetter Healthcare Network, an FQHC, to provide primary care and dental care in the mental health center for approximately 20 years. Fetter staff are in the Charleston clinic one day a week. CDMHC currently receives enough referrals to support more days; however, space is a barrier. Fetter is in the process of expanding services to the Dorchester clinic.

CDMHC also began the Highway to Hope program in 2008. This program builds on partnerships with four health clinics in rural areas in Charleston County and an urban homeless shelter. An RV owned by CDMHC is staffed by two mental health professionals and a psychiatrist who rotate on a monthly basis. The RV travels to the partnering locations and offers mental health services to health clinic patients who would otherwise face transportation barriers.

6. Santee Wateree Community Mental Health Center (SWMHC)

SWMHC offers co-located care four days a week in partnership with Sandhill Medical Foundation, Inc., an FQHC, in its Kershaw County Mental Health clinic site. Through this partnership, the center reports that it has been able to successfully expedite patient acceptance into psychiatric hospitals and quickly respond to medical issues for patients as well as provide COVID-19 testing during the coronavirus pandemic.

7. Waccamaw Center for Mental Health (WCMH)

WCMH provides two MHPs who deliver homeless outreach services through a Mental Health Service Expansion grant with the Little River Medical Center. These clinicians can provide integrated care to those unable to access care as a result of the lack of stable housing.[456]

Pee Dee Highway to Hope Mobile Response Program

DMH received a one-year SAMHSA grant in October 2020 in the amount of $6.4 million. The grant, named Highway to Hope (H2H), was awarded to support integrated mental health and primary care for residents experiencing mental health and substance use crises in the Pee Dee area as a result of Hurricane Florence. The grant funds the Pee Dee H2H Mobile Response program and serves adults and children.[457] The Pee Dee H2H Mobile Response program utilizes a fleet of nine RVs that are operated by the staff of three DMH mental health centers. Six of the RVs are staffed with a registered nurse, an adult-serving MHP and a child-serving MHP. These RVs are designated for patients in the area's most rural communities. The remaining three RVs are staffed with an RN, a school mental health clinician and an adult clinician and are designated for patients at local schools not currently offering DMH school mental health services.[458]

The H2H Mobile Response program is operational in the Pee Dee Mental Health Center, Tri-County Mental Health Center and Waccamaw Mental Health Center as of February 1, 2021 and all centers will have RVs by June of 2021 to provide mobile outreach. During the initial year of implementation, DMH expects the H2H Mobile Response program to have a mental health caseload of at least 1,440 adults and 360 children at any given time. With new patients and readmissions, the H2H Mobile Response program will serve at least 3,000 South Carolinians.[459]

The concept is based on the approach taken by the CDMHC and offers direct crisis services, assessment, evidenced-based therapies, primary care, nursing care, psychiatric care and suicide prevention strategies. It also provides a "one-stop shop" for referrals to additional services including employment assistance, care coordination, case management, peer support, homeless/housing assistance, deaf services and services for non-native English speakers. Both in-person and virtual services are available through the H2H Mobile Response program.[460]

DMH will continue to support a range of integrated care options that are aligned with the needs and preferences of communities served. At the time of the writing of this report, DMH's leadership is in the process of building out a strategic initiative to expand integrated care options for various centers. The strategic goals outlined include enhancing its EMR system so primary care can be documented and billed for reimbursement.[461] The EMR documentation changes could support the expansion of the Catawba CMHC model that utilizes a DMH advanced practice registered nurse registry. While DMH plans to seek reimbursement for primary care services, 50% of the patients currently served at CCMHC are uninsured, and recent budget constraints are a barrier for sustaining care for uninsured patients.[462]

Opportunities for partnerships and funding for DMH include the following:

1. Funding for the expansion of primary care initiatives in mental health centers so every center and rural site has access to effective integrated care models;
2. Funding for additional RVs to travel to rural communities to deliver medical services, behavioral care and supportive services;
3. Funding for state infrastructure improvements such as a certified outpatient EMR;
4. Expanded partnerships with the South Carolina Department of Health and Human Services to develop new financing strategies; and
5. Expanded partnerships with the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) to identify, refer and treat patients with co-occurring conditions.[463]

Existing partnerships between DMH and DAODAS include a program manager position that facilitates collaboration and communication between the agencies and projects. This has resulted in two new initiatives that include a project-securing evidence-based curricula for cross training between agencies and a project offering dual diagnosis capability.

5

Developing an Adequate Behavioral Health Workforce

Educating, recruiting and retaining a comprehensive behavioral health workforce is necessary to ensure access to care for the one in five Americans who suffer from a behavioral health disorder.[464] One of the best ways to create and sustain an adequate behavioral health care system is by addressing the shortage of qualified behavioral health workers. South Carolina faces many barriers to sustaining a behavioral health workforce, including maintaining an adequate training pipeline, providing livable wages and recruiting and retaining professionals.

The behavioral health workforce is diverse in terms of types of providers. Psychiatrists, nurse practitioners and clinical nurse specialists can prescribe medication for mental illnesses and SUDs. Social workers, psychologists, licensed professional counselors and other types of counselors provide counseling and behavioral therapies. Access to prescribers, which are critical for supporting patients' medication adherence, and access to counselors is maldistributed between urban and rural areas of South Carolina.[465]

The initial *Hope for Tomorrow: The Collective Approach for Transforming South Carolina's Behavioral Health Systems* report published in 2015 outlined the vision to support a comprehensive behavioral health system by creating and sustaining a stronger and larger behavioral health professional workforce.[466] Although there have been some improvements, there are still behavioral health staffing shortages across South Carolina. *The Evolving Workforce: Redefining Health Care Delivery in South Carolina 2019* report published by the South Carolina Institute of Medicine and Public Health outlined several recommendations from the Workforce for Health Taskforce that addressed behavioral health workforce needs.[467]

Behavioral health workforce recommendations included the following actions:

1. Improve reimbursement for behavioral health services within government agencies and community-based organizations to increase compensation for behavioral health professionals;
2. Reduce financial barriers to entry for students interested in behavioral health certifications and degrees;
3. Ensure educational entities, students and employers are aware of the need for behavioral health professionals across the state; and
4. Place special emphasis on creating a positive, supportive work environment with opportunities for growth in behavioral health settings.[468]

Barriers to developing a comprehensive behavioral health workforce, such as a noncompetitive compensation and difficulty accessing field placements, must be addressed to keep up with the mental health and substance use disorder (SUD) care system demands.

Workforce Numbers and Distribution

Many states, including South Carolina, collect data on licensed health care professionals, such as physicians and nurses, through the licensure process or surveys. Behavioral health professionals can be very difficult to track due to the varying complexity of behavioral health workforce credentialing and clinical practice. Data on professions that do not require a license to practice is missing altogether.

National professional associations along with the federal Health Resources and Services Administration and the Behavioral Health Workforce Research Center at the University of Michigan provide minimum data set guidelines that improve data collection and generate consistency with comprehensive data on the health workforce.[469,470,471,472] When gathering health workforce information, basic data elements include demographic, educational, credentialing and practice characteristics of health professionals.[473] Currently, South Carolina does not follow minimum set data guidelines which makes it difficult to understand the gaps in the workforce, like those described above. Efforts to improve data collection are underway. Better data will allow South Carolina to fully understand behavioral health workforce and resource allocation needs.

Psychiatrists

Psychiatrists are defined by the American Psychiatric Association as medical doctors who specialize in the diagnosis, treatment and prevention of mental health illness and SUDs.[474] Psychiatrists earn a Doctor of Medicine (MD) or a Doctor of Osteopathic Medicine (DO) degree in addition to completing a four-year residency program in psychiatry and specialized fellowship training as applicable.[475] In 2018, there were 30,451 practicing general psychiatrists in the United States.[476] In 2019, the most recent year for which data is available, there were 436 general psychiatrists practicing in South Carolina which translates to 8.5 general psychiatrists for every 100,000 South Carolinian.[477]

Psychologists

Psychologists are defined by the American Psychological Association as a doctoral-level professional who research, study and treat brain and environmental behaviors as well as mental and emotional illnesses. The Association reports that there are 102,000 active doctoral-level psychologists in the United States as of 2018. In South Carolina, there were 11.5 general psychologists per 100,000 residents in 2018.[478] This was the lowest rate in the country.[479]

The University of South Carolina is the only American Psychological Association accredited doctoral program in the Palmetto State, accepting 11 to 15 candidates per year. Across the state there are four pre-doctoral internship sites, accepting a combination of 31 candidates per year and placing them at sites located at Clemson University, the University of South Carolina, the Medical University of South Carolina and the Wm. Jennings Bryan Dorn Veterans Affairs Medical Center.[480] The pre-doctoral internship is a requirement of American Psychiatric Association accredited programs, a necessity to receive licensure in all states and is an important requisite for individuals entering into the workforce.[481]

Additional Licensed Behavioral Health Professionals

The South Carolina Area Health Education Consortium's (AHEC) Office for Healthcare Workforce (OHW) analyzes data on licensed health professionals in the state.[482] According to OHW, the 436 general practicing psychiatrists reflected in the 2019 count were non-federal, non-resident-in-training physicians with a specialty in general psychiatry. In addition to general psychiatrists in the state, there were 80 physicians practicing child

and adolescent psychiatry, 12 practicing geriatric psychiatry and 26 practicing in other psychiatry specialties. There were 2,362 clinical social workers in 2017, the first year OHW began tracking them.[483]

Clinical social workers are defined by the South Carolina Health Professions Data Book as licensed professionals whose license status are clinical practice (CP), advanced practice (AP), Dual or Licensed Master Social Worker (LMSW).[484] Clinical social workers hold either a Master of Social Work, Doctor of Social Work or PhD in Social Work degree and are employed in non-profit social service agencies, government agencies, hospitals and other health care delivery entities.[485,486]

Licensed marriage and family therapists (LMFT) have either earned a master's or doctorate degree or post-graduate clinical training program.[487,488] LMFTs come from a variety of backgrounds including nursing, social work, education and psychiatry.[489] LMFTs are trained in psychotherapy and family systems and are licensed to diagnose and treat mental and emotional disorders. LMFTs focus on relationship issues within the family structure.[490]

Licensed professional counselors (LPC) hold a master's degree and provide mental health counseling to individuals, families and groups to treat behavioral and emotional problems or disorders.[491,492] LPCs, also known as licensed clinical professional counselors or licensed mental health counselors, practice in several capacities including research, diagnosis and treatment, psychoeducational techniques and consultation to individuals or groups.[493]

According to the American Association of Nurse Practitioners, psychiatric mental health nurse practitioners (PMHNP) evaluate, diagnose and treat behavioral health patients.[494] PMHNPs require a master's degree in nursing or a doctorate in nursing practice. PMHNPs focus on assisting patients who have psychiatric disorders and substance use disorders.[495]

Clinical nurse specialists are advance practice registered nurses (APRN) who provide new techniques to nurses on patient care.[496] Clinical nurse specialists have earned a master's or doctorate degree and are employed in a variety of health care settings including outpatient care facilities, hospitals, laboratories and emergency rooms.[497,498]

Addiction counselors, also known as substance abuse counselors, hold a master's degree in psychology, social work, sociology or other related fields.[499,500] Though addiction counselors focus on treating patients to overcome drugs or alcohol dependency, they do not prescribe medicine or provide medical or psychological therapies.[501]

According to the National Association of School Psychologists, licensed psycho-educational specialists are school psychologists that have earned either a master's or doctorate degree.[502] School psychologists are licensed professionals who provide evaluation and treatment interventions for students with learning, developmental and behavioral disorders that impact learning and instruction.[503]

The South Carolina Board of Examiners in Psychology and Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psycho-Educational Specialists only recently began collecting basic data to more accurately identify psychologists and counselors that are practicing within the state. Data collected at license renewal include demographic and education information, form of employment and practice setting. The most recent data gathered from 2018 will be published by OHW in the coming year. However, without understanding the supply and distribution of those specific professionals, other licensed workers and unlicensed workers, it is difficult to fully understand the workforce available to support the behavioral health needs of South Carolina's population.[504]

Building a Sufficient Pipeline

It is important to work collaboratively to develop a comprehensive strategy to educate, recruit and retain professional behavioral health practitioners. Providing incentives for providers to practice in rural communities is a key strategy, in addition to targeting rural and underserved students and professionals for mentorship and other professional opportunities. Developing an effective pipeline so that youth and young adults feel prepared to take on the responsibilities as a behavioral health provider and are capable of providing for themselves and their families once they become professionals would simultaneously allow South Carolina to improve health outcomes and build prosperity throughout the state.[505]

Strategies to Support Rural Recruitment and Retention

Evidence shows that health care providers who grew up in rural areas are more likely to practice in rural areas than those who grew up in urban areas.[506] Efforts to attract students from the state's rural areas and prepare them for admission to health profession programs may help increase the number of future health professionals that practice in rural communities. South Carolina AHEC and its four regional centers coordinate health career programs for high school and college students, focusing on underserved and underrepresented populations. These programs include exposure to a variety of health careers, job shadowing, training on professionalism and leadership development and preparation for the Medical College Admission Test. In addition to supporting a future workforce that may serve rural communities, these programs also support the development of a diverse workforce that is reflective of the communities it will serve.[507]

Additional factors that influence the choice to practice in rural areas include exposure to rural training opportunities and a desire to serve rural communities.[508] South Carolina AHEC provides a variety of health profession students with community-based training experiences, exposing them to the possibility of working in rural and underserved areas of South Carolina through the South Carolina AHEC Scholars Program.[509] One of the core topics of the program is behavioral health integration, which touches on the importance of the integration of social work and clinical medicine. Nine out of the 60 participants in the first two cohorts were social work students.[510] Students accepted into the AHEC Scholars Program receive preference for innovative, team-based clinical fieldwork placements. AHEC Scholars also have opportunities to network with state leaders and primary care professionals from across the state to prepare and support them in their desire to practice in a rural location.

Finally, research shows that financial incentive programs improve recruitment and retention of health professionals in rural areas.[511] The South Carolina AHEC Rural Physician Program addresses the maldistribution of health care professionals by administering state financial incentives to primary care physicians and advanced practice professionals in the state who commit to practice in a rural or underserved area for up to four years.[512] Since 1989, the program has funded over 500 health care providers throughout South Carolina.[513]

Workforce Diversity and Cultural Competency

Access to quality care is dependent on a diverse and inclusive workforce. In the absence of linguistically or culturally appropriate behavioral health services, many of the most vulnerable South Carolinians are left without comprehensive behavioral health care.[514] Nationally, African Americans are less likely to be offered evidence-based mental health treatments compared to the general population due to lack of culturally competent care.[515] Addressing the social barriers that exist which limit minority matriculation in health professional studies in addition to the current state of mental health within minority populations would promote a healthy and welcoming environment, thus improving the quality of care.

The lack of provider diversity contributes to undertreatment, misdiagnosis and lower-quality care provided for behavioral health patients.[516] Barriers to equitable care include language barriers in the workforce, lack of racial and ethnic diversity among providers and lack of culturally competent providers. As of 2018, 67.3 million Americans spoke a language other than English at home, reflecting a significant need for linguistically inclusive behavioral health services.[517] Through their health careers programs, South Carolina AHEC seeks to improve diversity in the health careers pipeline by working with students from rural, underserved and underrepresented populations.

Development, Attraction and Retention

With the number of vacancies within the behavioral health system, the current training systems in our state are not sufficient.[518] In rural areas, which have fewer behavioral health professionals, training opportunities are even more limited. Ensuring that all students have on-site training placement is a challenging, complex problem, but it is also a solvable one. Based on recommendations in the June 2019 report, *The Evolving Workforce: Redefining Health Care Delivery in South Carolina*, the action step proposed was ensuring that educational entities, students and employers were aware of the need for behavioral health professionals in South Carolina. The solution further proposes that health and human service providers partner with government agencies as well as academic and training institutions to publicize behavioral health positions to middle school, high school and college students.[519] Creating a collaborative pipeline that contributes to the development of a competitive workforce can be done by addressing current training and educational needs and guiding students to experiences that shape their interests around behavioral health career paths.

More behavioral health care providers and support professionals at all levels, including both licensed and unlicensed professionals, are essential to meeting the behavioral health needs of this state. Licensed social workers (LSWs), licensed professional counselors (LPCs) and licensed marriage and family therapists (LMFTs), among other roles, face credentialing obstacles that limit the ability to adequately staff these roles.[520] With solutions outlined in the IMPH report Increasing *Access to Behavioral Health Care Providers in South Carolina* published in 2020, there are opportunities to improve access to behavioral health providers across the state through adjustments to licensing and credentialing processes.[521]

One option to increase the behavioral health workforce in South Carolina is to participate in the Interstate Medical Licensure Compact. The Compact consists of 29 states, as well as the District of Columbia and the Territory of Guam. The Compact began in 2017 with the purpose of simplifying the traditional licensing process for physicians who want to practice in multiple states, offering a voluntary expedited pathway to licensure and increasing access to health care.[522] A bill supporting the interstate agreement was introduced into South Carolina legislation in 2019. However, the bill died in the Senate Committee on Medical Affairs on November 8, 2020.[523] As of January 2021, South Carolina does not participate in the Compact.

A second option to increase the behavioral health workforce in South Carolina is to participate in the Psychology Interjurisdictional Compact (PSYPACT). PSYPACT was approved by the Association of State and Provincial Psychology Boards (ASPPB) in 2015. This interstate agreement is governed by the PSYPACT Commission and authorizes psychologists to practice telepsychology and temporary in-person, face-to-face practice of psychology across jurisdictional state boundaries.[524] As of December 2020, there are 15 PSYPACT participating states, and three states, including the District of Columbia, with pending PSYPACT legislation.[525] Currently, South Carolina is not a PSYPACT participating state. However, as of February 9, 2021, the South Carolina General Assembly House Bill 3833, allowing the state to enter into the multistate compact, resides in the House Committee on Medical, Military, Public and Municipal Affairs.[526]

Another option for South Carolina to increase the behavioral health workforce is to expand license reciprocity. License reciprocity is the process in which a professional who practices in one state is allowed to coordinate supervised license transfers across state boundaries to fill unmet needs in other states.[527] South Carolina does not have licensure reciprocity with any state for social worker titles including licensed baccalaureate social worker (LBSW), licensed master's social work (LMSW), licensed independent social workers-clinical practice (LISW-CP) and licensed independent social workers-advanced practice (LISW-AP). While a current state license is required to practice in the state, the South Carolina Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists, Addiction Counselors and Psycho-Educational Specialists accepts applications from out-of-state social workers.[528] Accepting applicants from out of state to fill the talent pool can help address staffing barriers.

Entering into reciprocal agreements, like those mentioned above, is an important element in reducing barriers to licensure and improving access to behavioral health providers across South Carolina.

Recruitment and Retention in the Department of Mental Health

In South Carolina, it is difficult to recruit behavioral health professionals in the public service system and fill open positions due to noncompetitive salaries, an element that is important to solid workforce recruitment and retention efforts.[529]

In *The Evolving Workforce: Redefining Health Care Delivery in South Carolina*, another action step recommended by the Workforce for Health Taskforce was to increase behavioral health professional pay bands in the public health sector. This recommendation encouraged the governor, the Department of Administration and the State Legislature to work together to provide salaries that reflect the level of education and expertise required for behavioral health professionals.[530]

In March of 2020, the South Carolina House of Representatives Legislative Oversight Committee proposed three recommendations to the South Carolina Department of Mental Health (DMH) and the General Assembly regarding sufficient employee compensation:

1. DMH should seek funding to maintain mean salaries at or above the midpoint for each classification;
2. DMH should review mental health salaries in Georgia and North Carolina counties bordering South Carolina to maintain a competitive market for the recruitment and retention of mental health professionals; and
3. The General Assembly should consider re-establishing the Classification and Compensation Study Committee for the purpose of examining findings and recommendations to the Department of Administration, Human Resources Division on the state's classification and compensation system.[531]

In March of 2020, the same time that the South Carolina House of Representatives Legislative Oversight Committee proposed recommendations to address employee compensation, the Committee proposed another four recommendations related to the recruitment and retention of DMH employees as follows:

1. In collaboration with relevant state agencies and the state's higher education institutions, DMH should study existing education and training paths for mental health professionals to determine if the capacity exists to meet future estimated needs for mental health professionals at all levels;
2. DMH should collect data to evaluate efficiency of its recruitment efforts;
3. DMH should continue to employ current retention strategies, implementing a method to determine which strategies are most effective and research new or evolving retention strategies; and
4. DMH should ensure that a range of employee levels are represented on agency-wide committees
5. Impacting employee onboarding, training and retention.[532]

Significant progress has already been initiated to support enhancements to the behavioral health service systems in South Carolina. However, much work remains to keep up with the mental health demands of South Carolina's population.

DMH has been proactive for several years in the development and implementation of the Talent Acquisition and Retention Program (TARP), which addresses the agency's recruitment and retention needs.[533] TARP focuses on recruiting professionals for the most critical needs such as direct patient care, management and other executive level positions. Traditional recruiting campaigns via social media, pre-determined digital locations, online search engines, print and broadcast media have been implemented to draw applicants to the agency.[534]

However, DMH has faced challenges in recruiting and maintaining a diverse talent pool as well as recruiting and maintaining a skilled workforce. This includes providers such as psychiatrists and primary care physicians, advanced practice providers such as advanced nurse practitioners and physician assistants as well as licensed clinical social workers, peer counselors, registered nurses and certified nursing assistants.[535]

Despite increases in appropriations from the General Assembly for expanded service delivery, continued workforce issues will hamper DMHs efforts to maintain sufficient staff to provide existing services.[536] For example, as the workforce continues to age, South Carolina will need to provide more attractive compensation packages to attract younger practitioners. In 2020, the average age of DMH's nursing staff was 59 years old.[537]

Although DMH has created initiatives that nurture succession planning and work-life balance, employers outside of the agency often provide much higher salaries than what DMH can offer. The inability to offer competitive salaries forces the agency to rely on overtime hours, which can contribute to burnout, and expensive temporary nurse staffing agencies to adequately provide coverage in hospitals and nursing homes.[538] DMH began outsourcing to fill vacant positions in 2007. Additionally, certified law enforcement officers provide security for DMH hospitals and inpatient facilities and transportation for patients who must be in secure custody when traveling to outside medical appointments or to court.[539] Officers, traditionally employed by DMH Public Safety, are needed to support daily operations. Currently, the agency competes with local, state and federal law enforcement agencies throughout South Carolina to recruit and retain officers.[540]

DMH provides a suite of workforce enhancements including increased compensation, job restructuring and flexible work schedules intended to attract and retain talent.[541] These are helpful benefits and are intended to recruit practicing behavioral health practitioners and retain the talent since the agency cannot adequately sustain outsourcing services for new nursing positions, public safety officers, telehealth positions or its current workforce. DMH has developed a plan to gradually increase compensation for various categories of employees.

DMH's plan would support the initial phase of a multi-year agency approach to address recruitment and retention challenges with many hard-to-fill positions. Future plans to enhance workforce retention within the agency include an in-depth analysis of high turnover areas, diversity and inclusion programs and strategies to attract and retain younger practitioners. As of January 2021, DMH has no mechanism to measure the effectiveness of its enhanced recruitment and retention tools.[542]

Table 4 represents the average turnover rate by percent across divisions within DMH.

TABLE 4

DMH Average Turnover Rate Across Divisions Fiscal Year 2018[543]

Source: South Carolina Department of Mental Health, 2020

Department	Turnover Rate
Inpatient Services	27%
Community Mental Health Services	20%
Administrative Services	21%
Public Safety	27%

Recruitment and Retention in Other Areas

Some state agencies and associations are trying to address the workforce issue by dedicating funds to behavioral health professional training and education programs aimed at other health professionals to increase their knowledge and skills. One example is the Continuing Professional Development (CPD) program provided by the South Carolina AHEC system. This regional approach offers local and affordable continuing education sessions, workshops and web-based learning to many practicing health care professionals, including those in behavioral health care, to maintain licensure requirements and stay current with best practices. AHECs CPD coordinators work closely with hospital education departments, educational institutions, regional health professionals, associations and agencies to assess, develop and deliver continuing education programs to health professionals.[544]

It is imperative that South Carolina work with local and state stakeholders to develop a sustainable, comprehensive behavioral health workforce that can meet the needs of each South Carolinian. Workforce needs will continue to be a recurring theme across state budget requests until an adequate workforce is developed.

Community Coalitions and Taskforces Transforming South Carolina's Behavioral Health Systems

To enhance community focus on behavioral health needs, a variety of behavioral health organizations across the state have developed active taskforces and coalitions. These county and multi-county networks develop goals, coordinate resources and direct positive change for behavioral health care within their jurisdictions. In many cases, like the South Carolina Behavioral Health Coalition (SCBHC), these organizations serve as conveners that allow diverse groups of stakeholders to discuss issues and collaborate for improvement. With a local focus, these organizations leverage their regional network of resources and relationships to target the area's specific needs. The initial *Hope for Tomorrow: The Collective Approach for Transforming South Carolina's Behavioral Health Systems* report published in 2015 discussed the Spartanburg County Behavioral Health Task Force.[545] Since then, several other local behavioral health coalitions have been developed.[546]

This section of the report will inform readers on developments attained by the Well-Being Partnership of Greenville County, provide updates on the progress realized by the Spartanburg County Behavioral Health Taskforce and highlight the goals and aspirations of a newer initiative, Healthy Tri-County.

The Well-Being Partnership of Greenville County

There are many organizations working to address mental and behavioral health needs, all of which have their own unique purpose within the community. While each group has its own mission and vision, there are overarching goals within the behavioral health community which benefit all. In late 2018, the Greenville County Behavioral Health Coalition was formed to identify and align these goals through collective actions. The coalition is an association of behavioral health partners who work to increase access to care and prevention efforts by strengthening the community capacity of Greenville County. Stalled by the coronavirus pandemic, stakeholders used the time to refocus and reposition the coalition for success. For the past six months, leaders across the behavioral health field have been providing input on goals and strategies for action and a framework and structure to support the collaborative work. In 2021, the coalition relaunched as the Well-Being Partnership of Greenville County (WBP).

Progress within the behavioral health sphere of Greenville County is due to the grassroots work of many organizations, ranging from traditional counseling to recovery-focused community healing. WBP takes on the capacity-building role in improving Greenville's well-being by focusing on three main roles: Data & Learning, Advocacy & Public Policy and Solutions & Innovation. Within each of these three main areas, WBP has created broad goals which focus on supporting and magnifying the work of partners.

1. **Data & Learning:** WBP hopes to serve as a source of data for Greenville behavioral health organizations by collecting, tracking and disseminating information throughout the community. WBP's broad goal is to serve as a means for quantitative and qualitative behavioral health data to be regularly and systematically collected and used to drive action and decision-making at both the organizational and system levels. Through this, WBP hopes to foster a culture of learning across the partnership.

2. **Advocacy & Public Policy:** WBP will work to align and coordinate the advocacy efforts of our partners to increase public knowledge and influence local behavioral health policy. Well-being in terms of mental and behavioral health is a community-wide priority for action in Greenville County which is accomplished through policy change and community initiatives.

3. **Solutions & Innovation:** WBP hopes to serve as a convener which facilitates the development of local behavioral health solutions in the Greenville area. WBP's broad goal is for every resident is able to access a range of services and support for behavioral health needs. WBP convenes and/or supports partner organizations working on targeted strategies, exploring strategic alliances and considering new innovative approaches.

Below are several highlights achieved by WBP as of December 2020:

Data

The Bon Secours St. Francis Hospital conducted a *Community Health Needs Assessment* (CHNA) in 2019 which provided data and insight on the state of behavioral health in Greenville, South Carolina. The report has eight pages dedicated to statistics concerning mental health and substance use. This is a stark increase from the 2016 CHNA report, which had only three pages dedicated to behavioral health. The additional data has been useful in identifying specific focus areas for the WBP as well as highlighting the need for behavioral health services. An effort is underway to compile all existing local standardized data using the data tracking tool developed by the South Carolina Behavioral Health Taskforce. This tool will serve as a foundation for an expanded data collection and help guide future assessment work.

Community Capacity

On November 16, 2020, the Phoenix Center hosted a Lunch & Learn for faith-based organizations to help provide an understanding of addiction and substance use from a spiritual, biological, psychological, experiential and social perspective. The event served as a prime example of collaboration across multiple community partners and areas. Collaborations, such as this event, highlight the fact that behavioral health intervention should not be solely confined to clinicians and service providers but extended to a much-needed community capacity that strengthens the broader system of care.

Access to Care

In December of 2020, local partners convened to address crisis stabilization across the behavioral health spectrum. These partners include the Phoenix Center, the National Alliance on Mental Illness (NAMI) Greenville, Mental Health America (MHA) of Greenville County, Prisma Health and the Greater Greenville Mental Health Center. The collaboration includes the relocation of NAMI Greenville and MHA of Greenville County's offices to the facility which houses the Phoenix Center's Medical Detoxification program. The Phoenix Center is

submitting a request to the South Carolina Department of Health and Environmental Control (DHEC) and the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) to add six residential beds in addition to the existing 10 medical detoxification beds that currently operate out of the facility.

The additional six beds will be utilized for crisis assessments and will potentially coexist with mental health and substance use patients that require short term residential care. Psychiatric services will be provided to patients by Prisma Health and follow-up mental health services will be provided by the Greater Greenville Mental Health Center. The co-location of NAMI, MHA of Greenville County and the Phoenix Center creates a collaborative hub that addresses behavioral health needs and improves access for clients and providers. Collaborative activities include use of the existing CRISIS line and Reassurance Line as well as access to high-quality training programs such as Trauma Informed Care, Motivational Interviewing, Crisis Intervention, Screening and Brief Intervention and Referral to Treatment.

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Spartanburg County Behavioral Health Taskforce

Throughout its seven-year history, the Spartanburg County Behavioral Health Taskforce has remained focused on developing equitable prevention strategies that reduce the demand for one-on-one behavioral health interventions. In addition to the creation of these strategies was the need to expand community awareness of where mental and behavioral health issues fit within the health care conversation. Understanding the importance of health beyond just physical health is how the Spartanburg Behavioral Health Taskforce has come to define the commonalities of mental and behavioral health in relation to physical health.

Since the initial *Hope for Tomorrow: The Collective Approach for Transforming South Carolina's Behavioral Health Systems* report, the Spartanburg County Behavioral Health Taskforce has consistently worked towards confronting behavioral health needs in their region.[547] The initial *Hope for Tomorrow* report highlighted achievements made during the first year of addressing Spartanburg County's unmet need for attention to behavioral health disorders and services. Following that original report, all of the initiatives created by the taskforce have remained; although, some of these initiatives are now financed or maintained by other organizations. Over the last five years, the Spartanburg County Behavioral Health Taskforce has continued to meet the need for behavioral health awareness through new projects, partnerships, programs, trainings and initiatives that include the following:

1. Compassionate Schools Model and ACEs Awareness, a national framework used to train teachers and individuals who work with students to become "trauma-sensitive" and "trauma-informed" so that students, schools and communities become "trauma-resilient." The project accomplishes this goal by training individuals and school staff on how to properly recognize and address signs of Adverse Childhood Experiences.[548] The taskforce began utilizing the Compassionate Schools model in early 2016 and by May 2017, over 400 local educators received training under this model.[549] As of August 2020, the taskforce has trained over 5,000 school staff members and stakeholders of the local education system under the Compassionate Schools model since the initiative's adoption in 2017.[550]

2. Peer Support Living Rooms, a crisis management service emerging throughout the state. The taskforce observed the unmet need of intervening before a crisis develops. Leadership of the taskforce traveled to Asheville, North Carolina, to witness the operational processes by which pre or early-crisis situations were managed through peer support living rooms. The peer support living rooms are staged like a family den and offer safe and comfortable rooms for individuals ages 17 and older to recover from settings or situations that could develop into a crisis. The taskforce then helped the local office of the South Carolina Department of Mental Health (DMH) dedicate $250,000 in budget funding to construct a peer support living room in Spartanburg County. The Eubanks Peer Support Living Room opened in the fall of 2018 and it is staffed with peer support specialists who intervene to prevent the need for emergency treatment.[551]

3. Telepsychiatry Efforts, with funding from The Duke Endowment, where the Spartanburg County Behavioral Health Taskforce worked in partnership with the Medical Group of the Carolinas and Emerge Family Therapy to develop a telepsychiatry model that provides access to psychiatrists and embeds counselors within physician practices.[552] This model, developed in 2018, allows physicians to consult with psychiatrists in real-time regarding patient care planning, management and telepsychiatry visits. This fully integrated care delivery model further enables patients to receive behavioral health treatment in different health care settings.

4. Reassurance Line, a program that allows peer support specialists to make daily outgoing calls to individuals with severe mental health diagnoses and persistent behavioral health needs. The Reassurance Line was created in 2002 through an initiative started by MHA Greenville County. Peer support specialists from MHA Greenville County call clients on the Reassurance Line to offer upstream interventions for referred populations. Clients receive reminders to take medications, schedule appointments and to live a healthy life. The Reassurance Line began servicing Spartanburg county in 2017 in partnership with the Behavioral Health Taskforce and Mental Health America of Greenville County. This collaborative effort was made possible with a grant from the BlueCross® BlueShield® of South Carolina Foundation.[553] During 2017, more than 33,300 calls were made to clients of the Reassurance Line.[554]

5. Community Opioid Overdose Response, a training of 50 community members on medically assisted opioid response techniques with a recent grant from the J. M. Smith Foundation. This grant enabled individuals who may encounter opioid overdoses to become trained on the administration of Narcan in the community. The graduating 50 community members received two doses of Narcan to be administered should the trainees encounter an opioid overdose emergency.[555]

6. Mental Health First Aid Training, a program that provides Mental Health First Aid training to 2,000 Spartanburg community stakeholders over the course of three years.[556] In late 2015, the BHTF and SC THRIVE received a $375,000 grant from SAMHSA to equip students to recognize, de-escalate and address the behavioral health

needs of individuals in a community setting. This training acknowledges that behavioral health needs may arise in numerous scenarios, but these needs can often be immediately triaged in the community to decrease the necessity for downstream intervention.

7. Court System Expansion, a framework that recognizes that some behavioral health populations require different legal settings so the law can be appropriately interpreted and applied. In 2001, Spartanburg County developed the Seventh Circuit Drug Court for individuals with a substance use disorder. Utilizing this successful model, the BHTF was able to collaboratively support efforts to begin a court for veterans. In early 2020, a mental health court model was approved. Installing such systems within the county encourages the fair and just treatment of the most vulnerable populations.

These achievements are all made possible through the BHTF's focus on spreading awareness of behavioral health issues and services throughout the community. The BHTF helped reestablish the Mental Health America of Spartanburg affiliate as a satellite of the Columbia agency to aid with advocacy efforts, education and training. Similarly, the BHTF assisted with the restructuring of NAMI Spartanburg to continue and improve NAMI's ability to offer peer support and education services within the county.[557] By collaborating with partners like MHA and NAMI Spartanburg, the BHTF has helped to increase awareness and access to additional behavioral health resources.

Targeted Impact

In the *2017-2018 United Way of the Piedmont Report to the Community*, BHTF had a special section that highlighted several achievements from that time frame of action.[558] The BHTF continued many of its efforts to expand access to and knowledge of behavioral health services discussed in the original *Hope for Tomorrow* report. Recent updates to the public have shown that the BHTF is widening its scope of partnerships to accomplish these goals. Among other communally beneficial focal points in recent years, Spartanburg's BHTF has placed a special focus on improving the availability of mental and behavioral health services to children and adolescents.

In 2019, the Mary Black Foundation funded the Spartanburg County Child and Adolescent Behavioral Health Study that led to the development of recommendations to align the county's partners under common aims and goals for child and adolescent behavioral health.[559] With a focus on prevention and early intervention, 10 recommendations were developed. The BHTF served on the committee that developed the recommendations and once the recommendations were developed, the BHTF was charged with guiding implementation of the recommendations within the community. With these recommendations, the BHTF developed a plan to properly coordinate behavioral health resources, improve knowledge related to behavioral health issues and services, increase mental health services available in schools and other settings, enhance the ability to support parents and caregivers in handling children and to engage in other community efforts that aim to reduce behavioral health disparities among Spartanburg's children.[560]

The BHTF set forth to accomplish these recommendations through several avenues including the continued use and expansion of the Adverse Childhood Experiences (ACEs) awareness training, a Compassionate Schools initiative. This module enables teachers to utilize trauma informed skills and behaviors to create inclusive, trauma-resilient students, classrooms and schools. To further expand awareness of ACEs, these trainings are beginning to be offered to other audiences such as preschool teachers, caregivers and law enforcement officers.

The Spartanburg BHTF is also involved with satisfying the recommendation that would embed a mental health professional within every school in the region. Under leadership of DMH, this effort is on track to accomplish this recommendation by 2022.[561] All of the recommendations from the Child and Adolescent Behavioral Health Study focus on eliminating the stigma associated with behavioral health issues and services by targeting upstream factors that encourage early treatment of behavioral health disorders.

Spartanburg County recognizes that in order to have a community with healthy adults, there must be an emphasis on caring for children's mental health. Further, efforts to improve mental and behavioral health outcomes must spread to ages beyond childhood and adolescence. The BHTF organizes numerous community resources to meet the behavioral health goals instituted for Spartanburg County. In terms of trainings available to behavioral health providers and stakeholders, Compassionate Schools addresses children and ACEs while other strategies like Screening, Brief Intervention and Referral to Treatment, Motivational Interviewing and Mental Health First Aid are also organized and taught through the BHTF.[562]

These courses and training sessions utilize national models, like Compassionate Schools, that develop the workforce to be better equipped to appropriately manage the behavioral health needs that may arise in the field. Beyond training and developing the skills of behavioral health treatment providers, the BHTF is also involved with enhancing and adding behavioral health services where needed by leveraging the resources available within the community. Doing so has allowed the BHTF to improve the taskforce's focus on priority populations like children, seniors, people in need of housing and individuals who are incarcerated.[563]

Conclusion and Looking Forward

The Spartanburg County Behavioral Health Taskforce's work continues to mitigate the unmet need for behavioral health services and awareness through community education, behavioral health services initiation, collaborative partnerships and upstream intervention. The importance of the BHTF's work is further stressed as the world battles the effects of COVID-19 on the population's mental health. As the COVID-19 pandemic progresses, the trauma-sensitive tools and strategies taught and used by the BHTF will likely prove valuable in managing the behavioral health needs that may arise from this situation. Even with the proper tools and strategies employed, the continued and enhanced collaboration between the BHTF and other behavioral health organizations is essential to meeting the need for behavioral health services in Spartanburg County.

> Going forward, we see an expanded demand for child and adolescent services and a recent study underwritten by local funders and the BHTF have pointed in a number of constructive directions. But the greater concern must be the long-term impact of Covid-19 and the demand for mental and behavioral health services. Documentation is already suggesting that the impact of expanded substance and alcohol abuse, child and spousal abuse, suicidal ideation, depression and anxiety, frustration of underachieving students, and missed medical procedures and childhood vaccines – all compounded by severe economic dislocation – will stretch thin the available services. That is the legacy of the coronavirus and the challenge we hope we are able to meet.
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> **TOM BARNET,** Chair, Spartanburg County Behavioral Health Taskforce

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Healthy Tri-County

The 2016 *Tri-County Community Health Needs Assessment Report* identified several key areas in which Charleston, Dorchester and Berkeley counties required improvement.[564] This needs assessment determined that the Tri-County area required specific attention to five critical sectors of health as follows:

1. Access to care;
2. Behavioral health;
3. Clinical preventive services;
4. Maternal, infant and child health; and
5. Obesity, nutrition and physical activity.

The Healthy Tri-County (HTC) initiative was formed in early 2017 as a collaborative partnership between Trident United Way, the Medical University of South Carolina Health and Roper St. Francis Healthcare. With the overall goal to improve the health and well-being of all people in Charleston, Dorchester and Berkeley counties, HTC developed several workgroups to create, implement and guide the organization's goal. The four workgroups include the HTC Executive Committee, the Tri-County Health Improvement Plan (TCHIP) Workgroup, the Health Data Workgroup and the Tri-County Diabetes Coalition. The HTC Executive Committee is comprised of stakeholder leadership and serves as the governing body over the three workgroups. The TCHIP Workgroup focused on the development of the original *Our Health, Our Future: 2018-2023 Tri-County Health Improvement Plan* through interpretation of the *Tri-County Health Needs Assessment.*

The TCHIP Workgroup now focuses on the implementation and monitoring of the TCHIP's goals that align with the sectors requiring attention, identified in the 2016 needs assessment. The Health Data Workgroup worked to analyze the regional healthcare data and developed the *2019 Tri-County Health Needs Assessment.* The Health Data Workgroup also created a regional health resource hub that houses information about available local health resources. This workgroup performs continuous focused analyses on the health data collected from the Tri-County providers.

The Health Data Workgroup uses the information that it collects and analyzes to measure the Tri-County's adherence to the TCHIP Workgroup goals and to address the specific areas of health improvement for the Tri-County region. *The 2016 Tri-County Health Needs Assessment* also identified Type II Diabetes to be a major cause of poor health outcomes and high cost, and so, the HTC formed the Tri-County Diabetes Coalition as an additional workgroup. The Tri-County Diabetes Coalition has two primary goals that drive the coalition's operations that focus on increasing awareness and preventing new incidences of diabetes mellitus.[565]

These workgroups collaborate to collectively create action and impact relevant to the five priority areas identified by the 2016 needs assessment. The *Our Health, Our Future: 2018-2023 Tri-County Health Improvement Plan* addresses each of the five priority areas with goals, action steps and tools for measuring results.[566]

Behavioral Health

Among other worthy topics, behavioral health is the second of the original five priority elements of health, and the TCHIP employed a regionally tailored approach to addressing nationally relevant behavioral health issues. Within the behavioral health section of the TCHIP, two overarching goals are introduced along with their associated recommendations, action plans and key indicators for the counties' behavioral health stakeholders to focus on improving.

Goal One: Increase the Tri-County's knowledge about behavioral health issues and services/resources in order to reduce stigma and increase service utilization.

The first goal for behavioral health in the Tri-County was discussed in the TCHIP alongside the statistic that over 160,000 residents in the Tri-County region experience behavioral health issues that require treatment within any year; however, the report also indicated that half of Tri-County residents experiencing behavioral health issues do not receive treatment.[567] The TCHIP report further argued that this issue may be attributed to a lack of awareness of the behavioral health services available in the Tri-County area. To determine the citizens' awareness of behavioral health services, the TCHIP report recommended that behavioral health surveys are conducted to measure the region's providers as well as the public's awareness of behavioral health issues and knowledge of available services. The recommendations specifically state that awareness of behavioral health issues can be measured and should be increased by 10% within the Tri-County by 2023. The plan further suggests that stakeholders should deliver surveys that measure providers' and residents' knowledge of behavioral health resources and awareness of behavioral health issues as treatable conditions. With initial surveys collected, baselines and benchmarks can be properly established for the region and improvement in accordance to TCHIPs behavioral health goals can be measured and monitored.

To accomplish the first behavioral health goal and recommendations established in the TCHIP, HTC provided action steps and strategic activities that will guide implementation of the data collection processes. The procedure for establishing community benchmarks through surveying stakeholders is addressed in the first action step introduced following this behavioral health priority goal of increasing awareness. The second action step to help increase awareness included creating a community education plan regarding behavioral health illnesses and services. The TCHIP discusses these action steps and strategic activities as follows:

1. Gather Tri-County baseline data on behavioral health awareness
    a. Define behavioral health topics to be included in the provider surveys and identify a pre-existing survey that meet the criteria.
    b. Complete provider awareness surveys to assess awareness of behavioral health resources and referral processes.
    c. Include questions in the CHNA that measure community members' knowledge of resources and awareness of behavioral health issues as treatable conditions.
2. Develop and implement an education plan for increasing public awareness of behavioral health conditions (e.g. trauma, opioid misuse, drug/alcohol misuse, depression, anxiety and suicidality)

a. Create a collaborative brochure, flyer or mobile app to distribute to providers so that patients receive information regarding behavioral health services available in the Tri-County.
b. Create an outreach and education plan for safety net providers, such as referral processes or services available, that increase understanding of behavioral health conditions and local resources.
c. Identify target groups for awareness campaign (e.g., schools, law enforcement, medical providers, first responders).
d. Conduct community awareness activities in alignment with and support of current and planned activities (e.g. social media, media, billboards, multimedia, ads, PSAs, community, parenting programs, PTA meetings, expos, faith-based events).[568]

Goal Two: Improve access to and utilization of behavioral health services for all citizens of the Tri-County.

The second and final goal of the section took aim at addressing access and utilization of behavioral health services in the area.[569] The plan outlines an adequate representation of mental health providers relative to other counties and regions in South Carolina, but these services have experienced limited utilization. This underutilization may result from several barriers to access including insurance coverage, time availability, difficulties with travel and reimbursement for telehealth service consultations. With all of these barriers in mind, behavioral health service providers must take a collaborative approach that is in alignment with improving access in the Tri-County.

TCHIP developed a recommendation to "identify and reduce barriers (e.g. lack of coverage, outdated legislation and provider recruitment, training and education) to accessing behavioral health services, and expand where necessary, resulting in increased utilization of current and new behavioral health services by December 2023".[570] The TCHIP goes on to identify four action steps and several strategic activities that support implementation of the recommendation so that the second goal is met. These action steps and the relevant strategic activities are as follows:

1. Identify unknown barriers to accessing mental health services.
    a. Develop and include questions in 2019 Tri-County CHNA that assess those barriers.
2. Decrease known barriers and support an increased use of telehealth
    a. Gain approval for Medicaid reimbursement for behavioral health services by master and doctorate-level licensed behavioral health providers.
3. Address known barriers and increase available behavioral health inpatient and outpatient treatment facilities
    a. Increase behavioral health services offered at primary care locations.
    b. Increase co-location of behavioral health providers in schools (office-based, telehealth, and mobile unit).
    c. Increase the number of psychiatric, inpatient beds available to individuals experiencing acute behavioral health problems.
    d. Expand the use of drug courts and the presence of counselors in law enforcement facilities.
4. Identify and increase current utilization of community health workers, including but not limited to, public health workers, care coordinators/navigators, nurse navigators and patient advocates, as referral sources for behavioral health providers and to ensure behavioral health patient engagement
    a. Identify current processes for behavioral health follow-up and engagement completed by providers and patients.
    b. Identify possible improvements to existing processes for behavioral health follow-up and engagement.[571]

Current Progress

Leadership of Healthy Tri-County (HTC) quickly adopted the Tri-County Health Improvement Plan following its creation and began addressing the behavioral health goals with its network of community members. While much of the work directed within the TCHIP is ongoing, HTC included questions in the *2019 Community Health Needs Assessment* to assess the community's knowledge of available behavioral health resources and awareness of behavioral health issues as treatable conditions. This action led to the collection of 5,304 surveys that allowed for the creation of baseline county data and the satisfaction of two activities defined within the TCHIP. Additionally, the questions included in the CHNA surveys gave HTC leadership a better understanding of the barriers to accessing behavioral health services and the negative factors impacting behavioral health outcomes within the region. The remaining TCHIP behavioral health activities are on-going and remain on track as planned, and the TCHIPs behavioral health goals are still relevant to HTC's strategic direction. The HTC Health Data Workgroup will publish a report soon to directly update stakeholders and the community on current progress related to the goals and activities established within the plan.

One of HTC's successes is the improved engagement and integration of behavioral health priorities within other HTC activities. This engagement is evidenced by the growth of CHNA survey participants from 338 in 2013 to 5,304 in 2019. Additionally, this increase in community engagement has coincided with an increase in HTC membership. With a larger membership, HTC has access to a larger pool of applicable behavioral health data that can be used to evaluate the behavioral health issues impacting the region. Ultimately, HTC expects to make an impact on the barriers to accessing behavioral health services because of the ongoing collaborative data collection and analysis.[572]

Conclusion and Looking Forward

The Healthy Tri-County initiative is equipped with the tools, activities and strategies to accomplish the behavioral health goals introduced in the TCHIP. By collecting survey data related to behavioral health, HTC can assess and address the community knowledge of behavioral health issues and available services in the Tri-County. To secure the longevity of the changes made within the Tri-County, stakeholders must continue to collaborate on strategic alignment, data collection and delivery of care. With the effects of COVID-19 rippling through the region, HTC must continue to place a special emphasis on identifying and eliminating barriers that prevent individuals from accessing behavioral health services. Because the COVID-19 pandemic has created challenges that have had significant impacts on HTC and the TCHIP, HTC leadership will continue to review the action plans so that the region's behavioral health goals are satisfied. Furthermore, it will be important for HTC to continue to develop creative solutions to intervene in patient cases involving behavioral health illnesses. The HTC initiative has established a formal process where behavioral health providers in the region can collaborate and collectively improve behavioral health outcomes in the Tri-County.

Acknowledgements

The South Carolina Institute of Medicine and Public Health and the South Carolina Behavioral Health Coalition extend special gratitude to Renee Linyard-Gary, director of health for Trident United Way, for her assistance in developing the content of this section. Individuals interested in more information can contact Renee Linyard-Gary at rlinyardgary@tuw.org.

Conclusion

While the need for behavioral health services continues to rise across the Palmetto State, it is clear an ever-evolving behavioral health care system that can meet the needs of all South Carolinians is essential. Though there are noteworthy improvements, there are also considerable areas of opportunity to grow. The South Carolina Institute of Medicine and Public Health and the South Carolina Behavioral Health Coalition will continue to work to support collaborative efforts to provide robust behavioral health coverage, access and coordination of services at the community level across South Carolina.

Appendices

Appendix A:
South Carolina Behavioral Health Coalition Participating Member Organizations

Absolute Total Care
Absolute Total Care - Centene Corporation
AccessHealth Networks
Adult Spectrum Transitions
Aiken Regional Medical Center, Aurora Pavilion
Alkermes
Alliant Health Solutions- Alliant ASO
American Association of Retired Persons South Carolina
American Psychiatric Association, SC Chapter
Amerigroup Partnership Plan, LLC (for Healthy Blue)
Anderson-Oconee-Pickens Mental Health Center
AnMed Health
Anthem Blue Cross Blue Shield
Association of Maternal and Child Health Programs
Association of Positive Behavior Support
Atlanta-Carolinas High Intensity Drug Trafficking Area
BabyNet
Baptist Easley Hospital
Beaufort County Human Services Alliance
Beaufort Memorial Hospital
Behavioral Health Services Association
BlueCross BlueShield of SC
BlueCross BlueShield of South Carolina Foundation
Bon Secours Health System
Bon Secours St. Francis Health System
Bon Secours St. Francis Hospital
CareSouth Carolina
Carolina Counseling Consultants
Centene
Center for Behavioral Health South Carolina/South Carolina Association for the for the Treatment of Opioid Dependence
Chester Regional Medical Center
Children's Trust of South Carolina
Clemson University, Safe & Humane School
Colleton Medical Center
Community Medical Clinic of Kershaw County
Companion Benefit Alternatives
Criminal Justice Coordinating Council
Dickerson Children's Advocacy Center
Disability Rights SC (formerly Protection & Advocacy for People with Disabilities)
Eat Smart Move More South Carolina
Eau Claire Cooperative Health Center
Faces And Voices of Recovery (FAVOR) SC
Family Connections
First Choice by Select Health
Gateway Behavioral Health Services
Grand Strand Behavioral Health
Grand Strand Medical Center
Greenville Family Partnership
Greenville Free Medical Clinic
HCA Health Care
Healthy Learners
HopeHealth
Janssen Neuroscience
Johnson & Johnson
Kershaw County Emergency Medical Services
Keystone Substance Abuse Services
Lexington Medical Center
Lexington Medical Center - Lexington Medical Specialists
Lighthouse Behavioral Health Hospital
Mary Black Health System
McLeod Behavioral Health Services
McLeod Florence
McLeod Health Clarendon
McLeod Health/McLeod Loris Seacoast
McLeod Regional Medical Center
Medical University of South Carolina
Medical University of South Carolina Boeing Center for Children's Wellness
Mental Health America of Greenville
Mental Health America South Carolina
Mental Health Partners, LLC
Mental Illness Recovery Center, Inc.
Molina Healthcare of South Carolina
Monarch Behavioral Health
National Alliance on Mental Illness South Carolina
National Association of Emergency Medical Technicians
Otsuka Pharmaceutical
Palmetto Care Connections
Palmetto Employee Assistance Program
Palmetto Lowcountry Behavioral Health
Pelham Medical Center
Piedmont Medical Center
Prisma Health Midlands
Prisma Health Tuomey
Prisma Health Upstate

Prisma Health Upstate Department of Psychiatry/ Clemson University
Ralph H. Johnson VA Medical Center
Rebound Behavioral Health Hospital
Regency Southern Care Hospice Services
Regional Medical Center
Richland County Probate Court
Roper St. Francis Foundation
Roper St. Francis Physician Partners
SC Thrive
Select Health of South Carolina
Self Regional Healthcare
Self Regional Hospital
Shoreline Behavioral Health Services
South Carolina Area Health Education Consortium
South Carolina Bar Association
South Carolina Behavioral Health Services Association
South Carolina Birth Outcomes Initiative
South Carolina Care Coordination Institute
South Carolina Child Well Being Coalition
South Carolina Children's Hospital Collaborative
South Carolina Coalition Against Domestic Violence and Sexual Assault
South Carolina College Of Emergency Physicians
South Carolina Dental Association
South Carolina Department of Administration
South Carolina Department of Alcohol and Other Drug Abuse Services
South Carolina Department of Children's Advocacy
South Carolina Department of Corrections
South Carolina Department of Disabilities and Special Needs
South Carolina Department of Education
South Carolina Department of Health and Environmental Control
South Carolina Department of Health and Human Services
South Carolina Department of Juvenile Justice
South Carolina Department of Labor, Licensing and Regulation
South Carolina Department of Mental Health
South Carolina Department of Mental Health, office of Suicide Prevention
South Carolina Department of Probation, Pardon and Parole Services
South Carolina Department of Social Services
South Carolina Department of Vocational Rehabilitation
South Carolina Eating Disorder Association
South Carolina First Steps to School Readiness
South Carolina Free Clinic Association
South Carolina Health Care Association
South Carolina Hospital Association
South Carolina Institute for Child Success
South Carolina Institute of Medicine & Public Health
South Carolina Joint Legislative and Citizens Committee on Children
South Carolina Law Enforcement Division
South Carolina Medical Association
South Carolina Office of Rural Health
South Carolina Office of the Lieutenant Governor
South Carolina Pharmacy Association
South Carolina Primary Healthcare Association
South Carolina Revenue and Fiscal Affairs Office
South Carolina Sheriff's Association
South Carolina Telehealth Alliance
Spartanburg Regional Healthcare System
SpringBrook Behavioral Health
Sumter Family Health Center
Tandem Health
The Carolina Center for Behavioral Health
The Carolinas Center for Medical Excellence
The Forrester Center for Behavioral Health
The Phoenix Center
Three Rivers Behavioral Health
Tidelands Health
Trident Medical Center
Trinity Behavioral Health Care
United Way Association of South Carolina
United Way of Greenville County
United Way of the Midlands
United Way of the Piedmont
UnitedHealthcare
University of South Carolina Arnold School of Public Health
University of South Carolina College of Nursing
University of South Carolina College of Social Work
University of South Carolina Counseling & Psychiatry
University of South Carolina Department of Neuropsychiatry & Behavioral Science
University of South Carolina Department of Psychology
University of South Carolina Institute for Families in Society
University of South Carolina School of Medicine
Walgreens
WellCare Health Plans of South Carolina
Wm. Jennings Bryan Dorn Veterans Affairs Medical Center

Appendix B:
South Carolina Behavioral Health Coalition Charter Highlights

Vision

Every person in South Carolina has timely access to the needed mental health and/or substance use disorders services and resources to achieve health and well-being.

Misssion

To establish a comprehensive system at the state and community level that ensures access to, coverage for, effective coordination and awareness of mental health and substance use disorders services and resources for individuals and families living in South Carolina.

Purpose Statement

To implement a multi-sector coalition built on a common improvement agenda and focused on a mutually defined set of strategic goals and actions for collectively improving the availability and access to behavioral health services for all South Carolina residents.

Strategic Priority Areas

- Ensure efficient and effective crisis stabilization and management of patients with mental health and/or substance use disorders.
- Maximize integration and alignment of mental health and substance use disorders services within primary care services settings.
- Support interdisciplinary, cross-sector systems and efforts that prevent and effectively treat substance use disorders.
- Facilitate and support greater collaboration for the justice involved population to reduce justice system involvement, including jail diversion, reentry and recidivism.
- Promote effective behavioral health programming for children and youth age 0 through 25, including intervention, school behavioral health and community systems of care.
- Institute a collaborative data analytics and informatics team focused on collecting, analyzing and disseminating key mental health and substance use disorder metrics.
- Institute a policy team focused on identifying policies that will help improve access to behavioral health treatment and services, including education and advocacy for positive change.

Guiding Principles and Member Responsibilities

- Each team will work to cultivate public policy and perception of behavioral health illnesses as diseases of the brain that include both mental health and substance use disorders.
- Each team will reinforce the need to promote early detection, intervention and prevention of behavioral health illnesses.
- Each team will focus on needs of individual communities and promote learning, forming or strengthening partnerships at the local community level.
- Each team will reinforce recommendations by advocating for policy and systems change.

Coalition Structure

- South Carolina Hospital Association serves as the backbone organization
- Executive Leadership Committee
- Core Leadership Team
- Strategic Priority Area Action Teams
- Data Analytics and Informatics Committee
- Policy, Legislative and Regulatory Committee

Appendix C:
South Carolina Behavioral Health Coalition Core Leadership Team Members

Gerald Wilson, MD
Chair
South Carolina Behavioral Health Coalition

Graham Adams, PhD
Chief Executive Officer
South Carolina Office of Rural Health (SCORH)

Teresa Arnold
State Director
American Association of Retired Persons (AARP) South Carolina

Robert L. Bank, MD
Deputy Director, Division of Medical Affairs
South Carolina Department of Mental Health

Deborah Blalock, M.Ed, LPCS
Deputy Director, Division of Community Mental Health Services
South Carolina Department of Mental Health

Maggie Cash
Director, Medical University of South Carolina Center for Child Advocacy
Medical University of South Carolina
Executive Director, Children's Hospital Collaborative

Allison E. Farrell, MPH, LISW-CP
Director, Office of Emergency Services
South Carolina Department of Mental Health

Beth Franco
Executive Director
Disability Rights South Carolina

Sara Goldsby, MSW, MPH
Director
South Carolina Department of Alcohol and Other Drug Abuse Services

Melanie Hendricks, LISW-CP, ACSW
Deputy Director
Division of Rehabilitative Services
South Carolina Department of Juvenile Justice

Rich Jones
CEO/COO
Faces and Voices of Recovery (FAVOR) Greenville

Mark Keel
Chief
South Carolina Law Enforcement Division

Sazid Khan, PhD
State Epidemiologist, Research and Evaluation
South Carolina Department of Alcohol and Other Drug Abuse Services

J. Thornton Kirby, Jr.
President & CEO
South Carolina Hospital Association

Chris Kunkle, PsyD
Deputy Director of Behavioral Health
South Carolina Department of Corrections

Mike Leach
State Director
South Carolina Department of Social Services

Ann Lefebvre, MSW, CPHQ
Executive Director
South Carolina Area Health Education Consortium (AHEC)

Bill Lindsey
Executive Director
National Alliance on Mental Illness-South Carolina

George McConnell
Director, Morris Village Alcohol and Drug Addiction Treatment Center
South Carolina Department of Mental Health

The Honorable Amy W. McCulloch
Judge, South Carolina Probate Court
Richland County

Aunyika Moonan, PhD
Executive Director, Data & Measurement
South Carolina Hospital Association

Maya Pack, MS, MPA
Executive Director
South Carolina Institute of Medicine and Public Health

L. Gregory "Greg" Pearce, Jr.
Chair
South Carolina Mental Health Commission, Second Congressional District
South Carolina Department of Mental Health

April Richardson, MD
Medical Director
Blue Cross Blue Shield of South Carolina Companion Benefits Alternatives

Kenneth M. Rogers, MD
State Director
South Carolina Department of Mental Health

Kathy Schwarting, MHA
Chief Executive Officer
Palmetto Care Connections

Amy Shapely, MA
Director of Community Access
Able South Carolina

Janelle Smith, MHA, ACHE
Deputy Director for the Office of Health Programs
South Carolina Department of Health and Human Services

The Honorable Molly M. Spearman
Superintendent of Education
South Carolina Department of Education

Anne Summer
Consultant
Mental Health Partners, LLC

Richelle Taylor
General Counsel & Senior Vice President of Advocacy & Communications
South Carolina Medical Association

Mark Weist, PhD
Professor, Clinical-Community and School Psychology, Department of Psychology
University of South Carolina

Amanda F. Whittle
State Child Advocate and Director
South Carolina Department of Children's Advocacy

Appendix D:
2020 Mental Health America Rankings Methodology

The rankings are based on the percentages, or rates, for each state collected from the most recently available data from sources including the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Center for Behavioral Health Statistics. For most indicators, the data represents events occurring up to 2017. States with positive outcomes are ranked higher (closer to 1) than states with poorer outcomes. The overall, adult, youth, prevalence and access rankings were analyzed by calculating a standardized score (Z score) for each measure and ranking the sum of the standardized scores. For most measures, lower percentages equated to more positive outcomes (e.g. lower rates of substance use or those who are uninsured). There are two measures where high percentages equate to better outcomes. These include Youth with Severe Major Depressive Disorder who Received Some Consistent Treatment and Students Identified with Emotional Disturbance for an Individualized Education Program. Here, the calculated standardized score was multiplied by -1 to obtain a Reverse Z score that was used in the sum. All measures were considered equally important, and no weights were given to any measure in the rankings.[573]

School Mental Health Services[574]

The "Youth with Major Depressive Episode Who Did Not Receive Mental Health Services" was calculated using 2016-2017 data from the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Behavioral Health Statistics and Quality National Survey on Drug Use and Health. Youth rankings were analyzed by calculating a standardized score for each measure and ranking the sum of the standardized scores. For most measures, lower percentages equated to more positive outcomes.

Measures used to calculate "Youth with Major Depressive Disorder Who Did Not Receive Mental Health Services" included those who responded "Yes" to "Youth with at least one past year major depressive episode" and those who responded "No" to "ANYSMH2," which indicates whether a youth reported receiving specialty mental health services in the past year from any of six specific inpatient, residential or outpatient specialty resources for mental health issues that are not caused by alcohol or drugs.

This variable was created based on the following six sources of treatment variables: (1) stayed overnight in a hospital, (2) stayed in a residential treatment facility, (3) spent time in a day treatment facility, (4) received treatment from a mental health clinic, (5) received treatment from a private therapist and (6) received treatment from an in-home therapist.

Youths who reported a positive response to one or more of the six questions were included in the "yes" category regardless of how many of the six questions they answered. Youth who did not report a positive response but answered all six of the questions were included in the "no" category. Youth who did not report a positive response and did not answer all the questions, and adults were included in the "unknown or 18+" category.

Developing an Adequate Behavioral Heath Workforce[575]

A ranking from one through 13 for "Prevalence of Mental Illness" indicates a lower frequency of mental health and substance use issues compared to states that ranked from 39 through 51. The "Prevalence of Mental

Illness" measure consists of six variables including:

(1) Adults with Any Mental Illness (AMI),
(2) Adults with Substance Use Disorder in the Past Year,
(3) Adults with Serious Thoughts of Suicide,
(4) Youth with At Least One Major Depressive Episode (MDE) in the Past Year,
(5) Youth with Substance Use Disorder in the Past Year, and
(6) Youth with Severe MDE[576]

The "Access" measure considers access to insurance, access to treatment, quality and cost of insurance, access to special education and workforce availability. A high access ranking (1-13) indicates that a state provides relatively more access to insurance and mental health treatment. The nine measures which make up the access ranking include:

(1) Adults with AMI who Did Not Receive Treatment,
(2) Adults with AMI Reporting Unmet Need,
(3) Adults with AMI who are Uninsured,
(4) Adults with Cognitive Disability who Could Not See a Doctor Due to Costs,
(5) Youth with MDE who Did Not Receive Mental Health Services
(6) Youth with Severe MDE who Received Some Consistent Treatment
(7) Children with Private Insurance that Did Not Cover Mental or Emotional Problems
(8) Students Identified with Emotional Disturbance for an Individualized Education Program, and
(9) Mental Health Workforce Availability[577]

Limitations in the data listed by Mental Health America include the fact that the NSDUH does not collect information from persons who are homeless and who do not stay at shelters, those who are active-duty military personnel and those who are institutionalized (i.e., in jails or hospitals). This limitation means that those individuals who have a mental illness who are also homeless or incarcerated are not represented in the data presented by the NSDUH. If the data did include individuals who were homeless and/or incarcerated, we would possibly see prevalence of behavioral health issues increase and access to treatment rates worsen.[578]

In addition, these data points were gathered through 2018, with the majority of survey data only being available through 2017. This means that the data points are most useful in providing some comparative baselines in the states for the needs and systems that were in place prior to the COVID-19 pandemic.

Appendix E:

Percent Change in Non-Specific Drug Overdose Deaths and Opioid Overdose Deaths in South Carolina Counties, 2018-2019[579]

Non-Specific Drug Overdoses

	2018		2019		PERCENT CHANGE
County of Occurence	Number of Deaths	Age-adjusted death rate per 100k	Number of Deaths	Age-adjusted death rate per 100k	
South Carolina	1103	17.39	1131	22.72	3%
Abbeville	3	11.74	0	0.00	*
Aiken	34	20.52	29	17.58	-15%
Allendale	1	16.41	0	0.00	*
Anderson	28	13.32	36	18.91	29%
Bamberg	0	0.00	0	0.00	0%
Barnwell	4	16.32	1	5.24	-75%
Beaufort	16	9.89	26	16.42	63%
Berkeley	32	13.60	36	15.53	13%
Calhoun	2	18.18	1	7.27	-50%
Charleston	121	28.95	123	28.20	2%
Cherokee	4	7.08	7	15.48	75%
Chester	3	11.16	4	12.11	33%
Chesterfield	3	4.01	8	18.31	167%
Clarendon	4	13.39	6	17.72	50%
Colleton	10	27.33	5	15.92	-50%
Darlington	6	9.89	7	12.37	17%
Dillon	4	14.45	5	19.34	25%
Dorchester	36	22.80	20	12.28	-44%
Edgefield	0	0.00	1	3.65	*
Fairfield	1	4.52	3	11.59	200%
Florence	37	25.78	28	22.37	-24%
Georgetown	23	43.86	15	27.20	-35%
Greenville	172	33.66	140	27.02	-19%
Greenwood	25	36.94	12	19.78	-52%
Hampton	1	6.60	2	10.81	100%

Non-Specific Drug Overdoses

	2018		2019		PERCENT CHANGE
County of Occurence	Number of Deaths	Age-adjusted death rate per 100k	Number of Deaths	Age-adjusted death rate per 100k	
Horry	105	35.05	153	49.23	46%
Jasper	8	27.41	9	35.94	13%
Kershaw	13	22.56	11	17.12	-15%
Lancaster	14	17.00	35	37.66	150%
Laurens	16	24.37	11	17.76	-31%
Lee	0	0.00	4	24.68	*
Lexington	55	19.41	65	22.48	18%
Marion	1	3.86	4	11.48	300%
Marlboro	1	3.59	2	8.31	100%
McCormick	2	25.66	2	31.38	0%
Newberry	2	5.56	2	4.38	0%
Oconee	17	21.63	26	37.47	53%
Orangeburg	10	12.13	21	26.60	110%
Pickens	34	31.86	36	28.59	6%
Richland	85	20.53	69	16.75	-19%
Saluda	0	0.00	1	5.07	*
Spartanburg	82	26.56	75	23.90	-9%
Sumter	29	28.43	27	27.34	-7%
Union	0	0.00	2	8.55	*
Williamsburg	4	16.79	4	16.84	0%
York	55	20.27	57	20.27	4%

* Undefined
Source: South Carolina Department of Health and Environmental Control, 2019

Appendix E (continued)

Opioid Specific Drug Overdoses

	2018		2019		PERCENT CHANGE
County of Occurence	Number of Deaths	Age-adjusted death rate per 100k	Number of Deaths	Age-adjusted death rate per 100k	
South Carolina	816	16.72	876	17.83	7%
Abbeville	1	4.21	0	0.00	*
Aiken	27	16.23	21	12.26	-22%
Allendale	0	0.00	0	0.00	*
Anderson	15	6.84	27	14.45	80%
Bamberg	0	0.00	0	0.00	0%
Barnwell	2	5.72	1	5.24	-50%
Beaufort	14	9.23	16	9.81	14%
Berkeley	24	10.02	31	13.14	29%
Calhoun	2	18.18	1	7.27	-50%
Charleston	100	24.10	107	24.84	7%
Cherokee	2	3.63	3	6.80	50%
Chester	3	11.16	4	12.11	33%
Chesterfield	1	1.34	3	8.93	200%
Clarendon	3	8.61	2	5.31	-33%
Colleton	6	15.68	3	9.95	-50%
Darlington	5	8.34	6	10.16	20%
Dillon	3	10.78	5	19.34	67%
Dorchester	30	19.04	14	8.41	-53%
Edgefield	0	0.00	1	3.65	*
Fairfield	0	0.00	2	9.31	*
Florence	26	18.76	24	19.18	-8%
Georgetown	16	28.91	13	25.30	-19%
Greenville	131	26.39	102	20.31	-22%
Greenwood	19	27.99	9	15.83	-53%
Hampton	1	6.60	0	0.00	-100%

Non-Specific Drug Overdoses

	2018		2019		PERCENT CHANGE
County of Occurence	Number of Deaths	Age-adjusted death rate per 100k	Number of Deaths	Age-adjusted death rate per 100k	
Horry	85	29.07	131	42.95	54%
Jasper	7	25.38	8	32.21	14%
Kershaw	11	19.42	9	14.18	-18%
Lancaster	12	15.36	32	35.11	167%
Laurens	12	18.82	10	16.84	-17%
Lee	0	0.00	4	24.68	*
Lexington	42	15.14	48	16.72	14%
Marion	0	0.00	2	5.81	*
Marlboro	0	0.00	2	8.31	*
McCormick	1	20.12	1	12.16	0%
Newberry	1	3.97	1	1.59	0%
Oconee	15	19.66	16	24.09	7%
Orangeburg	8	9.58	15	19.48	88%
Pickens	22	19.37	22	17.12	0%
Richland	51	12.30	52	12.77	2%
Saluda	0	0.00	0	0.00	*
Spartanburg	56	18.42	55	17.52	-2%
Sumter	17	17.09	19	19.08	12%
Union	0	0.00	1	4.27	*
Williamsburg	2	8.49	4	16.84	100%
York	43	15.99	49	17.54	14%

* Undefined
Source: South Carolina Department of Health and Environmental Control, 2019

Appendix F:
South Carolina Behavioral Health Coalition Letter to Director Baker

SCBHC
South Carolina Behavioral Health Coalition
1000 Center Point Road • Columbia, SC 29210-5802 • 803.744.3520 • SCBHC.org

April 7, 2020

Mr. Joshua Baker, State Director
SC Department of Health and Human Services
1801 Main Street
Columbia, SC 29202

Dear Director Baker:

On behalf of the SC Behavioral Health Coalition (SCBHC), I am writing in support of the March 18 request from the Department of Mental Health (DMH) to temporarily approve all community mental health services currently billable to Medicaid when delivered face to face to also be billable when delivered telephonically. I also write to support the 32 local alcohol and drug abuse authorities that are seeking expansion of current service to be able to offer services through telehealth and telephonic means.

The inclusion of certain behavioral health services as telehealth services, as outlined in the Agency's March 28, 2020 Bulletin has been helpful. However, further expansion is very much needed in the current crisis. Reimbursement should be extended to allow for DMH unlicensed staff and peer support staff, that are able to bill for face to face services, to provide those same services via telehealth. These staff are able to receive supervision through laptops for guidance simultaneously to providing telehealth to the patient. Additionally, all allowable behavioral health telehealth should be expanded to new, as well as to existing patients.

With social-isolation precautions in place, there is tremendous need for the 301 provider system to provide clinical service delivery such as reimbursement to licensed and certified clinicians for individual crisis services, behavioral health screenings, assessments, peer support, substance abuse counseling and psychotherapy. Services for non-admitted persons calling for assistance are also critical. COVID-19 has impacted the ability for these patients to receive these services at their local agency, therefore the agencies have begun providing individual telehealth and telephonic services to meet the needs of the patient.

Since its formation in 2017, the SCBHC has supported systemic and legislative progress for the 1 in 5 South Carolinians living with serious mental illness disorders. The mission of the SCBHC is to ensure every person in SC has timely access to the needed mental health and/or substance use disorder services and resources to achieve health and well-being in South Carolina. Visit our website at www.scbhc.org.

During this time of crisis, South Carolina's behavioral health population is especially vulnerable. It is imperative for those in need to access appropriate services at the appropriate time. Thank you for consideration of this critical need. Please feel free to contact me by reaching out to Elizabeth Harmon at 803-609-6869.

Respectfully,

Gerald Wilson, MD
Chairman

Copy: SCBHC Executive Leadership Committee, Laura Aldinger

Appendix G:
South Carolina Behavioral Health Coalition Letter to Governor McMaster

SCBHC
South Carolina Behavioral Health Coalition

1000 Center Point Road • Columbia, SC 29210-5802 • 803.744.3520 • SCBHC.org

April 7, 2020

Mr. Joshua Baker, State Director
SC Department of Health and Human Services
1801 Main Street
Columbia, SC 29202

Dear Director Baker:

On behalf of the SC Behavioral Health Coalition (SCBHC), I am writing in support of the March 18 request from the Department of Mental Health (DMH) to temporarily approve all community mental health services currently billable to Medicaid when delivered face to face to also be billable when delivered telephonically. I also write to support the 32 local alcohol and drug abuse authorities that are seeking expansion of current service to be able to offer services through telehealth and telephonic means.

The inclusion of certain behavioral health services as telehealth services, as outlined in the Agency's March 28, 2020 Bulletin has been helpful. However, further expansion is very much needed in the current crisis. Reimbursement should be extended to allow for DMH unlicensed staff and peer support staff, that are able to bill for face to face services, to provide those same services via telehealth. These staff are able to receive supervision through laptops for guidance simultaneously to providing telehealth to the patient. Additionally, all allowable behavioral health telehealth should be expanded to new, as well as to existing patients.

With social-isolation precautions in place, there is tremendous need for the 301 provider system to provide clinical service delivery such as reimbursement to licensed and certified clinicians for individual crisis services, behavioral health screenings, assessments, peer support, substance abuse counseling and psychotherapy. Services for non-admitted persons calling for assistance are also critical. COVID-19 has impacted the ability for these patients to receive these services at their local agency, therefore the agencies have begun providing individual telehealth and telephonic services to meet the needs of the patient.

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During this time of crisis, South Carolina's behavioral health population is especially vulnerable. It is imperative for those in need to access appropriate services at the appropriate time. Thank you for consideration of this critical need. Please feel free to contact me by reaching out to Elizabeth Harmon at 803-609-6869.

Respectfully,

Gerald Wilson

Gerald Wilson, MD
Chairman

Copy: SCBHC Executive Leadership Committee, Laura Aldinger

Appendix H:

South Carolina Department of Alcohol and Other Drug Abuse Services Memorandum on Medication-Assisted Treatment Services

South Carolina Department of Alcohol and Other Drug Abuse Services

HENRY McMASTER
Governor

SARA GOLDSBY
Director

Memorandum

April 3, 2020

TO: Directors, County Alcohol and Drug Abuse Authorities

FROM: Sara Goldsby, Director

SUBJECT: Medication-Assisted Treatment Via Telemedicine During COVID-19 Emergency

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In light of circumstances related to the COVID-19 pandemic that are exacerbating mental health and substance use crises among very vulnerable citizens, we truly hope that your agency and contracted medical service providers are still admitting new patients to services, particularly those with opioid use disorder.

Regarding the delivery of medication-assisted treatment (MAT) services via telemedicine, the Department of Labor, Licensing and Regulation, on behalf of the Board of Medical Examiners (BOME), issued the attached order for the state of emergency last week. You will see in the order that practitioners previously approved by the BOME to initiate MAT without an in-person visit *(see attached MUSC document)* may continue to do so.

Any practitioner whom the BOME has not already approved who wishes to initiate MAT with new patients via telemedicine during the outbreak must meet qualifying conditions outlined in the order. They also must request that DAODAS petition the BOME for approval.

In order to request approval from the BOME in a timely fashion for our entire system, we ask that your agency please submit the following information for new practitioners to Lee Dutton by close of business on Thursday, April 9.

First and Last Name
Practitioner Credential (M.D., N.P., D.O., etc.)
South Carolina License Number

Please feel free to contact Mr. Dutton at sldutton@daodas.sc.gov if you have any questions.

SG/jmm

DAODAS

mailing: Post Office Box 8268 • Columbia, South Carolina 29202
location: 1801 Main Street, 4th Floor • Columbia, South Carolina 29201
telephone: 803-896-5555 • *fax:* 803-896-5557 • www.daodas.sc.gov

Appendix I:

South Carolina Department of Alcohol and Other Drug Abuse Services Memorandum on the Approval of Cellular Phones

South Carolina Department of Alcohol and Other Drug Abuse Services

HENRY McMASTER
Governor

SARA GOLDSBY
Director

Memorandum

March 31, 2020

TO: Directors, County Alcohol and Drug Abuse Authorities

FROM: Sara Goldsby, Director

SUBJECT: Cellular Telephones for Tele-Services During COVID-19 Outbreak

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Please note that the use of and reimbursement for tele-services will remain in effect for the duration of the current declared public health emergency.

We are approving county authorities to purchase cellular telephones and minutes to be **loaned** to patients for engagement in treatment services until such time as full on-site services are available. Each county authority will have a budget of $5,000.00 **per county** for the acquisition and distribution of cellular telephones to patients. We expect that your selection of cellular plans will be economical to maximize the budget and patient access.

Please see the attached policy, "Use of Cellular Telephones for Tele-Service Provision by County Alcohol and Drug Abuse Authorities." If you have any questions, contact Roberta Braneck at rbraneck@daodas.sc.gov or 803-896-4228.

SG/jmm

Attachment

DAODAS

mailing: Post Office Box 8268 • Columbia, South Carolina 29202
location: 1801 Main Street, 4th Floor • Columbia, South Carolina 29201
telephone: 803-896-5555 • *fax:* 803-896-5557 • www.daodas.sc.gov

Appendix J:

South Carolina Department of Alcohol and Other Drug Abuse Services Memorandum on the Expansion of Reimbursements for Telephonic Services

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Joshua D. Baker DIRECTOR
P.O. Box 8206 • Columbia, SC 29202
www.scdhhs.gov

TO: Sara Goldsby, Director
South Carolina Department of Alcohol and Other Drug Abuse Services

FROM: Joshua D. Baker, Director

DATE: April 17, 2020

SUBJECT: Telehealth Clarification for Act 301 Local Alcohol and Drug Abuse Authorities

This memorandum details the applicability of telemedicine guidance to Act 301 local alcohol and drug abuse authorities (local authorities), adopts and clarifies the applicability of guidance issued by the South Carolina Department of Alcohol and other Drug Abuse Services (DAODAS) on March 19, 2020, and provides additional flexibilities for addiction service providers.

This memorandum applies only to services delivered in a mode or manner that differs from the standard Medicaid benefit for addiction services, as described in the South Carolina Department of Health and Human Services (SCDHHS) Rehabilitative Behavioral Health Services (RBHS) provider manual. Services delivered in accordance with existing benefits, including existing telemedicine benefits, should be delivered and billed in the customary manner.

Reimbursement for the telephonic services addressed below is available if the interaction with a Healthy Connections Medicaid member includes at least one telephonic component. Interactions that also include video interaction may also be billed, but other forms of electronic communication, such as email and instant and text messaging, are not eligible for reimbursement. **SCDHHS will begin accepting claims for the changes noted below no later than May 1, 2020, for dates of services on or after March 18, 2020.** The temporary policy changes outlined below will remain in effect for the duration of the federally declared public health emergency, unless rescinded or superseded by SCDHHS.

Existing Telemedicine Benefits and Additional Temporary Flexibilities Previously Authorized
Psychological testing/management and crisis intervention provided telephonically are currently reimbursed by SCDHHS. More details about these benefits can be found in the RBHS provider manual available on SCDHHS' website. SCDHHS temporarily expanded telehealth reimbursement to include several additional behavioral health services, including individual psychotherapy when provided by a licensed independent practitioner (LIP), associate-level provider, or licensed master social worker (LMSW). These coverage expansions are detailed in Medicaid bulletins issued on March 19, March 28, and April 16, 2020, and are available at www.scdhhs.gov/covid19.

Applicability of DAODAS-issued Guidance on March 19, 2020

On March 19, 2020, and March 24, 2020, DAODAS issued guidance allowing reimbursement to local authorities for the following services when provided via telehealth:

Code	Description
H0001	Alcohol and drug assessment- initial w/o physical
H0004	Alcohol and drug counseling- individual
H0032	Mental health service plan Development – non-physician
H0038	Peer support service (individual only)
99408	Alcohol and drug screening and brief intervention service
90832	Psychotherapy, 30 minutes (individual only)
90834	Psychotherapy, 45 minutes (individual only)

To the extent not already addressed in previous bulletins, SCDHHS confirms coverage for these services when provided by local authorities via telehealth, so long as services are otherwise rendered in a manner that is consistent with existing Medicaid coverage requirements, as described in the SCDHHS RBHS manual.

Additional Flexibilities

Service Delivery

In addition to LIP, associate-level, and LMSW providers, SCDHHS will reimburse for the services listed above when provided via telehealth by **certified or licensed addiction counselors**, so long as services are otherwise rendered in a manner that is consistent with existing Medicaid coverage requirements and the providers' credential.

Finally, SCDHHS is permitting reimbursement for the telehealth delivery of an additional psychotherapy service, so long as it is otherwise rendered in a manner that is consistent with existing Medicaid coverage requirements, as described in the SCDHHS RBHS manual. The use of this code via telehealth is described in SCDHHS bulletins 20-009 and 20-016. Coverage of this service is intended to align the flexibilities authorized for local authorities with those allowed for other behavioral health providers.

Code	Description
90837	Psychotherapy, 60 minutes (individual only)

Managed Care Organizations (MCOs)

SCDHHS has issued guidance to MCOs to operate with necessary flexibility to ensure continuity of care with respect to prior authorization and documentation requirements for providers. SCDHHS will continue to monitor the provider community and address any issues between providers, beneficiaries, and MCOs, as needed.

In addition, the Centers for Medicare and Medicaid Services (CMS) has issued guidance on Health Insurance Portability and Accountability Act (HIPAA) enforcement discretion regarding services authorized for telemedicine, which is available on its website.

Finally, SCDHHS has submitted an 1135 waiver to CMS for a variety of administrative flexibilities. The SCDHHS waiver submission, as well as the initial CMS approval, are available at www.scdhhs.gov/covid19.

Appendix J (continued)

Requirements and Limitations

Providers engaging in telemedicine services are required to ensure that the quality of care delivered is the same as if engaging the beneficiary in a face-to-face format. Not all interventions and services or beneficiaries are suited for delivery via telemedicine, and families and providers should use professional judgement when deciding to offer services via telemedicine or defer services due to the current public health emergency. Finally, SCDHHS has not varied the scope of billable or non-billable activities with this bulletin, only the appropriate mode of delivery.

Local authorities should use a GT modifier to indicate the delivery of a service via telehealth. Other modifiers, and described in the SCDHHS RBHS manual, continue to be required. For codes otherwise billed without a modifier, the GT modifier should be in the first position. For codes generally billed with another modifier, the GT modifier should be placed in the second position.

Families and beneficiaries should be given every opportunity to make informed decisions about the receipt of services via telemedicine, including the clinical appropriateness of the intervention, its limitations, privacy and confidentiality, and the effect the provider's setting has on each of these issues.

With the flexibilities noted above, several exclusions remain in-place during the COVID-19 response to ensure that Medicaid reimbursement is available only when the quality of patient care remains at a clinically appropriate level:

- Only individual services are eligible for telemedicine. Group or multi-family interventions are not reimbursable, nor are services when beneficiary-to-staff ratio is greater than one-to-one.
- Providers may not conduct interventions remotely with more than one individual concurrently and must conclude any intervention or visit with one patient before commencing an intervention or visit with the next.
- Providers must still follow the course of therapy and limitations detailed in the beneficiary's individual plan of care.

Any additional guidance regarding coverage policy will be communicated in future bulletins or correspondence as needed.

SCDHHS will continue to facilitate the ongoing exchange of information with DAODAS and welcomes any feedback as we continue to work every day to ensure that South Carolina's Medicaid beneficiaries have access to care that is essential to maintain their health and safety during the COVID-19 pandemic.

Thank you for your continued support of the South Carolina Healthy Connections Medicaid program.

Appendix K:
South Carolina Behavioral Health Coalition Safe School Environment Vision and Call to Action

SCBHC
South Carolina Behavioral Health Coalition
1000 Center Point Road • Columbia, SC 29210-5802 • 803.744.3520 • SCBHC.org

Safe School Environment Vision and Call to Action
March 2018

The South Carolina Behavioral Health Coalition is committed to improving the health, safety and well-being of all South Carolinians. In particular, leaders of this Coalition believe that all children in our state should have the opportunity to learn and grow in a school environment that is safe and that promotes behavioral health and wellbeing.

Of specific concern to the Coalition is the epidemic of gun violence in our society, and the repeated tragic impact it is having on our nation's schools. As America tackles the problem of gun violence, the South Carolina Behavioral Health Coalition calls on our state's leaders to prioritize the safety of our children by establishing a vision for safe schools. As our leaders in education, law enforcement, and mental health articulate concrete steps to achieve this vision, every South Carolinian should seek opportunities to help make the vision a reality.

As professionals who are engaged with addressing behavioral health issues on a daily basis, we urge consideration of the following guiding principles to ensure a safe school environment:

1. That violence is not intrinsically a product of mental illness; most people who suffer from mental illness are not violent, and most people who act out violence are not mentally ill.
2. That the most effective way to address behavioral health issues in the school setting is through prevention, education and early intervention.
3. That school violence prevention and preparedness programs be implemented and that these programs be non-stigmatizing in nature.
4. That we continue to support and remove any barriers to research into the contributing factors behind gun violence so that we can develop evidence-based prevention and intervention strategies in school and community settings.
5. That policies should be established to reduce access to firearms by troubled youth or those who are of immediate danger to themselves or others.
6. That all students should have direct and timely access to school-based mental health counselors.
7. That every effort is made to increase the number of mental health professionals available to youth in the school and community setting.
8. That public and private payers and employers should provide coverage for school-based mental health counseling and treatment.

With these principles in mind, the SC Behavioral Health Coalition calls on leaders across our state and in all walks of life to support the vision of safe schools articulated by Governor McMaster, the State Superintendent of Education, the Chief of our State Law Enforcement

Division, and the Director of our State Department of Mental Health. That vision for safe schools is set forth below.

Call to Action - South Carolina Safe School Environment

To be implemented immediately:

1. The Department of Education working with law enforcement and mental health experts will develop virtual training modules for students, teachers, and staff, parents, and community members to identify characteristics of potentially dangerous behavior and the importance of reporting this potentially dangerous behavior.

2. The comprehensive district safety plan shall be developed and practiced yearly with local law enforcement and will include intruder/lockdown drills.

3. The Department of Education working with SLED will review all statutes and regulations regarding school safety requirements in schools and updated/implemented by the 2018-2019 school year.

To be implemented by 2020:

1. A trained law enforcement school resource officer in every school.

2. Best security practices must be included in any future school building plans.

3. Recommend expansion of state health care coverage for mental health counseling.

To be implemented by 2022:

1. Access to school-based mental health counselors in every school.

This call to action was adopted by the Core Leadership Team of the South Carolina Behavioral Health Coalition on March 29, 2018. Amended October 31, 2018.

Gerald Wilson, MD
Chairman

Appendix L:

Three-year, age-adjusted suicide mortality rate by South Carolina county, 2016-2018[580]

COUNTY	AGE-ADJUSTED SUICIDE MORTALITY RATE PER 100,000
South Carolina	15.8
Abbeville	22.4
Aiken	22.9
Allendale	2
Anderson	17.7
Bamberg	19.7
Barnwell	12.2
Beaufort	13.1
Berkeley	15.4
Calhoun	15
Charleston	14.2
Cherokee	23.9
Chester	23
Chesterfield	16.8
Clarendon	9.4
Colleton	22
Darlington	17.5
Dillon	11.3
Dorchester	17.7
Edgefield	8.8
Fairfield	13.5
Florence	7.9
Georgetown	12.1
Greenville	15.9
Greenwood	14.3
Hampton	10.5

COUNTY	AGE-ADJUSTED SUICIDE MORTALITY RATE PER 100,000
Horry	16.9
Jasper	20.9
Kershaw	19
Lancaster	16.3
Laurens	20.5
Lee	12.7
Lexington	17.8
Marion	20.1
Marlboro	12.6
McCormick	18
Newberry	14.7
Oconee	19.4
Orangeburg	12
Pickens	22
Richland	12.9
Saluda	9.8
Spartanburg	18.8
Sumter	9.3
Union	13.8
Williamsburg	5.9
York	15.6

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The South Carolina Institute of Medicine and Public Health (IMPH) is a nonpartisan, nonprofit organization working to collectively inform policy to improve health and health care in South Carolina. In conducting its 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.

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