



South Carolina Institute of
Medicine & Public Health



PROGRESS REPORT

HOPE FOR TOMORROW

The Collective Approach for Transforming South Carolina's

BEHAVIORAL HEALTH SYSTEMS

OCTOBER 2016

To access the 2016 Progress Report and the 2015 Taskforce Report, please visit www.imph.org and select Publications & Resources. The 20 recommendations issued in the taskforce report in May of 2015 highlighted six areas for action. This report provides a status update for each recommendation.

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

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

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

FOR INFORMATION

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

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THE GOAL OF THIS EFFORT IS TO IMPROVE OUR STATE'S SYSTEM OF BEHAVIORAL HEALTH SERVICES AND IT HAS SUCCEEDED IN CREATING SIGNIFICANT MOMENTUM AMONG STAKEHOLDERS INVESTED IN EXPANDING SERVICES FOR THE THOUSANDS OF PEOPLE IN SOUTH CAROLINA WITH A BEHAVIORAL HEALTH CONDITION.

BACKGROUND

In May 2015, the South Carolina Institute of Medicine & Public Health (IMPH) released the report *Hope for Tomorrow: The Collective Approach for Transforming South Carolina's Behavioral Health Systems*. The publication of this report was the result of 18 months of work among more than 60 professionals convened by IMPH to address a set of priority areas related to improving care and outcomes to better serve our residents with behavioral health illnesses. The report outlined 20 recommendations in six areas: access to clinical services, integrated care, housing, school-based services, services for justice-involved individuals and workforce. Please see Appendix A for the list of recommendations.

The taskforce's mission was to create lasting improvements in our state's system of behavioral health services and supports by developing and recommending cost-effective, actionable solutions to existing challenges. The recommendations were created to support this mission and the taskforce's vision that South Carolina's behavioral health system and its supports are accessible, comprehensive, cost-effective, integrated, built on science and evidence-based practice, focused on wellness and recovery and centered on people living with behavioral health illnesses and their families.

Upon publication of the taskforce report and its recommendations, IMPH continued to play a convening role to ensure the recommendations in the report were continually discussed and strategic efforts would be made to achieve progress related to the goals.

Through the Behavioral Health Implementation Leadership Council (ILC), IMPH convenes state leaders to foster collaborations and propel forward movement in support of the recommendations and continue to bring attention to the issues at hand. The role of the ILC is to keep continued, focused attention on the recommendations, provide the vision for how the recommendations will be achieved, minimize or eliminate barriers to implementation, promote and track progress toward implementation and issue an annual report demonstrating progress to date. Please see Appendix B for a list of ILC members.

The goal of this effort is to improve our state's system of behavioral health services and it has **succeeded in creating significant momentum among stakeholders invested in expanding services for the thousands of people in South Carolina with a behavioral health condition.**

The ILC has met quarterly since the publication of *Hope for Tomorrow*. The Council focused conversations to date on **expanding crisis intervention services** around the state. This includes the development of **crisis stabilization facilities, mobile crisis services and expanded outpatient hours**. The ILC has also explored the need for a new licensure category for crisis stabilization centers.

The intent of this progress report is to reflect and celebrate the collective momentum around the recommendations and to highlight successes, while identifying areas that continue to require our attention. While significant barriers continue to exist, considerable action is being taken by a number of partners to enhance a variety of services for South Carolina residents with behavioral health challenges. Through this collective action, **we are making progress in achieving the vision established by the taskforce**.

INTRODUCTION

Mental health and substance use disorders are the leading causes of disease in the U.S.¹, and our behavioral health system is failing people and communities in need. The evidence is overwhelming: more suicides every year, overflowing jails and prisons, an opioid addiction and overdose epidemic and Emergency Departments (EDs) with patients in psychiatric distress with nowhere to go. The number of people and families in our state and nation affected by mental health conditions and substance use disorders is substantial and growing. South Carolina ranks near the bottom on many measures of the adequacy of the behavioral health services system, including the availability of public psychiatric beds, efforts to divert mentally ill individuals and per capita state mental health expenditures.² Recent findings from the World Health Organization suggest that every dollar invested in mental health treatment can provide four-fold returns in work productivity.³ The social, economic and human toll of behavioral health issues is unprecedented and, more than ever, we must collaborate and invest to improve the health and well-being of the people of South Carolina.

PREVALENCE & TRENDS

Behavioral health illnesses are more common than most people realize. Nearly one in five adults in South Carolina has a mental illness, and nearly nine percent have an addiction to alcohol or illegal drugs. For South Carolinians ages 18 to 25, the percentage is even higher with 14.5% addicted to alcohol or illegal drugs.⁴ Table 1 reflects a number of indicators of behavioral health prevalence for the U.S. and South Carolina.

The mental health and opioid crises are closely linked; the majority of individuals with a serious mental illness have more than one diagnosis, including substance use, which often leads to time in jail or imprisonment.⁵ The increase in all-cause mortality (increased by 134 deaths per 100,000) among middle-aged white and non-Hispanic men and women with low levels of education between 1999 and 2013 is largely attributed to the increase in suicides and drug poisonings.⁶

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

Percentages, Annual Averages Based on 2013 and 2014 National Surveys on Drug Use and Health (NSDUH)

	12–17	18–25	18+
	%	%	%
Illicit Drug Dependence or Abuse (1)			
SC	3.23	6.73	2.49
US	3.50	7.00	2.55
Alcohol Dependence or Abuse			
SC	2.56	10.58	6.24
US	2.76	12.64	6.89
Had at Least One Major Depressive Episode (2)			
SC	9.95	7.31	5.80
US	11.01	9.00	6.63
Serious Mental Illness (3)			
SC		4.29	4.31
US		4.52	4.15
Any Mental Illness (4)			
SC		16.92	17.59
US		19.75	18.29
Had Serious Thoughts of Suicide			
SC		6.91	4.15
US		7.44	3.94

(1) Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically. Illicit Drugs Other Than Marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically. These estimates include data from original methamphetamine questions but do not include new methamphetamine items added in 2005 and 2006.

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

(3-4) Mental Illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, assessed by the Mental Health Surveillance Study (MHSS) Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders (MHSS-SCID), which is based on the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Three categories of mental illness severity are defined based on the level of functional impairment: mild mental illness, moderate mental illness, and serious mental illness (SMI). Any mental illness (AMI) includes individuals in any of the three categories.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013 and 2014.

Trends in Mental Illnesses

Between 1990 and 2013, the number of people suffering from depression and anxiety worldwide increased by nearly 50% to a total of 615 million.³ Comparing the U.S. with other similar countries, the U.S. retains the highest rate of death from mental health and substance use disorders.⁷ Severe mental illness is twice as common among adults living below 200% of the federal poverty level and is more prevalent among adults who are uninsured.^{7,8}

Suicide

Around the world, self-harm takes more lives than war, murder and natural disasters combined⁹, with suicide rates increasing by 60% globally over the last 45 years¹⁰ Someone dies from suicide in the U.S. every 12.3 minutes¹¹, and in South Carolina every 11.5 hours.¹² Between 1999 and 2014, the overall suicide rate increased by 24% in the U.S.¹³ Since 1998, suicide death rates among those with a high school degree or less increased by 81%, and since 1999 suicide death rates rose approximately 40% among middle-aged adults in the U.S.^{6,14} The suicide rate among women and men aged 45 to 64 has increased by 63% and 43% respectively since 1999.¹³ About 43,000 Americans die by suicide every year, making it the 10th leading cause of death.¹¹ Suicide is the second leading cause of death for ages 44 and under, and the fifth leading cause of death for people age 45 to 54.¹² Veterans comprise 22.2% of suicides nationally.¹² Painkillers are the third leading cause of death by suicide among middle-aged Americans, as well as leading the list for the most common substance implicated in adult poison exposures.^{15,16} Ten percent of people dying by suicide presented in the ED within 60 days of their death.¹⁷

Death by suicide is prevalent in South Carolina; more than twice as many people die by suicide each year than by homicide.¹²

In South Carolina, suicide is:

- 1st leading cause of death aged 10-14
- 3rd leading cause of death aged 15-24
- 2nd leading cause of death aged 25-34
- 4th leading cause of death aged 35-44
- 5th leading cause of death aged 45-54
- 9th leading cause of death aged 55-64¹²

Trends in Substance Use Disorders

Since 1998, deaths from disease or cirrhosis of the liver have increased by 50% in the U.S.⁶ There has been a four-fold increase since 1998 of deaths associated with drug and alcohol poisoning by people with a high school degree or less.⁶ The age-adjusted drug overdose rate in the U.S. increased from 6.2 per 100,000 in 2000 to 14.7 per 100,000 in 2014, and just in 2014, there was a 6.5% increase in drug overdose death rates totaling 47,055 lives.¹⁸

Opioid Use Disorder

According to the Centers for Disease Control and Prevention (CDC), the prescription opioid epidemic is the worst drug epidemic in U.S. history¹⁹ and is now killing over 27,000 people a year in the U.S.²⁰ Among

all ages, there has been a 369% increase in opioid-related deaths and a 439% increase in heroin-related deaths since 1999.²⁰

About 75% of those using heroin used prescription drugs prior to trying heroin.²¹ In 2012, health care providers wrote 259 million prescriptions for opioid pain medication, which would allow for every adult in the U.S. to have a bottle of pills.²²

Consider an average day in the U.S.:

- Over 650,000 opioid prescriptions are dispensed,
- 3,900 individuals use prescription opioids for a non-medical purpose for the first time,
- 580 people initiate heroin use, and
- 78 people die from opioid-related overdoses.²³

South Carolina is one of the highest opioid prescribing states; by the CDC's estimate we had around 102 prescriptions per 100 individuals in 2014.²⁴ Between July 2014 and June 2015, over four million opiate prescriptions were dispensed to a little over 1.2 million individuals in South Carolina for a total of nearly 300 million opiate pills dispensed in the state that year. Approximately 4.8 million people lived in South Carolina in 2014.²⁵

The impact of excess opioid prescriptions and availability of illegal drugs is clear. In 2008, South Carolina had 504 drug overdose deaths. By 2014, there were 682 deaths. This increase was due to the increase in heroin and prescription drug overdoses (534 were from opioids).²⁵ For example, in Horry and Georgetown counties, in 2010, there were 249 drug arrests (ranging from simple possession to the trafficking of heroin); in 2015, there were 546 arrests of the same type.²⁶

The Cost of Behavioral Health Illnesses

In 1996, the most costly medical conditions in the U.S were heart conditions (\$105 billion per year), and mental health disorders were second (\$79 billion per year).²⁷ In 2004, these illnesses had equal spending, but in 2013 mental health disorders reached costs of \$201 billion compared with \$147 billion for heart conditions.²⁷

In the U.S., suicide costs in 2010 were \$44 billion in medical costs and work loss¹¹; in South Carolina, the lifetime medical and work loss costs of suicide in 2010 were \$748,610,000 (this is an average of \$1,175,213 per suicide death).¹²

Costs of crime, lost work productivity and health care needs associated with substance use disorders recently reached \$700 billion in the U.S. annually. Health and social costs of \$55 billion are solely associated with prescription opioid abuse, which includes \$20 billion in EDs and inpatient care costs for opioid poisoning.^{23,28}

SOLUTIONS & OPPORTUNITIES

On the federal and state level, a number of efforts are underway to address the suicide and opioid epidemics. The following provides a summary of select initiatives not directly addressed by one of the 20 recommendations in *Hope for Tomorrow*.

SOUTH CAROLINA

Suicide Epidemic

The South Carolina Department of Mental Health (DMH) recently received a federal Substance Abuse and Mental Health Administration (SAMHSA) grant to develop new suicide prevention strategies for youth in South Carolina. The South Carolina Youth Suicide Prevention Initiative (SCYSPI) aims to reduce deaths by suicide and suicide among youth and young adults aged ten to 24. This initiative will focus on increasing access to screening and mental health services, raising awareness through social media marketing, increasing protective factors through training across community domains, supporting clinicians and educators in implementing evidence-based interventions, utilizing safety plans in EDs and strengthening statewide infrastructure. Within the focus population, DMH will concentrate on the subpopulations of those with Serious Mental Illness (SMI), individuals involved with the justice system and LGBT youth. [SMIs are those mental illnesses that cause serious functional impairment that substantially interferes with or limits major life activities. Common SMIs include bipolar disorder and schizophrenia.]

Strategies and interventions include a marketing/outreach campaign as well as suicide prevention programming conducted in school districts, on college campuses and in hospitals and other community settings; providing screening, assessment and therapeutic services; improving state infrastructure through training and re-creating the South Carolina Suicide Prevention Coalition; improving discharge protocols in EDs and developing a universal response protocol to respond when it is suspected that a young person is suicidal.

Opioid Epidemic

The South Carolina Reporting and Identification Prescription Monitoring System (SCRIPTS) is South Carolina's Prescription Drug Monitoring Program (PDMP). The integrated database tracks pharmacy prescriptions across the state and was created to efficiently detect discrepancies with prescription drug dispensing across the state and to communicate with the 17 other states participating in PDMPs.²⁹ After an update to SCRIPTS made in 2014, a report including tracking of patient drug history, prescriber information and locations where drugs are dispensed can be made to the system 24 hours a day, seven days a week.²⁹ Facilities exempt from monitoring are long-term care facilities, assisted living facilities, Veteran's Affairs facilities, methadone clinics, EDs prescribing less than 48 hours of medication and veterinary offices prescribing five days or less of medication. As of September 2016, SCRIPTS reached 14,463 registered users with 380,000 patient prescription entries.³⁰ This year, the South Carolina Department of Health & Environmental Control (DHEC) received \$1.3 million from the CDC to continue to enhance South Carolina's PDMP.

The chance of surviving a drug overdose depends greatly on how fast one receives medical assistance. The time that elapses before an overdose becomes a fatality presents a vital opportunity to intervene and seek medical help. In June 2015, South Carolina passed the Overdose Prevention Act, which allows first responders to carry and administer Naloxone, an opioid overdose reversal drug. A number of state and local agencies have procured Naloxone, and providers are administering it to prevent overdose emergencies from ending in death. In 2015, 6,570 incidents of Emergency Medical Services providers administering Naloxone were documented across the state, up from 5,823 two years before.³¹

One way to incentivize overdose witnesses to seek medical help is to exempt them from arrest for possession or use of illegal drugs, an approach often referred to as Good Samaritan immunity laws. Good Samaritan laws do not protect people from arrest for other offenses, such as selling or trafficking drugs or driving while drugged; these policies only protect the caller and overdose victim from prosecution for simple drug possession, possession of drug paraphernalia and being under the influence.³² Twenty states, including North Carolina and Washington DC, have put laws into place to provide this limited immunity for minor drug law violations for people who summon help at the scene of an overdose.³² The South Carolina Overdose Prevention Act does not include provisions to provide immunity for people who seek help for an overdose.³³

Beginning in October of 2015, the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) received \$880,000 in funding from SAMHSA over five years to address needs of individual communities for prevention strategies with prescription drug use with a program called Strategic Prevention Framework-Partnerships for Success. The funding is primarily for counties that were identified as having a significant non-medical use of prescription drugs for those aged 12 to 25.³⁴

In FY 2016-17, DAODAS received \$1.75 million in new, recurring state resources to support the provision of Medication-Assisted Treatment (MAT), an evidence-based tool for detoxification from opioids. In 2017, DAODAS will also receive over two million dollars in federal grant funding for a new initiative, the South Carolina Overdose Prevention Project (OPP). The OPP will support communities in their capacity to train first responders and caregivers of those with opioid use disorder to recognize the signs of an overdose and deliver Naloxone as well as provide law enforcement in areas of high need with the drug.³⁴

FEDERAL

Parity

The existence of reliable, effective therapies for mental health and substance use disorders is not enough if the therapies are not accessible and affordable. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA or Parity Law) was designed to ensure mental health and addiction illnesses are covered as completely as physical health illnesses by health insurance plans. However, MHPAEA is currently not being fully enforced and many Americans are denied access to behavioral health care. Additional work must be done to guarantee that health insurance plans are fully adhering to the Parity Law.³⁵

Helping Families in Mental Health Crisis Act of 2016 (HR 2646)

The Helping Families in Mental Health Crisis Act of 2016 passed the House in July 2016 and is currently

in the Senate. The wide-ranging bill invests in new mental health initiatives, the evaluation of current practices and the enforcement of mental health parity legislation.

As the bill is currently written, HR 2646 also creates grants to:

- Integrate behavioral health into pediatric primary care and to develop, maintain and enhance infant and early childhood mental health promotion programs;
- Support the recruitment, education and clinical training of health services psychology students in community mental health settings and support community colleges to train and certify behavioral health professionals;
- Provide law enforcement agencies and first responders specialized training to help them in recognizing and intervening with individuals with mental illness;
- Establish community treatment programs including crisis response systems;
- Expand assisted outpatient treatment;
- Develop evidence-based interventions for evaluating models for preventing and treating mental illness that have been shown scientific promise but need further study and
- Expand and replicate evidence-based mental health programs.³⁶

To optimize mental health care funding, the bill creates The Center for Behavioral Health Statistics and Quality to evaluate mental health programs, collect data and recommend measurement standards for grant program evaluation. A policy laboratory will be established to collect information from grantees, reduce ineffective expenditures and make recommendations for improving outcomes.³⁶

HR 2646 also creates the Interdepartmental Serious Mental Illness Coordinating Committee to evaluate Federal mental health programs and improve outcomes for individuals with SMI. The bill plans a study and report on the mental health and substance use disorder workforce to direct workforce enhancement efforts. An Assistant Secretary and Deputy Assistant Secretary for Mental Health and Substance Use will be appointed to be responsible for establishing standards and evaluating requests for mental health grants.³⁶

Federal Solutions – Opioid Epidemic

In March 2015, the U.S. Department of Health & Human Services (DHHS) released an Opioid Initiative with three primary goals: a) changing opioid prescribing practices, b) expanding access to MAT and c) increasing the use of Naloxone in overdose situations.

a) The CDC recently released guidelines to help physicians prescribe opioids responsibly, since many opioid dependencies begin with the use of prescribed painkillers.²¹ These guidelines include limiting the use of opioids to cancer treatment, palliative care and end-of-life care, establishing and using the lowest effective dose of opioids and closely monitoring patients taking opioids.²² In order to lessen any perception that there is a financial incentive to overprescribe opioids, the Centers for Medicare and Medicaid Services (CMS) is proposing to remove the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey pain management questions from the hospital payment scoring methodology.³⁷

b) DHHS proposed a rule to increase the number of patients to whom a physician may prescribe buprenorphine, a medication commonly used during MAT, from 100 to 200, increasing the availability of MAT to end opioid dependence.²¹

c) The federal government is encouraging states to increase the use of Naloxone in communities. In addition to the passage of Good Samaritan Laws, three states, most recently North Carolina, authorized standing prescriptions of Naloxone, making it available at pharmacies without a prescription.³⁸

Comprehensive Addiction and Recovery Act

The Comprehensive Addiction and Recovery Act (CARA) became law on July 22nd, 2016. The law authorizes the U.S. Department of Justice to award grants to state, local and tribal governments to provide opioid addiction services. Under the President's budget proposal, South Carolina could be eligible for up to \$11 million dollars over two years to expand access to treatment for opioid use disorders.³⁹

CARA brings behavioral health providers, law enforcement, criminal justice systems and others together as key partners in collaborative efforts to address the opioid crisis. CARA will allow nurse practitioners and physician assistants to serve as authorized prescribers for medications that support treatment. CARA supports access to a comprehensive range of services and supports, including MAT. Furthermore, it supports the use and access of Naloxone and training for law enforcement.⁴⁰

To address the role prescription opioid misuse plays in the opioid crisis, CARA creates a task force to establish best practices for prescribing pain medication, expands and develops prescription disposal sites and incentivizes PDMPs to help identify illegal activity and intervene for those in need of addiction treatment by tracking opioid prescriptions. CARA augments education prevention efforts aimed at teens and parents and increases resources for incarcerated individuals with substance use disorders.⁴⁰

RECOMMENATION UPDATES

ACCESS TO CLINICAL SERVICES

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

Access to behavioral health treatments in the U.S. is limited. As services have been eliminated or scaled back, more and more people with behavioral health illnesses are becoming homeless, incarcerated or presenting in EDs, all unsuitable environments for people experiencing a behavioral health emergency. A serious need persists for states and communities across the country to expand programming so people have access to crisis response services during times of emergency and to ongoing outpatient support to maintain health while living with and managing one or more chronic illnesses.

Only 40% of people with a behavioral health illness (any mental illness or substance use disorder) are getting treatment for that illness; 60% are not getting any treatment.⁴¹ Due to a shortage of specialists, most patients are receiving their behavioral health care in a primary care settings, but only 13% of people with a behavioral health illness receive minimally adequate treatment in that setting.⁴¹

About 30% of adults with an SMI are not receiving mental health treatment,^{7,42} and only 11% of the 22.7 million Americans who needed drug or alcohol treatment in 2013 received it.⁴³ While some people go without care by choice because of the negative stigma associated with these illnesses, a majority experience barriers in accessing desired treatments.

For example, people with SMI are four times more likely not to get medical care because of cost than those without SMI.⁴⁴ Expanded access to insurance would contribute to addressing cost-related access barriers; about 87,000 South Carolinians who suffer from mental illness or substance use disorders would qualify for Medicaid if the state expanded eligibility as permitted by the Affordable Care Act.^{44,45}

Lack of insurance parity also causes access barriers; 29% of respondents in a 2015 national survey reported that they or a family member were denied behavioral health care based on “medical necessity criteria,” compared to 14% who reported being denied general medical care.⁴⁶

Minority populations have additional access barriers; compared to whites, African Americans and Latinos are less likely to receive mental health treatment.⁸ Despite the expansion of overall treatment rates in 2014, there is no evidence of a reduction in the wide racial and ethnic disparities in mental health treatment.⁴⁷ Dramatic increases in health insurance coverage have not resulted in corresponding increases in mental health treatment in the African American population.⁴⁷

The access barriers that exist across the U.S. are even more dramatic in South Carolina due to workforce shortages, an under-resourced public services system and a population with relatively high numbers

of uninsured individuals ages 18 to 64. If we choose to invest more in prevention, crisis response and chronic care management, this will provide a cost savings to the health care system and the justice system in the long term and improve quality of care while supporting a healthier state.

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

Although the updates related to service provision focus on the two biggest statewide provider systems – DMH and DAODAS, we recognize that there is a large variety of hospital-based programs, private mental health providers, Veterans Administration programs and other providers with after-hours services. We are faced with the challenge of gathering comprehensive data on these disparate provider groups.

Mental Health Services

Eleven of the 17 Community Mental Health Centers (CMHCs) of DMH are open at least one day a week past 5:00 p.m. at one of their locations, and the Charleston/Dorchester CMHC has Saturday hours.

- Aiken/Barnwell
- Beckman
- Berkeley
- Catawba
- Charleston/Dorchester
- Coastal
- Columbia
- Lexington
- Pee Dee
- Piedmont
- Santee Wateree

These CMHCs do not have any locations with extended hours:

- Anderson/Oconee/Pickens
- Greenville
- Orangeburg
- Spartanburg
- Tri County
- Waccamaw

In addition to these extended hours, the DMH telepsychiatry program significantly extends psychiatric services outside business hours. The program provides real time, state-of-the-art high definition video-and-voice consultation from psychiatrists 16 hours a day, seven days a week to patients in EDs in over 23 hospitals across the state, with more expansion likely. Consultations with DMH psychiatrists have increased the quality and timeliness of triage, assessment and initial treatment of patients, reduced the length of stay for many individuals in EDs and allowed participating hospitals to direct critical personnel and financial resources to other needs. Almost 30,000 consultations were done since the program’s inception in April of 2009.

DMH provides numerous services outside of center and clinic hours. Each of the 17 centers has a 24/7 on-call line where patients experiencing a mental health crisis can contact a master’s level clinician telephonically. DMH provides master’s level mental health clinicians who visit EDs, sometimes outside regular business hours, to help ED staff assess, divert or treat patients in psychiatric crisis. Finally, DMH’s Care Coordination service assists people in maintaining community tenure and reduces the need for psychiatric hospital stays by addressing needs of daily living.

Substance Use Disorder Services

Eighteen of the 32 local alcohol and other drug abuse authorities across the state that are part of DAODAS have extended outpatient hours.

These providers in the DAODAS system have extended hours (Open past 5:00 p.m. at least one day per week):

- Aiken
- Berkeley
- Charleston
- Cherokee
- Chester
- Clarendon
- Darlington
- Dorchester
- Fairfield
- Florence
- Georgetown
- Greenville
- Horry
- Lancaster
- Laurens
- Marion/Dillon/Marlboro
- Tri-County (Orangeburg, Bamberg and Calhoun)
- York

These providers do not have any extended hours:

- Anderson/Oconee
- Barnwell
- Beaufort
- Colleton
- Greenwood/Edgefield/McCormick/Abbeville
- Kershaw/Chesterfield/Lee
- Lexington/Richland
- Lowcountry (Hampton, Jasper and Allendale)
- Newberry
- Pickens
- Saluda
- Sumter
- Union
- Williamsburg

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

Language barriers decrease the odds of utilizing behavioral health services, so it is important to provide bilingual services to meet the needs of the non-English speaking portion of the population.⁴⁶

In the public mental health service system, 13 of the 17 CMHCs have at least one bilingual professional on staff. The primary second language is Spanish, although both the public mental health and substance use disorder service systems employ professionals who speak other languages. Telephonic translation services are available to all CHMCs through a state-wide contract.

DMH has a Cultural & Linguistic Competence Strategic Plan, which includes:

- Special recruitment efforts to hire bilingual frontline staff and mental health professionals
- Definition of “agency criteria” for hiring bilingual mental health professionals

Neither of these objectives have yet been attained.

PASOs, the Consortium for Latino Immigration Studies and the University of South Carolina’s (USC) Department of Psychology are currently conducting a study about the mental health service utilization and needs of the Latino community. The findings of this study will be used to inform DMH’s approach to improving services for the Latino population.

In the public substance use disorder system, every local alcohol and other drug abuse service authority that is part of DAODAS has translation services available by phone through a contract DAODAS maintains with one of the providers. According to a recent survey, 13 of the 32 providers across the state also have bilingual professionals on staff.

3. Develop a network of Mobile Crisis Units¹ around the state.

An initial, albeit significant step towards implementing mobile crisis services across the state will soon be taken by DMH. The South Carolina Department of Health and Human Services (SC DHHS) and DMH are finalizing a contract to support the development of Community Crisis Response and Intervention (CCRI) services across all 46 counties in the state with a recurring allocation of \$3,648,000 in the SC DHHS budget. Regions will be set up and territory will be determined based upon a 60-minute response time from the point of origin. A 1-800 number will be established to help residents access services, and calls will be routed to the appropriate regional hub. All residents of South Carolina experiencing a psychiatric emergency will be eligible for the services regardless of payer source. For patients that are covered by Medicaid, DMH will be able to submit for reimbursement.

An office of CCRI will be created at DMH within the Community Mental Health Services Division to address program monitoring, data collection and fiscal management. The office will employ mental health staff for crisis intervention during after-hours, weekends and holidays. Staff will be organized similarly to the Clinical Care Coordination office, with staff housed locally across the state. Local CMHCs will expand the current system of crisis response by adding or reassigning employees to current crisis response staff to be able to respond on-site during working hours. The CMHCs will maintain and provide data to the state CCRI office for activity occurring during working hours (the CCRI staff will maintain data for activity occurring after-hours). There will also be a CCRI regional supervisor to address local and regional issues.

CCRI staff will provide follow-up with individuals accessing CCRI, train law enforcement and first responders in evidence-based practices for crisis intervention and mental health issues and conduct stakeholder meetings to identify strengths and areas of improvement for program operations.

To measure the success of the program, DMH will submit quarterly reports to DHHS, broken down by regions, tracking the number of calls, patient demographics, crisis categories, the type of response provided and outcomes of on-site service (i.e., a. intervention and referral [stayed in current location], b. intervention and went to ED, c. intervention and went to jail) and telephonic service (i.e., informational and referral, brief counseling, etc.).

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

An allocation of \$1,000,000 was placed into DMH's budget for the current fiscal year by legislators interested in seeing communities pursue the creation of crisis stabilization units. The department has discretion over the breakdown and utilization of those funds, but they are intended to support the existing effort in Charleston, as well as expansion of coverage into other areas.

¹ Now being referred to as Community Crisis Response and Intervention (CCRI) services

Charleston

Between 1999 and 2009, the Charleston/Dorchester CMHC ran a ten-bed crisis stabilization center licensed as a Community Residential Care Facility (CRCF) in Charleston. In 2009, a regulation previously not enforced by the South Carolina Department of Health & Environmental Control (DHEC) mandating CRCFs to screen patients for tuberculosis with a chest x-ray within 30 days prior to admission was required to be complied with in order to continue operations. At that time, the Charleston/Dorchester CMHC requested a waiver from DHEC for this requirement as it does not fit with the model of crisis response services. Their request for a waiver was denied, and the crisis unit was closed.

When this occurred, the admission of patients from the Medical University of South Carolina (MUSC) ED to its Institute of Psychiatry increased dramatically, from 470 patients per year in 2006, 2007 and 2008 (when the crisis unit operated) to 1,300 patients per year after it was closed (2010). These admissions have steadily risen since the closing of the crisis unit, and in 2015 the number rose to 2,000.

When re-applying in July 2014 for a waiver to re-open the facility in Charleston as a CRCF, it took one year of communication with DHEC to achieve receipt of the waiver. The Behavioral Health Taskforce identified the need for a new licensure category dedicated to crisis stabilization units in *Hope for Tomorrow*. If a new licensure category is in place, other communities planning such facilities will have a more efficient process in getting them established. CRCF requirements do not make sense in the crisis setting; the regulations are related to creating appropriate environments for long-term residential care.

To aid in the process of the development of a new licensure category, IMPH staff researched the manner in which Crisis Stabilization Units (CSUs) are licensed in other states. North Carolina operates 22⁴⁸, Georgia has 26⁴⁹, Mississippi has nine⁵⁰ and Kentucky operates 19⁵¹ such facilities.

IMPH and DHEC staff members have met to discuss the need for a new licensure category to fully implement the program in South Carolina. A new licensure category will have to be authorized by legislation. The licensing regulations for CSUs in several other states were summarized and provided to DHEC to provide a starting place for developing a licensure category for South Carolina upon the passage of authorizing legislation.

The crisis unit the Charleston community is planning to re-open will require approximately \$1.1 million in the first year and \$1 million annually for operations. It received approximately \$200,000 a year from Medicaid reimbursements when it operated previously. Roper St. Francis and MUSC are each dedicating \$250,000 per year to the unit's operation, and Trident Medical Center is dedicating an amount that has yet to be determined. The hospitals are making this financial commitment so that patients can be treated in a clinically appropriate setting costing significantly less than their EDs. The Charleston/Dorchester CMHC will run the facility with \$250,000 in its annual operating budget earmarked to support operations, once it shifts funds from other programming that will be replaced by the Crisis Stabilization Center.

The unit being planned will have 12 to 15 beds, be open 24/7/365 and admit patients ages 18 and over who are in psychiatric distress. In the absence of this unit, most patients in this situation are going to a hospital setting. The unit will also serve as a drop-off for law enforcement, which will help to prevent inappropriate incarceration. Other referral sources will include CMHC staff, hospital EDs, inpatient psychiatric units (as a step-down), the detention center, families, churches and the mental health and drug courts in the area. The unit will not accept committed patients. Patients can stay up to 14 days. However, average length of

stay at the previous facility was 3.2 days, and it is anticipated to stay at a similar level. The new unit will provide social detoxification services; if patients need medical detoxification, they will be referred to the Charleston Center, the community's drug and alcohol authority operated by the County of Charleston. The crisis facility will have a 'wet room' with 10-15 chairs for social detoxification for patients who are intoxicated and need to be clear of drugs and/or alcohol before being fully psychiatrically assessed.

A psychiatrist will round two hours a day, and during the day shift there will be four to five staff onsite. The unit will have the capacity to care for some physical health ailments (i.e., some wound care), but patients with significant or emergency physical health concerns cannot be treated in this setting. The unit will be able to accept patients coming out of the corrections setting if needing psychiatric "step down" support. The Charleston County Sheriff's Office will provide around-the-clock law enforcement presence at the unit and the meals for patients in-kind.

A stakeholder advisory board will oversee the strategic interest of the facility. Currently, the Charleston/Dorchester CMHC is waiting for the Charleston Center to identify its new location so that it can establish the crisis unit in the same building; co-locating with the substance use disorder service system is a key element to the program's design. In the meantime, the unit is tentatively scheduled to be re-established in its prior location in January 2017.

Four additional communities in South Carolina have begun conversations about crisis stabilization units since the release of *Hope for Tomorrow*:

Anderson: AnMed Health, in partnership with the Anderson/Oconee/Pickens CMHC, is developing plans for a CSU in the Anderson community.

Greenville: The Greenville Mental Health Center, the Greenville Health System, Bon Secours St. Francis Health System, the City of Greenville, the County of Greenville and the Phoenix Center (Greenville County's alcohol and drug authority) are working to develop a crisis stabilization center in Greenville. The planning committee is working to identify what resources each partner can provide to support the operations of the center. The plan is to begin the service with a focus on individuals identified by law enforcement in need of mental health services and will also operate as a homeless shelter.

Florence: Geoff Mason, Deputy Director with DMH and Thornton Kirby, CEO of the South Carolina Hospital Association and ILC member, recently met with Ron Boring, Chief Operating Officer of McLeod Health to discuss the development of a CSU for the Florence community. Mr. Boring indicated he was going to examine hiring a consultant to assess need, cost and viability of a CSU.

Spartanburg: The Spartanburg Behavioral Health Taskforce recently voted to explore the possibility of a crisis stabilization unit in their community. A committee has been formed to examine the possibility. Maya Pack, Associate Director, Research & Strategic Initiatives for IMPH serves on the taskforce and the new committee.

CSU in Prison System

The South Carolina Department of Corrections (SCDC) has recently opened a CSU for inmates in psychiatric distress. Previously, inmates were held at their individual facilities, often in restrictive housing, during a crisis situation. The new CSU provides partial hospitalization and out-of-cell/restorative time

for the inmates. The CSU opened at the end of March at the Broad River Correctional Institution. It has the capacity to house 32 inmates and is averaging about 15 inmates while staffing is ramping up. The staffing model for the CSU includes seven mental health techs, four qualified mental health professionals, full-time nursing presence and correctional officers with a psychologist providing oversight and a psychiatrist who rotates through weekly. SCDC's goal is to have inmates in the CSU no more than 15 days at a time.

SCDC recently developed a volunteer inmate watcher program modeled from the Federal Bureau of Prisons. Model inmates who are well-vetted and have had no disciplinary actions taken against them volunteer to live in the CSU to provide peer-to-peer-service with the inmates experiencing a behavioral health crisis. Watchers receive work credit for their service and provide encouraging words and surveillance to make sure inmates in distress are not hurting themselves. Thirty-two watchers live in the CSU and are on a rotation to avoid burn-out.

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

There are 58 public medical detox beds in South Carolina at four locations operated by DAODAS providers (Charleston, Greenville, Richland and York counties). DMH operates 42 detox beds at Morris Village in Columbia. All of these facilities are operating at capacity. In addition to the need for more inpatient detox capacity, there is a significant need in our state for outpatient Medication Assisted Treatment (MAT), an evidence-based treatment for chemical dependence that includes FDA-approved medication in combination with counseling therapy specifically for patients addicted to opioids. Historically, most DAODAS providers have not had MAT services.

In the FY 2017 budget, DAODAS has \$1.75 million in new, recurring state dollars to support local providers in developing and/or expanding MAT programs. This initiative will make treatment available to uninsured clients on an outpatient basis who previously may have been referred to inpatient detoxification. The goal is that every person in our state struggling with opioid use has every option available to them to successfully reach recovery.

Funding for the capacity building and expansion of MAT services in FY 2017 will be considered for catchment areas of highest need but are available to any DAODAS agencies. Areas were identified by DAODAS based on county-level data that determines prevalence of morbidity and mortality related to opioid use disorder, including the prevalence of accidental deaths due to overdose of prescription drugs and heroin, ED discharges with an opioid dependence diagnosis, ED discharges with an opioid overdose diagnosis and frequency of Naloxone administration by EMS.

Additional agency-specific factors to be considered when prioritizing distribution of funds in addition to the prevalence data include:

- Agency counts of clients reporting problems related to opiate use,
- Percent of opiate related admissions,
- Array of available services (in-patient and ambulatory detoxification services, etc.),
- Agency interest and willingness to meet expectations for the receipt of funds and
- Consideration of providers serving rural populations

Since this new funding is meant to increase access to treatment for South Carolinians who do not have the means to pay for private services, an additional consideration is the availability and accessibility of other public or grant-funded evidence-based treatment in a community.

Through this analysis, DAODAS identified and funded the following providers as high-need:

- The Charleston Center (Charleston County)
- The Forrester Center for Behavioral Health (Spartanburg County)
- Keystone Behavioral Health Services (York County)
- LRADAC (Lexington and Richland Counties)
- Pickens Behavioral Health Services (Pickens County)
- The Phoenix Center (Greenville County)
- Shoreline Behavioral Health Services (Horry County)
- TriCounty Drug and Alcohol Commission (Bamberg, Calhoun and Orangeburg Counties)

All treatment options, including the medications methadone, buprenorphine and naltrexone will be made accessible to assist in the comprehensive treatment of opioid use disorder for clients diagnosed with the disease.

The new funds may be used for physician contract costs and other personnel directly related to MAT services, medications and pharmacotherapy-related services and other services directly related to pharmacotherapy (e.g. lab work, medical assessments, medical follow-up and Hepatitis C testing).

Meanwhile, the Spartanburg County Behavioral Health Taskforce is considering the possibility of re-opening a detoxification facility in their community that closed in 2010. Between 2010 and 2014, Spartanburg Regional Healthcare System recorded a 19% increase in the number of visits to their ED for behavioral health illnesses including drug and alcohol dependency. The cost of these services was \$11.1 million in 2014, which is more than ten times the cost of \$175 per day for treatment at the former detox center.⁵²

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

Between 1997 and 2015, state psychiatric hospital beds in the U.S. declined by 24%.⁵³ In a recent survey, 90% of ED physicians reported boarding psychiatric patients, primarily due to a lack of inpatient mental health beds and community resources^{54,55} (70% reported holding psychiatric patients for over 24 hours and 10% reported holding patients for over a week).⁵⁶ A full 80% of ED physicians report that the mental health care systems in their regions are not working.⁵⁷

In 2016, South Carolina ranked 34th in the ratio of state psychiatric beds to the population, with a total of 373 beds averaging 7.5 beds per 100,000 compared with national average of 11.7 per 100,000.⁵⁵ More inpatient psychiatric beds are urgently needed in our state due to the growing number of people with serious mental illness who are being held in jails, prisons or EDs, waiting on placement in a mental health hospital. The current State Health Plan demonstrates a need for 111 new psychiatric beds across the state.⁵⁸

DMH inpatient hospitals are operating at capacity with waiting lists. During the period July 1, 2015 through June 30, 2016, through a combined total of approximately 611 operational inpatient psychiatric beds, G.

Werber Bryan, Patrick B. Harris, William S. Hall and Morris Village Alcohol & Drug Addiction Treatment Center had a combined average daily census of 594 patients. In the budgeting process for FY 2017, DMH requested \$4,803,872 to increase forensic capacity and was approved for \$2,500,000.

There are also plans to incrementally increase capacity at each DMH inpatient facility during the current fiscal year. This involves directed, systemic efforts to increase bed turnover by strategically developing and accessing appropriate community placement options. These initiatives will be accomplished by enhancing the collaboration with CMHCs and other community-based partners. Increased capacity for adolescent substance recovery and acute treatment beds occurred when the William S. Hall Psychiatric Institute relocated from Bull Street to the G. Weber Bryan campus, with an increase from 38 to 51 beds. Morris Village also increased capacity by seven beds.

Despite the planned increased capacity of operational beds, the overall demand for inpatient beds will not be met.

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

Residential treatment sites operated by DAODAS providers exist in six communities across South Carolina: Charleston (women and men), Florence (women only), York (women and men), Horry (women only), Greenville (women only) and Orangeburg (adolescents only). Holmsview in Greenville and Palmetto Center in Florence are similar facilities operated by the South Carolina Vocational Rehabilitation Department. In addition, Morris Village, which is operated by DMH, has both detox and rehab capacity. These facilities are all operating at capacity.

During FY 2016, Morris Village increased its number of operational beds by seven. Based on bed days and average length of stay, it is estimated that with the increase of seven operational beds, Morris Village will admit an additional 15 individuals per year with a primary diagnosis of opioid use disorder. A primary diagnosis of opioid use disorder accounted for 20% of admissions (250 individuals) to Morris Village during FY 2015.

For those with opioid use disorders, the new MAT program could lessen the need for residential treatment beds. Residential care is needed especially for co-occurring patients who need a place to live as they age.¹⁷ There is also a need for more recovery housing where those recovering from addiction live together in a safe place where no drugs or alcohol are permitted.

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

Because the number of inpatient psychiatric beds decreased considerably over the last two decades, patients are sicker and in a more acute state when they reach the point of an inpatient admission. Because of this and the severity of their illnesses, some patients become long-term residents in our state's psychiatric hospitals. During FY 2016, Bryan Hospital's Forensic Unit discharged 205 patients who had an average length of stay of 263 days. Bryan Hospital's Civil Unit and Harris Hospital discharged a total of 637 patients from acute units with an average length of stay of 65 days. There were also 29 patients from chronic units with an average length of stay of 1,138 days.

These patients could be better cared for in a less restrictive and less costly but highly supervised environment if there were more residential, long-term treatment environments.

For example, CRCFs meet a critical need for individuals discharged from inpatient facilities who need a more structured environment than independent living. CRCFs are licensed and monitored by DHEC's Division of Health Licensing. A significant limitation to this option is the Medicaid Institutions for Mental Diseases (IMD) exclusion, which prohibits the use of federal Medicaid financing for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds. The exclusion applies to all Medicaid beneficiaries under the age of 65 who are patients in an IMD, except for payments for inpatient psychiatric services provided to beneficiaries under age 21.

DMH is seeking partnerships with additional CRCF operators in communities across South Carolina; however, it remains a significant challenge, due in part to the IMD exclusion and licensing restrictions.

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

The State Health Plan has specific standards for the development of inpatient psychiatric capacity. When adding psychiatric beds or changing the licensure of an acute bed to a psychiatric bed, hospitals are required to obtain CON approval from DHEC. No CON reform bills have yet passed the South Carolina legislature, but the possibility of CON reform remains for the upcoming legislative session.

INTEGRATED CARE

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

As the U.S. health care system moves from a fee-for-service payment model to one that is value-based and focused on outcomes, the need for better integrated behavioral and physical health care is more apparent than ever. In order to achieve the Triple Aim of an improved patient experience, improved population health and reduced costs, patients must be treated holistically and their care must be better coordinated.

Behavioral health problems often first present in general medical settings, and psychosocial issues account for more than 70% of primary care visits.⁵⁹ Primary care providers must be familiar with behavioral health illnesses and symptoms in order to mitigate the negative impact on the patient through early treatment. Although there are many barriers in doing so, primary care providers should consistently provide screening for behavioral health considerations in addition to those for physical health illnesses.

Due to barriers in accessing specialty behavioral health services, primary care providers are forced to deliver more and more behavioral health care; approximately two-thirds of primary care physicians reported in a recent national survey that they experience significant challenges when attempting to obtain mental health referral for their patients.⁶⁰ About 23% of patients who receive mental health treatments receive them from their primary care provider.⁴¹ Unfortunately, primary care providers often do not have the time or resources to provide effective treatment for many behavioral health conditions.

However, excellent evidence-based interventions that add behavioral health expertise into primary care practices are being adopted around the country.⁴¹ This is due to more stakeholders understanding the benefits of integrating primary care and behavioral health: improved health outcomes, convenience and care for those with comorbidities; cost savings and patient satisfaction; reduced stigma and access barriers; and strengthened patient-physician relationships.³

Patients with both a chronic behavioral health illness and a physical health illness are exponentially more costly and often do not receive adequate interventions. Excess costs of \$293 billion in 2012 were attributed to comorbidities in Medicaid and Medicare beneficiaries and those with commercial insurance.⁶¹ Between \$26 and \$48 billion could be saved with effective physical health and behavioral health integration.⁶¹

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

The type of resource envisioned by the Taskforce is not yet developed, but progress is being made on planning services that will better integrate behavioral health and physical health. In 2015, SC DHHS in partnership with DMH and DAODAS were selected to participate in the National Academy for State Health Policy (NASHP) Learning Collaborative for “Supporting State Strategies to Design and Deliver Whole-Person Care in Ambulatory Settings.” SC DHHS, DMH, DAODAS and client advocacy groups are engaged in a technical learning collaborative to identify ways to promote physical and behavioral health integration. Directors Magill (DMH) and Soura (SC DHHS) met on July 22nd with the South Carolina Learning Collaborative team along with representatives from NASHP and SAMSHA to discuss next steps for moving forward with an adult Behavioral Health Home model targeting individuals with serious, persistent mental illness, substance use disorders and an increased risk for chronic physical health conditions. The group will pursue a planning grant to continue this effort.

As of July 1, 2016, behavioral health and primary care services for the managed care Medicaid population are now being provided through the Coordinated Care benefit provided by SC DHHS’s contracted Managed Care Organizations (MCO). This policy change supports more integrated and coordinated benefits for beneficiaries.

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

Though no state-level committee has been formed, efforts exist throughout the state to improve the coordination of behavioral health services for patients with more than one provider. Through the planning grant being pursued as a result of the NASHP Learning Collaborative, opportunities will be identified to improve the coordination of care for patients accessing both DMH and DAODAS services.

For Medicaid clients who are members of MCOs, behavioral health care is now more coordinated and a broader array of services is being provided.

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

SC DHHS will apply to CMS for a 1915(c) waiver for children and youth up to age 21 with significant behavioral health challenges who would otherwise be treated for psychiatric conditions in inpatient settings. This waiver, called the Palmetto Coordinated System of Care waiver, would create a new array of home and community-based services to help children and youth live in the community, stay in school and when possible live in their home. The implementation of this waiver has the potential to significantly reduce expenditures for this population, while at the same time providing more effective services.

Research indicates effective home and community-based services can be less costly and provide better outcomes for children, youth and their families. Proposed services include care coordination utilizing High Fidelity Wraparound, peer support, employment skills development, career exploration and assessment, intensive supported employment, short term respite, individualized goods and services (flex funds), non-

medical transportation and community psychiatric supports and treatment. The waiver is expected to start with 200 participants and expand to 400 over a five-year period. Depending on CMS approval, the waiver is targeted to begin in early 2017.

DMH, DAODAS and SC DHHS are currently examining the potential for coordinated services for adults with serious, persistent mental illness and/or substance use disorders.

HOUSING

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

Affordable supportive housing is critical to the recovery process for people with serious behavioral health illnesses.⁶² Those with mental illness are often discriminated against not only by landlords, but also by homeless shelters,⁶³ though serious mental illness, substance abuse or both affects up to half of the homeless adult population.⁶⁴

Supportive housing helps to keep patients healthy and out of hospitals and the justice system. In one recent meta-analysis, between 63 and 90% of homeless adults with a mental illness have a history of arrests and between 48 and 67% have been incarcerated.⁶⁵ Another study of jail inmates indicated those who were homeless a year prior to incarceration illustrated symptom groupings indicative of mania, depression, psychosis and substance use at 10 to 22% higher rates than those who were not homeless.⁶⁶ The risk of homelessness is 10 to 20 times greater for those with mental illness. It is not uncommon for the homeless population to have multiple concurrent psychiatric disorders, substance abuse and chronic medical conditions as well as history with the legal system.⁶⁴

On a single night in South Carolina in January 2015, 5,354 people were identified as homeless, and of those, 653 (12%) were found to have a serious mental illness (SMI) and 1,285 (24%) identified as having a substance use disorder. Of those with a substance use disorder, 49% were not sheltered, and of those with SMI, 31% were not sheltered.⁶⁷

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

Funds from the sale of the DMH Bull Street property will go to support the development of housing units, supportive apartments and/or rehabbing units across the state. DMH's Commission decided to use at minimum the initial proceeds from the sale of the Bull Street property to develop housing for their clients.

DMH is currently developing and drafting the procurement method to award these funds and beginning conversations with interested developers (both non-profit and for-profit) and housing authorities.

The state budget for FY 2016 provided Mental Health America – South Carolina \$1.8 million in new dollars for clustered housing in Florence for people with a serious mental illness, and plans for development are underway.

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

Beginning in FY 2015, \$1.5 million was allocated to DMH to develop a Community Housing Program to provide rental assistance and related costs for their clients living with serious mental illnesses. In FY 2016, DMH received an additional \$400,000 for rental assistance from the General Assembly, for a total of \$1.9 million. These are recurring dollars and the program is expected to continue.

Currently, 261 units are being supported throughout the state, up 153 from this time last year. Twelve CMHCs, the Office of Clinical Care Coordination and the Office of Deaf and Hard of Hearing Services received funds to implement Community Housing Programs. All of these units are scattered-site and integrated in community settings.

Challenges include a lack of available housing units in some communities, identifying landlords willing to participate in the program and the clients' ineligibility to lease as a result of criminal background checks.

In addition, DMH received a Cooperative Agreement to Benefit Homeless Individuals (CABHI) grant through SAMHSA. The \$1.8 million annually for three years beginning in September 2015 will provide evidence-based services such as Assertive Community Treatment (ACT) for people with a serious mental illness who are chronically homeless. DMH is contracting with Palmetto Health in Columbia and Greenville Mental Health Center in Greenville to provide these services. Part of the goal of the ACT services is to assist CABHI clients in securing appropriate housing.

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

Senate bill 686, which aimed to provide the South Carolina Housing Trust Fund the flexibility to grant funds to other state agencies to support housing initiatives, was introduced in the South Carolina legislature by Senator Thomas Alexander in April 2015. The bill did not become law in either the 2015 or 2016 legislative sessions, but may be re-introduced during the 2017 legislative session.

SCHOOL-BASED SERVICES

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

Schools provide a natural setting to provide behavioral health services for students. Many students face bullying and violence, isolation, family challenges and addiction and/or mental health challenges. Often the initial symptoms and signs of a behavioral health illness are observed in the school setting. There is significant unmet need and a lack of resources to address behavioral health concerns in the school setting. Delivery of school-based services is also at times a reactive system and should transition to a preventative system of universal screening and early intervention.⁶⁸

Research demonstrates that effective behavioral health services in school settings lead to better academic outcomes and a better overall environment for all students.^{69,70} When universal school-based behavioral health interventions are used, not only do academic outcomes improve, but the interventions are also associated with improvements in behaviors known to lead to academic success.⁶⁹

Students who receive school-based behavioral health interventions illustrate greater motivation, confidence, commitment to school and ability to adapt when transitioning between grades, which lead to better time management, goal setting, problem solving skills, grades and reduced truancy.⁷⁰ Schools report having less violence, bullying and conflict between students.⁶⁹

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

No state-level taskforce to examine the need for school-based services in all of South Carolina's schools has been established to date. DMH currently has a clinician assigned to 519 schools across the state (40% of public schools). Some schools provide their own services or contract with private entities for mental health services. No comprehensive catalog of these services exists.

In FY 2017, DMH received \$500,000 in new, recurring state dollars to support their school-based programming. DMH will use \$400,000 to add services to 16 schools. The remaining \$100,000 will be used for the development of a mental health alternative school initiative. These new, recurring state dollars provide the potential for leveraging a \$1,155,000 in new Federal Medicaid dollars through the Medicaid program, for a total of \$1,650,000.

Through funding from the Blue Cross/Blue Shield Foundation of South Carolina, 10 DMH clinicians and two care coordinators have been added in targeted rural communities covering 12 elementary schools in the Pee Dee. The service model in these communities will be focused on prevention and early identification and DMH will develop best practices for the provision of school-based mental health services through this grant with the eventual goal of moving the new model into other elementary schools where they provide services. The approach in these 12 schools is the Multi-Tiered System of Supports (MTSS), which includes a dedicated mental health professional in the school working closely with the school nurse,

teachers and school administrators and the implementation of safety and support teams. The teams are multi-disciplinary and use data to identify students in need of early intervention, treatment and ongoing support. Beyond early intervention, the goal of this new programming is to increase student resiliency and parent and community engagement.

As of February 1, 2015, DMH contracted with the USC School Mental Health Team to provide guidance and assistance in the ongoing evaluation, quality assessment and improvement of school-based mental health services provided by DMH. A separate, independent advisory committee was created to examine and provide specific recommendations to improve and enhance DMH's school-based services in South Carolina.

The offices of Student Intervention Services and Medicaid Services at the South Carolina Department of Education (SCDE) are working to increase student access to counselors, social workers and mental health professionals to support the whole child and promote students' ability to learn. SCDE provides various trainings including technical assistance and professional development opportunities to school districts to help them provide support to students who need behavioral health services and serve as medical providers able to bill Medicaid. Due to recent SC DHHS policy changes to create more integrated and coordinated benefits for beneficiaries, a need exists to build capacity in some school districts to meet the requirements of serving as a medical provider in order to bill for and receive Medicaid reimbursement.

SCDE has secured a grant for emergency management to help develop system infrastructure and partners related to crisis events in school settings. These funds are used for workshops that provide school-based mental health professionals and other school crisis intervention team members with the knowledge necessary to meet the mental health needs of students and staff following a school-associated crisis event.

Drug and alcohol prevention and recovery services funded through DAODAS are provided through the 301 provider system across the state. Currently, 41 substance abuse counselors are working in South Carolina schools through DAODAS entities delivering substance use disorder services.

SERVICES FOR JUSTICE-INVOLVED INDIVIDUALS

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

One result of a lack of resources and capacity in community-based behavioral health care is that jails and prisons have become the institutions in which we house and punish, rather than treat, those with serious mental illness.⁷¹ The number of mentally ill persons in prisons and jails is now 10 times the number in state hospitals.²

Inmates with behavioral health illnesses are more costly to incarcerate, typically stay in prison longer than other offenders and have higher rates of recidivism.⁷¹ Personnel in correctional settings are typically unprepared to interact with inmates who have behavioral health illnesses,⁷² and inmates often do not get the treatment they need.⁷³

About 20,000 individuals are currently in the custody of SCDC (about 9,000 are admitted and released per year). Of these inmates, 13% of male and 36% of female inmates have a mental illness, and 37% of male and 50% of female inmates have a chemical dependency.⁷⁴

In January 2014, the SCDC was found deficient in its treatment and care of inmates with serious mental illnesses. As a result of a settlement between SCDC and Protection and Advocacy for People with Disabilities Inc., new programs are available to inmates with behavioral health illnesses and new resources are coming to SCDC.⁷⁵ In FY 2015, Governor Nikki Haley and the South Carolina General Assembly supported SCDC with \$8.2 million in new dollars over three years to address the need for improved behavioral health services for inmates. The department hired a medical recruiter and is working on salary equity for behavioral health staff in order to be a competitive employer. They are utilizing telepsychiatry services from MUSC for inmates and are in the process of implementing electronic medical records to support coordination of care and integrated physical and behavioral health care. The number of psychiatrists and psychiatric nurse practitioners on staff has gone from 4.67 FTEs in 2013 to 8.1 today (and they are currently recruiting more). Nine mental health technicians have also been hired.

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

Ex-offenders often face significant challenges upon reentry to the community setting.⁷⁶ Lacking health care coverage increases an individual's vulnerability and chances of reentry to a correctional setting. Community-based behavioral health responses can lead to reduced costs to the criminal justice and health care systems and reduce recidivism among those with behavioral health conditions; a reduction of state spending is possible when justice-involved individuals who are eligible for Medicaid are enrolled

to provide access to behavioral health and physical health services and supports, keeping them healthy and out of the criminal justice system.⁷⁷

For a decade, SC DHHS has had an enrollment specialist placed in the state prison system to assist in the enrollment of Medicaid-eligible inmates who need an inpatient stay (the only medical cost that can be paid by Medicaid while an individual is incarcerated; other medical services must be provided by state funds through SCDC).

The challenge in helping Medicaid-eligible ex-offenders gain coverage once they are released from prison was an ongoing concern of both agencies, but **there is now an initiative at SC DHHS allowing certain classes of inmates in the custody of SCDC to have their Medicaid benefits suspended rather than terminated.** The project also consists of an outreach component identifying inmates who will be released within a month and who are likely Medicaid-eligible. A dedicated team of Medicaid eligibility workers meets with those individuals and completes Medicaid applications for them. Those who are determined Medicaid eligible are enrolled so that eligible individuals leave incarceration with Medicaid coverage.

In 2015, the Aspen Institute reached out to SC DHHS to determine if South Carolina was interested in collaborating on a project to solve an agency policy challenge with the goal of health improvement through access to Medicaid benefits. Agency leadership at SC DHHS, in partnership with agency leadership at SCDC, decided to utilize the technical assistance being offered to identify a path to change the policy of automatically canceling Medicaid benefits for adults who became incarcerated to a system that allowed for the suspension of benefits. This would support the goal of improved health and access to health services for this population and also help to reduce recidivism, because ex-offenders with a behavioral health illness are less likely to reenter the prison system if they are able to manage their illness through access to health care.

One of the first steps in the project was to determine how many inmates would potentially be eligible to have their benefits suspended rather than terminated. Through a SC DHHS and SCDC data exchange, it was discovered that 50% of inmates had been covered by Medicaid at some point in their life. In some cases, incarcerated individuals were enrolled in Medicaid managed care and the agency was paying a capitated rate for their coverage. However, incarcerated individuals are not eligible for Medicaid, with the exception of inpatient hospitalizations greater than 24 hours. So, even though SC DHHS was paying managed care organizations a capitated rate for these inmates, they were not receiving the related services.

Through a data exchange that uncovered many inmates on the Medicaid rolls, an unanticipated opportunity for cost savings was discovered. SC DHHS was able to be reimbursed by the managed care organizations responsible for the medical care of these individuals since they were not eligible to receive most Medicaid-reimbursable care. With the new, ongoing data exchange, an incarcerated Medicaid recipient is put into a fee-for-service Medicaid plan with a suspended eligibility status, saving SC DHHS significant resources.

By suspending rather than terminating Medicaid benefits for inmates while they are incarcerated, the data exchange is also allowing more Medicaid-eligible ex-offenders to avoid the re-enrollment process and leave the prison system with their Medicaid benefits intact. Matching federal dollars are available for the administrative costs associated with suspending benefits.

As a result of the project, between February and June 2016, over 500 people in SCDC custody had their Medicaid benefits suspended rather than terminated. In addition, between March 1 and July 1 of this year, over 390 SCDC inmates left custody with Medicaid coverage.

Additional changes and programs are being considered as the project continues. Both agencies are currently working to determine how these individuals could leave the prison system with a 30-day supply of their medication and an appointment with a primary care provider within a few weeks of their release date. The next phase is to consider how to help family members of individuals who become incarcerated because for many, it could change their eligibility status. An information and education campaign about accessing Medicaid (and other social services) benefits could have a significant positive impact on the health and well-being of the family members left behind when a family’s primary earner is incarcerated. Another potential information and education campaign is being considered for parole officers. In 2015, the South Carolina Department of Probation, Pardon and Parole Services (SC DPPPS) had 30,932 individuals under active supervision. If SC DHHS could educate and train parole officers to assess eligibility and enroll their clients in Medicaid, it would help to improve client’s access to care.

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

Studies indicate Crisis Intervention Team (CIT) training for police, jail and prison guards and teachers makes a significant difference in outcomes.⁵ The training gives law enforcement special preparation in spotting and responding to individuals in psychiatric crisis. CIT has been shown to significantly increase the likelihood that law enforcement contact with a person with a serious mental illness will result in transport to a treatment facility rather than arrest and booking.⁷⁸

The National Alliance on Mental Illness – South Carolina (NAMI SC) is the primary CIT training organization in South Carolina. NAMI SC has three staff members who provide CIT training to law enforcement agencies across South Carolina. This service has been supported through state funds (\$170,500) since 2007. In FY 2016, NAMI received an additional \$250,000 in a one-time designation for CIT from the General Assembly.

NAMI SC provides five different CIT courses (one hour, two hours, three hours, four hours and forty hours). Table Two demonstrates how many people were trained in each of these courses over the last three years. One of the three staff members providing trainings began in July of this year, so it is expected that the number of people trained in the future will be significantly higher.

Table Two: NAMI SC CIT Trainings FY 2014 – FY 2016			
Number of People Trained	FY 2014	FY 2015	FY 2016
One Hour Course	307	266	251
Two Hour Course	1,737	1,734	1,853
Three Hour Course	0	100	51
Four Hour Course	372	217	109
Forty Hour Course	111	222	218

The Greenville (City) Police Department leads the state with the proportion of law enforcement officers trained in CIT. Currently, 147 Greenville Police officers have completed 40 hours of CIT training through NAMI SC. These officers are available to respond to calls for service 24/7. These officers utilize their training to communicate with people experiencing symptoms of a mental illness to maximize the chances of a safe outcome to a potentially unpredictable situation. During any given shift, three or more CIT-trained officers are on duty and available to respond to a call.

Under the leadership of SCDC Director Bryan Stirling, CIT training at SCDC began in 2014 to better prepare correctional officers, mental health techs and medical personnel to have successful, non-violent interactions with inmates experiencing symptoms of a behavioral health illness. Currently, 181 SCDC staff members are certified in CIT, meaning they received 40 hours of CIT training recognized by the National Institute of Corrections. Most of the Level Two and Level Three SCDC institutions have CIT certified staff. SCDC now has staff serving as internal CIT trainers.

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

Inmates with a behavioral health illness may not have the capacity or resources to plan their return to community life. They often need intensive case management to ensure successful reentry to society. Successfully re-integrating ex-offenders into their communities requires advance planning.

Formal discharge planning for SCDC inmates begins 90 days before the anticipated release date. Approximately 900 inmates are discharged annually from SCDC with behavioral health needs. Discharge planning components consist of linkages to behavioral health aftercare appointments, medical appointments, housing and social security/disability applications.

Many inmates are provided with behavioral health appointments after their release date, but the show rate is not known or tracked at this time. For adult ex-offenders, SCDC does not follow inmates after release. One challenge in ensuring continuity of care once they are in the community is that, although having a mental health classification while incarcerated, some inmates do not meet the diagnostic criteria for admission at CMHCs.

To enhance the inmate discharge planning services, SCDC, DMH and SC DPPPS are working on a Memorandum of Understanding that could include the following:

- Designation of a state-level liaison from each organization
- Designation of CMHC Care Coordinators and SCPPP reentry staff to serve as liaisons for the coordination of interagency referrals of offenders being released to local communities
- Contract between SCDC and DMH for initial appointments to be provided to inmates meeting clinical criteria within 30 days of being released, and for DMH to schedule an appointment within five business days of the individual being released from SCDC based on the inmate's approved residence
- Exchange and sharing of inmate records between SCDC, DMH and SC DPPPS
- Monthly meetings between SCDC and SC DPPPS to review the behavioral health needs of all offenders being released from SCDC within 120 days
- Medication provided to meet SCDC inmates needs upon release until the scheduled clinical appointment

WORKFORCE DEVELOPMENT

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

One of the most noteworthy barriers to accessing behavioral health care services is a significant shortage in the number of professionals needed to treat patients. Mental health professionals in particular are in dire shortage; in 2013, of the nation's 3,100 counties, 55% had no practicing psychiatrists, psychologists or social workers.⁷⁹ At the same time, an estimated 14,000 of America's 35,000 practicing psychiatrists are nearing retirement age, and new psychiatrists are not graduating at a rate fast enough to replace them.⁷⁹ From 2008 to 2013, both the number of doctoral level psychologists per capita declined from one per 3,653 to 3,802 and psychiatrists per capita declined from one per 7,825 to 8,467.⁸⁰

South Carolina continues to rank 38th out of 51 states (DC is included) in the availability of mental health providers.⁸¹ Mental health workforce availability is based on the ratio of the population to the number of mental health providers including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advance practice nurses specializing in mental health care.⁸¹

Hope for Tomorrow reported that in 2013 South Carolina had 410 general psychiatrists, 72 child and adolescent psychiatrists and 11 geriatrics psychiatrists licensed and practicing. In 2015, there were 399 general psychiatrists, 76 child and adolescent psychiatrists and 10 geriatric psychiatrists licensed and practicing in South Carolina.⁸²

In 2012, there were 75 nurse practitioners and 28 clinical nurse specialists specializing in mental health. In 2014, there were 69 mental health nurse practitioners and 41 clinical nurse specialists licensed to practice in South Carolina.⁸³

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

While many stakeholders are committed to an expanded behavioral health system and recognize the need to expand the behavioral health workforce, there is not yet an organized, formal, statewide conversation to create a strategy to maximize the potential of the existing behavioral health workforce or to increase the quantity of behavioral health professionals in South Carolina. Providers are working to find creative ways to recruit, retain and utilize different types of behavioral health providers to maximize their ability to care for patients.

However, efforts to address the workforce shortage do exist. A new program launched at the USC College of Nursing in the fall of 2015 will significantly increase the number of Psychiatric-Mental Health Nurse Practitioners (PMHNP) in South Carolina. PMHNPs are advanced practice nurses who are educated,

licensed and nationally certified to evaluate and manage mental health problems across the lifespan. Sixty-one students are currently enrolled in the USC PMHNP program. Of these, 42 students are residents of South Carolina and 20 are from underserved counties. The first cohort of students will graduate in August 2017 and is expected to produce 16 new PMHNPs. The Blue Cross/Blue Shield of South Carolina Foundation has provided funding for 20 scholarships to increase mental health provider capacity in rural and underserved areas of South Carolina. Scholarship recipients are required to work for at least one year in South Carolina upon graduation.

A new initiative led by USC and Emory University will examine the comparative effectiveness of peer support specialists versus mental health professionals in care for patients who have sought emergency care via telepsychiatry for their mental illness. The project was funded through the Patient-Centered Outcomes Research Institute (PCORI) and will be conducted at DMH sites across eight locations in South Carolina.

DMH and DAODAS have formed a workforce sub-committee of the Joint Council on Children and Adolescents.

The activities of the workforce sub-committee include:

- Workforce needs assessments and training opportunities,
- The initiation of a Learning Management System,
- Statewide trauma informed care trainings and the completion of a trauma map and
- Cultural and linguistic competency trainings.

In addition, DMH, in partnership with USC's Arnold School of Public Health, provided online licensure courses for 85 students and clinicians during FY 2016.

In 2012, DAODAS began a clinical initiative with the goal of bringing a uniform understanding of the disease of addiction and addiction treatment to clinicians and patients across the state. DAODAS committed to providing a staff development initiative for addiction counselors to ensure a thorough understanding of the bio-psycho-social-spiritual experiential model of addiction in order to help them better understand the disease they are treating. To date, 116 clinicians across the state have engaged in this effort.

CONCLUSION

As evidenced in this report, significant progress has been initiated to support enhancements to the behavioral health service systems in South Carolina. However, substantial work remains. As the ILC moves into the second year of the implementation phase of this work, it will reassess its priorities and consider how to accelerate progress through a model of expanded collective impact.

References

- ¹ Peterson-Kaiser Health System Tracker. 2016. *What are the current costs and outcomes related to mental health and substance abuse disorder?* Partnership of Peterson Center on Healthcare and the Henry J. Kaiser Family Foundation. <http://www.healthsystemtracker.org/chart-collection/what-are-the-current-costs-and-outcomes-related-to-mental-health-and-substance-abuse-disorders/?slide=31>(accessed July 20, 2016).
- ² Torrey, E. Fuller, Mary T. Zdanowicz, Aaron D. Kennard, H. Richard Lamb, Donald F. Eslinger, Michael C. Biasotti, and Doris A. Fuller. 2014. *The treatment of persons with mental illness in prisons and jails: A state survey*. Arlington, VA: Treatment and Advocacy Center. <http://www.treatmentadvocacycenter.org/evidence-and-research/studies> (accessed June 8, 2016).
- ³ Horn, Marissa. 2016. "WHO: Better mental health care means a better economy." *USA Today*, April 12. <http://www.usatoday.com/story/news/2016/04/12/who-better-mental-health-care-means-better-economy/82940732/> (accessed June 7, 2016).
- ⁴ Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality. 2014 *National Survey on Drug Use and Health, 2013 and 2014 – South Carolina*. SAMHSA. <http://www.samhsa.gov/data/sites/default/files/1/1/NSDUHsaeSouthCarolina2014.pdf> (accessed June 8, 2016).
- ⁵ Ornstein, Norm. 2016. "How to Fix a Broken Mental-Health System." *The Atlantic*, June 8. <http://www.theatlantic.com/politics/archive/2016/06/getting-mental-health-on-the-docket/485996/> (accessed June 15, 2016).
- ⁶ Case, Anne, and Angus Deaton. 2015. "Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century." *Proceedings of the National Academy of Sciences* 112, no. 49 (December). 15078-15083. <http://www.pnas.org/content/112/49/15078.full> (accessed June 14, 2016).
- ⁷ Peter-Kaiser Health System Tracker. 2015. *What are the current costs and outcomes related to mental health and substance abuse disorders?* New York, NY: Peter-Kaiser Health System Tracker. <http://www.healthsystemtracker.org/chart-collection/what-are-the-current-costs-and-outcomes-related-to-mental-health-and-substance-abuse-disorders/?slide=5> (accessed June 7, 2016).
- ⁸ Bassett, Mary T. 2016. "New York City Offers a Model for Mental-Health Treatment." *Time*, May 31. <http://time.com/4352592/nyc-mental-health-treatment/> (accessed June 14, 2016).
- ⁹ American Foundation for Suicide Prevention. 2016. *Suicide Claims more lives than war, murder, and natural disasters combined*. New York, NY: American Foundation for Suicide Prevention. <http://theovernight.donordrive.com/?fuseaction=cms.page&id=1034> (accessed June 15, 2016).
- ¹⁰ World Health Organization. 2016. *Prevention for Suicidal Behaviors: A Task For All*. Geneva: World Health Organization. http://www.who.int/mental_health/prevention/suicide/background/en/ (accessed August 24, 2016).
- ¹¹ American Foundation for Suicide Prevention. 2016. *Suicide: 2016 Facts & Figures*. New York, NY: American Foundation for Suicide Prevention. <http://afsp.org/wp-content/uploads/2016/06/2016-National-Facts-Figures.pdf> (accessed September 14, 2016).
- ¹² American Foundation for Suicide Prevention. 2016. *Suicide: South Carolina 2016 Facts & Figures*. New York, NY: American Foundation for Suicide Prevention. <https://afsp.org/about-suicide/state-fact-sheets/#South-Carolina> (accessed June 14, 2016).
- ¹³ Tavernise, Sabrina. 2016. "U.S. Suicide Rate Surges to a 30-Year High." *The New York Times*, April 22. <http://www.nytimes.com/2016/04/22/health/us-suicide-rate-surges-to-a-30-year-high.html> (accessed June 14, 2016).
- ¹⁴ Hempstead, Katherine A. and Julie A. Phillips. 2015. "Rising suicide among adults aged 40–64 years: The role of job and financial circumstances." *American journal of preventive medicine* 48, no. 5 (May). 491-500. DOI: <http://dx.doi.org/10.1016/j.amepre.2014.11.006> (accessed June 7, 2016).

References

- ¹⁵ Xu, Jiaquan, Sherry L. Murphy, Kenneth D. Kochanek, and Brigham A. Bastian. 2016. "Deaths: Final Data for 2014." *National Vital Statistics Report* (U.S. Department of Health and Human Services) 64, no. 2 (February). 1-119.
- ¹⁶ Mowry, James B., Daniel A. Spyker, Daniel E. Brooks, Naya McMillan, and Jay L. Schauben. 2014 annual report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 32nd annual report. *Clin Toxicol* 2015 Dec; 53(10): 962-1147. DOI:10.3109/15563650.2015.1102927. PubMed PMID: 26624241.
- ¹⁷ McKeon, Richard T. 2016. "SAMHSA, Safety and the chain of care." *National Council Magazine*, no. 1. 10-11.
- ¹⁸ Rudd, Rose A., Noah Aleshire, Jon E. Zibbell, and Matthew Gladden. 2016. Increases in Drug and Opioid Overdose Deaths—United States, 2000-2014. Centers for Disease Control and Prevention (CDC) 64, no. 50 (January). 1378-1382. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm> (accessed June 15, 2016).
- ¹⁹ Cherkis, Jason. 2015. "Dying To Be Free." *The Huffington Post*, January 28. <http://projects.huffingtonpost.com/dying-to-be-free-heroin-treatment> (accessed June 21, 2016).
- ²⁰ Nolan, Dan and Chris Amico. 2016. "How Bad is the Opioid Epidemic?" *FRONTLINE*, February 23. <http://www.pbs.org/wgbh/frontline/article/how-bad-is-the-opioid-epidemic/> (accessed June 8, 2016).
- ²¹ Martin, Lindsay and Mara Laderman. 2016. "A Systems Approach Is The Only Way To Address The Opioid Crisis." *Health Affairs Blog*, June 13. <http://healthaffairs.org/blog/2016/06/13/a-systems-approach-is-the-only-way-to-address-the-opioid-crisis/> (accessed June 21, 2016).
- ²² Caffrey, Mary. 2016. "CDC Gives Primary Care Doctors Guideline on Prescribing Opioids." *The American Journal of Managed Care*, March 15. <http://www.ajmc.com/focus-of-the-week/0316/cdc-gives-primary-care-doctors-guideline-on-prescribing-opioids> (accessed June 22, 2016).
- ²³ U.S. Department of Health & Human Services. 2016. *The Opioid Epidemic: By the Numbers*. Washington, DC: U.S. Department of Health & Human Services.
- ²⁴ Centers for Disease Control and Prevention. 2014. "Opioid Painkiller Prescribing Infographic." <http://www.cdc.gov/vitalsigns/opioid-prescribing/infographic.html> (accessed June 7, 2016).
- ²⁵ Goldsby, Sara, Acting Director. 2016. South Carolina Department of Alcohol and Other Drug Abuse Services. Correspondence with Maya Pack. August 29.
- ²⁶ Rodriguez, Jason M. 2016. "How Heroin is impacting Horry and Georgetown Counties." *Myrtle Beach Online*, April 19. <http://www.myrtlebeachonline.com/entertainment/weekly-surge/article72617132.html> (accessed June 22, 2016).
- ²⁷ Roehrig, Charles. 2016. "Mental Disorders Top The List Of The Most Costly Conditions In The United States: \$201 Billion." *Health Affairs* 35, no. 6 (May). 1130-1135. <http://static1.squarespace.com/static/55f9afdf4b0f520d4e4ff43/t/574748a007eaa0c831d7d1da/1464289441778/Health+Aff-2016-Roehrig-hlthaff.2015.1659.pdf> (accessed July 5, 2016).
- ²⁸ National Institute on Drug Abuse. *Trends & Statistics: Costs of Substance Abuse*. Bethesda, MD: National Institute on Drug Abuse. <https://www.drugabuse.gov/related-topics/trends-statistics> (accessed July 20, 2016).
- ²⁹ Governor's Prescription Drug Abuse Prevention Council. 2014. *State Plan to Prevent and Treat Prescription Drug Abuse*. Columbia, SC: The Governor of South Carolina. <http://governor.sc.gov/ExecutiveOffice/Documents/Prescription%20Drug%20Abuse%20Prevention%20Council%20State%20Plan%20December%202014.pdf> (accessed September 14, 2016).
- ³⁰ Governor's Prescription Drug Abuse Prevention Council. 2016. *PDAP Council Update from DHEC, LLR and DAODAS*. Columbia, SC.

References

- ³¹ South Carolina Department of Health & Environmental Control. 2016. "Narcotics Administration Counts by County, 2011, 2013-2015." Table.
- ³² Drug Policy Alliance. 2016. "911 Good Samaritan Fatal Overdose Prevention Law." http://www.drugpolicy.org/911-good-samaritan-fatal-overdose-prevention-law?utm_campaign=WelcomeSeries&spMailingID=24581971&spUserID=MjcyMjEwMjc2MjEyS0&spJobID=802296179&spReportId=ODAyMjE0Nzc2S0 (accessed August 15, 2016).³¹[campaign=WelcomeSeries&spMailingID=24581971&spUserID=MjcyMjEwMjc2MjEyS0&spJobID=802296179&spReportId=ODAyMjE0Nzc2S0](https://www.drugpolicy.org/campaign=WelcomeSeries&spMailingID=24581971&spUserID=MjcyMjEwMjc2MjEyS0&spJobID=802296179&spReportId=ODAyMjE0Nzc2S0) (accessed August 15, 2016).
- ³³ Boughton, Melissa. 2016. "Charleston police first in Lowcountry to train, supply officers with opioid antidote." *The Post and Courier*, July 25. <http://www.postandcourier.com/20160725/160729604/charleston-police-first-in-lowcountry-to-train-supply-officers-with-opioid-antidote> (accessed September 14, 2016).
- ³⁴ South Carolina Department of Alcohol and Other Drug Abuse Services. 2016. "Funding for Prescription Drug Abuse Prevention Program." Report.
- ³⁵ The Kennedy Forum. 2016. "Video: The System We Need." <https://www.thekennedyforum.org/news/sotu-the-system-we-need-video> (accessed September 13, 2016).
- ³⁶ 114th Congress. 2016. H.R. 2646: *Helping Families in Mental Health Crisis Act of 2016*. Washington, DC: 114th Congress. <https://www.congress.gov/bill/114th-congress/house-bill/2646/text#toc-H4956C84975CD40A38595929DB8A0E854> (accessed September 13, 2016).
- ³⁷ The Department of Health & Human Services. 2016. *HHS announces new actions to combat opioid epidemic*. Washington, DC: The Department of Health & Human Services. <http://www.hhs.gov/about/news/2016/07/06/hhs-announces-new-actions-combat-opioid-epidemic.html> (accessed September 14, 2016).
- ³⁸ North Carolina Office of the Governor. 2016. *Governor McCrory Signs Life-Saving Overdose Prevention Legislation*. Raleigh, NC: North Carolina Office of the Governor. <https://governor.nc.gov/press-release/governor-mccrory-signs-life-saving-overdose-prevention-legislation> (accessed September 9, 2016).
- ³⁹ U.S. Department of Health & Human Services. 2016. HHS Awards \$53 million to help address opioid epidemic. Washington, DC: U.S. Department of Health & Human Services. <https://www.hhs.gov/about/news/2016/08/31/hhs-awards-53-million-to-help-address-opioid-epidemic.html> (accessed September 14, 2016).
- ⁴⁰ Community Anti-Drug Coalitions of America. 2016. *The Comprehensive Addiction and Recovery Act (CARA)*. Alexandria, VA: Community Anti-Drug Coalitions of America. <http://www.cadca.org/comprehensive-addiction-and-recovery-act-cara> (accessed September 12, 2016).
- ⁴¹ Fortney, John, Rebecca Sladek, Jurgen Unutzer, Henry Harbin, Bill Emmet, Lauren Alfred, and Gary Carneal. 2015. *Fixing Behavioral Health Care in America: A National Call for Integrating and Coordinating Specialty Behavioral Health Care with the Medical System*. The Kennedy Forum. http://thekennedyforum-dot-org.s3.amazonaws.com/documents/KennedyForum-BehavioralHealth_FINAL_3.pdf (accessed August 3, 2016).
- ⁴² National Association of Counties. *Behavioral Health Matters to Counties*. Washington, DC: National Association of County Behavioral Health & Developmental Disability Directors. <http://www.naco.org/sites/default/files/documents/NACo%20Behavioral%20Health%20Priorities.pdf> (accessed October 5, 2016).
- ⁴³ Szabo, Liz. 2015. "Addiction treatment hard to find, even as overdose deaths soar." *USA Today*, May 24. <http://www.usatoday.com/story/news/2015/05/24/addiction-treatment-shortage/27181773/> (accessed July 13, 2016).
- ⁴⁴ Cohen, Robin A., and E. P. Zammitti. 2016. Access to care among adults aged 18-64 with serious psychological distress: Early release of estimates from the national health interview survey, 2012-September 2015. Retrieved from https://www.cdc.gov/nchs/data/nhis/earlyrelease/er_spd_access_2015_f_aue.pdf (accessed June 8, 2016).

References

- ⁴⁵ Sausser, Lauren. 2016. "87,000 in S.C. with mental illness, addictions would qualify for Medicaid expansion." *The Post and Courier*, March 28. <http://www.postandcourier.com/article/20160328/PC16/160329456/87k-in-sc-with-mental-illness-addictions-would-qualify-for-medicaid-expansion> (accessed July 13, 2016).
- ⁴⁶ Alegría, Margarita, Kiara Alvarez, Rachel Zack Ishikawa, Karissa DiMarzio, and Samantha McPeck. 2016. "Removing Obstacles to Eliminating Racial and Ethnic Disparities in Behavioral Health Care." *Health Affairs* 35, no. 6: 991-999. <http://content.healthaffairs.org/content/35/6/991.full?ijkey=S0gGZIQ42vTS2&keytype=ref&siteid=healthaff%2520> (accessed August 24, 2016).
- ⁴⁷ Creedon, Timothy B., and Benjamin Lê Cook. 2016. "Access to Mental Health Care Increased but Not for Substance Use, While Disparities Remain." *Health Affairs* 35, no. 6: 1017-1021. <http://content.healthaffairs.org/content/35/6/1017.full.pdf+html> (accessed August 3, 2016).
- ⁴⁸ North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services. 2014. *Professional Treatment Services in Facility-Based Crisis Programs*. Raleigh, NC: North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. <https://ncdhhs.s3.amazonaws.com/s3fs-public/documents/files/facilitybasedcrisisservices4-29-014.pdf> (accessed September 21, 2016).
- ⁴⁹ Department of Behavioral Health and Developmental Disabilities. 2014. *Emergency Receiving (ER), Evaluation (E), Treatment (T) (ERET) Listing by County*. Atlanta, GA. https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/ERET%20Listing%20by%20County%207.16.14.pdf (accessed July 26, 2016).
- ⁵⁰ Mississippi Department of mental Health. nd. *A Guide to: Crisis Stabilization Services*. Jackson, MI: Mississippi Department of Mental Health. <http://www.dmh.ms.gov/wp-content/uploads/2012/08/Crisis-Stabilization-Brochure.pdf> (accessed August 9, 2016).
- ⁵¹ Kentucky Community Mental Health Center. 2015. *Kentucky Community Mental Health Center Crisis Services: Hours and Locations*. Frankfort, KY: Kentucky Community Mental Health Center. <https://dbhddid.ky.gov/dbh/documents/crisis-services.pdf> (accessed August 17, 2016).
- ⁵² Hicks, Alex. 2016. "Some see need for closed detox center to reopen." *GoUpstate.com*, June 23. www.goupstate.com/article/20160623/articles/160629844?template=printpicart (accessed July 19, 2016).
- ⁵³ Lutterman, Ted. 2015. *Tracking the history of state psychiatric hospital closures from 1997 to 2015*. Falls Church, VA: National Association of State Mental Health Program Directors Research Institute, Inc. http://media.wix.com/ugd/186708_afa348ce61184f4d902ae55c29fcb7b7.pdf (accessed October 5, 2016).
- ⁵⁴ Fuller, Doris A. 2016. *RESEARCH WEEKLY: Emergency in the ER*. Arlington, VA: Treatment Advocacy Center. <http://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/69-no-state/3015-research-weekly-emergency-in-the-er> (accessed August 3, 2016).
- ⁵⁵ Fuller, Doris A., Elizabeth Sinclair, Jeffrey Geller, Cameron Quanbeck, and John Snook. 2016. *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds*. Arlington, VA: Treatment Advocacy Center. <http://www.treatmentadvocacycenter.org/storage/documents/going-going-gone.pdf> (accessed October 5, 2016).
- ⁵⁶ American College of Emergency Physicians Emergency Medicine Practice Committee. 2014. *Care of the Psychiatric Patient in the Emergency Department – A Review of the Literature*. Irving, TX: American College of Emergency Physicians. https://www.acep.org/uploadedFiles/ACEP/Clinical_and_Practice_Management/Resources/Mental_Health_and_Substance_Abuse/Psychiatric%20Patient%20Care%20in%20the%20ED%202014.pdf (October 6, 2016).
- ⁵⁷ American College of Emergency Physicians. 2015. "Survey: 8 in 10 ER Docs Say Mental Health System Is Not Working For Patients." *PR Newswire*. December 15. <http://www.prnewswire.com/news-releases/survey-8-in-10-er-docs-say-mental-health-system-is-not-working-for-patients-300193187.html> (accessed July 19, 2016).

References

- ⁵⁸ South Carolina Health Planning Committee. 2015. *South Carolina Health Plan*. Columbia, SC: Department of Health & Environmental Control, Certificate of Need Program.
- ⁵⁹ Olsen, Deborah. 2014. "Integrating primary care and mental health: Key to improving patient care, lowering costs." *Medical Economics*, May 8. <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/affordable-care-act/integrating-primary-care-and-mental-health-key-im> (accessed July 12, 2016).
- ⁶⁰ Cunningham, Peter J. 2009. "Beyond Parity: Primary Care Physicians' Perspectives on Access to Mental Health Care." *Health Affairs* 28, no. 3: 490-501. <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.3.w490?ijkey=s9siD6/cY2nhw&keytype=ref&siteid=healthaff> (accessed July 20, 2016).
- ⁶¹ National Council of Behavioral Health. 2014. *The Business Case for Effective Mental Health Treatment*. Washington, DC: National Council of Behavioral Health. <http://www.thenationalcouncil.org/business-case-mental-health-substance-use-disorder-treatment/> (accessed August 24, 2016).
- ⁶² National Alliance on Mental Illness (NAMI). 2015. *State Mental Health Legislation 2015: Trends, Themes, & Effective Practices*. Arlington, VA: National Alliance on Mental Illness. <http://www.nami.org/statereport> (accessed August 19, 2016).
- ⁶³ National Alliance on Mental Illness (NAMI). 2014. *State Mental Health Legislation 2014: Trends, Themes, & Effective Practices*. <https://csgjusticecenter.org/mental-health/publications/state-mental-health-legislation-2014-trends-themes-effective-practices/> (accessed August 19, 2016).
- ⁶⁴ Viron, Mark, Iruma Bello, Oliver Freudenreich, and Derri Shtasel. 2014. "Characteristics of Homeless Adults with Serious Mental Illness Served by a State Mental Health Transitional Shelter." *Community Mental Health Journal* 50, no. 5 (July). 560-565. DOI:10.1007/s10597-013-9607-5. <http://link.springer.com/article/10.1007/s10597-013-9607-5> (accessed September 15, 2016).
- ⁶⁵ Roy, Laurence, Anne G. Crocker, Tonia L. Nicholls, Eric A. Latimer, and Andrea Reyes Ayllon. 2014. "Criminal behavior and victimization among homeless individuals with severe mental illness: a systematic review." *Psychiatric Services*. <http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201200515> (accessed September 14, 2016).
- ⁶⁶ Knopf-Amelung, Sarah. 2013. "Incarceration & Homelessness: A Revolving Door of Risk." *In Focus: A Quarterly Review of the National HCH Council* 2, no. 2 (November). http://www.nhchc.org/wp-content/uploads/2011/09/infocus_incarceration_nov2013.pdf (accessed September 14, 2016).
- ⁶⁷ Ewalt, Jo Ann G. 2015. *2015 Point-In-Time Report*. South Carolina Coalition for the Homeless, January. <http://www.schomeless.org/wp-content/uploads/2015/12/Final-DRAFT-PIT-Report-2015-statewide.pdf> (accessed August 19, 2016).
- ⁶⁸ Dowdy, Erin, Michael Furlong, Tara C. Raines, Bibliana Boverly, Beth Kauffman, Randy W. Kamphaus, Bridget V. Dever, Martin Price, and Jan Murdock. 2015. "Enhancing School-Based Mental Health Services with a Preventative and Promotive Approach to Universal Screening for Complete Mental Health." *Journal of Educational and Psychological Consultation* 25, no. 2-3 (November): 178-197. DOI: 10.1080/10474412.2014.929951. <http://dx.doi.org/10.1080/10474412.2014.929951> (accessed August 17, 2016).
- ⁶⁹ Price, Olga Acosta, M. Biehl, C. Solomon, and M. Weir. 2014. *The Impact of School-Connected Behavioral and Emotional Health Interventions on Student Academic Performance: An Annotated Bibliography of Research Literature*. Washington, DC: George Washington University Center for Health and Health Care in Schools. http://hsrc.himmelfarb.gwu.edu/sphhs_policy_facpubs/760/ (accessed August 19, 2016).
- ⁷⁰ National Association of School Psychologists. 2013. "An Overview of School-Based Mental Health Services." Bethesda, MD: National Association of School Psychologists.

References

- ⁷¹ Public Safety Committee of the Fairfax County Board of Supervisors. 2016. *Diversion First: Briefing, Progress-to-Date, and a Look to the Future*. February 9. <http://www.fairfaxcounty.gov/bosclerk/board-committees/meetings/2016/feb9-materials-safety-diversion-first.pdf> (accessed September 5, 2016).
- ⁷² Davies, Elizabeth, Samantha Harvell, and Lindsey Cramer. 2015. "The Justice Reinvestment Initiative." March. Washington, DC: Urban Institute. <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000158-The-Justice-Reinvestment-Initiative.pdf> (accessed September 6, 2016).
- ⁷³ Kim, KiDeuk, Miriam Becker-Cohen, and Maria Serakos. 2015. *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System*. <http://hdl.handle.net/11204/4035> (accessed September 7, 2016).
- ⁷⁴ Stirling, Bryan P. 2016. South Carolina Department of Corrections (SCDC) FAQs. June. http://www.doc.sc.gov/pubweb/research/SystemOverview/SCDC_FAQs_June_2016.pdf (accessed September 1, 2016).
- ⁷⁵ Monk, John. 2016. "Negligent SC prison system agrees to reforms for the mentally ill." *The State*. June 1. <http://www.thestate.com/news/local/crime/article81081252.html> (accessed September 6, 2016).
- ⁷⁶ Open Minds. 2015. *Serving the Criminal Justice Population: Reentry & Community Mental Health Programs*. Gettysburg, PA: OPEN MINDS.
- ⁷⁷ Heiss, Christian, Stephen A. Somers, and Mark Larson. 2016. Coordinating Access to Services for Justice-Involved Populations. *Milbank Memorial Fund*. <http://www.milbank.org/publications/milbank-issue-briefs/545-coordinating-access-to-services-for-justice-involved-populations> (accessed September 5, 2016).
- ⁷⁸ Watson, Amy C., and Anjali J. Fulambarker. 2012. "The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners." *Best practices in mental health* 8.2, 71. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3769782/> (accessed September 6, 2016).
- ⁷⁹ Fields, Gary, and Jennifer Corbett Dooren. 2014. "For the Mentally Ill, Finding Treatment Grows Harder." *The Wall Street Journal*, January 16. <http://www.wsj.com/articles/SB10001424052702304281004579218204163263142> (accessed August 19, 2016).
- ⁸⁰ Olfson, Mark. 2016. Building The Mental Health Workforce Capacity Needed to Treat Adults With Serious Mental Illness. *Health Affairs* 35 no. 6 (June): 983-990. doi: 10.1377/hlthaff.2015.1619. <http://content.healthaffairs.org/content/35/6/983.full> (accessed August 3, 2016).
- ⁸¹ Mental Health America. 2016. *Prevention and Early Intervention B4Stage4: The State of Mental Health in America 2016*. Alexandria, VA: Mental Health America. <http://www.mentalhealthamerica.net/issues/state-mental-health-america> (accessed August 2, 2016).
- ⁸² Office for Healthcare Workforce Analysis and Planning, South Carolina Area Health Education Center. 2016. *Clinical Specialty and County Location of Psychiatrists in the South Carolina Workforce, 2015*. Charleston, SC.
- ⁸³ Office for Healthcare Workforce Analysis and Planning, South Carolina Area Health Education Center. 2014. *Psych/Mental Health Advanced Practice RNs – Counts by Primary Practice County and Practice Type in the 2014 Workforce*. Charleston, SC.

Appendix A

Recommendations

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

Appendix B

Implementation Leadership Council (ILC)

Members

Mr. Kester Freeman, Jr. – Chair

Executive Director
South Carolina Institute of Medicine & Public Health

Dr. Alison Evans

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

Ms. Sara Goldsby

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

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