South Carolina

UNIFORM APPLICATION
FY 2020/2021 Community Mental Health Services Block Grant Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 02/21/2020 4.12.31 PM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2020

End Year 2021

State DUNS Number

Number 043980093

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name South Carolina Department of Mental Health

Organizational Unit Office of the State Director

Mailing Address 2414 Bull Street/P. O. Box 485

City Columbia

Zip Code 29202

II. Contact Person for the Grantee of the Block Grant

First Name Mark W.

Last Name Binkley, JD

Agency Name South Carolina Department of Mental Health

Mailing Address 2414 Bull Street/P. O. Box 485

City Columbia

Zip Code 29202

Telephone 803-898-8319

Fax 803-898-1383

Email Address mark.binkley@scdmh.org

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date 9/3/2019 2:02:42 PM

Revision Date 2/21/2020 4:11:28 PM

VI. Contact Person Responsible for Application Submission

First Name D. Stewart

Last Name Cooner, MHA

Telephone 803-898-8632

Fax 803-898-2206

Email Address stewart.cooner@scdmh.org

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2020

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
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as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
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Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Mark W. Binkley, JD

Signature of CEO or Designee[1]: _____

Title: Interim State Director of Mental Health Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

HENRY MCMASTER
GOVERNOR

August 14, 2019

Ms. Deepa Avula, MPH
Chief of Staff/Director of Office of Financial Resources
Substance Abuse and Mental Health Services Administration
Office of Financial Resources, Division of Grants Management
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Avula:

I delegate authority to Mark W. Binkley, JD, Interim Director of the South Carolina Department of Mental Health, for all transactions required to administer the Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Block Grant (MHBG).

Yours very truly,

Henry McMaster

HM/mp

STATE HOUSE • 1100 GERVAIS STREET • COLUMBIA, SOUTH CAROLINA 29201 • TELEPHONE: 803-734-2100

State of South Carolina
Department of Mental Health

MENTAL HEALTH COMMISSION:
Alison Y. Evans, PsyD, Chair
Sharon L. Wilson, Vice Chair
Louise Haynes
Bob Hiott, MEd

2414 Bull Street • P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

Mark Binkley
Interim State Director

September 3, 2019

Ms. Odessa Crocker
Grants Management Officer
Division of Grants Management, Office of Financial Resources
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Crocker:

Please find attached with this letter the following documents as required by the FY2020-2021 Substance Abuse and Mental Health Services Administration, Community Mental Health Services, Mental Health Block Grant Application due September 3, 2019. The documents conform to the requirements set forth in the WebBGAS application system as of July 1, 2019.

State Information
Chief Executive Officer's Funding Agreement
Disclosure of Lobbying Activities

Please note that while the Disclosure of Lobbying Activities is not applicable to the South Carolina Department of Mental Health, it is being submitted in its blank form in order to remain consistent with prior years' block grant applications.

The Department looks forward to submitting this Mental Health Block Grant Application and appreciates the opportunities the associated funding affords those citizens of the State of South Carolina who are affected by mental illnesses.

Sincerely,

Mark W. Binkley, JD
Interim State Director of Mental Health

MISSION STATEMENT
To support the recovery of people with mental illnesses.

DMH South Carolina Department of Mental Health

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Last Name Binkley, JD

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City Columbia

Zip Code 29202

Telephone 803-898-8319

Fax 803-898-1383

Email Address mark.binkley@scdmh.org

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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From

To

V. Date Submitted

Submission Date

Revision Date

VI. Contact Person Responsible for Application Submission

First Name D. Stewart

Last Name Cooner, MHA

Telephone 803-898-8632

Fax 803-898-2206

Email Address stewart.cooner@scdmh.org

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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

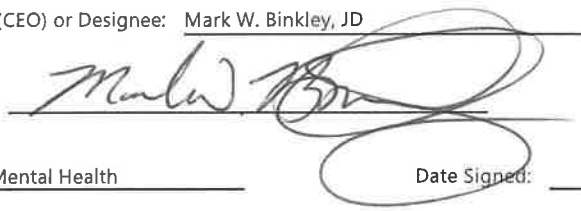
The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Mark W. Binkley, JD

Signature of CEO or Designee[1]: 

Title: Interim State Director of Mental Health

Date Signed: SEP 3, 2019

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Not Applicable

State of South Carolina
Department of Mental Health

MENTAL HEALTH COMMISSION:
Alison Y. Evans, PsyD, Chair
Sharon L. Wilson, Vice Chair
Louise Haynes
Bob Hiott, MEd

2414 Bull Street•P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

Mark Binkley
Interim State Director

Date: October 17, 2019

Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

Subject: Marijuana Attestation letter for South Carolina Block Grants for Community Mental Health Services Grant 3B09SM010048-19S4

To whom it may concern:

I certify that the South Carolina Department of Mental Health and all sub-recipients (contractor & sub-awardee) will comply with the following NoA language:

Grant funds may not be used directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements."); 21 U.S.C. §§ 812(c) (10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

Sincerely,

Mark W. Binkley, JD
Interim State Director

MISSION STATEMENT
To support the recovery of people with mental illnesses.

DMH South Carolina Department of Mental Health

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Not Applicable

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps – Step 1– Assess the Strengths and Organizational Capacity of the Service System to Address the Specific Populations

Assessing Strengths and Organizational Capacity

In order to assess the strengths and organizational capacity of the service system to address the specific populations of children with SED, adults with SMI, and older adults with SMI, among other identified groups, the South Carolina Department of Mental Health (SCDMH, DMH) systematically reviews its programs and services throughout the fiscal year. As a result of such reviews, SCDMH is able to determine the areas in which it particularly excels and subsequently share such excellence with its partners and stakeholders. Similarly, SCDMH is also able to determine the areas in which gaps or needs have arisen and subsequently address such shortages with its Senior Leadership and staff. Based on data-driven analyses, performance measurements, and feedback mechanisms, SCDMH is able to articulate its competence as the mental health authority in the State of South Carolina while continually evaluating, assessing, and refining its programs, services, and service delivery systems for its patients.

2006-2018 Developments and Achievements as Recorded on the Eve of the State Director's Retirement

South Carolina Department of Mental Health State Director John H. Magill has championed the cause of those with mental illnesses since he began his career with the Department at the former South Carolina State Hospital in the 1960's. During his career, he served as the State of Georgia's Director for Alcohol and Drug Abuse, he was the Founder and Chief Executive Officer of Fenwick Hall Hospital on Johns Island, South Carolina, and also served as a Vice President and Professor of Psychiatry at the Medical University of South Carolina Department of Psychiatry. John Magill returned to the Department of Mental Health in September, 2006, as its State Director.

Recently John Magill completed his 12th year as the State Director of the Department of Mental Health. He is currently the longest serving public mental health director in America.

On the eve of his announced retirement, to become effective January 11, 2019, it is worth noting the many positive accomplishments of the South Carolina Department of Mental Health during his tenure as State Director.

- **School Mental Health Services**
  - The number of public schools in South Carolina with an available SCDMH Community Mental Health Center therapist has substantially increased during the past 12 years. The agency now has out stationed therapists in over 50% of all public schools in South Carolina. During the 2018/2019 school year, more than 700 schools have SCDMH school mental health services available for students and their families.
  - Expansion of these highly regarded children's services was made possible not just with increased State funding, but as a result of financial partnerships with many school districts, and with support from the Blue Cross Blue Shield Foundation of South Carolina.
  - SCDMH and the South Carolina Department of Education have established an ambitious goal to have school mental health services available in every public school in the State by 2022.

- **Telepsychiatry Services**
  - DMH's Telepsychiatry programs have provided more than 100,000 psychiatric services since their inception.
  - Begun in 2009 with grant funding from The Duke Endowment during the depths of the Recession, SCDMH's innovative and award winning Emergency Department Telepsychiatry Program has provided almost 50,000 psychiatric services to patients in emergency departments across South Carolina.
    - The Program was developed to meet the critical shortage of psychiatrists in South Carolina's underserved areas, and assist hospital emergency rooms by providing appropriate treatment

to persons in a behavioral crisis, using real-time, state-of-the-art video-and-voice technology that connects DMH psychiatrists to hospital emergency departments throughout the state.
    - As with its School Based Mental Health Services, the program is supported by a blend of funding from multiple sources, including State appropriations, earned revenue, grant funding and fees from participating hospitals.
  - Built on the success of telepsychiatry services to emergency departments, DMH has equipped its hospitals, mental health centers, and clinics to provide psychiatric treatment services to its patients via telepsychiatry.
  - Since August 2013, the Community Telepsychiatry Program has provided more than 50,000 psychiatric treatment services to DMH patients throughout South Carolina. Currently over 20% of all community mental health center patient/psychiatrist appointments are accomplished using telepsychiatry.
  - The combined total of over 100,000 telehealth services makes DMH the largest provider of telehealth services by volume in South Carolina.

- **Services to Veterans**
  - The Department operates the South Carolina's 3 State Veterans Nursing Homes.
  - State Director John Magill organized the creation of the State's Veterans Policy Academy, and was its first Chair. The Veterans Policy Academy has grown into an important resource that helps to link South Carolina veterans and their families to needed community services. It also functions as a forum for multiple State and federal agencies and private organizations to identify gaps in services and devise programs to fill those gaps.
  - SCDMH is also working with the State Adjutant General to provide access to needed behavioral health services by Guardsman and their families.
  - Anticipating a growing veteran population, the General Assembly supported the Department's application in April, 2015 for U.S. Veterans Administration grant funds to construct three additional State Veterans nursing homes.
  - With guidance from the State's Joint Bond Review Committee, DMH identified areas with significant need for new veterans' nursing homes and proposed locating new 104-bed facilities in Florence, Richland, and Cherokee counties.
  - In May of 2018, the Department received official notification from the U.S. Department of Veterans Affairs that construction grant funding for the three homes had become available.
  - Design work is almost complete and the three projects will be advertised for bid in January, 2019. Construction will take approximately 18 months following award.

- **Community Mental Health Services**
  - The Department is one of only a few integrated mental health systems in the 50 states and 8 territories that provide a continuum of services that enable patient to receive, as appropriate, necessary inpatient and outpatient services.
  - The agency maintained the core features and services of an integrated mental health treatment system during the Great Recession. This enabled the agency to begin to expand access to treatment services as State funding has increased.
  - Since the Recession, thanks to the support of the Governor and the General Assembly, the Department's community mental health services have grown in numbers of patients served, and now exceed pre-Recession levels.
  - In 2013, the Department embarked on new initiatives to improve access to services. From FY14 to FY18, the Community Mental Health Services Division increased the percentage of all appointments meeting access standards by 17.28%, increased the percentage of new cases (new/readmissions) by 7.29%, and increased the number of patients treated by 6.42%.
  - Of significance, over half of the resources which SCDMH relies upon to provide community mental health services are derived from the revenue it receives for providing such services. The largest single source of earned revenue for its community mental health services is Medicaid.

- Both before and following the Recession, the Department's volume of community mental health services and its array of community services have been impacted by significant changes made in which mental health services Medicaid will pay for, at what level of reimbursement, and with what administrative requirements.
    - Adult clubhouse services and several types of intensive community services for children/adolescents which were available and widespread 10 years ago are today limited, or, in the case of some intensive children's community services, virtually non-existent due to changes in Medicaid reimbursement.
    - Several intensive children's community mental health services prior to 2008 were defined to encompass a range of clinical interventions, and the reimbursement rate which Medicaid paid providers closely approximated the actual cost to provide such services. An example of one of the services provided in this manner was Multi-Systemic Therapy (MST) also known as Intensive Family Services (IFS);
    - The changes SC DHHS made in almost all cases were to "unbundle" the multiple clinical interventions which made up a particular intensive "wrap" service, and require that each intervention be separately documented and billed, increasing the amount of administrative time clinical staff had to spend documenting, and substantially lowering the overall level of reimbursement to providers of these wrap services, often below the cost to provide the previous level of services to the patient and their family.
    - The impact on provider revenue following the 2008 changes led to a substantial loss of quality private Rehabilitative Behavioral Health Services (RBHS) providers available to children and adolescents in the custody or care of State agencies who were in need of intensive services as an alternative to institutionalization.
    - Beginning July 1, 2014, SC DHHS again made significant changes in the manner in which RBHS were authorized and reimbursed. Although the number of private RBHS providers in South Carolina dramatically increased as a result, the quantity was not matched by quality. The number of RBHS services provided by private providers, and the expense of paying for those services by SC DHHS, literally exploded. Moreover, there was no increase in the availability of the type of intensive outpatient "wrap" services needed by children and adolescents in State care and custody who were at high risk for institutionalization.
    - While there remains insufficient intensive community mental health services alternatives to a residential treatment setting for at-risk children and adolescents, the massive RBHS cost overruns to the State's Medicaid program as a result of the 2014 changes has appeared to eliminate any serious possibility of SC DHHS pursuing amendments to the State Plan to increase reimbursement to bring back such services.
    - In February, 2016, at least in partial reaction to the RBHS cost overruns, SC DHHS announced that Medicaid beneficiaries who were enrolled in one of the State's five (5) Medicaid Managed Care Organizations (MCOs) would, for the first time, have all community mental health services included as part of the services under managed care beginning July 1, 2016.
        - That enormous change and short suspense required SCDMH to negotiate provider agreements with the 5 MCOs, which, combined, insure the vast majority of the agency's current patients who are eligible for Medicaid;
        - SCDMH also had to negotiate requirements regarding prior authorization of services and medication with all 5 MCOs, and subsequently train its medical and billing staff about the new requirements in order for the Department's patients to receive their necessary treatment services and medication;
        - The Department in a very compressed time frame also had to revamp its community billing practices to accommodate the changes needed to bill the five separate Medicaid MCOs, including contracting with a clearinghouse.

- Over the past 10 years, SCDMH has addressed, and adapted to, these major changes and continues to offer a robust array of community mental health services Statewide to all persons in need of mental health services, regardless of ability to pay.
- Thanks to support from the General Assembly, the Department is currently in the process of using its recent increase in State funds to expand intensive community mental health services for both adults and children.

- **Hospital Services for adults and children**
  - As of November, 2015, when the Department's children's hospital program moved into newly constructed additions to its Bryan Psychiatric Hospital in Northeast Columbia, none of the Department's psychiatric hospitals are any longer located on its historic Bull Street property.
  - With the end of the Recession and the closure of all SCDMH buildings on Bull Street, the agency has realized both increased bed capacity and greater efficiency with the consolidation of its Columbia psychiatric hospitals.
  - The Department's Harris Psychiatric Hospital in Anderson has also increased bed capacity since the end of the Recession, as has the agency's alcohol and drug addiction hospital, Morris Village.
  - SCDMH's psychiatric hospitals are accredited by The Joint Commission, which seeks to improve healthcare by evaluating healthcare providers on a comprehensive list of standards, and through its Gold Seal, inspiring them to excel in the provision of safe, effective care of the highest quality and value.
  - In addition, Morris Village, the agency's inpatient drug and alcohol hospital, is accredited by CARF International.

- **Forensic Mental Health Services**
  - Mental health services provided to criminal defendants and juvenile offenders pursuant to court order differ legally, but not clinically, from the same services provided to patients who are admitted via civil procedures.
    - SCDMH is statutorily mandated to provide forensic services, without regard to the Department's available resources or current capacity.
    - In contrast, the services SCDMH provides to adults and children who voluntarily seek mental health treatment, or who are referred for admission through an involuntary civil process are limited to those available given the agency's current resources.
  - Like all public mental health systems, the Department has experienced increasing demand for the evaluation and treatment of defendants referred by the State's criminal and juvenile courts. The agency annually conducts almost 1,000 court ordered evaluations of defendants' capacity to stand trial. An increasing number of defendants are found to lack capacity and then ordered committed to the Department's secure 215 bed forensic hospital for treatment.
    - As in other States, the Department has been challenged by the increasing demand for forensic services and has faced the threat of legal action on more than one occasion.
    - However, SCDMH with increased resources provided by the General Assembly, has implemented multiple measures in an effort to provide timely services to forensic patients in accordance with the courts orders.
    - A significant number of other State mental health systems which have faced legal action over delays in admitting defendants court ordered for treatment have increased their forensic hospital capacity by means of a corresponding reduction in hospital capacity for civil patients.
    - SCDMH has so far been able to maintain its existing hospital capacity for civil admissions while increasing forensic mental health services.
  - SCDMH is also tasked with operating the State's Sexually Violent Predator Treatment Program (SVPTP).
  - The Department's negotiations with a vendor to design, build and operate a new facility for the SVPTP concluded successfully in 2016. Correct Care Recovery Solutions, Inc. (CCRS), assumed

operational control of the Program on December 1, 2016 in its current location, within the Broad River Correctional Institution, and pre-construction design activities by CCRS began thereafter.

- The scope of this undertaking involved coordinating numerous issues with State Procurement, the Department of Administration, the State Engineer, the State Fiscal Accountability Authority, the State Treasurer's Office and the Department of Corrections.
- Active construction on a site at the Broad River campus of the Department of Corrections began in May, 2017, and the new facility was substantially completed in November, 2018. Residents are scheduled to be moved in to the new facility in January, 2019.

- **Crisis Services**
  - As part of its efforts to improve access, the majority of the agency's mental health centers are able to see a patient in crisis on a walk in basis during Center hours.
  - All Centers have historically had after-hours and weekend crisis coverage, generally through telephone access to an on-call Mental Health Professional., and wait times for appointments with counselors and psychiatrists have been significantly reduced. A number of DMH clinics even offer extended hours of operation.
  - In 2018 SCDMH launched a new crisis response program, Community Crisis and Response and Intervention (CCRI). CCRI is the result of a partnership between DMH and the SC Department of Health and Human Services (SC DHHS), which provides adults and children with clinical screening, in person at the location of crisis, in person at a CMHC clinic, or by phone in order to de-escalate the crisis and provide linkage to ongoing treatment and other resources. CCRI services can be accessed via a toll free number: (833) DMH-CCRI.
    - Charleston, Dorchester, and Berkeley counties have been providing mobile response services since May of 2018.
    - On August 1, 2018, CCRI services launched in Horry and Beaufort counties; the Program aims to provide services to the entire coastal region by mid-October.
    - CCRI aims to establish statewide CCRI after-hours response coverage by the summer of 2019.
  - Other goals of CCRI include providing clinical response to mental health crises within one hour to 50% of the state within two years and 100% of the state within four years. DMH is also working with HHS to allow clinical responses to mental health crises to be delivered via telehealth, which would significantly reduce clinical response time.
  - In June, 2017 the agency's Charleston-Dorchester Mental Health Center opened a 10 bed crisis stabilization unit (CSU) in Charleston to divert individuals experiencing a psychiatric crisis from a hospital emergency department, when they can be safely cared for in a non-hospital residential setting.
  - The Charleston CSU is partially funded by the Department using funds appropriated by the General Assembly for that purpose, but the majority of support is provided from community partners including the County Drug and Alcohol Abuse Commission, the Medical University of South Carolina, Roper-St. Francis Hospital, the Charleston Sheriff's Department and the Charleston Police Department.
  - A somewhat different, less intensive program also aimed at assisting persons in a psychiatric crisis obtain services recently opened in Spartanburg, again as a result of a partnership between the agency's Spartanburg Area Mental Health Center, Spartanburg Regional Hospital and other community partners.
  - Other SCDMH Mental Health Centers are in current discussions with their local hospital and other potential partners to create crisis stabilization programs, similar to Charleston and Spartanburgs.

- **Long Term Care Services**
  - The number of nursing home beds operated by SCDMH – 700 – currently almost equals the number of the Department's functional hospital beds.

- With the addition of 3 additional State Veterans Nursing Homes, expected to open in the latter part of Fiscal 2021, the agency's Long Term Care Division will encompass a total of 7 nursing homes, 6 of which will be for eligible State Veterans.
- With the additional State Veteran Nursing Homes, the Long Term Care Division will be significantly larger in terms of bed capacity than the agency's hospitals.

- **Housing and Homeless Services**
  - It has long been recognized that in addition to psychiatric treatment, safe and appropriate housing is necessary to assist individuals with a serious mental illness recover and successfully remain out of the hospital.
  - Stable housing provides the foundation upon which people build their lives. Without a safe, affordable place to live, it is almost impossible to achieve good health, including managing the symptoms of a serious mental illness. Safe and affordable housing with access to mental health services, primary health care services, and other supportive services is fundamental to assisting persons with a serious mental illness remains stable and in recovery.
  - To address this critical patient need, SCDMH has for many years had a Housing and Homeless program for those of its patients who are in need of safe and affordable housing.
  - DMH is actively engaged in year three of its Cooperative Agreement to Benefit Homeless Individuals for SC (CABHI-SC). The $1.8 Million per year, three-year SAMHSA grant, awarded in late 2015, serves individuals who are chronically homeless and have a serious mental illness and has expanded partnerships with a number of organizations, including Palmetto Health, the University of South Carolina School of Medicine, the United Way of the Midlands, and the South Carolina Interagency Council on Homelessness.
  - The South Carolina Interagency Council on Homelessness has expanded, including representation from eight state agencies: DMH, DAODAS, Department of Corrections, Department of Education, HHS, SC Housing, DSS, and DHEC. The Council meets every other month and focuses on achieving better statewide coordination among stakeholders to address homelessness and mental health issues.
  - In August 2018, SAMHSA awarded DMH a treatment grant of $1 Million per year for five years, which will fund the continuation of evidence-based intensive treatment services and benefits assistance for individuals with serious mental illnesses and co-occurring disorders who are experiencing homelessness.
  - The Grant will also fund four new benefits specialist positions, one at the South Carolina Department of Corrections to assist offenders who have serious mental illnesses with applications prior to release, and one each at the Charleston Dorchester, Waccamaw and Greenville mental health centers. More than 500 individuals are expected to be served by the Grant over its five-year term.

- **Suicide Prevention**

  In September 2015, DMH received a youth suicide prevention grant of $736,000 per year for five years from the Substance Abuse and Mental Health Services Administration (SAMHSA). The award supports the SC Youth Suicide Prevention Initiative (SCYSPI), an intensive, community-based effort with the goal of reducing suicide among youths and young adults, aged 10 to 24, by 20% statewide by 2025.
  - Using various multi-media platforms, SCYSPI has surpassed its outreach and awareness goal of 300,000 individuals by year five, having reached more than 360,000 individuals across the state from 2016-2018.
  - SCYSPI offers trainings in suicide prevention to multi-disciplinary audiences and community members. To date, the Initiative has trained more than 9,000 individuals in suicide prevention.
  - More than 45 school districts in SC have adopted the SCYSPI *Comprehensive School Suicide Prevention Program*.
  - SCYSPI is implementing the ZEROSuicide model in Behavioral Health Care settings throughout South Carolina. The foundational belief of ZEROSuicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. SCYSPI will begin piloting the ZEROsuicide approach this year in six DMH mental health centers: Anderson-Oconee-Pickens,

Beckman, Berkeley, Lexington, Santee-Wateree, and Spartanburg, with the goal of eventual Agency-wide implementation.
- SCYSPI is implementing a ZEROSuicide protocol among Federally Qualified Health Providers.
- In August of 2018, DMH received a ZEROSuicide grant of $700,000 per year for five years from SAMHSA to increase the ability of organizations and professionals to provide coordinated, responsive, effective, rapid follow-up and aftercare to adults aged 25 and older who have attempted suicide and those who are assessed as being at risk of doing so, complementing the efforts and funding received for youth suicide prevention.
- In 2016, DMH collaborated with the SC chapters of the American Foundation for Suicide Prevention and Mental Health America, to form the SC Suicide Prevention Coalition with the goal of developing a State plan addressing suicide prevention.
- The Coalition, chaired by DMH State Director John H. Magill, comprises lawmakers and leaders in the non-profit arena, as well as public and private sectors.
- The Coalition recently completed its Suicide Prevention Plan for South Carolina.

- **Grant funding**
  - The Department is currently administering over $55 million in active grants, a five-fold increase over the past 10 years.
  - As noted above, grant funding has been integral to the Department's development of Telepsychiatry services, its Suicide Prevention efforts, as well as much of the Homeless Services it provides. Grant funding has also helped to expand SCDMH school mental health services.
  - The VA construction grant funding which the Department expects to receive in 2019 for the three new State Veterans Nursing Homes will exceed $80,000,000.
  - Some other recent examples include:
    - In May, 2017 the Department received grant funding from The Duke Endowment to expand the use of Mental Health Courts in South Carolina. Mental Health Courts rely on partnerships between the local DMH Community Mental Health Center, the County Probate Court and the Solicitor's office, with financial or in-kind support from all three.
    - A $1.2 Million School Mental Health Services grant from The Duke Endowment, awarded in spring 2018, will enable DMH to implement a countywide school telehealth initiative integrating mental health and primary health care for children in Darlington County. DMH's Pee Dee Community Mental Health Center, in partnership with the Medical University of South Carolina, the South Carolina Telehealth Alliance, the Darlington One school district, and several local private providers, will make multiple healthcare services available in participating schools.
    - In May 2018, The Duke Endowment announced that the SCDMH Community Telepsychiatry Program would receive a $600,000 award to increase access to psychiatric services by creating a varied roster of clinical care providers and administrative support, including the use of Advanced Practice Registered Nurses and Mental Health Professionals, and designing the most effective team structure for clinical service delivery.

- **The sale of Bull Street**
  - In 2007, in an action brought by SCDMH upon the recommendation of the Attorney General, the South Carolina Supreme Court held that the property comprising the former South Carolina State Hospital was impressed with a Charitable Trust in favor of SCDMH for the benefit of its patients.
  - After embarking on the effort to sell the property, SCDMH convened regular meetings with the Mayor and other City officials, the Columbia Chamber of Commerce, staff from the State Budget and Control Board and other State and local officials who had an interest in the future of the property.
  - By sharing information, soliciting advice from local and State officials, and keeping the public informed, agency leadership fostered a spirit of trust and cooperation which served the agency well during the long process of finding a qualified buyer.

- Despite substantial service relocation issues and the Great Recession causing the collapse of the commercial real estate market, the Department succeeded in completing an agreement in December of 2010, providing for a gradual sale of the property, at a price in excess of the property's appraised value, with annual financial guarantees for SCDMH.
- The sale by SCDMH is regarded as one of the most significant land transactions in the history of the City of Columbia.
- The Mental Health Commission subsequently directed that the initial sale proceeds be used to revive the Department's affordable housing development program, which had ceased during the Recession.
- The Developer remains ahead of the purchase schedule in the agreement, and SCDMH through a Statewide solicitation has begun working with responsive developers and committing some of the Bull Street proceeds to support affordable housing developments with corresponding guarantees of access for patients referred by their local mental health center.

- **Raising public awareness of the need for, and availability of mental health services**
  - Throughout his tenure, Mr. Magill has sought to raise public awareness and appreciation for the scope and availability of the Department's mental health services.
  - Since becoming State Director, Mr. Magill has made more than 60 presentations to large community civic organizations around the State.
  - He has also conducted community forums on a periodic basis in each community where the Department has the primary office of one of its community mental health centers or an inpatient facility.
  - These efforts have paid dividends for the patients of the agency, as they have often set the stage for partnerships with local hospitals and other community entities, leading to improved availability of mental health services.

Supplemental Information

In addition to the information provided above, the following should be included as supplemental information in the respective segments.

Community Mental Health Services

It should be noted that the Division of Community Mental Health Services is currently in the development stages of both Intensive Community Treatment (ICT) Teams and Multidimensional Family Therapy (MDFT) Teams.

- ICT Teams are multidisciplinary teams that provide intensive treatment services to patients. Patients are offered appointments at least weekly and are seen in the community. Staff to patient ratios are not to exceed 1:35.
- MDFT Teams provide intensive services for children and their families in the community with a significant emphasis on family engagement. Staff to patient ratios are not to exceed 1:15.

Crisis Services

Even before the advent in 2018 of the Community Crisis Response and Intervention (CCRI) Program, there existed for Crisis Services the Charleston-Dorchester Assessment/Mobile Crisis (AMC) Program. AMC is a psychiatric emergency services program created in 1987. The AMC team comprises 8 full-time Master's level clinicians, 2 part-time Master's level clinicians, a Master's level team leader, and 1 full-time nurse practitioner. When called by law enforcement, night or day, rain or shine, mobile crisis team members will go anywhere in the community, except emergency departments, to provide triage, assessments, and referrals. The service is available to anyone in psychiatric crisis.

Services to Veterans; Long Term Care Services; Grant Funding

The South Carolina Department of Mental Health will oversee the construction of two (2) – originally projected as three (3) – Veterans nursing homes. The Veterans nursing homes will be located in Florence, SC and Gaffney, SC. Each nursing home will provide for 104 residents encompassing two homes (13 residents each) comprising each of four (4) neighborhoods.

Forensic Mental Health Services
Residents of the Sexually Violent Predator Treatment Program moved into the new facility in January 2019.

Statutory Criterion for Mental Health Block Grant (MHBG)
The information provided below is a summary of SCDMH's fulfillment of the five (5) statutory criterion for the MHBG as further detailed in Environmental Factors and Plan, Item 9. Statutory Criterion for MHBG. It is substantiated by the attached presentations: *Inpatient Services; Nursing Homes and New Construction; CMHS Overview 1; CMHS Overview 2; CMHS Overview 3; Medical Affairs Overview; QM, Compliance, QI; Telepsychiatry Programs; and, Office of Transition Services*.

Criterion 1. Comprehensive Community-Based Mental Health Service Systems
SCDMH has a long-established and existent organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders (see attached *CMHS Overview 1; CMHS Overview 2; CMHS Overview 3*). Services and resources are available within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Criterion 2. Mental Health System Data Epidemiology
SCDMH participates in the Substance Abuse and Mental Health Services Administration's (SAMHSA) Uniform Reporting System (URS). From said system, SCDMH extracts a statewide estimate of the prevalence of SMI among adults and SED among children (URS Table 1).

As described later, SCDMH uses this data in conjunction with community-centric feedback to evaluate and substantiate planning and implementation activities for its mental health system of care.

Criterion 3. Children's Services
SCDMH provides for a system of integrated services in order for children to receive care for their multiple needs. Services are coordinated to provide for a comprehensive system of care that includes social services; educational services including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 4. Targeted Services to Rural and Homeless Populations and to Older Adults
SCDMH provides outreach to and services for individuals who experience homelessness; ensures community-based services to individuals in rural areas; and, cooperates in community-based services to older adults.

Criterion 5. Management Systems
The attached presentations – *Inpatient Services; Nursing Homes and New Construction; CMHS Overview 1; CMHS Overview 2; CMHS Overview 3; Medical Affairs Overview; QM, Compliance, QI; Telepsychiatry Programs; and, Office of Transition Services* – provide a comprehensive overview of SCDMH's management systems.

Public Mental Health in South Carolina
As referenced herein, the attached PowerPoint presentations provide a comprehensive overview of the mental health service system in South Carolina. It also details the methods by which SCDMH meets the expectation that it will not only offer a core array of usual and customary psychiatric services, but that it will also be the leader in innovative and technologically-advanced approaches to the delivery of mental health and other ancillary and support services.

[End]

The Division of Inpatient Services

Presentation

Versie J. Bellamy, DNP, MN, RN
Deputy Director



"Abstract A," by patient in SCDMH Art of Recovery Program

DIS

DIS – System of Care



2 Psychiatric Hospitals

G. Werber Bryan Psychiatric Hospital, Columbia, SC

Adult Services

Williams S. Hall Psychiatric Institute, Child & Adolescent Services

Forensic Services

Patrick B. Harris Psychiatric Hospital, Anderson, SC

1 Alcohol and Drug Addiction Treatment Program/Hospital

Morris Village Alcohol and Drug Addiction Treatment Center, Columbia, SC

1 Behavioral Treatment Program

Sexually Violent Predators Treatment Program, Columbia, SC

1 General Nursing Home

C.M. Tucker Nursing Care Center – Roddey Pavilion Nursing Home, Columbia, SC

3 Veterans Nursing Homes

Tucker Nursing Care Center – Stone Veterans Pavilion, Columbia, SC

Richard M. Campbell Veterans Nursing Home, Anderson, SC

Veteran's Victory House, Walterboro, SC

1 Central Medical Clinic, DIS Northeast - Midlands Center Campus, Columbia, SC

DIS – State-wide Services



Richard M. Campbell Veterans' Nursing Home -



Patrick B. Harris Psychiatric Hospital



G. Werber Bryan Hospital – Adult Services



G. Werber Bryan Hospital – Forensic Services



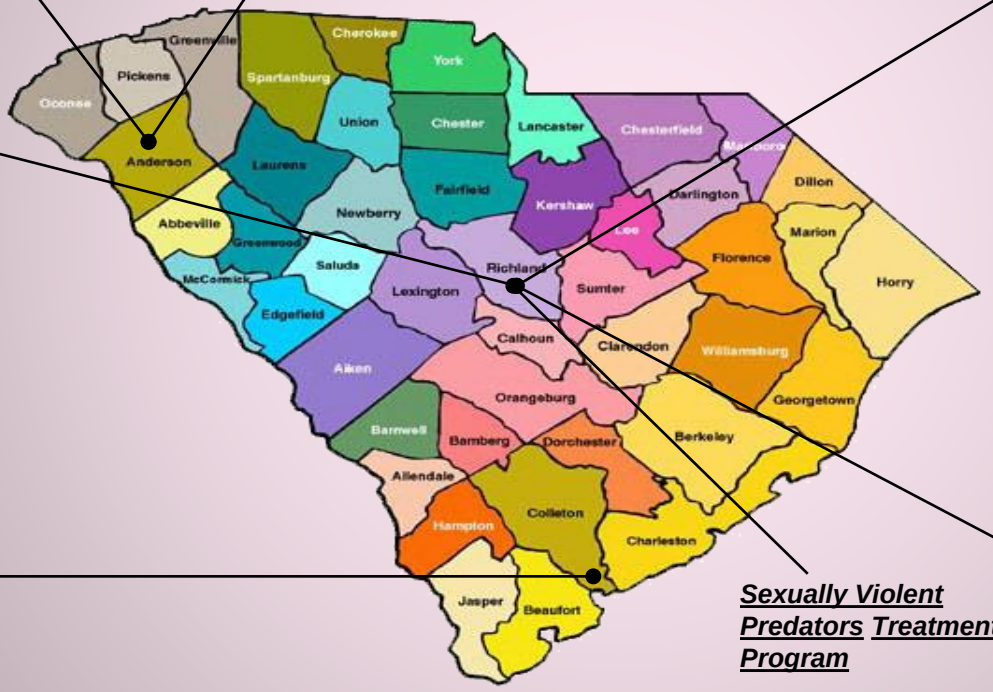
Tucker Nursing Care Center –
Roddey Pavilion –
General Nursing Home
Stone Pavilion –
Veterans Nursing Home



G. Werber Bryan Hospital - William S. Hall Psychiatric Institute, Child & Adolescent Services



Veterans' Victory House –
Veterans Nursing Home



Sexually Violent Predators Treatment Program



Morris Village Alcohol and Drug Addiction Treatment Center

G. Werber Bryan Psychiatric Hospital (BPH)







Adult, Child & Adolescent and Forensic Psychiatric Services

Stuart J. Shields, MSW, MHA, Director

DIS - BPH

Accredited by The Joint Commission (TJC)

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DMH South Carolina Department of Mental Health



- BPH was opened in February 1978 (accepting patients full time,
- first of the planned regional hospital, from the Village Concept.

- Treatment Team (Multifactor model of assessment/treatment evaluation)

- Licensed Clinical Staff, Activity Therapists, Nursing, Certified Physicians, Nurse Practitioners, and Recovery Educators.



Acute Services Bed Capacity = 66

Extended Care Services Bed Capacity = 127
Medically Enhanced Beds (7)

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G. Werber Bryan Psychiatric Hospital

William S. Hall Psychiatric Institute

Child & Adolescent Services



Holly Scaturo, MSN, RN

Acting Director, William S. Hall Psychiatric Institute

at Bryan Psychiatric Hospital

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Lodge C – Acute Programs

Adolescent Acute – Ages 13 – 17, 26 Beds

Child Acute – Ages 4 – 12, 9 Beds

Average LOS: 21 – 30 Days

Types of Admissions – Involuntary, Voluntary



Lodge D – Dual Diagnosis

Ages 13-17, 16 Beds

Average LOS: 77-90 days

Types of admissions-Involuntary, Voluntary, Judicial

G. Werber Bryan Psychiatric Hospital

Forensic Treatment Services

Contract Services Provided by
Wellpath (Formally Correct Care Recovery Solutions)



Stuart J. Shields, MSW, MHA, BPH Director

DIS – BPH - Forensic Services

Forensic Admissions



Admission to the Inpatient Hospital Service is based on the person's legal status.

Patients are admitted on court order set up by the authority Of statutes of the State of South Carolina.







The Bryan Hospital Forensic Services provides two forensic mental health programs:

Pretrial

Psychosocial Rehabilitation Program (PRP)

Forensic Evaluation Services (FES)



Evaluates adults and children referred by both General Sessions and Juvenile Courts.

Evaluations are for competency to stand trial and criminal responsibility.

In 2018, there were 1,152 court-ordered forensic evaluations (Adults-1,027 evaluations and Child-125 evaluations) completed.



The NGRI Outreach Clinic

monitors NGRI clients in the community to ensure compliance with the Circuit Court's conditions for discharge.

Patrick B. Harris Psychiatric Hospital
Adult Services



Allen M. McEniry, M.B.A.
Director

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Adult Services



Harris Hospital operates 131 beds in a facility that has a licensed capacity of 200 beds.

The adult psychiatric services provided are accredited by The Joint Commission and certified by CMS (Centers for Medicare & Medicaid Services).

Patients meeting the legal and clinical standards for involuntary admission are screened by community mental health centers or local emergency departments before referral and admission to Harris Hospital.



Morris Village

Alcohol and Drug Addiction Treatment Center



George McConnell, M.Div., CSAC
Director



History

- The Village opened in 1975 to serve patients throughout the 46 counties of the state of South Carolina.
- The Morris Village treatment program was an outgrowth of a pilot 56-bed addiction treatment program housed at Crafts-Farrow State Hospital from 1971 until completion of the current facility in 1975.
- The Village was designed as a typical small residential community. Fourteen cottages (patient living areas) were located on the periphery of the campus, while administrative offices, an infirmary and a library were located in the interior surrounded by a central court yard.

Contract Services Provided by Wellpath (Formally, Correct Care Recovery Solutions)



New SVPTP Building
Broad River Correctional Institution Campus

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A Sexually Violent Predator is …



A person who has been convicted of a sexually violent offense

A person who suffers from a mental abnormality or personality disorder

A person who is likely to engage in the predatory acts of sexual violence if not confined in a secure facility.



DIS-Sexually Violent Predators Treatment Program

The first person was admitted in February 1999.

As of February 2019:

- Admissions: 345
- Discharges (Releases): 123
- Deaths: 15
- Current Census 205
- Projected growth: 12 residents a year



FACTS

Q & A

The Division of Inpatient Services

Presentation

Versie J. Bellamy, DNP, MN, RN
Deputy Director



"Abstract A," by patient in SCDMH Art of Recovery Program

DIS

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Tucker Center- Roddey Pavilion



Campbell Nursing Home



Tucker Center- Stone Pavilion



Veterans Victory House

Ted Jones, Nursing Home Administrator, Roddey Pavilion
Robert Morgan, Director of Veterans Services and Nursing Home Administrator, Stone Pavilion





- **Tucker Nursing Home Center is located in Columbia, SC**
  - Tucker – Roddey Pavilion (General Nursing Home)
  - Tucker – Stone Pavilion(Veterans Nursing Home)

- The Roddey and Stone Nursing Homes are operated by the South Carolina Department of Mental Health, Division of Inpatient Services.

- **Onsite Resident Services**:
- Pharmacy Services

- Therapy Services
- (*Therapy services are also provided to residents/patients across the DIS*)
  - Physical Therapy
  - Occupational Therapy,
  - Speech Therapy
  - Respiratory Therapy,
  - Restorative Therapy
- Physician Services
  - Medical
  - Podiatry
  - Psychiatry
  - Dental
  - Neurology
- Psychology Services
- Nursing Services
  - C.N.A.s, RNs, LPNs
- Social Work Services
- Activity Therapy Services
- Dietician
- Beauty and Barber
- Chaplains
- Volunteer Services

DIS – Division of Long Term Care

Tucker Nurse Care Center
Roddey Pavilion



Ted Jones, Nursing Home Administrator, Roddey Pavilion

DIS – Division of Long Term Care

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Tucker Nursing Home Center- Roddey Pavilion



- The Roddey Nursing Home opened in 1983

- Some residents have unique diagnoses such as Huntington's Disease.

- **The Roddey Nursing Home admits**
  - residents throughout the state and other community residential homes and hospitals as well as
  - residents from within the SC Department of Mental Health.

- **The Roddey Nursing Home is**
  - accredited by The Joint Commission,
  - licensed by the SC Department of Health & Environmental Control, and
  - certified by the Centers for Medicare & Medicaid Services.

DIS – Division of Long Term Care

Tucker Nurse Care Center
Stone Pavilion
Veterans Nursing Home





Robert Morgan, Director of Veterans Services and Nursing Home Administrator for Stone Pavilion

DIS – Division of Long Term Care

Tucker Nursing Home Center- Stone Pavilion



- The Stone Pavilion Opened in 1971,
- Veterans Nursing Home.

Annual Events for Residents
- Memorial Day
- Fourth of July
- Veterans Day

Stone Admission Requirements
- Serving Combat Duty – An Honorable Discharge
- Resident of SC for 1 year

- **The Stone Pavilion is**
  - accredited by The Joint Commission,
  - licensed by the SC Department of Health & Environmental Control,
  - certified by the Centers for Medicare & Medicaid Services, and
  - regulated by the US Department of Veterans Affairs.



DIS – Division of Long Term Care

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Campbell Nursing Home

Veterans Nursing Home





DIS – Division of Long Term Care

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Richard M. Campbell Veterans Nursing Home



- Opened in 1990.
- Located in Anderson, SC
- Public/Private Partnership
  (A division of HMR Veterans Governmental Services, Inc. – a division of HMR Services, Inc.)
- On-site SCDMH Contract Monitor



DIS – Division of Long Term Care

Victory House

Veterans Nursing Home





DIS – Division of Long Term Care

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Veterans Victory House Nursing Nursing Home



- Opened in 2006.
- Located in Walterboro, SC
- Public/Private Partnership
  (Advantage Veterans Services, a Division of HMR Services, Inc.)
- On-site SCDMH Contract Monitor



DIS – Division of Long Term Care

Q & A

SCDMH DEVELOPING THREE NEW NURSING HOMES

- Approved by State Fiscal Accountability Authority in early 2015
- Funding became available April, 2018
- Will be located in Columbia, Florence and Gaffney
- Bids in process of being reviewed and awarded

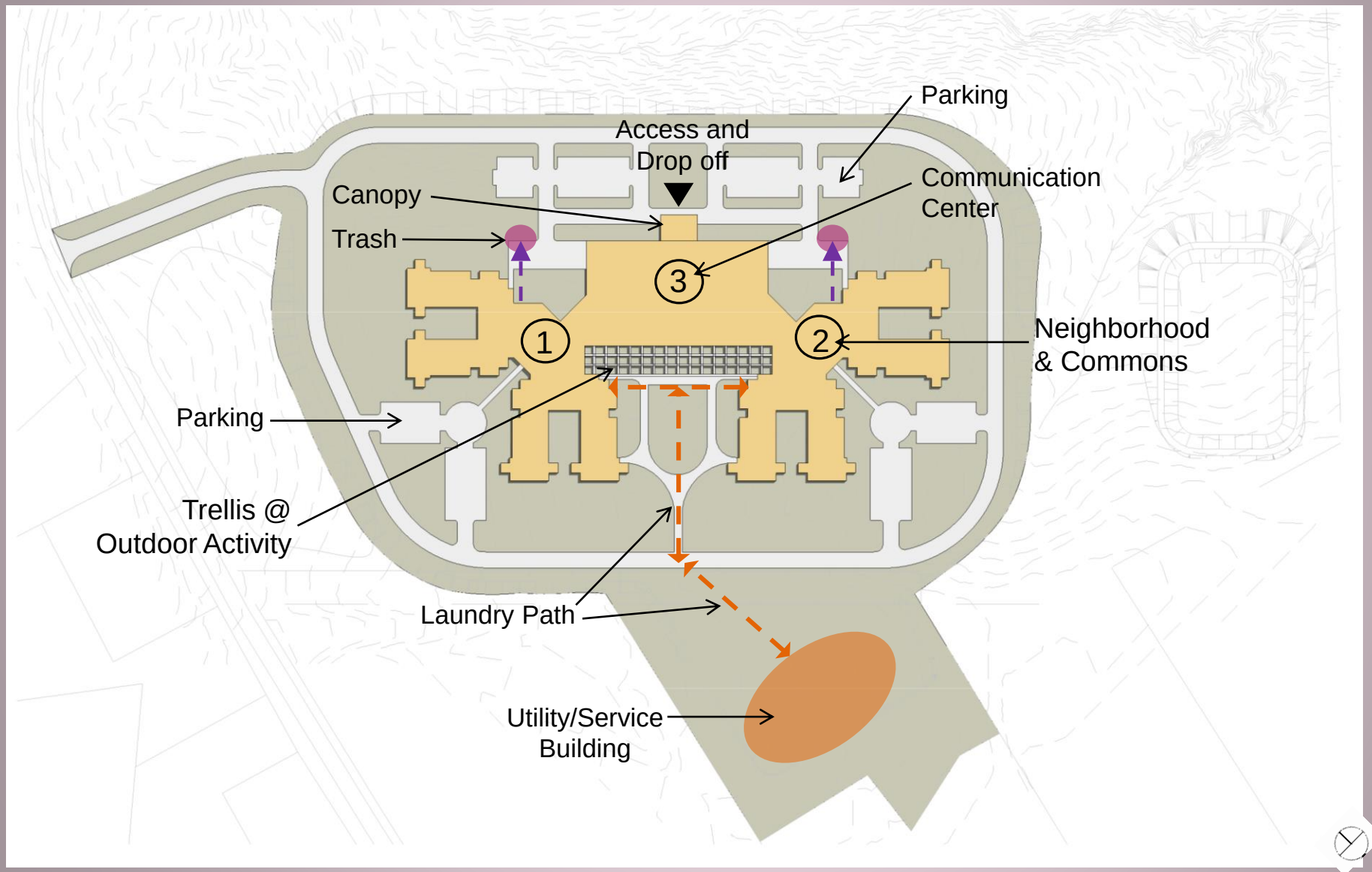
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2011 VA DESIGN GUIDE

- Philosophy:
  - Fewer Residents per unit
  - Environment that encourages development of a community
- SC Prototype:
  - 104 Residents
  - Two homes (13 residents each) comprise each of four neighborhoods

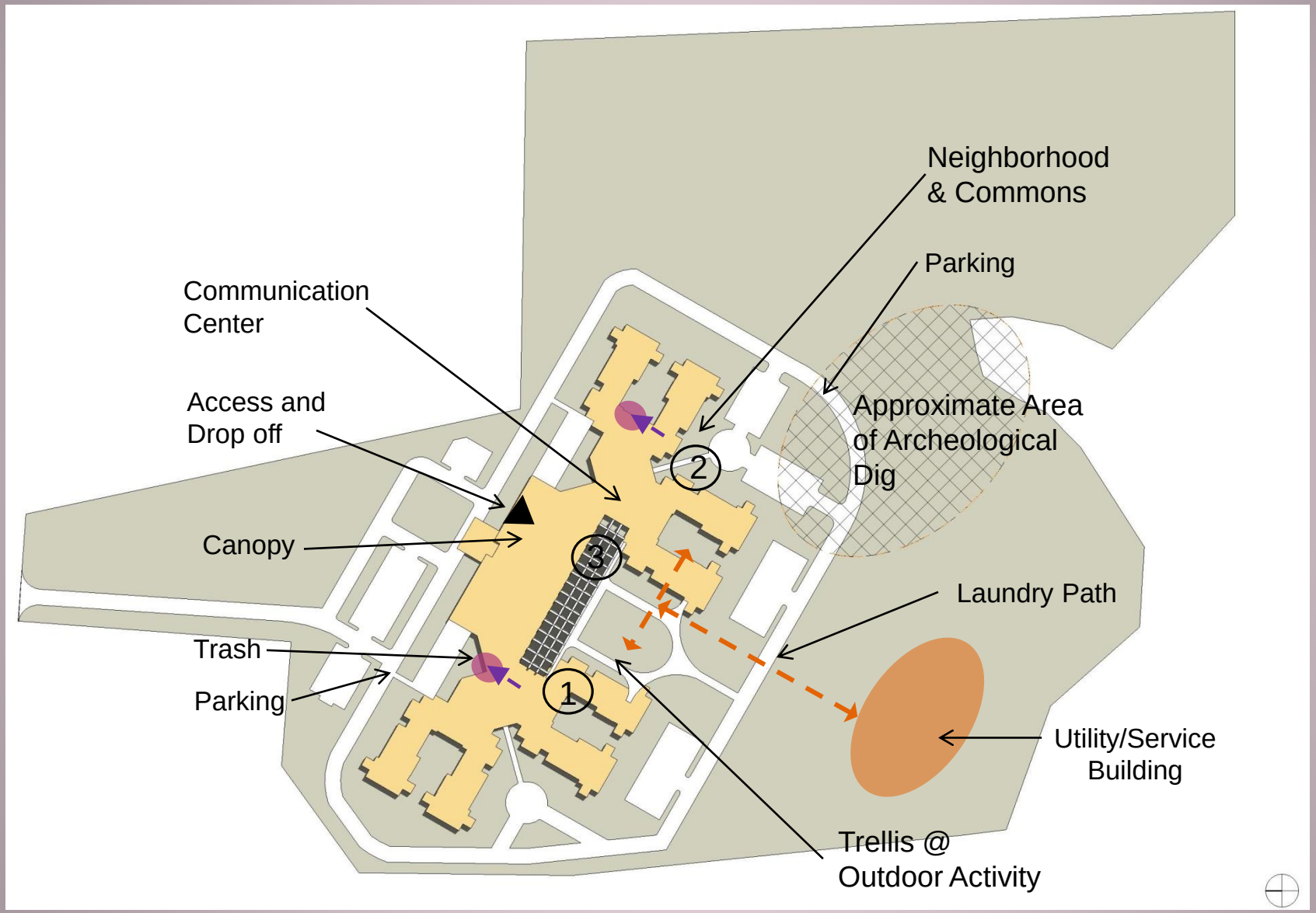
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Cherokee County – New Site Plan



DIS – Division of Long Term Care

Florence County – New Site Plan

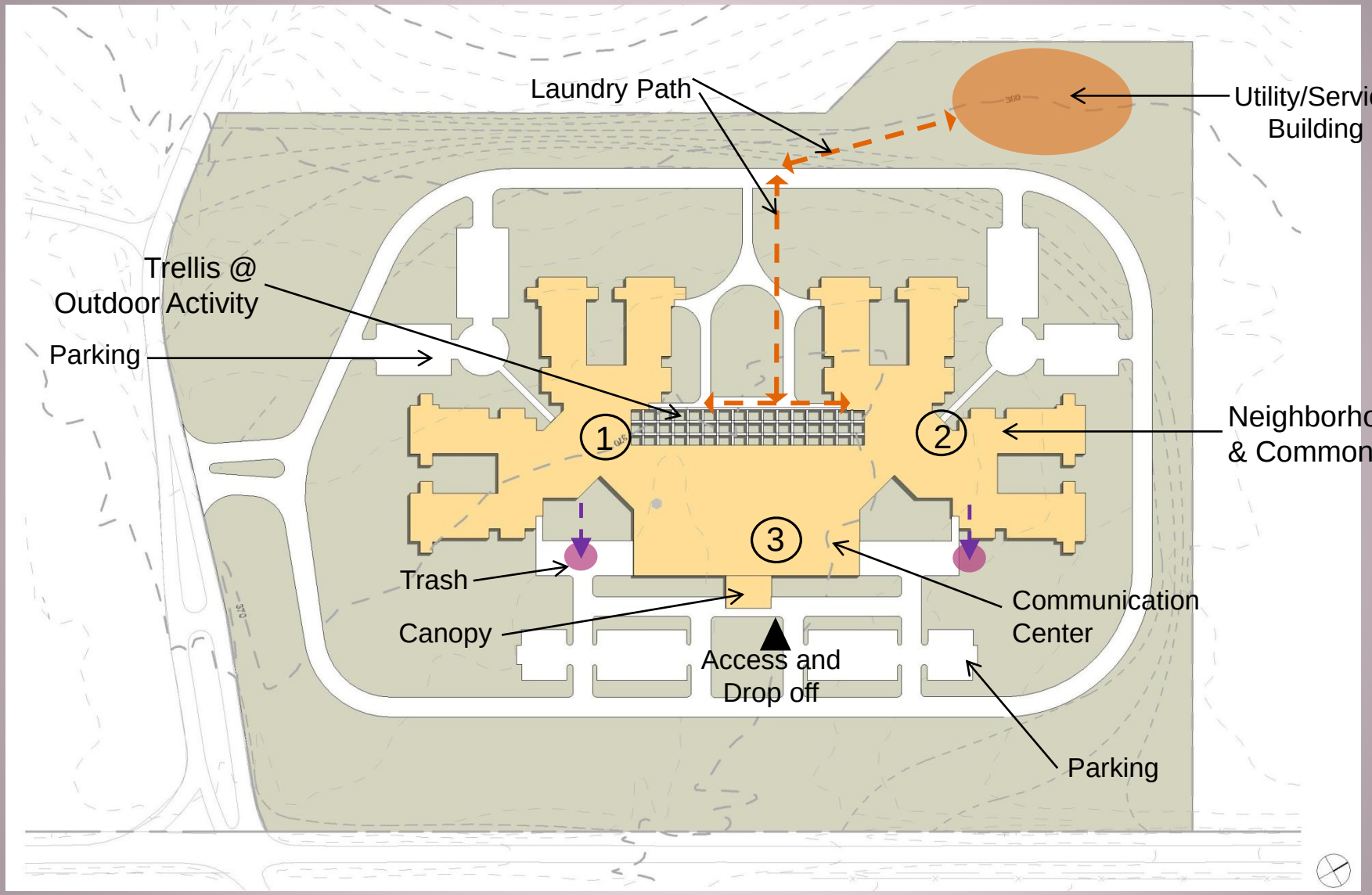


DIS – Division of Long Term Care

STEVENS & WILKINSON

Ernest Bland Associates, P.C.
Architecture & Planning

Richland County – New Site Plan



DIS – Division of Long Term Care

SCDMH State Veterans Nursing Home

STEVENS & WILKINSON

Ernest Bland Associates, P.C. Architecture & Planning

SCDMH COMMUNITY MENTAL HEALTH SERVICES (CMHS)

SERVING ALL 46 COUNTIES OF SOUTH CAROLINA TO SUPPORT THE RECOVERY OF PEOPLE LIVING WITH MENTAL ILLNESSES

DEBBIE BLALOCK

DEPUTY DIRECTOR

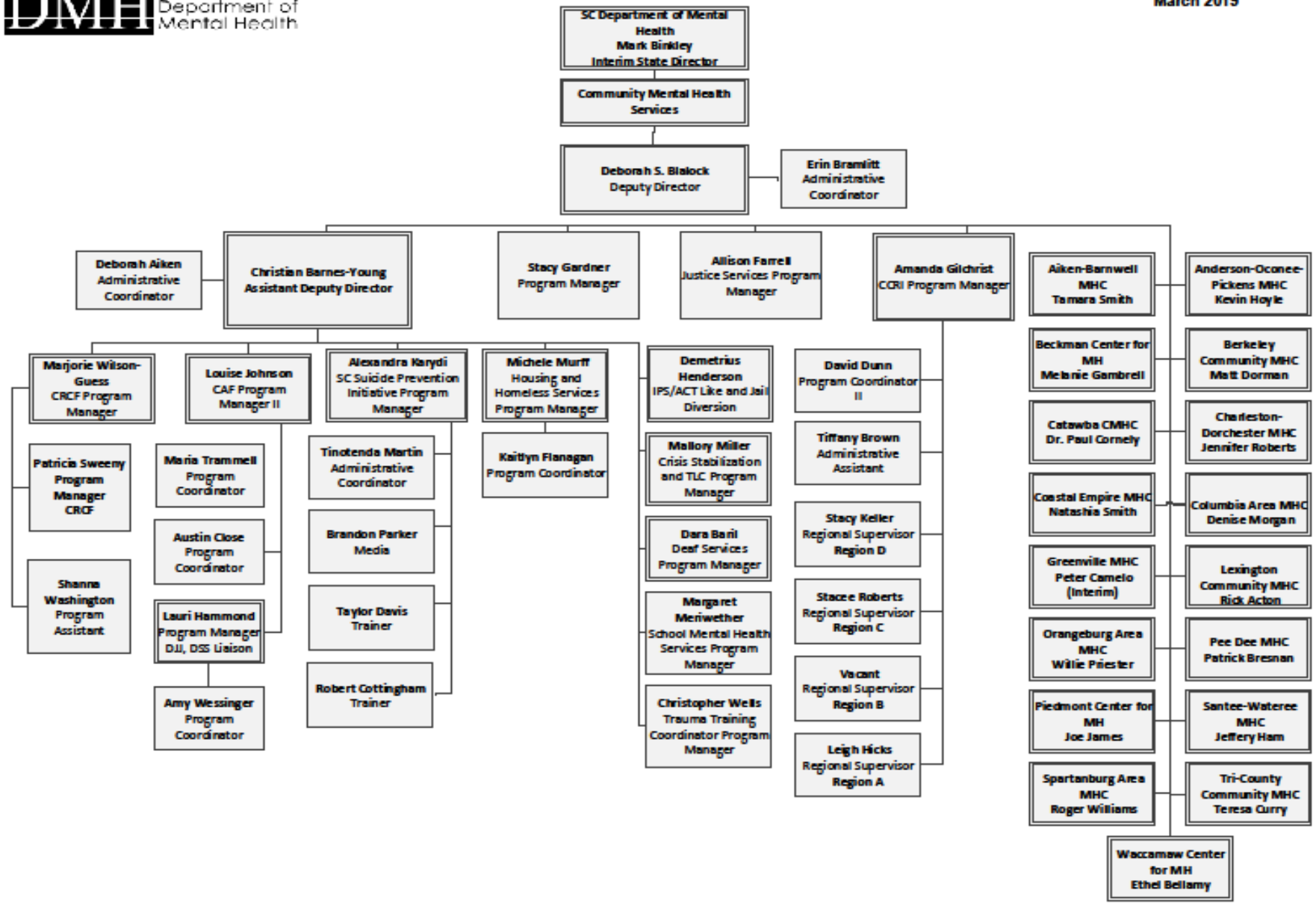
CMHS

APRIL 02, 2019

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DMH South Carolina Department of Mental Health

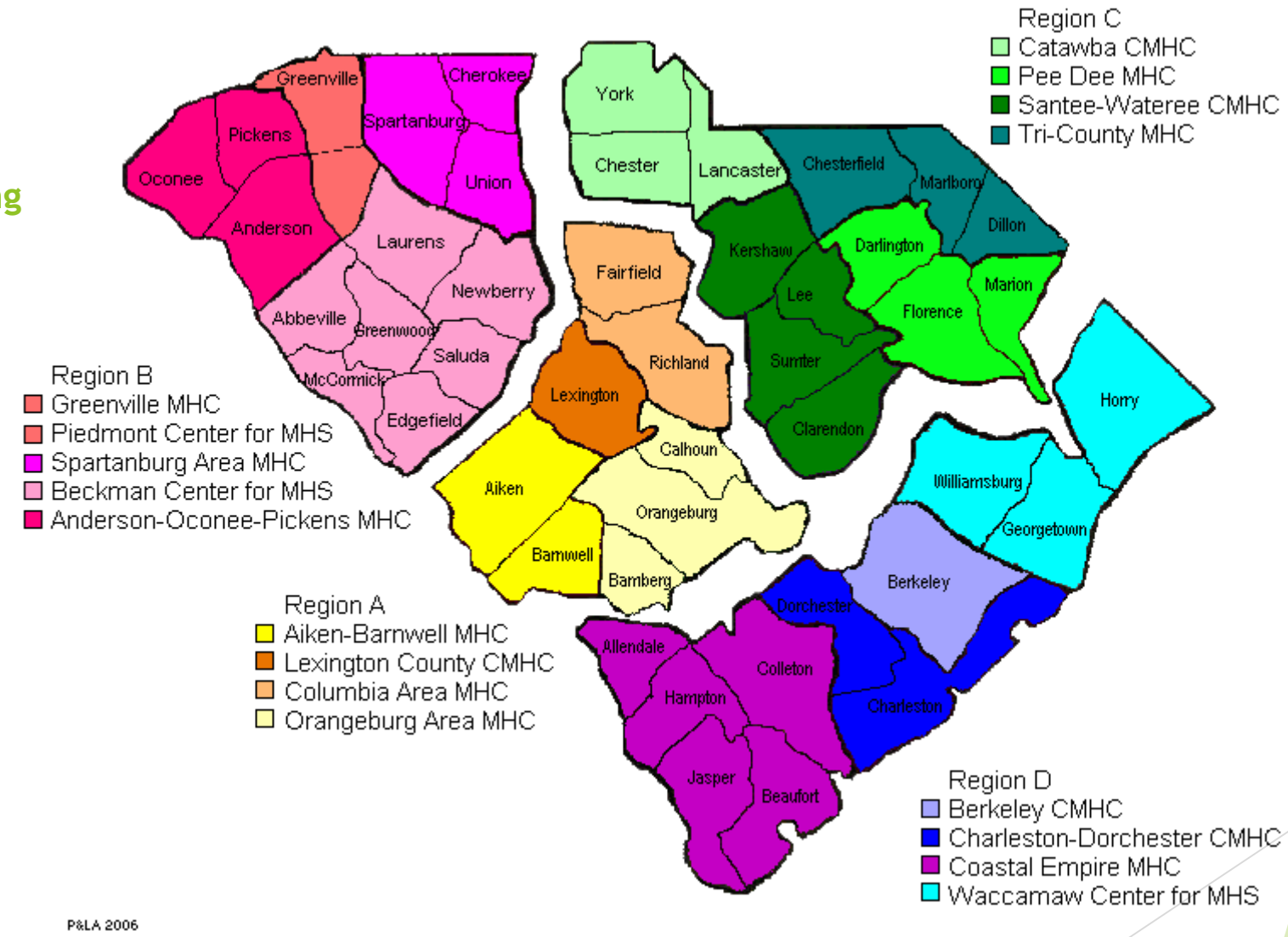
March 2019



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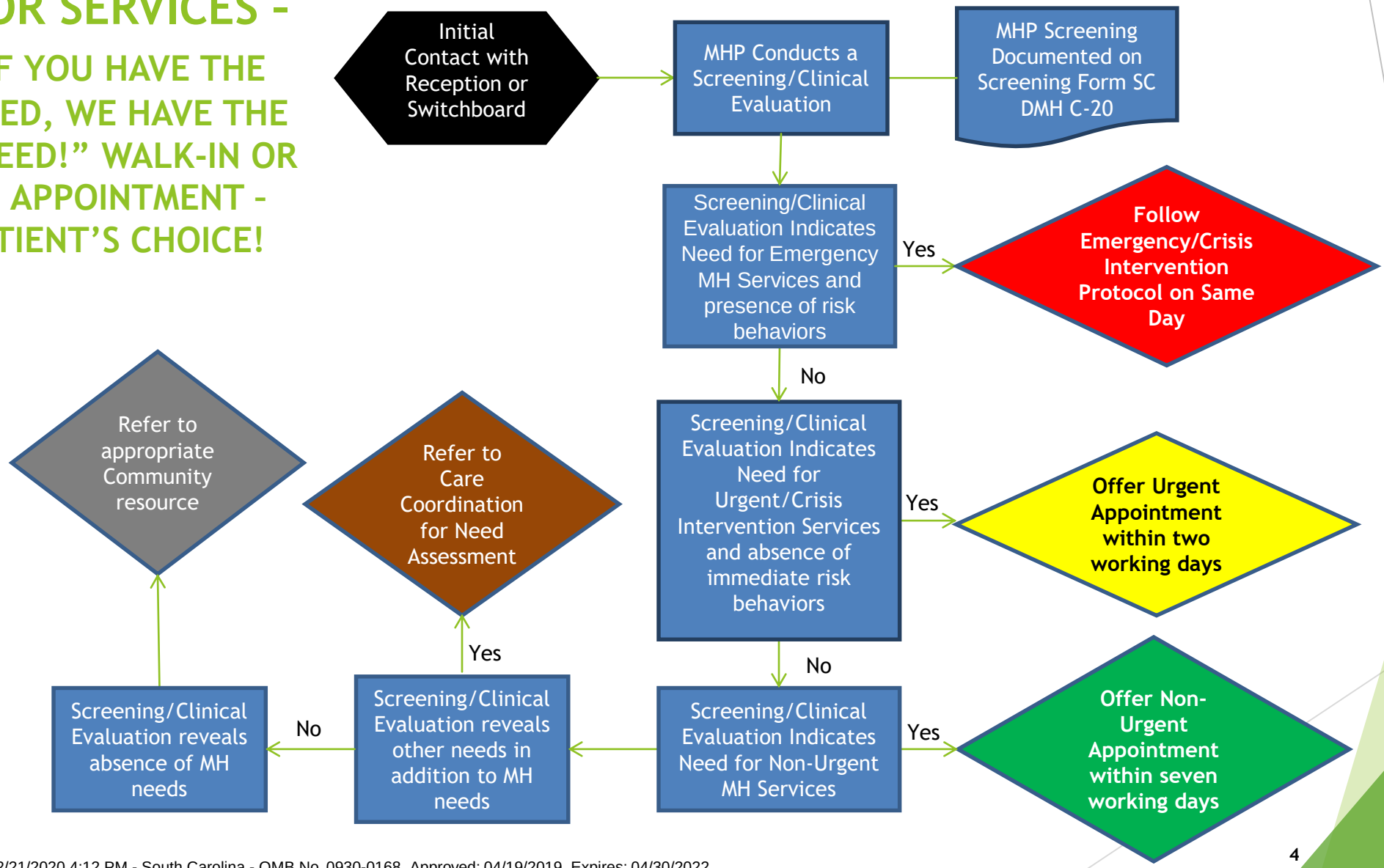
SCDMH MENTAL HEALTH CENTERS AND REGIONS

(Greenville and Piedmont are merging into Greater Greenville – fully effective 6/30/19)



INITIAL REQUEST FOR SERVICES –

"IF YOU HAVE THE NEED, WE HAVE THE SPEED!" WALK-IN OR AN APPOINTMENT – PATIENT'S CHOICE!



94% OF ALL INITIAL REQUESTS FOR SERVICE ARE OFFERED WITHIN THESE STANDARDS!

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SERVICES OFFERED TO ADULTS AND CHILDREN AGES 0 – 100+

- ASSESSMENTS
- INDIVIDUAL THERAPY
- GROUP THERAPY
- FAMILY THERAPY
- PSYCHIATRIC MEDICAL ASSESSMENT (PMA)
- NURSING SERVICES
- MEDICATION ADMINISTRATION (INJECTIONS)
- MEDICATION MONITORING
- PSYCHOSOCIAL REHABILITATION SERVICES
- CERTIFIED PEER SUPPORT SERVICES
- CRISIS INTERVENTION
- CARE COORDINATION

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A FEW OF THE EVIDENCE-BASED PRACTICES USED TO DELIVER THE AFOREMENTIONED SERVICES

- TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY (TFCBT)
- COGNITIVE BEHAVIORAL THERAPY (CBT)
- EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)
- PARENT CHILD INTERACTION THERAPY (PCIT)
- PROLONGED EXPOSURE THERAPY (PE)
- DIALECTICAL BEHAVIORAL THERAPY (DBT)
- INDIVIDUAL PLACEMENT AND SUPPORT (IPS)
- FIRST EPISODE PSYCHOSIS PROGRAMS (FEP)

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AIKEN-BARNWELL MHC – AIKEN AND BARNWELL COUNTIES

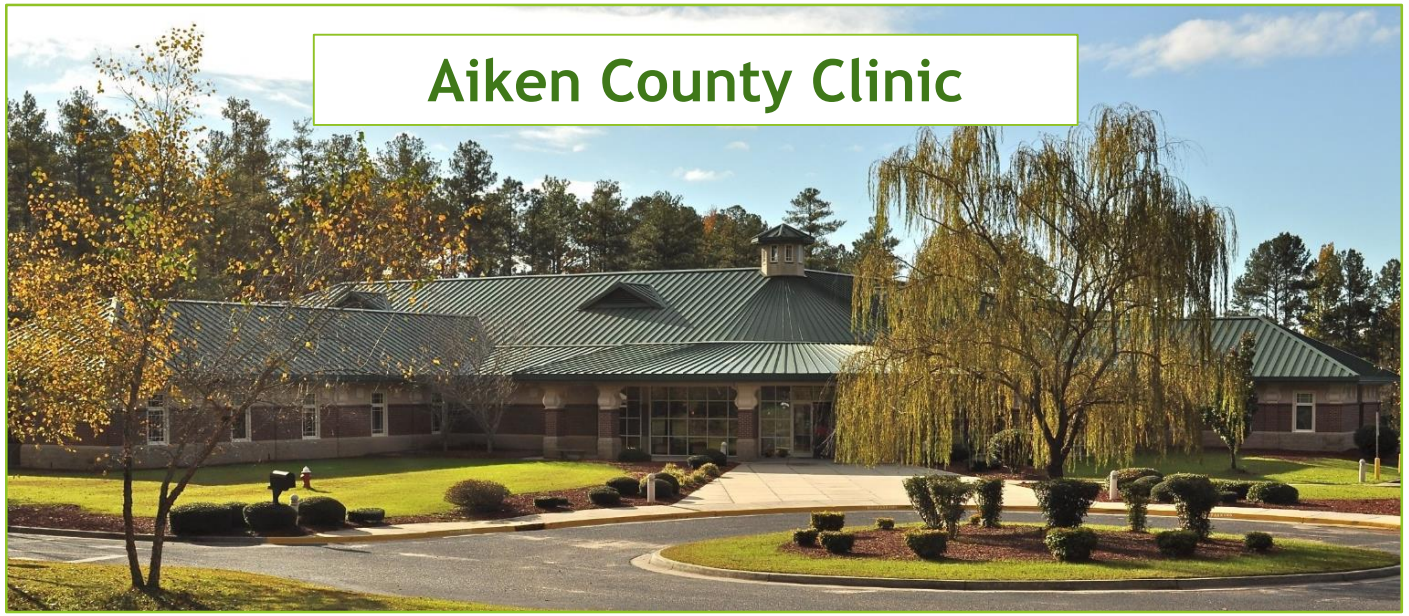


Tamara L. Smith LISW-CP, MAC
Executive Director

FY 2019 Budget:
$6,432,826

FY 2019 YTD Patients Served:
3,261

Current FTEs:
78







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AIKEN-BARNWELL MHC PROGRAM HIGHLIGHTS











Peer Support Services
- Employs 5 Certified Peer Support Specialists
- Recipient of Eli Lily Creative Program of the Year Award 2007
- Recipient of MHA-SC Outstanding Program of the Year 2014
- Operates 2 Peer Support Drop In Centers
- Facilitates NAMI Connections & Family Support Groups for Community
- Provides Peer Support Services @ Aiken County Detention Center
- Provided 56,651 Peer Support Contacts since inception of program

Behavioral Health Services @ Aiken County Detention Center
- Provided services to 469 inmates since 7/1/18
- Mental Health Professional housed at Aiken County Detention Center

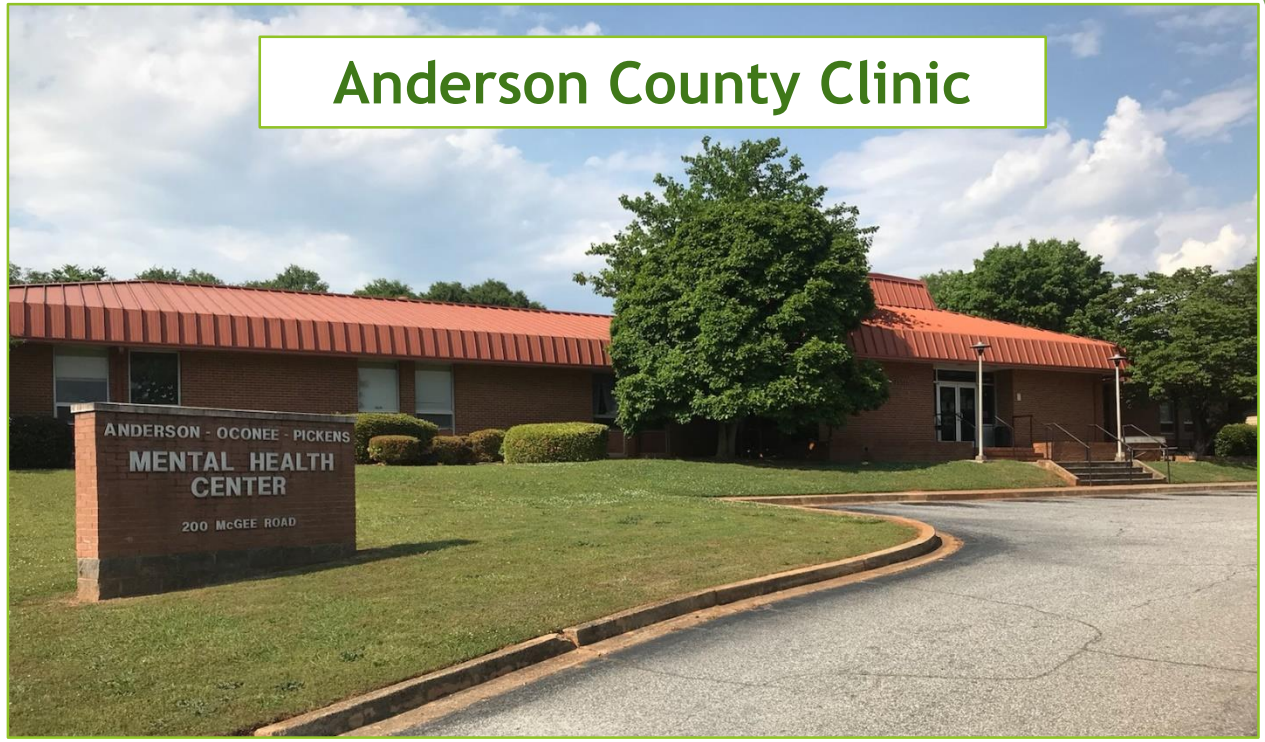
Housing Subsidies
- Provides rent guarantee assistance for 37 patients

Clinic-to-Clinic Telepsychiatry

New Initiatives
- Intensive Family Services
- Intensive Community Support
- Individual Placement Supported Employment Program
- Mental Health Professional Embedded @ Wagener Medical Clinic

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ANDERSON OCONEE PICKENS MHC – ANDERSON, OCONEE, AND PICKENS COUNTIES



Anderson County Clinic



Kevin W. Hoyle, MA
Executive Director

FY 2019 Budget: $11,894,775

FY 2019 YTD Patients Served: 5,113

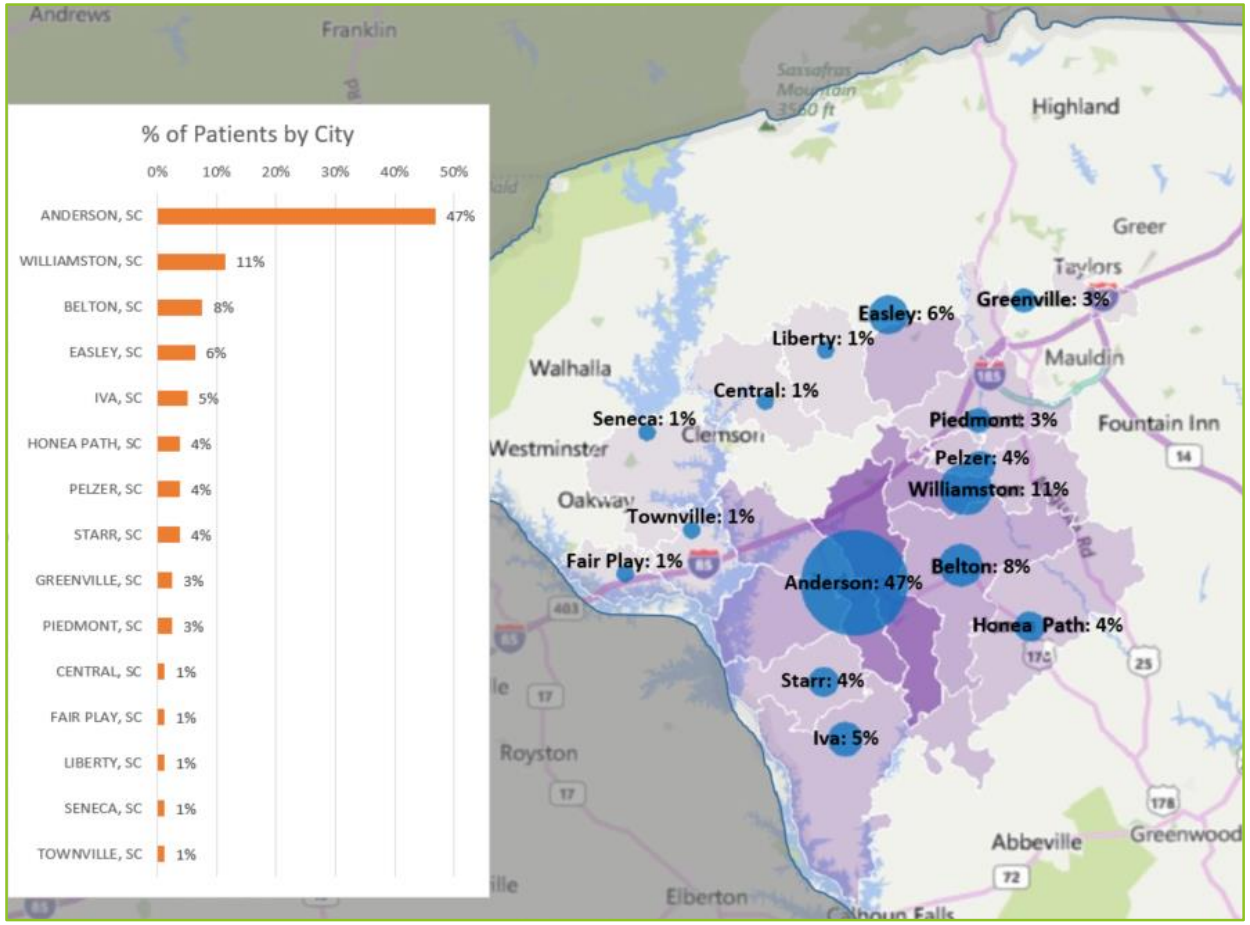
Current FTEs: 132


Pickens County Clinic



Oconee County Clinic

ANDERSON-OCONEE-PICKENS MHC SUPPORTED EMPLOYMENT DEMONSTRATION (SED) PROJECT



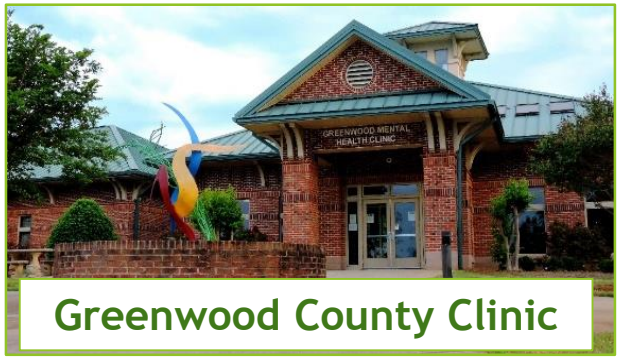
Where our participants are located



- A nationwide six-year study examining innovations to improve employment options for persons with mental illnesses
- Individual Placement Support (IPS) partners with area agencies and employers to provide competitive employment opportunities
- 79 SED participants, with 29% currently competitively employed and an additional 30% seeking work with program support
- 31 IPS participants, with 61% competitively employed
- Partnering with SC Vocational Rehabilitation and 25 local area employers

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BECKMAN MHC - GREENWOOD, LAURENS, EDGEFIELD, ABBEVILLE, SALUDA, NEWBERRY, AND MCCORMICK COUNTIES



Greenwood County Clinic



Administration/Greenwood County



Laurens County Clinic


Edgefield County Clinic


Abbeville County Clinic



McCormick County Clinic

FY 2019 Budget: $8,520,046

FY 2019 YTD Patients Served: 4,278

Current FTEs: 100



Newberry County Clinic



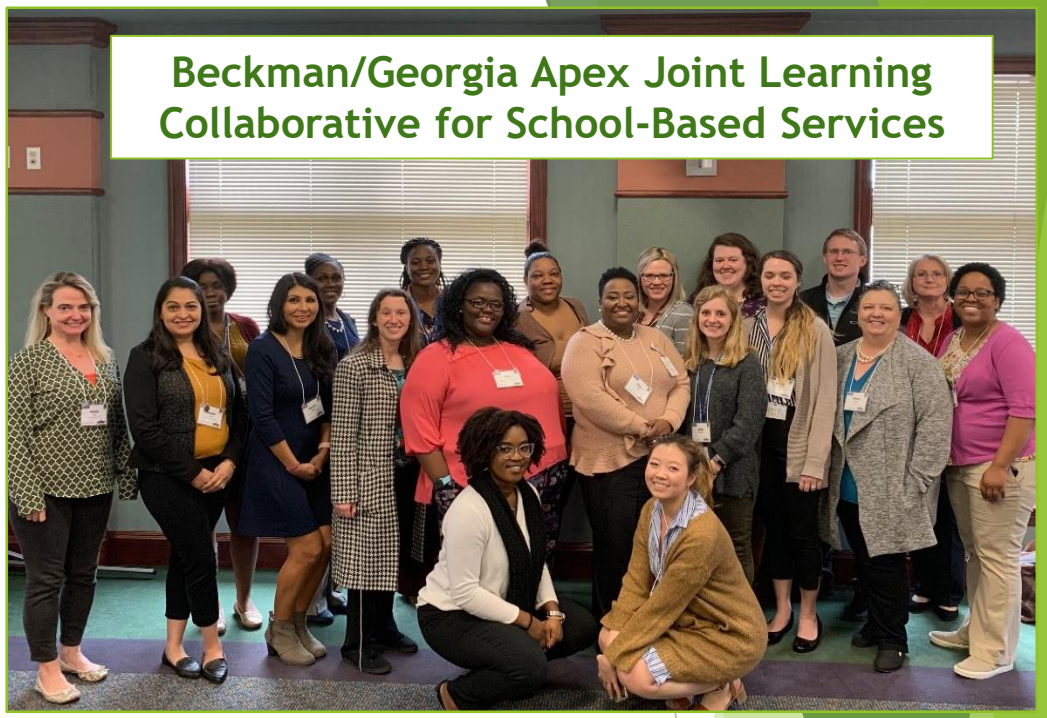
Melanie E. Gambrell, LPC, Executive Director

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BECKMAN COMMUNITY PARTNERSHIPS, OUTREACH, AND INNOVATION







Program Highlights

- **Beckman/Georgia Apex Joint Learning Collaborative for School-Based Services, 62 Professionals Trained from Georgia and South Carolina**
- **Clinical High Risk for Psychosis SAMHSA Grant Awarded September 2018, $400,000 per year for 4 years to provide Community Outreach and Treatment for Youth and Young Adults**
- **Telepsychiatry - all Clinics connected by telemedicine, 25% of Psychiatric Medical Assessments in FY 2019 occurred via telepsychiatry at Beckman**

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BERKELEY MHC – BERKELEY COUNTY



Administration/Berkeley County Clinic



J. Matt Dorman, M.Ed., LPC
Executive Director

FY 2019 Budget: $5,621,273

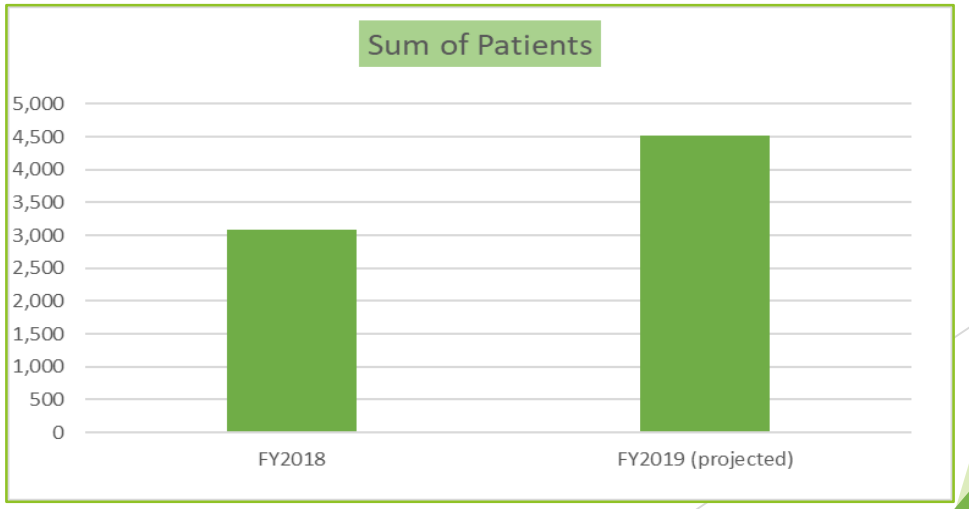
FY 2019 (YTD) Patients Served: 2,345

Current FTEs: 65

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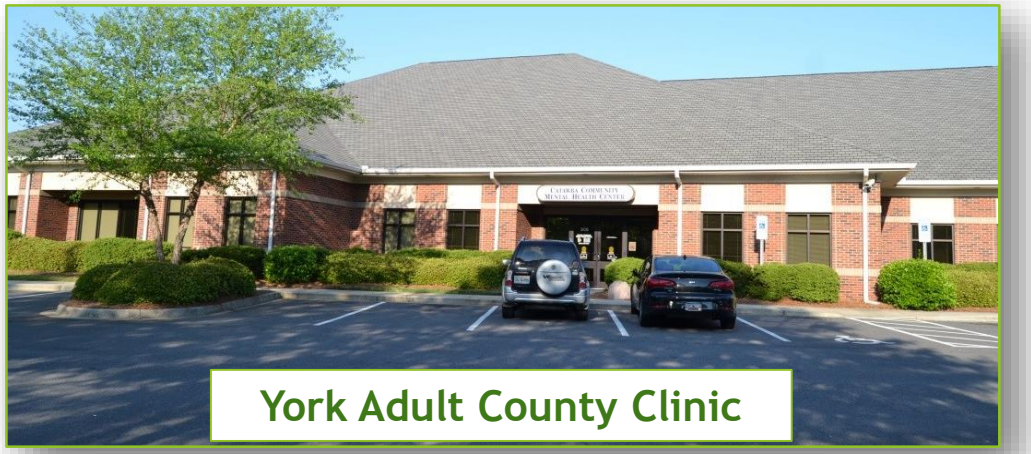
BERKELEY MHC – BERKELEY COUNTY

- **FY 2019 Programmatic Highlights**
  - **Access/Mobile Crisis—24/7 Crisis Intervention Service**
    - YTD 218 on-scene mental health crisis interventions
    - YTD 136 ER diversions
  - **Individual Placement and Support (Employment Services)**
    - YTD 30 of 33 patients enrolled in program have become employed
  - **Family Violence Treatment Program**
    - Clinicians embedded in 4 Berkeley Law Enforcement Agencies
    - FY 2019 (YTD) Program contacted 235 victims and enrolled 28 patients who were victims
    - of crime
  - **Unprecedented Growth**
    - FY 2018 3,079 enrolled
    - FY 2019 4,524 (projected) enrolled



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CATAWBA COMMUNITY MHC - YORK, CHESTER, AND LANCASTER COUNTIES



York Adult County Clinic

FY 2019 Budget: $9,753,570

FY 2019 Patients Served: 4,400

Current FTEs: 102



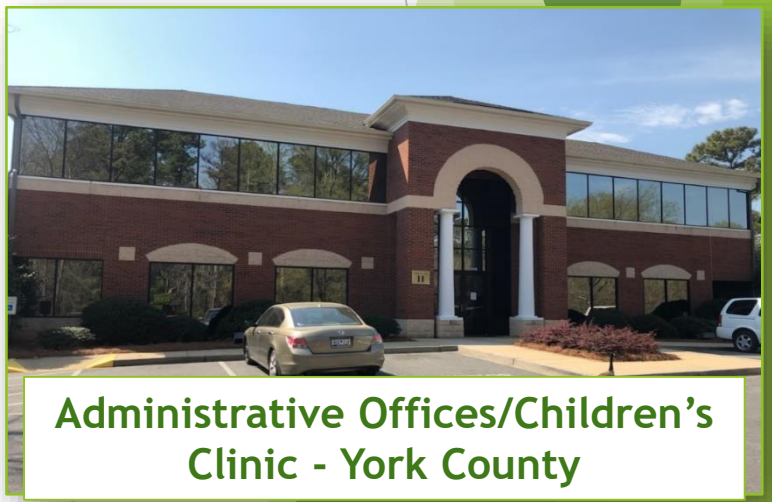
Paul J. Cornely, PhD, MPH
Executive Director



Lancaster County Clinic



Chester County Clinic



Administrative Offices/Children's Clinic - York County

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CATAWBA COMMUNITY MENTAL HEALTH CENTER

- School-based mental health services in 49 schools
- Synergy program - SAMHSA funded primary care and wellness integration project for adult patients
- Individual Placement and Support (IPS)
- Supported housing program
- Multidimensional Family Therapy (MDFT), Intensive Community Treatment (ICT), Dialectical Behavioral Therapy (DBT), Eye Movement Desensitization Reprocessing (EMDR), Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
- Peer support services



Community Education and Outreach



Synergy Health And Wellness

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CHARLESTON-DORCHESTER MHC – CHARLESTON AND DORCHESTER COUNTIES



Jennifer Roberts, LPC, CPM

Executive Director



Charleston County Clinic



Administration/Charleston County Clinic



Dorchester County Clinic

FY 2019 Budget: $20,980,195

FY 2019 YTD Patients Served: 8,443

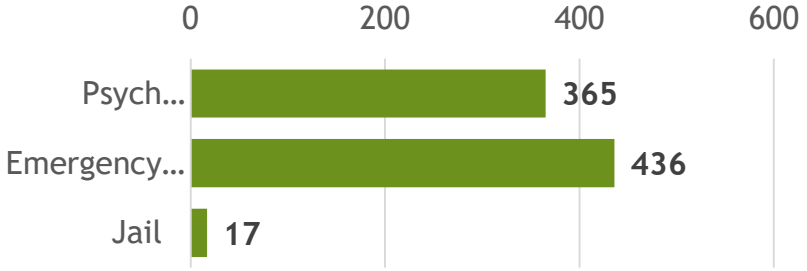
Current FTEs: 272

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CHARLESTON DORCHESTER MENTAL HEALTH CENTER
hope. healing. recovery.

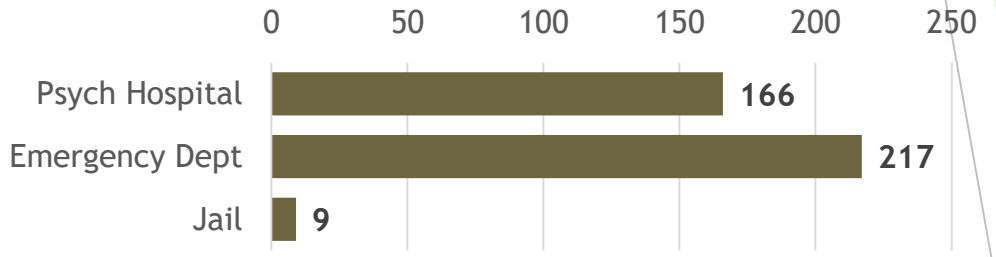
ED, Hospital, & Jail Diversions 7/1/18 – 2/15/19

Mobile Crisis Diversions



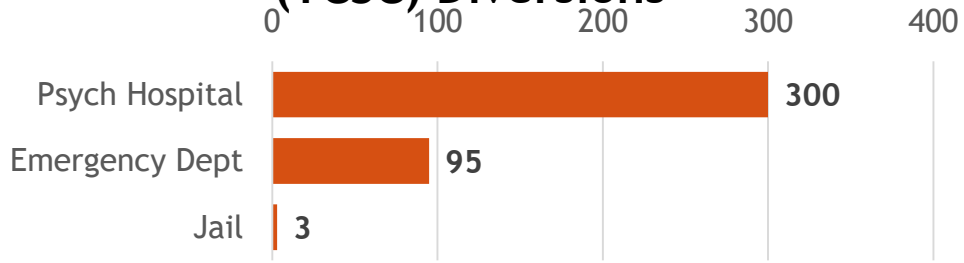
- 24/7/365 psychiatric assessment team, triage, and referral service
- Team responds to calls from the community and from law enforcement
- Mobile crisis team members go anywhere in the community except emergency departments to provide triage, assessments, and referrals
- Since 7/1/18, A/MC has responded to 1115 calls, walk ins, or LE drop offs

EMS Telehealth Diversions



- EMS supervisors and Mobile Crisis clinicians connect via video to complete psychiatric assessments for patients
- Ambulance returns to service when EMS supervisors arrive on scene to take over
- 58% of calls are diverted from an ED and/or hospital

Tri-County Crisis Stabilization Center (TCSC) Diversions

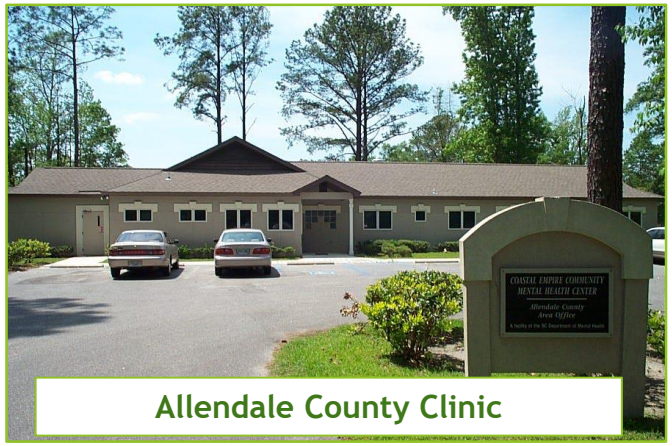


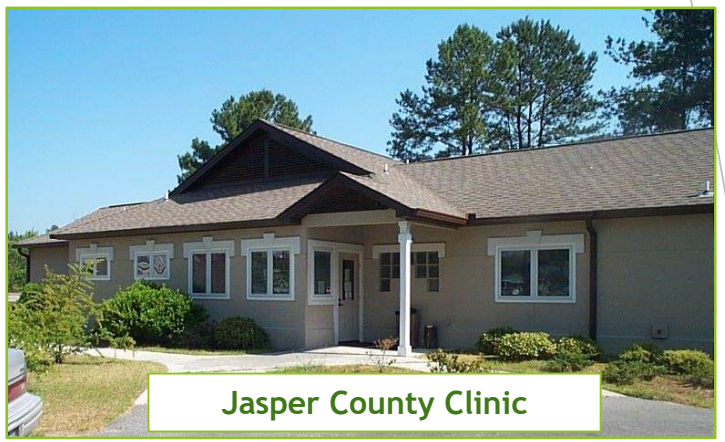
- 10 bed, voluntary ED, hospital, and jail diversion program for those in psychiatric crisis
- Also acts as a triage service for law enforcement and a drop-off alternative
- Average length of stay is 4 days

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COASTAL EMPIRE MHC – BEAUFORT, ALLENDALE, JASPER, COLLETON, HAMPTON COUNTIES


Colleton County Clinic


Allendale County Clinic


Jasper County Clinic


Dr. Natashia Smith, Ph.D, LPC
Executive Director


Hampton County Clinic


Administration/Beaufort County Clinic


Harrington Place - Beaufort County

FY 2019 Budget: $8,620,835

FY 2019 YTD Patients Served: 3,535

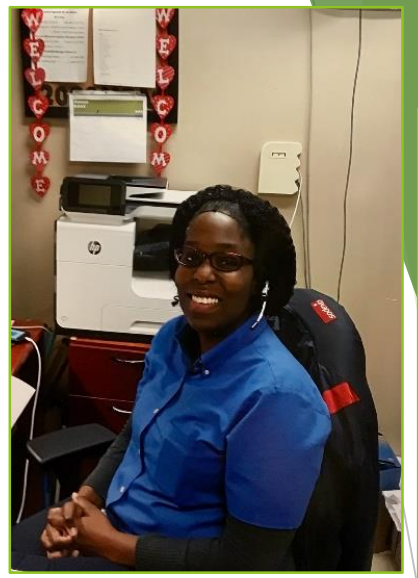
Current FTEs: 91


Hilton Head/Beaufort County Clinic

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COASTAL EMPIRE MHC – BEAUFORT, ALLENDALE, JASPER, COLLETON, HAMPTON COUNTIES

- Individual Placement & Support (IPS): Re-conceptualizing work for persons diagnosed with a mental illness
- Instituted at CECMHC in July 2016
- Assisted in placing 56 candidates in jobs
- 34 candidates currently in the program, 20 of whom are employed
- The program is expanding to cover Colleton, Hilton Head and Bluffton areas and has added 2 new Employment Specialists (ES)
- Team consists of 4 ESs and 1 Supervisor, as well a VR counselor and Benefits Specialist









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COLUMBIA AREA MHC – RICHLAND AND FAIRFIELD COUNTIES

FY 2019 Budget:
$16,887,590

FY 2019 YTD Patients Served: 5,969

Current FTEs: 150



Denise Morgan, M.Ed.
Executive Director



Administration/Richland County Clinic

Insights Young Adult Program





Lower Richland County Clinic



Emergency Services/Richland County Clinic

Fairfield County Clinic



MetCAC-Landmark Building/Richland County



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COLUMBIA AREA MHC

- Interagency Behavioral Health Team at Prisma Richland Emergency Department diverted 4,351 patients from the Emergency Department during FY 2018
- Dramatic decrease in length of stay waiting for an inpatient bed from a week or more in 2004 to 44 hours in 2018
- A Center Mental Health Professional on duty at Prisma Richland Emergency Department 8:00 a.m. to midnight seven days per week
- During FY 2019, CAMHC expanded its Mental Health Court program, a voluntary jail diversion program
- 14 active school-based therapists covering a total of 29 schools in Richland County School Districts 1 and 2 and Richland/Lexington School District 5
- Suicide Prevention Psychotherapy Program designed for patients who are at a high risk of suicide who do not meet hospitalization criteria
- Metropolitan Child Advocacy Center (MetCAC) - the only state-funded Child Advocacy Center in South Carolina, whose primary mission of conducting forensic interviews and medical exams of children referred by local law enforcement and DSS agencies due to allegations of abuse or neglect
- FY 2019 YTD - 622 center patients have received 622 services via SC DMH's Telepsychiatry Program



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GREATER GREENVILLE MHC - GREENVILLE COUNTY (result of recently merging the Piedmont and Greenville MHCs)



Peter Camelo, MS, LPC, LPC-S
Executive Director



Administration/Greenville County Clinic

FY 2019 Budget: $20,847334

FY 2019 YTD Patients Served: 9,210

Current FTEs: 254



Simpsonville Clinic



Greer Clinic

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GREATER GREENVILLE COMMUNITY-BASED SERVICES FOR CHILDREN AND ADOLESCENTS

- 98 Greenville County schools and programs have school-based mental health services on site
- 85 therapists are stationed in schools full-time
- 3,380 students received school-based mental health services in the 2017-2018 school year



Haircuts at Great Clips


Rock Climbing with GOAT


School-Based Group Therapy


Hiking at Jones Gap State Park


Basketball at Greenville City Parks

- Greater Greenville's Intensive Community-Based Services keep children engaged in services during school breaks
- Our innovative program uses highly engaging services and activities to develop social and emotional skills children need to thrive in their communities
- Vendors across Greenville County partner in making activities available
- In Summer 2018, 569 children and adolescents participated in group therapy, individual therapy, and psychosocial rehabilitation


Tae Kwon Do at Greenville Martial Arts


Biking on the Swamp Rabbit Trail

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LEXINGTON MHC – LEXINGTON COUNTY


Adult Services

FY 2019 Budget: $9,549,550

FY 2019 YTD Patients Served : 4,800

Current FTEs: 114


Richard L. Acton, ACSW
Executive Director


Batesburg Clinic


Administration


Gaston Clinic


Children's Services


New Alternatives Adult Services

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LEXINGTON COUNTY COMMUNITY MENTAL HEALTH CENTER

- Provides mental health services in all five (5) county school districts utilizing 32 staff in 54 schools
- Provides an extensive continuum of housing options for chronically mentally ill adults
- In collaboration with Lexington Medical Center and Three Rivers Behavioral Health, the Center provides crisis inpatient beds for indigent seriously mentally ill patients
- Provides coordinated housing and mental health treatment services to young adults in partnership with Growing Home Southeast, Inc.



Youth-in-Transition Apartments at Leaphart Place with Growing Home Southeast, Inc.

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ORANGEBURG MHC - ORANGEBURG, CALHOUN & BAMBERG COUNTIES

FY 2019 Budget: $6,340,001

FY 2019 Patients Served YTD: 2,239

Current FTEs: 60



Willie L. Priester, M.Ed., LMSW
Executive Director



Administration/Orangeburg County Clinic



St. Matthews/Calhoun County Clinic



Holly Hill/Orangeburg County Clinic



Denmark/Bamberg County Clinic

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HIGHLIGHTS OF THE ORANGEBURG MHC

- Emergency Department Liaison in The Regional Medical Center



- OAMHC School Based Services Program (2019)
- Serving 23 area schools



- OAMHC Housing Program





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PEE DEE MHC – FLORENCE, MARION, DARLINGTON COUNTIES



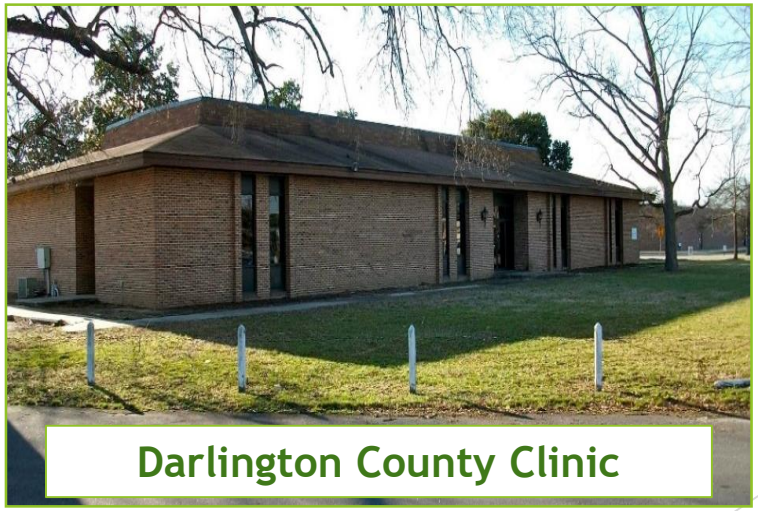
Patrick Bresnan, MBA
Executive Director



Administration/Florence County Clinic



Marion County Clinic



Darlington County Clinic



Lower Florence County Clinic

FY 2019 Budget: $11,913,688

FY 2019 YTD Patients Served: 3,408

Current FTEs: 135

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PEE DEE MHC

Reaching Families Project

Goal: To enhance student and caregiver engagement in school-based mental health services.

- 260 families screened
- 153 cases found eligible for participation
- 68 cases invited to participate
- 36 cases consented and enrolled
- 22 cases completed







Pee Dee Resiliency Project

- Funded by the BCBS of SC Foundation and consists of the following collaborators: SCDMH and Pee Dee Mental Health, Children's Trust, School Districts in Florence, Darlington, and Marion Counties, and the University of South Carolina (USC) School Behavioral Health Team
- Critical importance for development of school-based mental health (SBMH) programs for youth in elementary schools in the Pee Dee region



Darlington Co. CARES Project

- $1.2 Million School Mental Health Services grant from The Duke Endowment funding the implementation of a countywide school mental telehealth initiative integrating mental health and primary health care for children in Darlington County
- Pee Dee Community Mental Health Center, in partnership with the Medical University of South Carolina, the South Carolina Telehealth Alliance, the Darlington One School District, and several local private providers, making multiple healthcare services available in participating schools
- Expected to improve student health, reduce absenteeism, and correspondingly improve student achievement

Silver Years Program

Intensive Services for Elderly Patients









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SANTEE-WATEREE MHC – LEE, SUMTER, CLARENDON, AND KERSHAW COUNTIES



Jeffery L. Ham, CPM
Executive Director



Clarendon County Clinic



Administration/Sumter County Clinic

FY 2019
Budget: $10,510,719

FY 2019 YTD Patients Served: 5,017

Current FTEs: 117



Kershaw County Clinic



Lee County Clinic

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SANTEE-WATEREE MHC-SERVING OUR COMMUNITIES WITH INNOVATION

- IPS: Individual Placement and Support: *Competitive job placement and support program for patients- CARF accreditation, 74% employment rate*
- SMHS: School Mental Health Services: *Mental Health counselors in all counties with goal to be in all schools in each county - 36 schools*
- ROI: Roads of Independence: *Youth in Transition Program in three counties - three drop-in Centers*
- Co-located FQHC: *Medical services practice operates 4 days a week in Kershaw county*
- Project Home: *Program with 7 supported housing units*
- Telepsychiatry: *Clinic-to-Clinic and other Center to SWMH Center access – 1,649 patients served FYTD*



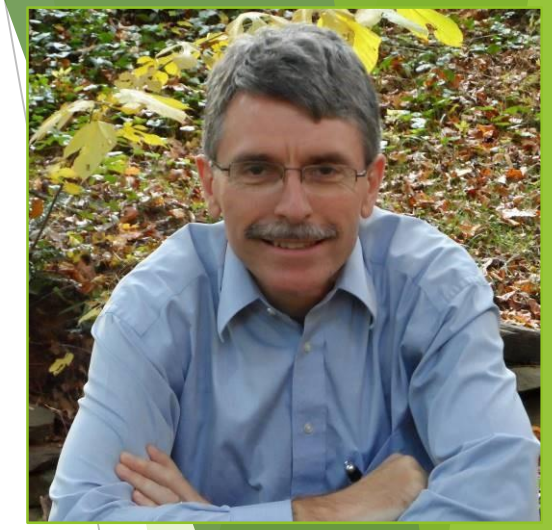




RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

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SPARTANBURG MHC – SPARTANBURG, UNION, AND CHEROKEE COUNTIES



Roger C. Williams, LISW-CP, CT, NAD 5, QMHI-S
Executive Director

FY 2019 Budget: $11,592,925

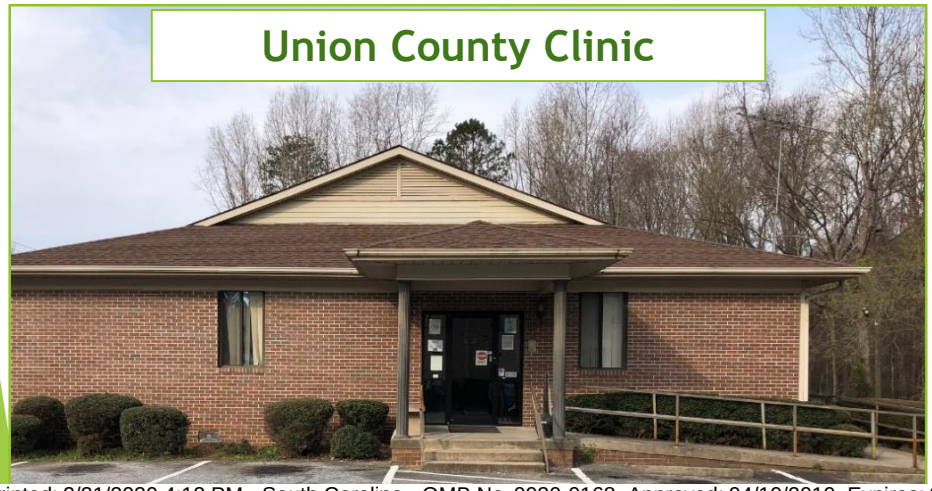
FY 2019 YTD Patients Served: 2,638

Current FTEs: 136

Administration/Spartanburg County Clinic



Union County Clinic



Cherokee County Clinic



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SPARTANBURG AREA MENTAL HEALTH CENTER - NEW INITIATIVES FY 2019

- Eubanks Center – Peer drop-in "living room" concept hospital diversion program
  - Provides individuals with a mental illness an additional support system outside of the clinical setting
  - 3 Peer support specialists, 2 clinicians, and a part-time care coordinator
  - 44 individuals diverted from emergency room or hospital
- Housing subsidies
- Automated appointment reminder system
- Individual Placement and Support
- Advance Practice Registered Nurses
- Intensive Community Treatment
- Intensive Family Support





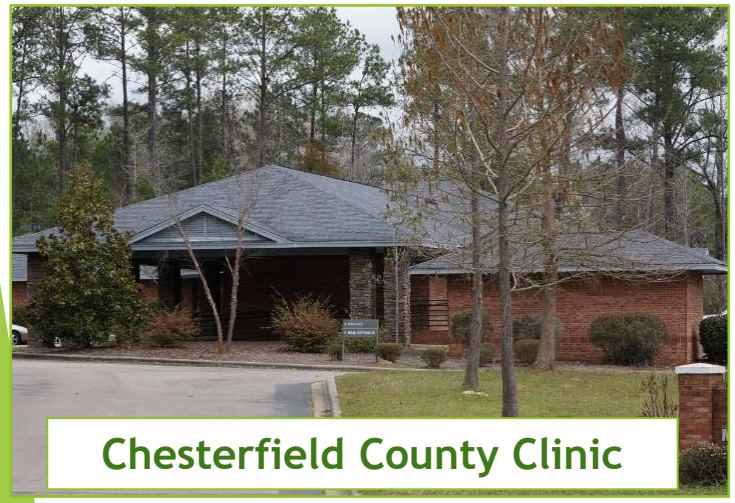
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TRI-COUNTY MHC – DILLON, MARLBORO, AND CHESTERFIELD COUNTIES


Dillon County Clinic



Administration/Marlboro County Clinic


Chesterfield County Clinic


Administration/Marlboro County Clinic


Teresa Curry, MA
Executive Director

FY 2019 Budget: $5,077,146

FY 2019 YTD Patients Served: 1,796

Current FTEs: 47

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- Master's level clinician stationed at 12-unit apartment complex where residents are mental health patients who are able to live independently with this support
- Center offers transportation services to patients without other means to get to Center
- No public transportation system in place that covers all three counties
- Center is heavily reliant on telepsychiatry to take care of patients
- Delivered over 100,000 services to patients through telepsychiatry
- Psychiatrists from as far away as Texas treat patients









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WACCAMAW MHC - HORRY, WILLIAMSBURG, AND GEORGETOWN COUNTIES



Ethel Blake Bellamy, MA, LPC/S
Executive Director



Administration/Conway/Horry County Clinic



Georgetown County Clinic

FY 2019 Budget: $11,607,652

FY 2019 Patients Served: 4,618

Current FTEs: 135



Kingstree/Williamsburg County Clinic



Southstrand/Horry County Clinic

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WACCAMAW MHC – HORRY, WILLIAMSBURG, AND GEORGETOWN COUNTIES

- South Strand Clinic opened in Myrtle Beach - current caseload is 289 and growing with 2,107 patient contacts year to date
- Homeless Outreach Program, embedded at Little River Medical Center (FQHC), reached 258 homeless persons and linked them to community services including mental health care
- School Mental Health Services provided services to 1,620 children in the 37 schools served by WCMH Mental Health Professionals
- WCMH & SCDVR expanded IPS into Georgetown County, developing 153 Business Partnerships serving 40 patients and placing approximately 50% of patients in competitive employment; hosted 3 Job Fairs for patients and general public; 21 employers present and 92 patient participants
- Employees from the Center involved in local disaster recovery efforts after Hurricane Florence and 2018 Floods





Center & Community Working Together During Disaster Recovery

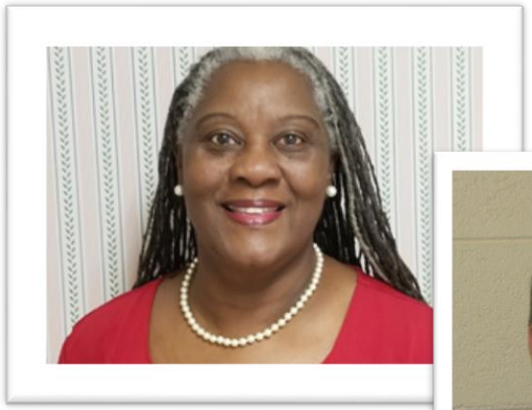
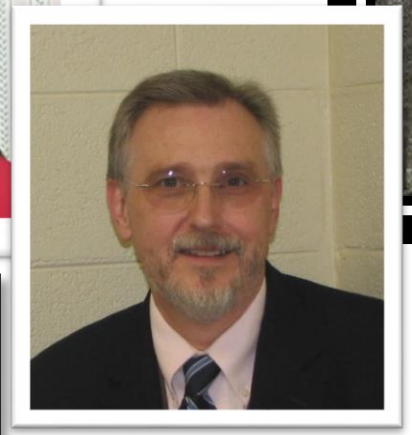




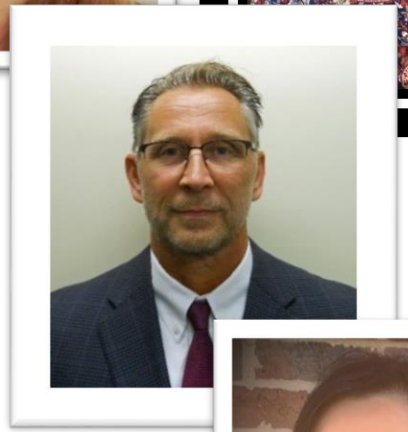
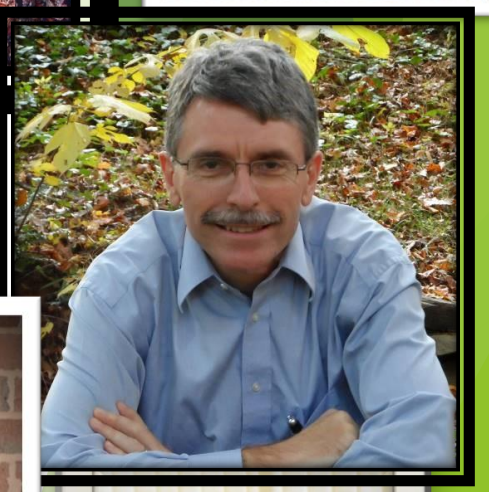
Job Fair

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OUR DIVERSE COMMUNITY LEADERSHIP!











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NEXT SESSION

COMMUNITY MENTAL HEALTH SERVICES PROGRAMS THAT BLANKET THE STATE TO INCLUDE:

- HOUSING – RENTAL ASSISTANCE, SUPPORTED APARTMENTS, HOMESHARE, COMMUNITY RESIDENTIAL CARE FACILITIES
- DEAF SERVICES
- CRISIS SERVICES – MOBILE CRISIS TEAMS, COMMUNITY CRISIS RESPONSE AND INTERVENTION (CCRI), CRISIS STABILIZATION CENTERS, INPATIENT COST SHARES, EMERGENCY DEPARTMENT EMBEDDED CLINICIANS
- SCHOOL MENTAL HEALTH SERVICES
- JUSTICE INVOLVED SERVICES – MENTAL HEALTH COURTS, LAW ENFORCEMENT EMBEDDED CLINICIANS, CLINCIANS EMBEDDED IN DETENTION CENTERS, FIRST RESPONDER SUPPORT TEAMS, CRITICAL INCIDENT STRESS MANAGEMENT SERVICES, CRISIS INTERVENTION TEAM SUPPORT, SOUTH CAROLINA LAW ENFORCEMENT ASSISTANCE PROGRAM SUPPORT
- SUICIDE AWARENESS, PREVENTION AND POSTVENTION SERVICES
- VOCATIONAL SERVICES – INDIVIDUAL PLACEMENT AND SUPPORT, LIAISON TO SC VOCATIONAL REHABILITATION SERVICES
- CHILDREN, ADOLESCENT AND FAMILY SERVICES – LIAISON TO DJJ, DSS, CONTINUUM OF CARE; GRANT ACQUISITION FOR CHILDRENS' SERVICES

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COMMUNITY MENTAL HEALTH SERVICES – ONLY AS STRONG AS OUR STAFF

MENTAL HEALTH CENTER RECRUITMENT AND RETENTION EFFORTS, OPPORTUNITIES, AND CHALLENGES

RECRUITING AND RETAINING GREAT STAFF – *BEING THE MENTAL HEALTH EMPLOYER OF CHOICE*

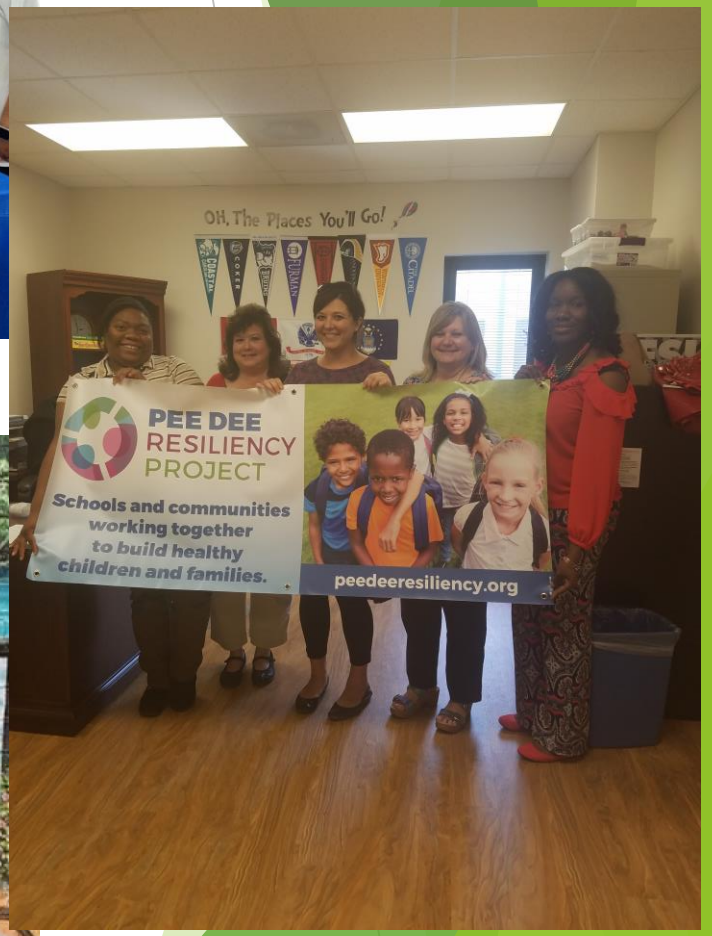
- DEFINING MISSION AND PURPOSE
- SCOUTING MASTERS DEGREE PROGRAMS
- CREATING INTERNSHIP PROGRAMS
- CREATING THE JOHN H. MAGILL SCHOOL MENTAL HEALTH CERTIFICATE PROGRAM AT USC
- PARTICIPATING IN JOB FAIRS AND OTHER COMMUNITY EVENTS
- CREATING A SAFE, PLEASANT, AND SUPPORTIVE WORK ENVIRONMENT
- PROVIDING ONGOING TRAINING, MENTORING, AND STAFF DEVELOPMENT OPPORTUNITIES
- PROVIDING LICENSURE SUPERVISION
- RECOGNIZING STAFF FOR EXCELLENT WORK
- CARING FOR THE CAREGIVER

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SUPPORTING THE RECOVERY OF PEOPLE WITH MENTAL ILLNESSES

- ALWAYS REMAINING MISSION CENTRIC
- EVERY POSITION, MISSION CRITICAL
- A VOCATION WITH A PURPOSE
- ALL HANDS ON DECK CULTURE
- POSITIVELY IMPACTING LIVES







JOB FAIRS AND OTHER COMMUNITY EVENTS









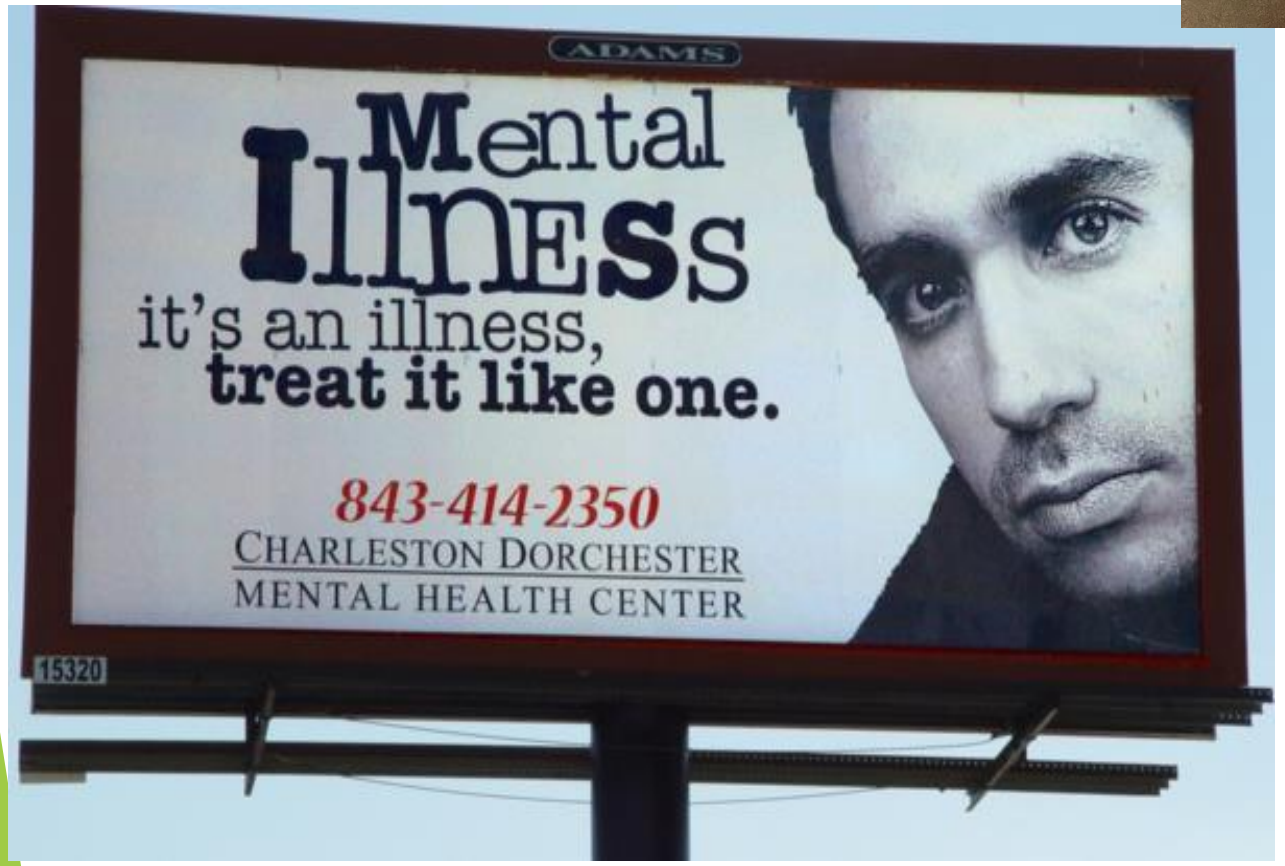


GETTING THE WORD OUT





SWAG





MAKING OUR CLINICS WELCOMING – *MURALS BY STAFF AND PATIENTS*



AOPMHC







AOPMHC



CDMHC



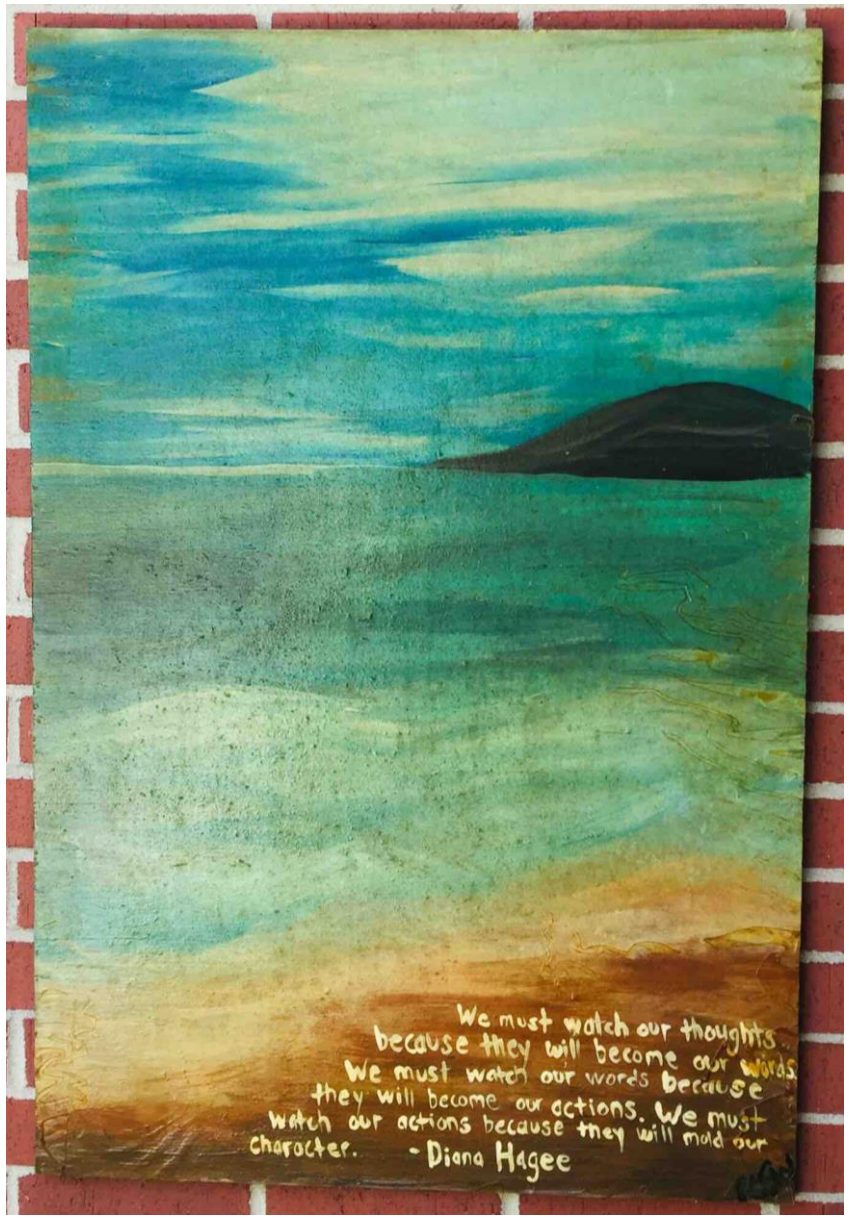
ABMHC



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ART FOR THE SOUL - *BY STAFF AND PATIENTS*









CREATING BEAUTIFUL, HEALING SPACES AT OUR CLINICS



A Memorial Garden to Celebrate the Life of a Staff Member



Garden of Courage



Beautiful Borders

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CREATING WELCOMING ENVIRONMENTS AND FUN!





“POT” Contest



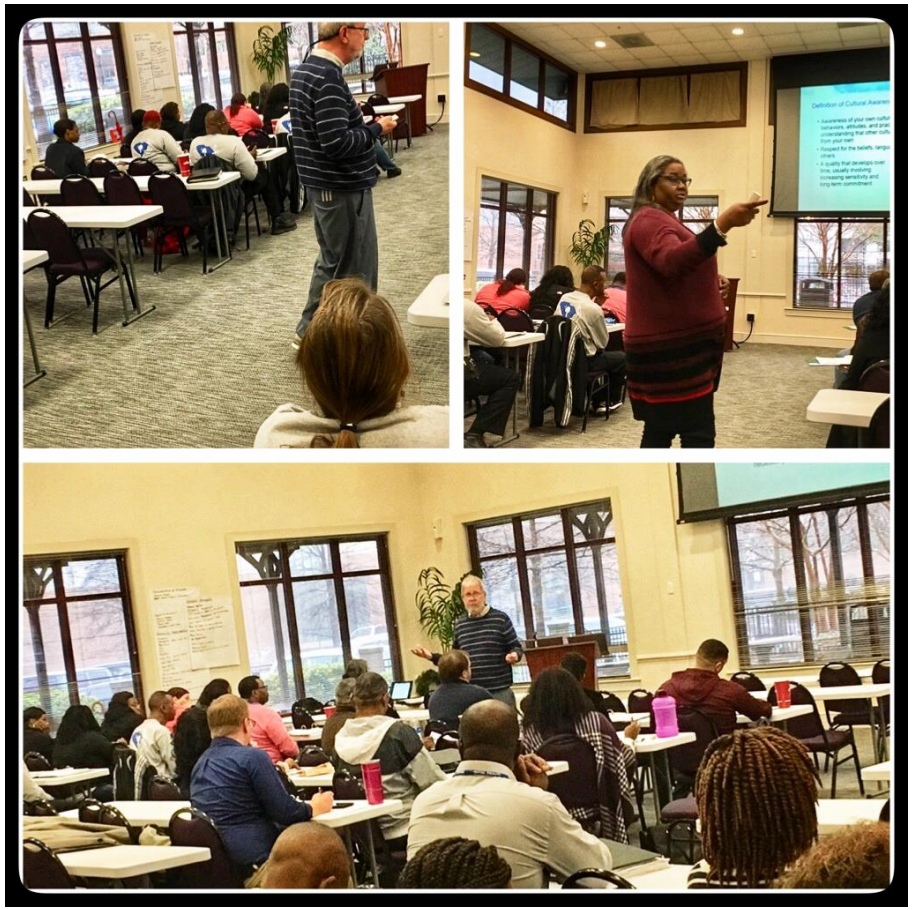




Holiday Door Decorating Contests

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CONTINUAL CLINICAL TRAINING AND OTHER TRAINING OPPORTUNTIUES



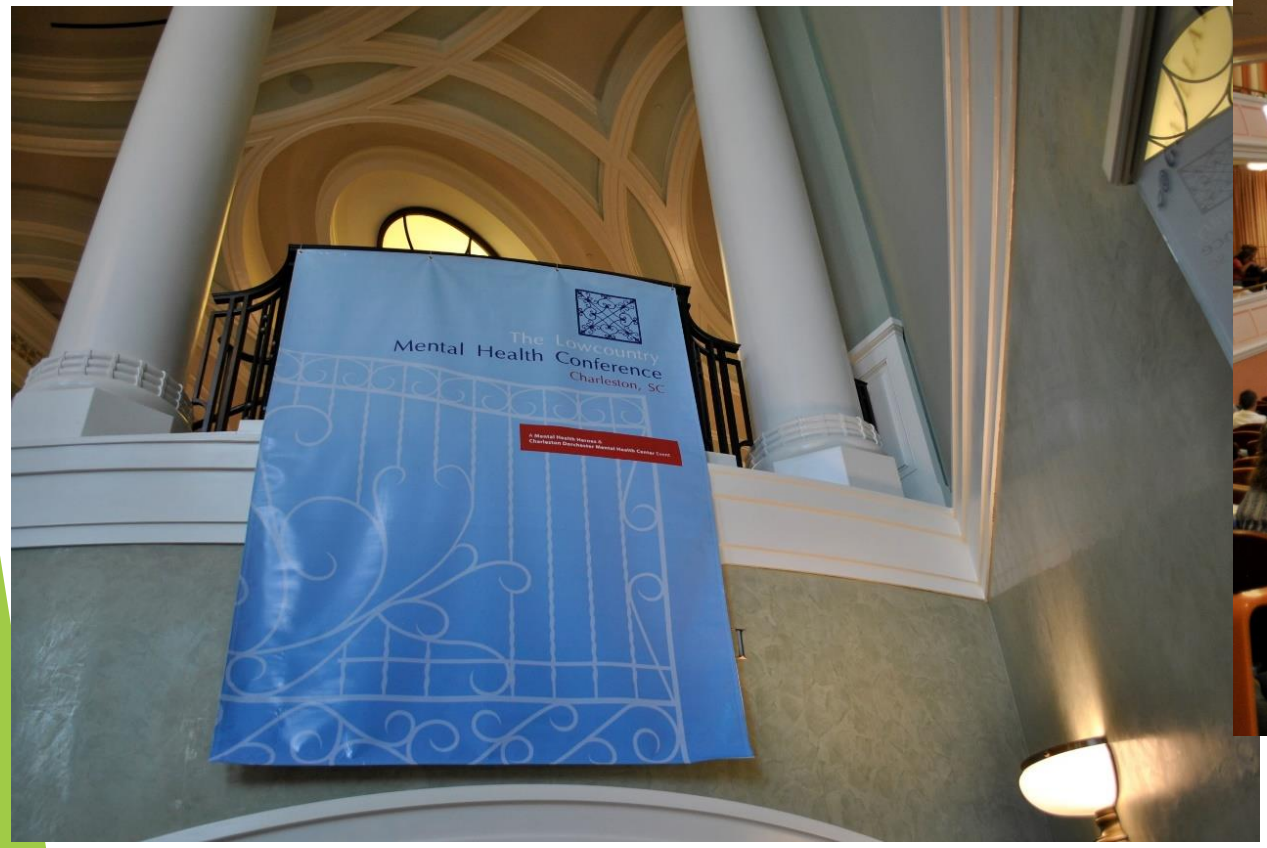
FEMA Crisis Counseling Program Training



Florence Police Department
2019 Citizen Police Academy
Graduates – *Pee Dee MHC Staff Included*

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MENTAL HEALTH RELATED CONFERENCES – *SCHOOL MENTAL HEALTH, SOUTHEASTERN SYMPOSIUM, LOWCOUNTRY, CROSS CULTURAL, ETC.*





Annual Lowcountry Mental Health Conference at the Gaillard Center

ACTIVE SHOOTER TRAINING WITH LAW ENFORCEMENT







PROVIDING FREE LICENSURE SUPERVISION TO STAFF - *A VALUABLE BENEFIT*



The State of South Carolina

Board of Examiners for Counselors, Therapists, and Psycho-Educational Specialists

This is to certify that

Deborah Dinobo, M.Ed.

having satisfactorily met the statutory requirements is hereby licensed as a

Professional Counselor Supervisor

In witness whereof the undersigned has caused this certificate of licensure to be issued and seal of said Board to be affixed. This 20th day of March, 1999.

License Number 3225

Margaret Zeidler Burggraf, Ph.D.

President

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STAFF WELLNESS AND RECOGNITION DAYS – *RECOGNIZING AND CARING FOR STAFF*





Employee Wellness Day



Employee of the Year Recognition



Employee Donated Silent Auction Items



STAFF TEAM BUILDING AND RECOGNITION EVENTS – *CELEBRATING STAFF*



Staff Retirement Celebrations



Staff Pride at Job Fairs



Fourth Of July Party

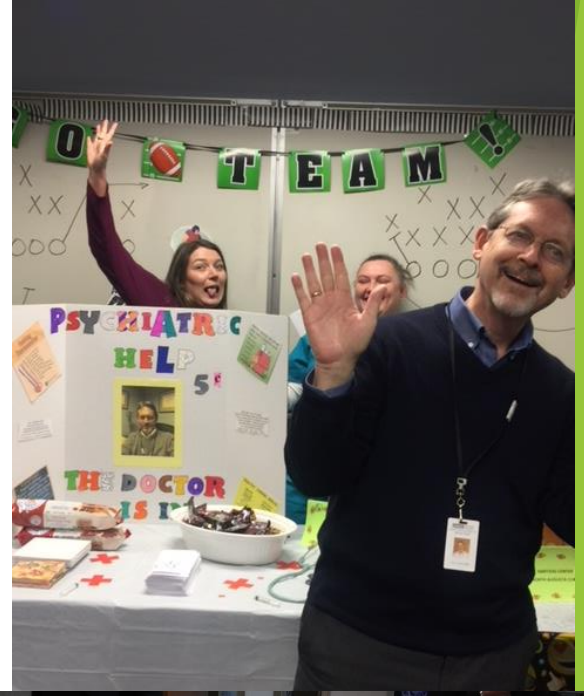




Staff Spring Fling Picnic

STAFF TEAM BUILDING EVENTS - *FOOTBALL FUN AND ITALIAN NIGHT!*













Football fun

MANGIA!

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Mental Health Professionals

in the

Community Mental Health System

Definition: Mental Health Professional

Graduate of an accredited university or college with a master's degree or doctoral degree in a program that is primarily psychological in nature (e.g. counseling, social work, guidance or social science equivalent). Additional evidence of coursework in Psychological Diagnostics, Psychopathology, Assessment and Ethics.

SCDMH has affiliation agreements with numerous Universities and Colleges that offer graduate degree programs in fields qualifying its graduates as Mental Health Professionals. These institutions include:

- University of South Carolina
- Clemson University
- The Citadel
- Winthrop University
- Limestone College
- Francis Marion University
- Coker College
- Webster University
- South University
- Newberry College
- Capella University
- Appalachian State University

Position Description: **MENTAL HEALTH PROFESSIONAL**

Job Purpose: Provides behavioral health services to children, adolescents, adults and families in order to improve overall functioning.

Essential Job Duties:

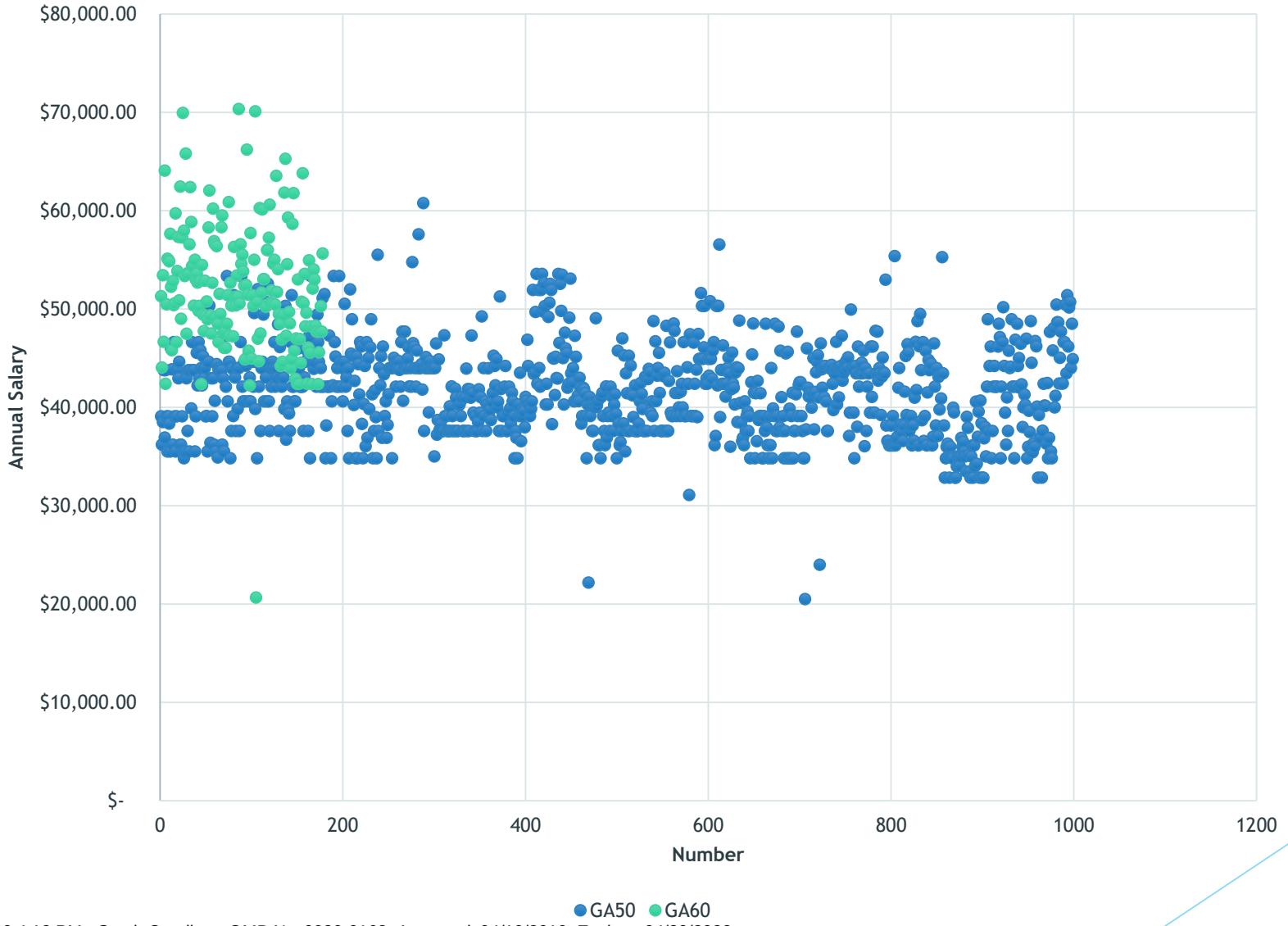
- Develop individualized treatment plans with the patient indicating the type of services and frequency of services to address needs and achieve goals.
- Provides an array of complex and evidenced based mental health therapies to patients in support of their recovery. Includes Crisis Management; Individual, Family, Group Therapies.
- Completes documentation [e.g. therapy notes, treatment plans and plan updates, telephone calls with or about patients] according to DMH standards which include but are not limited to the practice of collaborative documentation.
- Meets or surpasses annual productivity benchmarks.
- Ensures quality customer services provided to patients and stakeholders

SC State Office of Human Resources Classification and Compensation Structure

Classification and Band	Minimum Salary	Midpoint Salary	Maximum Agency Delegated Salary
GA50 Band 5	$32,838	$46,799	$60,760
GA60 Band 6	$39,960	$56,947	$73,935

On June 1, 2018, **956** employees in Community Mental Health Centers were classified as Mental Health Professionals.

CMHC Mental Health Professional Salaries



FISCAL YEAR 2018
Filled FTEs by Quarter

Number of Filled FTEs	GA50	GA60
6/27/17	822	138
9/26/17	818	141
12/29/17	830	144
3/30/18	831	144
5/31/18	817	139
FY18 FTE Average	823.6	141.02
FY18 Separations	169	15
FY18 Turnover Rate Average	22%	10%

Mental Health Professional Tenure

Community Mental Health Centers	GA50		GA60	
	Average (Months)	Average (in Years)	Average (Months)	Average (in Years)
Aiken-Barnwell	62.15	5.18	45.50	3.79
Anderson Oconee Pickens	72.15	6.01	201.40	16.78
Beckman	33.80	2.82	113.67	9.47
Berkeley	43.60	3.63	235.00	19.58
Catawba	47.58	3.96	144.67	12.06
Charleston-Dorchester	58.90	4.91	139.54	11.63
Coastal Empire	81.61	6.80	195.67	16.31
Columbia Area	85.17	7.10	163.81	13.65
Greenville	47.87	3.99	124.33	10.36
Lexington	68.60	5.72	115.22	9.60
Orangeburg	93.54	7.79	189.20	15.77
Pee Dee	72.21	6.02	174.14	14.51
Piedmont	42.80	3.57	150.29	12.52
Santee Wateree	58.23	4.85	200.29	16.69
Spartanburg	46.42	3.87	182.89	15.24
Tri-County	37.21	3.10	55.25	4.60
Waccamaw	78.80	6.57	150.63	12.55
AVERAGE TENURE		5.1 years		13 years

“Competition” for Employees in Mental Health Professional Classifications

Schools Districts

Department of Juvenile Justice

Department of Social Services

Department of Corrections

Department of Vocational Rehabilitation

Veterans Administration Hospital Systems

Federal Government

Private Practice Opportunities

SCDMH Activities to Recruit and Retain Mental Health Professionals

- Practicum and Internship placements
- School-based Mental Health Professional sponsored internship (USC School of Social Work)
- Loan repayment for critical needs positions
- Adjusted work schedules
- Out-stationed work locations
- Support and supervision for Professional Licenses
- Training in evidenced-based clinical practices
- Participation in practice innovations
- DMH Mentoring Program
- DMH GA50 and GA60 classification salary increases 2015 and 2018

AN IN-DEPTH LOOK AT SCDMH COMMUNITY MENTAL HEALTH SERVICES (CMHS)

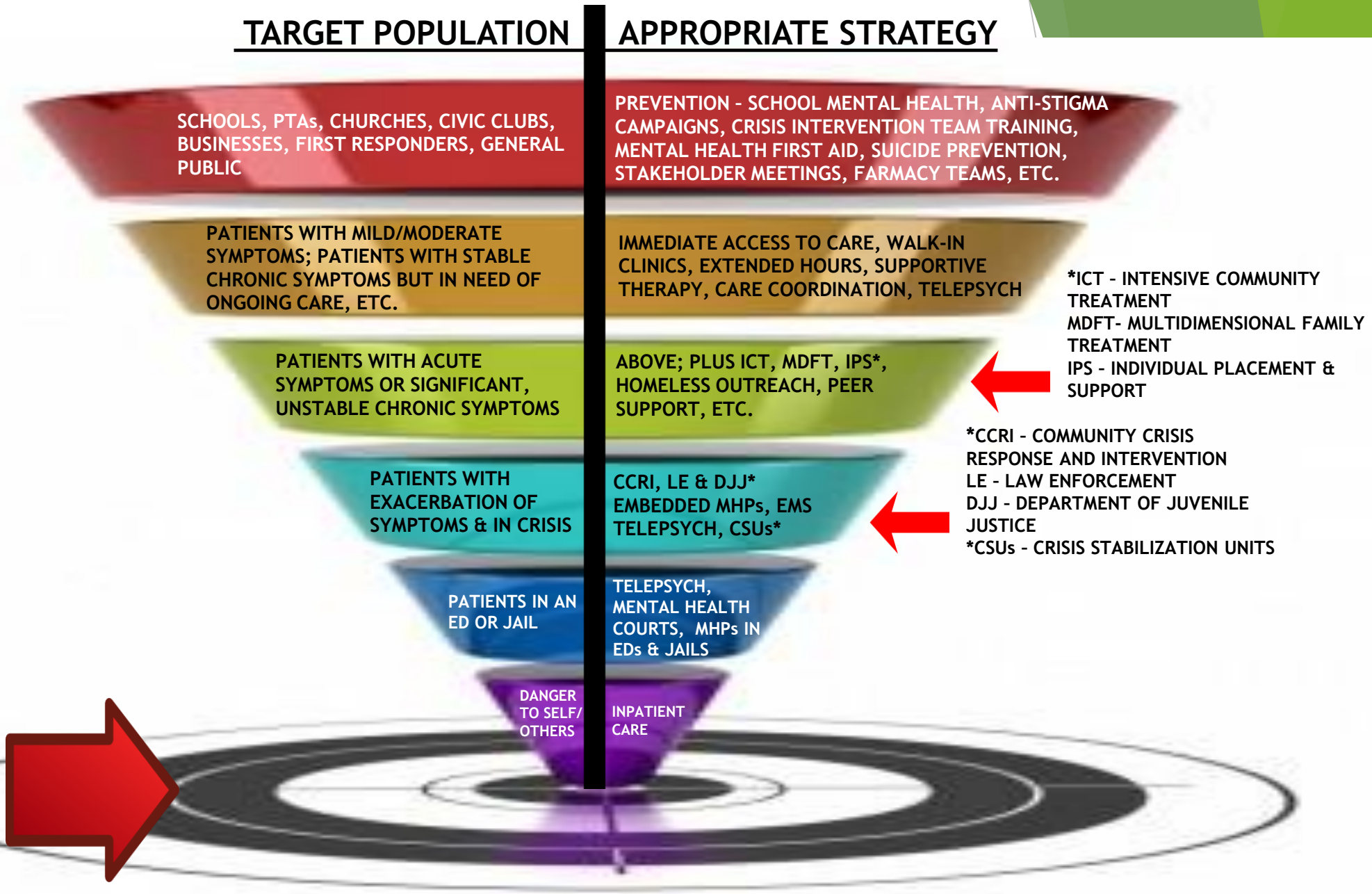
DEBBIE BLALOCK
DEPUTY DIRECTOR
CMHS

June 20, 2019

SCDMH TREATMENT CONTINUUM

PROVIDING THE RIGHT TREATMENT AT THE RIGHT TIME IN THE RIGHT PLACE BY THE RIGHT PROVIDER

SCDMH TREATMENT CONTINUUM – *A BRIEF OVERVIEW*



*ICT - INTENSIVE COMMUNITY TREATMENT
MDFT- MULTIDIMENSIONAL FAMILY TREATMENT
IPS - INDIVIDUAL PLACEMENT & SUPPORT

*CCRI - COMMUNITY CRISIS RESPONSE AND INTERVENTION
LE - LAW ENFORCEMENT
DJJ - DEPARTMENT OF JUVENILE JUSTICE
*CSUs - CRISIS STABILIZATION UNITS

TARGET - RIGHT TREATMENT AT THE RIGHT TIME IN THE RIGHT PLACE BY THE RIGHT PROVIDER - *PREVENTING AVOIDABLE EMERGENCY DEPARTMENT(ED) VISITS, HOSPITALIZATIONS, INCARCERATIONS & DEATHS BY SUICIDE*

COLLABORATION + COMMUNICATION + EDUCATION = PREVENTION

BUILDING RELATIONSHIPS WITH STAKEHOLDERS

- HOSPITALS
- SUBSTANCE ABUSE PROVIDERS
- PRIVATE PRACTITIONERS
- LAW ENFORCEMENT
- COURTS
- ADVOCATES
- SCHOOLS
- FAMILIES
- PATIENTS
- EMS
- FIRE SERVICE
- OTHER AGENCIES
- POLITICIANS
- MEDIA









STAKEHOLDERS - *COMMUNITY FORUMS*

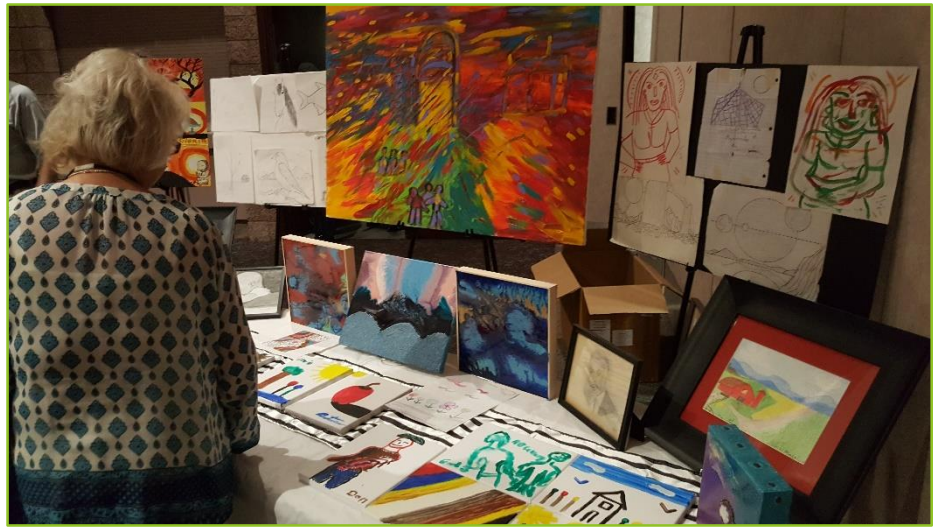








STAKEHOLDERS - PATIENTS
CELEBRATING RECOVERY











STAKEHOLDERS - *BACK TO SCHOOL EVENTS, HEALTH FAIRS AT SCHOOLS, ETC.*









MENTAL HEALTH FIRST AID

- Evidence-based practice formed in Australia in 2001
- 8-hour classes on mental illnesses for lay people, including teachers, church members, civic club members, etc.
- Trainees learn to apply 5-step action plan
- In 2006, the National Council for Behavioral Health began implementing Mental Health First Aid in the United States
- More than 740,000 people across the country have been trained in the program



FIGHTING STIGMA - *MENTAL HEALTH MONTH PROCLAMATIONS, MENTAL HEALTH HEROES*









FIGHTING STIGMA -
FESTIVALS, CONFERENCES, AND OTHER EVENTS











FIGHTING STIGMA -

FARMERS' MARKETS, HEALTH FAIRS, AND SUICIDE PREVENTION EVENTS





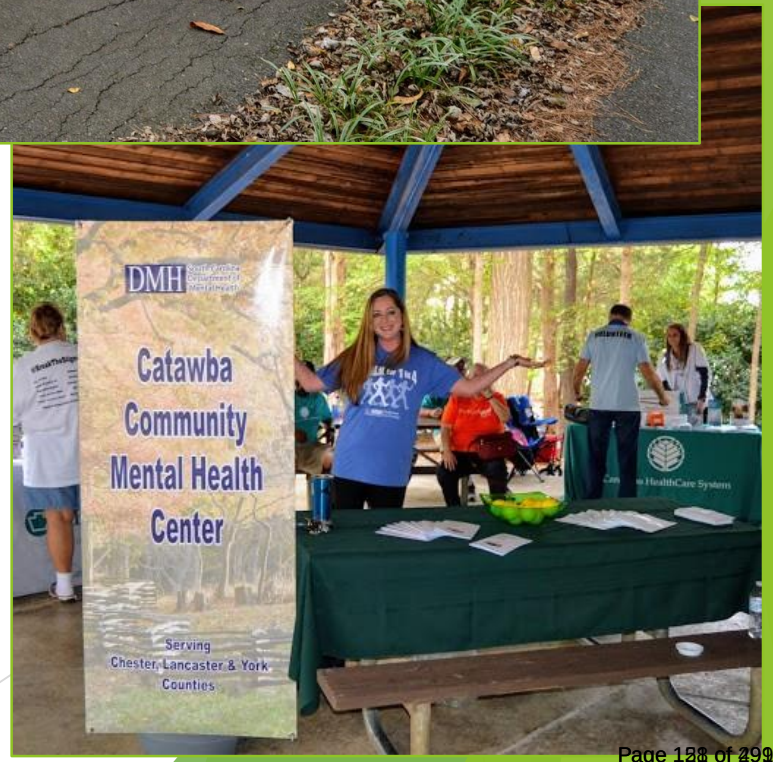


FIGHTING STIGMA -
NAMI WALKS









FIGHTING STIGMA -
HOLIDAY PARADES







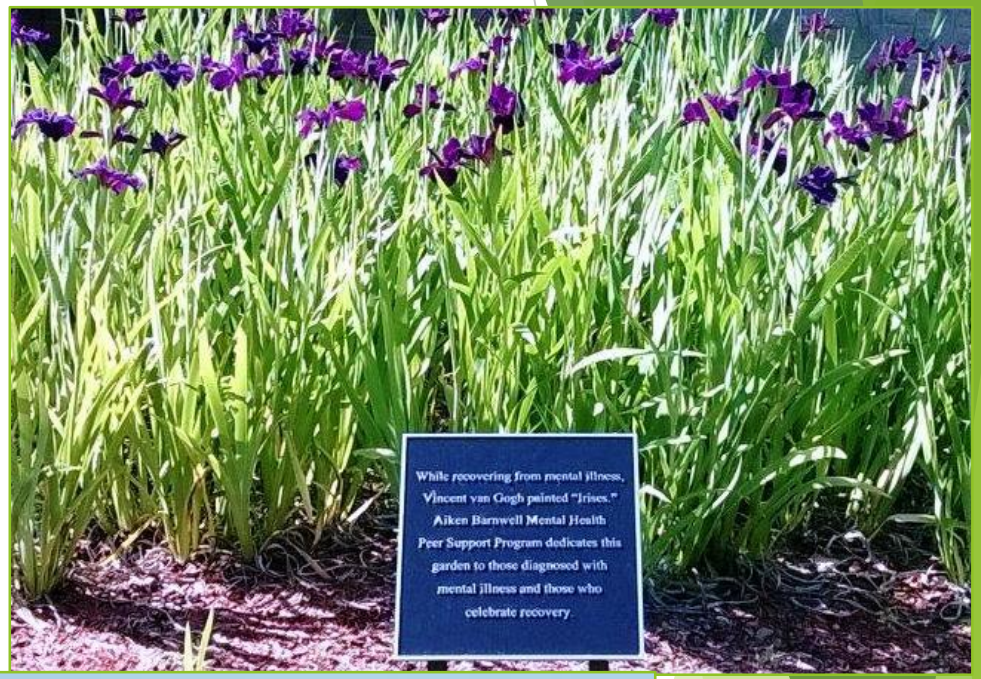






FIGHTING STIGMA - *SUICIDE AWARENESS BALLOON RELEASE, RECOVERY GARDENS AND ANTI-STIGMA BILLBOARDS*







ACCESS –TAKING TREATMENT TO THE STREETS FOR THOSE WHO CAN'T MAKE IT TO A CLINIC

FARMACY – *A MULTIAGENCY AND MULTIDISCIPLINARY STREET MEDICINE TEAM – EMS, CPD, PRIMARY CARE, FOODBANK, ALCOHOL AND DRUG AGENCY, AND MENTAL HEALTH*









HIGHWAY TO HOPE – A MENTAL HEALTH MOBILE

Parking in rural and even urban areas where citizens needing care may be without the means needed to come into a traditional clinic

Currently only at CDMHC, but being planned at SWMHC, SMHC, CAMHC, and CMHC



HOMELESS OUTREACH TEAMS

Currently at CDMHC, WMHC, GGMHC, and in the Columbia Community with funding from SCDMH to MIRCI



CMHS STATEWIDE PROGRAMS

CHILD, ADOLESCENT, & FAMILY SERVICES (CAF)



Louise Johnson, MS
Program Director,
Children, Adolescents &
Their Families

$6,800,000 in Grant Initiatives

Roads of Independence

- $1,000,000 per year/5 years
- Goal is to improve access to treatment and support services for youth and young adults ages 16-25 in Kershaw, Lee, and Sumter Counties

Darlington County Cares

- $600,000 per year/3 years
- Behavioral and physical healthcare integration in 23 Darlington County schools

Clinician LPC Licensure

- Agency collaboration with University of South Carolina
- Partnership provides continuing education and opportunities to support LPC licensure

Cultural and Linguistic Competency (CLC) Initiative

- CAF organizes annual CLC Summit for 300+ participants from child service agencies and organizations in SC
- Day-long training and networking to exchange best practices with the goal of creating a culture of inclusion

National Adoption Competency Mental Health Training Initiative (NTI)

- Training impacts how mental health professionals work with youth and families experiencing adoption and guardianship
- Among the 625 training enrollees in SC, 439 completed NTI training
- Completion rate of 70%, highest of all 8 pilot states in United States

CAF COLLABORATION WITH DEPARTMENT OF JUVENILE JUSTICE (DJJ)

SCDMH/DJJ Memorandum of Agreement (MOA)

MOA between SCDMH and DJJ outlines process by which juveniles with serious mental illness (SMI) are committed to custody of State are transferred for treatment to SCDMH

Staffings

In 2018, ~20 Serious Mental Illness (SMI) inclusion staffings/indeterminate sentences and 45 behavioral health staffings/determinate sentences

Mental Health Services Provision

SCDMH's Community Mental Health Centers (CMHCs) provide needed mental health services to paroled juveniles with serious mental illnesses on a priority basis

SCHOOL MENTAL HEALTH SERVICES



Margaret Meriwether, PhD
Program Director,
School Mental Health Services

Mission

To promote academic and personal success through identifying and intervening at early points and to support social and emotional/behavioral well-being of children and youth in SC

Services

Prevention, early intervention, clinical assessment, individual/family/group therapy, crisis intervention, psychiatric assessment and evaluation, care coordination, and mental health awareness

New Program

Initial cohort of *John H. Magill School Mental Health Certificate Program* started in January 2019 with 7 Master's level students from 6 degree programs working with 5 CMHCs

Funding

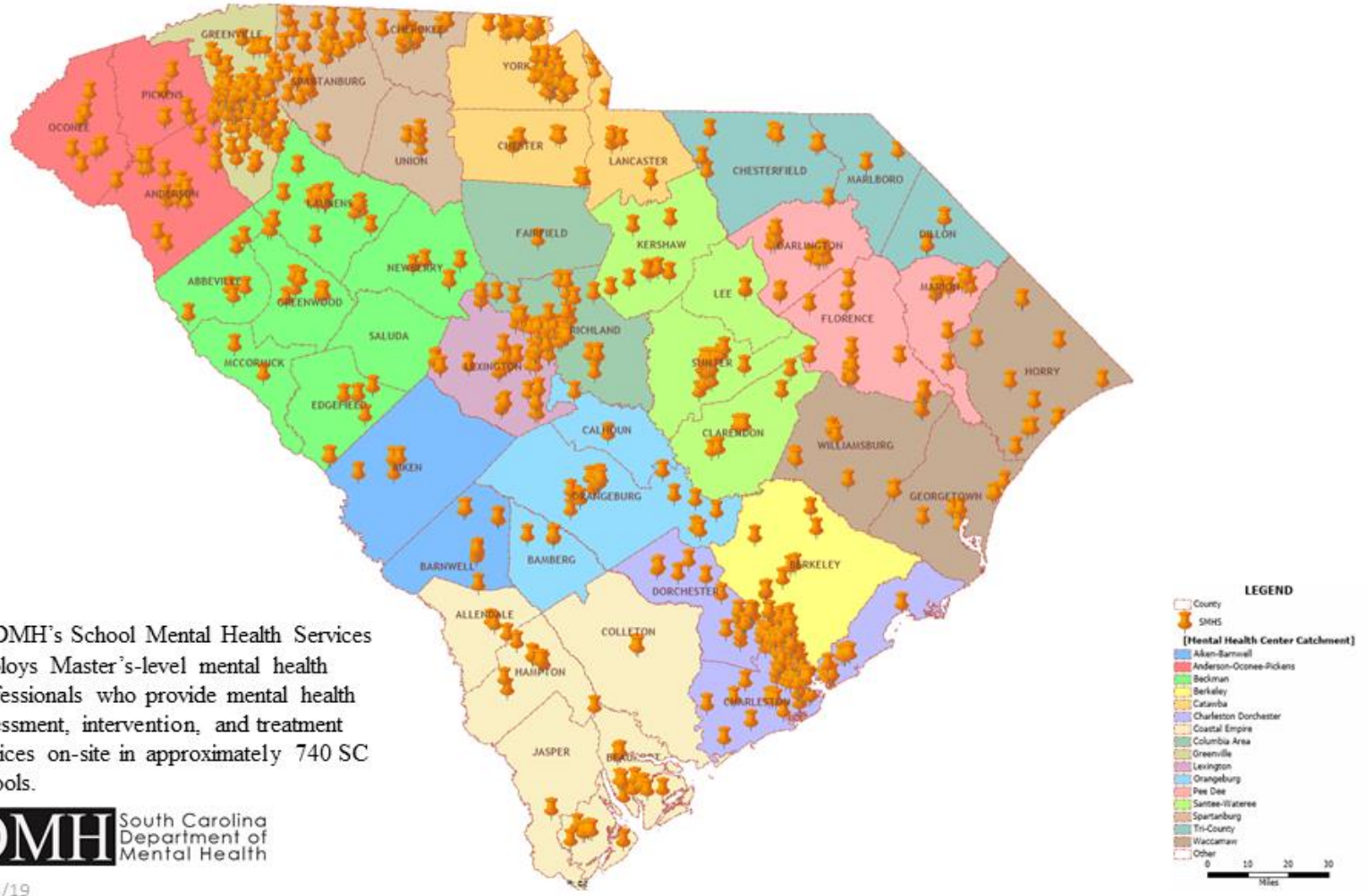
In FY 2019, SCDMH received $4M from General Assembly for expansion of school mental health services

FY19 Services Reach

In FY 2019, with funds from General Assembly, SCDMH school mental health programs provided clinicians to approximately **740 of 1,267** public schools in SC (approximately **58% of schools** as of April 2019)

SCHOOL MENTAL HEALTH SERVICES

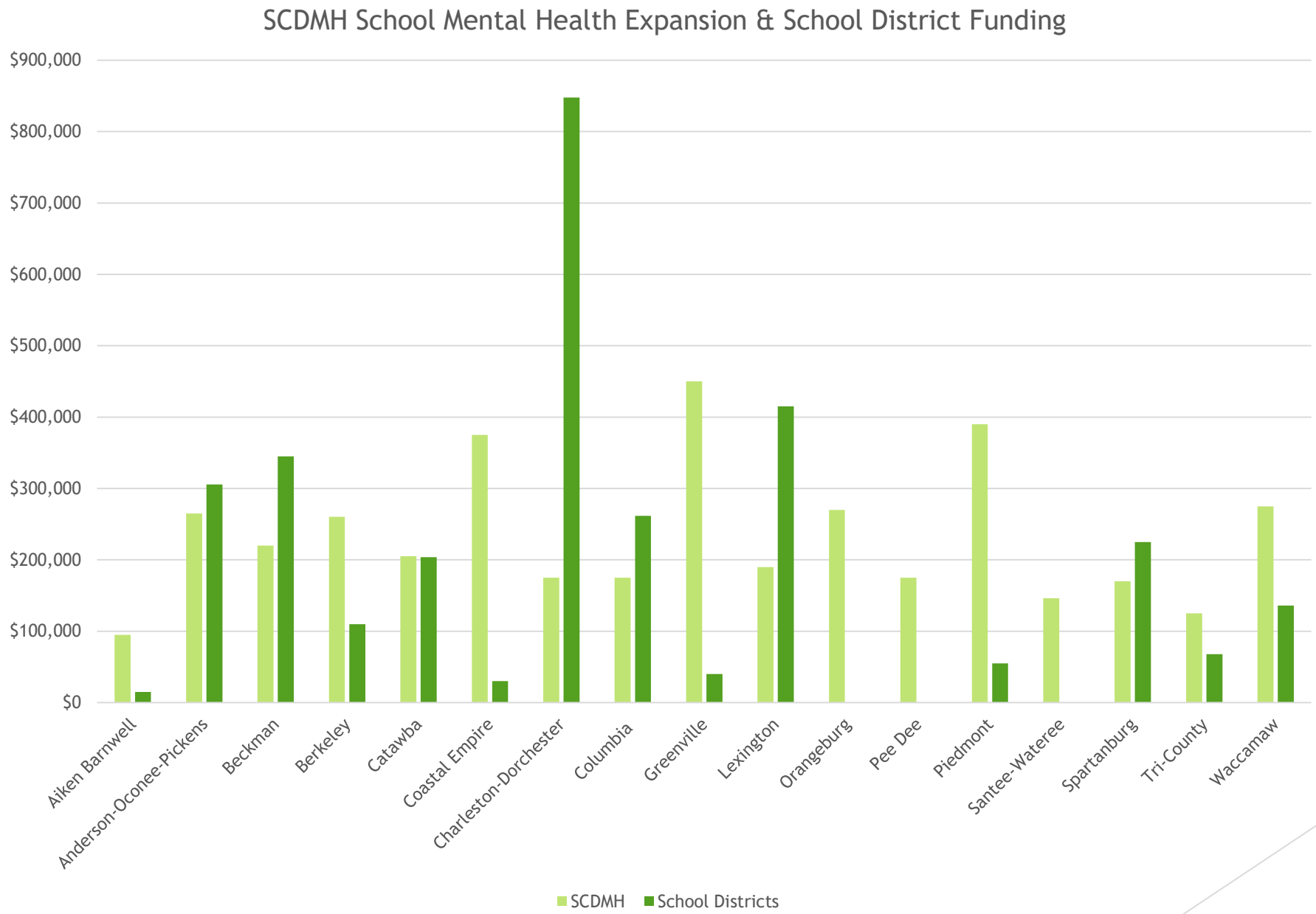
SCDMH School Mental Health Services (SMHS)



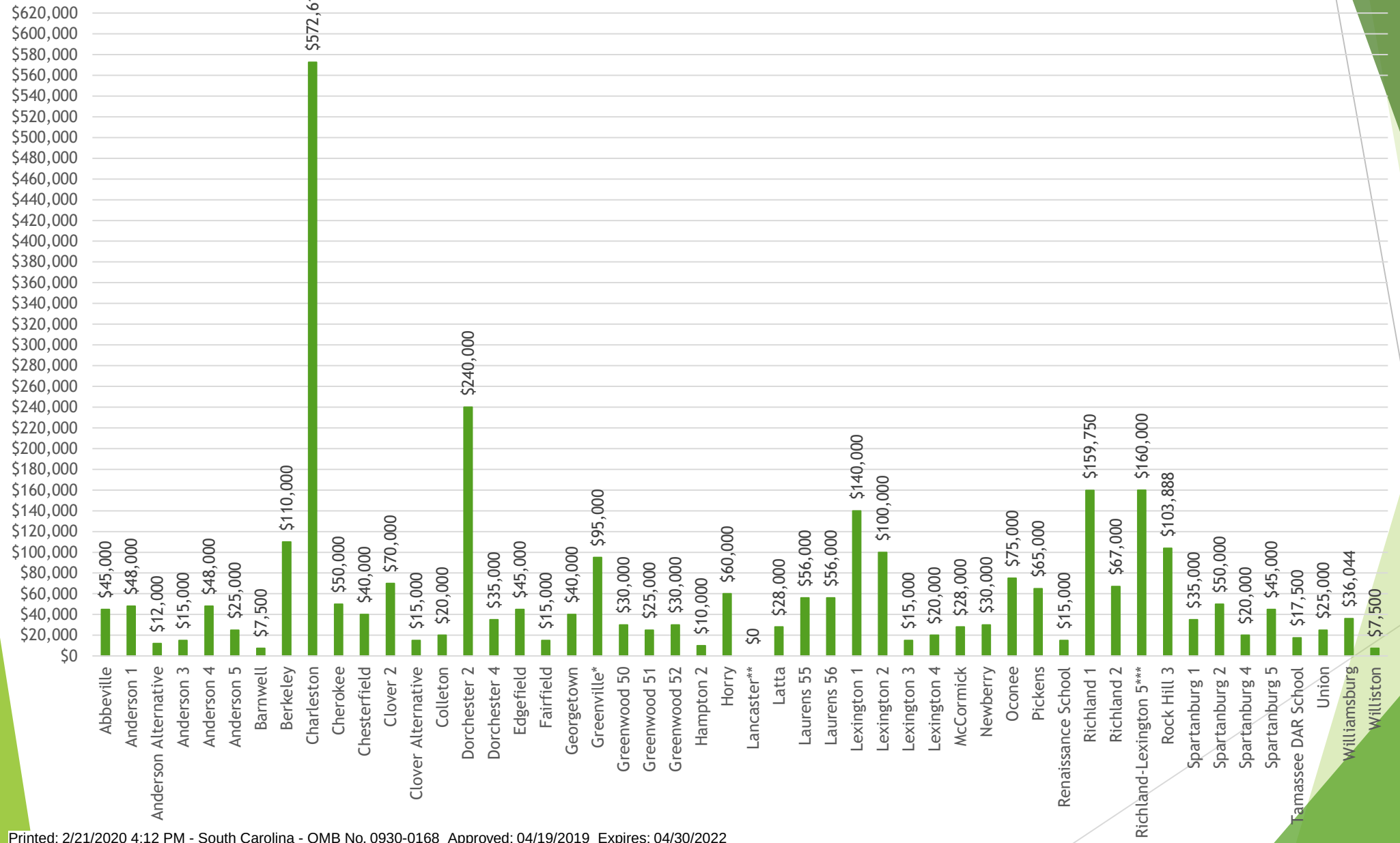
SCDMH's School Mental Health Services employs Master's-level mental health professionals who provide mental health assessment, intervention, and treatment services on-site in approximately 740 SC schools.

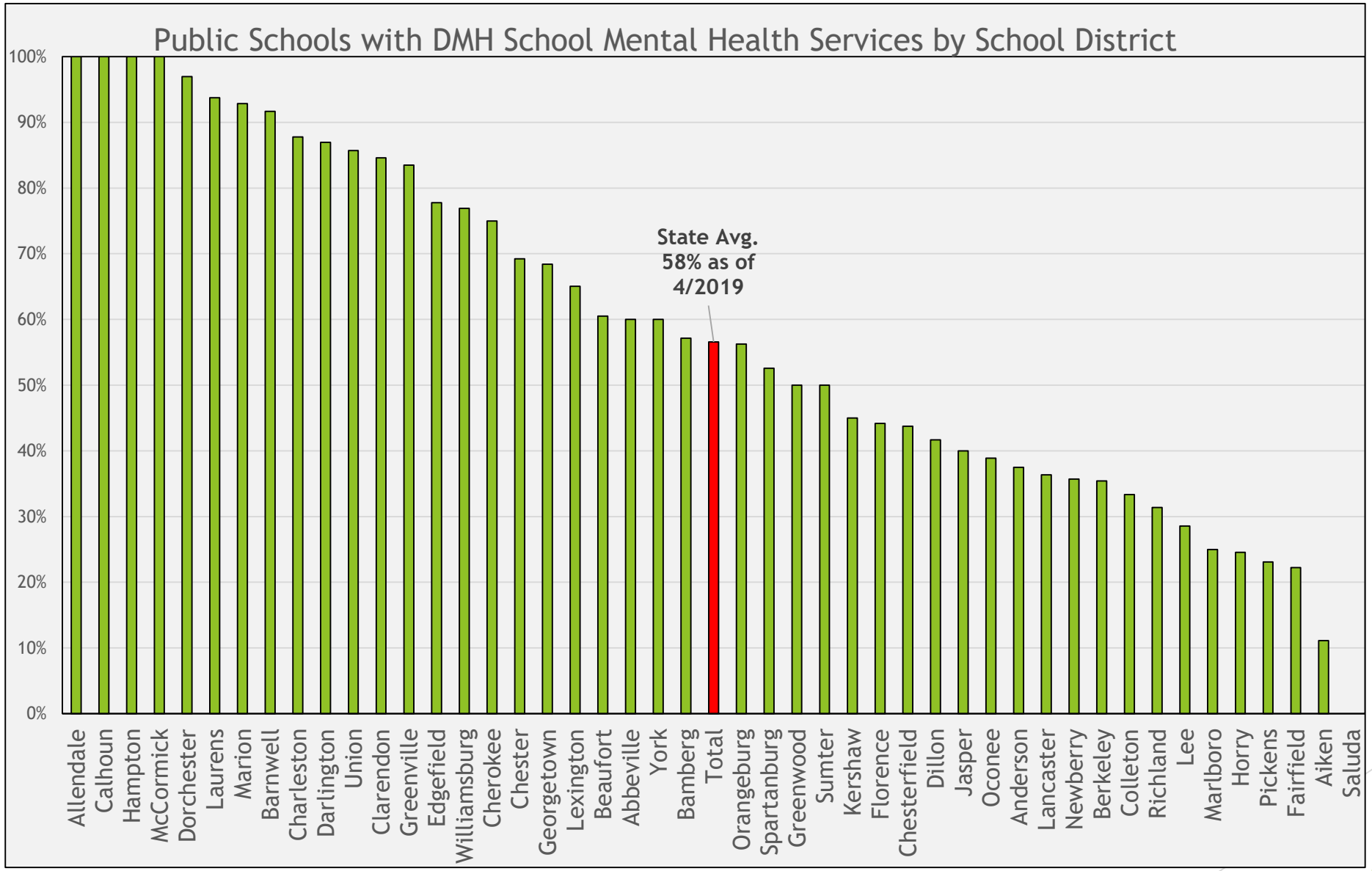
DMH South Carolina Department of Mental Health

3/15/19


SCDMH School Mental Health Expansion & School District Funding
$900,000
$800,000
$700,000
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$0
Aiken Barnwell
Anderson-Oconee-Pickens
Beckman
Berkeley
Catawba
Coastal Empire
Charleston-Dorchester
Columbia
Greenville
Lexington
Orangeburg
Pee Dee
Piedmont
Santee-Wateree
Spartanburg
Tri-County
Waccamaw
SCDMH
School Districts

SC Public School District Contributions to SCDMH School Mental Health Services as of April 20, 2019




Public Schools with DMH School Mental Health Services by School District
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
State Avg. 58% as of 4/2019
Allendale
Calhoun
Hampton
McCormick
Dorchester
Laurens
Marion
Barnwell
Charleston
Darlington
Union
Clarendon
Greenville
Edgefield
Williamsburg
Cherokee
Chester
Georgetown
Lexington
Beaufort
Abbeville
York
Bamberg
Total
Orangeburg
Spartanburg
Greenwood
Sumter
Kershaw
Florence
Chesterfield
Dillon
Jasper
Oconee
Anderson
Lancaster
Newberry
Berkeley
Colleton
Richland
Lee
Marlboro
Horry
Pickens
Fairfield
Aiken
Saluda

DEAF SERVICES

- SCDMH's Deaf Services Program provides a continuum of outpatient and inpatient behavioral health services to persons who are Deaf and Hard of Hearing
- Program uses innovative technological and human service program initiatives to ensure all services are delivered in a cost-effective and timely manner statewide
- *Services*
  - Outpatient services for children, families, and adults, using itinerant counselors who are part of regional teams located across the state
  - School Mental Health services in collaboration with SC School for the Deaf and the Blind
  - Residential services in supported apartments at locations statewide
  - Use of telemedicine and videotext to provide accessible services to rural areas
  - Inpatient services at Patrick B. Harris Hospital and William S. Hall Psychiatric Institute





Dara Baril, MA
Program Director,
Office of Deaf Services

EMPLOYMENT SERVICES

- Individual Placement & Support (IPS) is an evidence-based model of supported employment helping people with SMI obtain and/or maintain competitive employment in community
- IPS in SC is partnership between SCDMH and SC Department of Vocational Rehabilitation
- IPS programs currently located in 12 sites at SCDMH CMHCs
- IPS-supported average employment rate of 60% in SC in FY 2019; national benchmark rate for IPS-supported employment is 40%
- In FY 2019, SCDMH funded IPS programs at all CMHCs
- 350+ SCDMH patients actively participating in IPS services
- 2 IPS programs participating in Social Security Administration (SSA) funded study to determine impact of IPS on people initially denied social security benefits



Demetrius Henderson, M.Ed., MBA
Program Director,
Employment Services

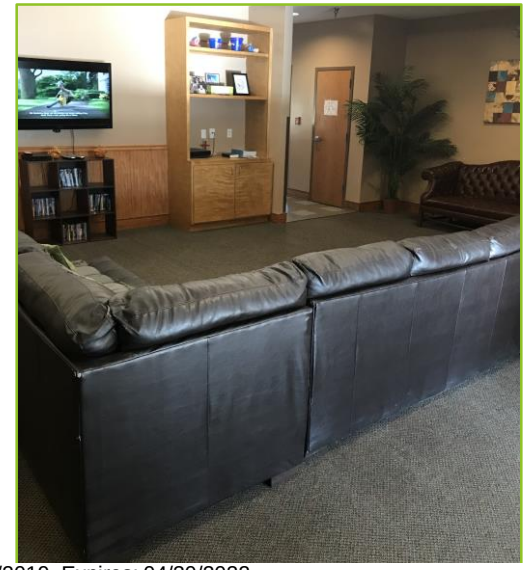
COMMUNITY RESIDENTIAL CARE FACILITIES (CRCFs)



Marjorie Wilson-Guess, MA
Program Director,
Community Residential Care Facilities

- Aiken County—Generations of Monetta (16 beds)
- Lee County—Emerald (5 beds)
- Lexington County—Brook Pine (16 beds)
- Richland County—Kiva Lodge (5 beds), Turning Point (15 beds), Piedmont Pathways (15 beds)
- Greenville County—McKinney (8 beds), Gregory's (32 beds)







COMMUNITY RESIDENTIAL CARE FACILITIES (CRCFs)

- 117 patients served by SCDMH CRCFs
- Referrals received primarily from SCDMH inpatient facilities
- Some patients have histories of behavioral difficulties, justice involvement, dual diagnoses
- CRCFs ensure continuity of care through collaboration with local CMHCs
- CRCF designed to help patients develop skills needed to live independently; discharge planning begins at admission
- DLA-20 tool used to measure patients' functioning at admission and every 45 days







TOWARD LOCAL CARE (TLC)

- TLC Program Established in 1989
- Program Accomplishments
  - Building infrastructure
  - Addressing needs following downsizing of long-term psychiatric hospitals
  - Creating 1,093 options for high utilizers of inpatient services
  - 4,915 patient discharges to TLC since 1991
  - Increasing patients' community tenure
  - Decreasing patients' reliance on inpatient hospitals for psychiatric treatment
  - Fewer patient hospital days and fewer hospital admissions
  - All CMHCs have TLC with at least two program types
  - HOMESHARE – adult foster care



Mallory Miller, MSW, LMSW
Program Director,
Toward Local Care

HOMESHARE

- HOMESHARE integrates psychiatrically disabled adults into community households who have a desire to help others and are willing to share their homes.
- HOMESHARE is in 12 community mental health centers representing 23 counties: Aiken, Allendale, Bamberg, Beaufort, Berkeley, Calhoun, Charleston, Chesterfield, Clarendon, Darlington, Dorchester, Florence, Greenwood, Georgetown, Horry, Laurens, Lexington, Marion, Orangeburg, Richland, Saluda, Sumter, and Williamsburg counties.
- 170 clients are currently living in a HOMESHARE.
- 448 patients have been served by HOMESHARE since 1992.
- There are currently 291 providers on contract to provide standard, respite, and/or enhanced respite type of housing needs.
- HOMESHARE providers receive a stipend for patients' room and board of $1,339 monthly. Patients contribute 74% of their income towards the stipend, and State funds support the rest.

HOUSING AND HOMELESS SERVICES



Michele Murff, MCP
Program Director,
Housing & Homeless Programs

Statewide Housing Units For Persons With Mental Illnesses

- Since FY '92, SCDMH has invested agency funds to develop over 1,100 housing units
- Proceeds from sale of Bull Street property used to fund new housing developments in partnership with private non-profit and for-profit organizations

Community Housing Rental Assistance Program

- Program began in 2015 using SCDMH funding of $1.5M provided through agreement with DHHS, as well as $400,000 in funds from General Assembly
- Currently, SCDMH is assisting 293 units/496 patients and family members at average annual cost/unit of <$6,500

HUD Continuum of Care Permanent Supportive Housing Programs

- Provide >$1.1M annually for rental assistance for formerly homeless patients and their families in 5 counties
- Currently assisting 135 units/174 patients and family members





HOUSING AND HOMELESS SERVICES

Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH)

- Formula grant program funds enable SCDMH to provide outreach and clinical services to people with serious mental illnesses/co-occurring disorders who are experiencing homelessness
- Programs currently based in Columbia, Greenville, Myrtle Beach, and Charleston areas
- PATH programs served >2,000 individuals in FY ‘18

Supplemental Security Income/Social Security Disability Insurance Outreach, Access, and Recovery (SOAR) Initiative

- SOAR is SAMHSA best practice that increases access to SSA disability programs for individuals with serious mental illnesses who are experiencing homelessness
- SCDMH serves as lead agency and partners with SSA and SC Disability Determination Services
- SC SOAR initiative achieved a 69% approval rate for initial SOAR applications in FY ‘18 with average decision time of 78 days, exceeding national outcomes

Treatment for Adults Experiencing Homelessness in SC

- SAMHSA grant to assist homeless persons in receiving mental health services
- In 2018, SCDMH received 5-year award of $1M/year

TRAUMA-INFORMED SYSTEMS

SAMHSA Definition of Trauma

- A widespread, harmful, and costly public health problem, which occurs as a result of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful experiences
- Has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation

SCDMH Trauma-Informed Systems

- Support development and implementation of policies, procedures, and practices
- All patients offered evidence-based trauma assessments
- Patients experiencing trauma-related symptoms are offered evidence-based treatment options
- Practices in CMHCs and facilities do not create, nor recreate, traumatizing events for patients



Christopher Wells, M.Ed.
Program Director,
Trauma-Informed Care Systems

FY 2019 TRAUMA-INFORMED SYSTEMS TRAININGS

- 69 SCDMH clinicians completed 3-day Trauma Focused-Cognitive Behavioral Therapy (CBT) for children, adolescents and their families training
- 48 SCDMH clinicians graduated from 3-day Cognitive Behavioral Therapy for Post-Traumatic Stress Disorder (PTSD) Therapy for Adults training
- 100+ SCDMH staff have participated in Trauma-Informed Care trainings

JUSTICE-INVOLVED PROGRAMMING



Allison Farrell, MPH, LISW-CP
Program Director,
Justice-Involved Services

Mental Health/Justice/Law Enforcement Liaison

- State Office initiative to support SC law enforcement agencies statewide
- Liaison to SC jail administrators; SC detention centers; SC Department of Corrections; SC Sheriffs' Association; SC Police Chiefs' Association; State Law Enforcement Division (SLED); SC Department of Probation, Parole and Pardon Services; SC Department of Public Safety; SC Department of Natural Resources; and all state law enforcement agencies
- Partnership with SC Law Enforcement Assistance Program (SCLEAP) to support the needs of law enforcement and their families

TRAINING FOR LAW ENFORCEMENT & EMS

- Crisis Intervention Training (CIT) - NAMI SC
  - Formulated 1988 by Major Sam Cochran of Memphis Police Department
  - Program designed to teach law enforcement about mental illnesses and de-escalation techniques
  - These 40-hour classes are taught by mental health staff, National Alliance on Mental Illness (NAMI), law enforcement peers, and sometimes other community providers (e.g., 301 providers)
- Adverse Childhood Experiences (ACEs) beginning in FY '20
- Applied Suicide Intervention Skills Training (ASIST) - Office of Suicide Prevention



In this Sept. 2, 2015 file photo, New York City Police Officer Lamont Edwards talks to actor Nathan Purdee during a Crisis Intervention Training class at the New York Police Department Police Academy, in New York. (AP Photo/Mary Altaffer, File)

JUSTICE-INVOLVED PROGRAMMING

First Responder Support Team (FRST)

- Charleston-Dorchester Community Mental Health Center - 2009
- Initiative to expand statewide

SCLEAP

- Partnership to support the needs of law enforcement and their families
- Post Critical Incident Seminar (PCIS)
  - Eye Movement Desensitization & Reprocessing (EMDR)
- Critical Incident Stress Management – (CISM)

JUSTICE-INVOLVED PROGRAMMING

Embedded Mental Health Professionals (MHPs)

- Law Enforcement Agencies
  - 7 Victims of Crime Act (VOCA) funded MHPs throughout Charleston and Dorchester Counties, serving child and adult victims of crime
  - Mental Health/Law Enforcement Alliance Project (Alliance)
  - $847,000 funded by BlueCross BlueShield of South Carolina Foundation over 3 years
  - $1.2 budget request to support 25 additional FTEs (FY '21)
- Detention Centers (Jail Liaisons)
- Embedded Clinician in 911 Consolidated Dispatch – Pilot Project
- Local Hospital EDs - 10 CMHCs have MHPs embedded in local hospital EDs



Former Charleston Police Chief Greg Mullen awarding the first embedded MHP, Denise Jones, the department's Excellence in Service Award!

JUSTICE-INVOLVED PROGRAMMING

Mental Health Courts

- Goal - Diversion of non-violent, adult offenders with serious mental illness from criminal justice system
- Five County Courts in SC - Charleston, Greenville, Horry, Richland, and York
- Funding - $400,000 in recurring State appropriations, as well as $1,220,000 3-year grant from The Duke Endowment to standardize existing courts, establish two new courts, and conduct research study on outcomes

OFFICE OF SUICIDE PREVENTION



Alex Karydi, Ph.D., LMFT, LAC, CSAC
Program Director,
Office of Suicide Prevention

Federally funded by SAMHSA, our efforts include but are not limited to:

- Comprehensive School Suicide Prevention Program
- Zero Suicide initiative implementation in health and behavioral health care settings
- Providing access to information and resources
- Best Practice suicide safety policy and protocol development
- Follow-up/aftercare planning and development
- De-stigmatization and awareness strategies
- Tiered comprehensive best practices for community members and multi-disciplinary audiences
- Cultural competency trainings focused on high risk populations (e.g., LGBTQI populations, individuals living with serious mental illnesses, trauma-informed care, etc.)
- Coalition and task force development
- Post-intervention consultation

ZEROSuicide IN HEALTH AND BEHAVIORAL HEALTH CARE

ask? ask about suicide to save a life

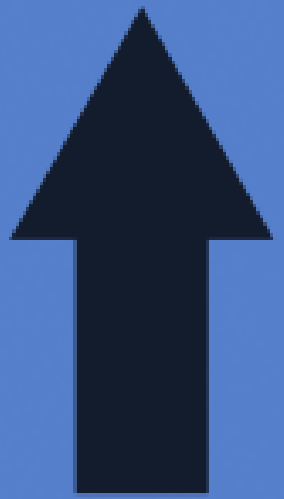
SUICIDE safeTALK suicide alertness for everyone

ASIST

suicide to Hope aiding recovery and growth

SC Suicide Numbers for Ages 10-24

*2012-2017
**2010-2014



30% in suicide deaths*



43% in suicide attempts**

Suicide attempts for 10-14-year-olds **DOUBLED** in some S.C. counties

OFFICE OF SUICIDE PREVENTION

School Mental Health Services

- Since 2016, **40+** S.C. schools updated protocols to ensure best practices in suicide prevention
- SC Department of Education and SC School Board Association recently adopted our policy and best-practice suicide prevention protocol for SC schools
- While **97%** of teachers believe suicide prevention is an important part of their jobs, only **77%** knew what procedures to follow

SC Department of Mental Health
Office of Suicide Prevention
803.896.4740 | scdmh.org/osp



OFFICE OF SUICIDE PREVENTION

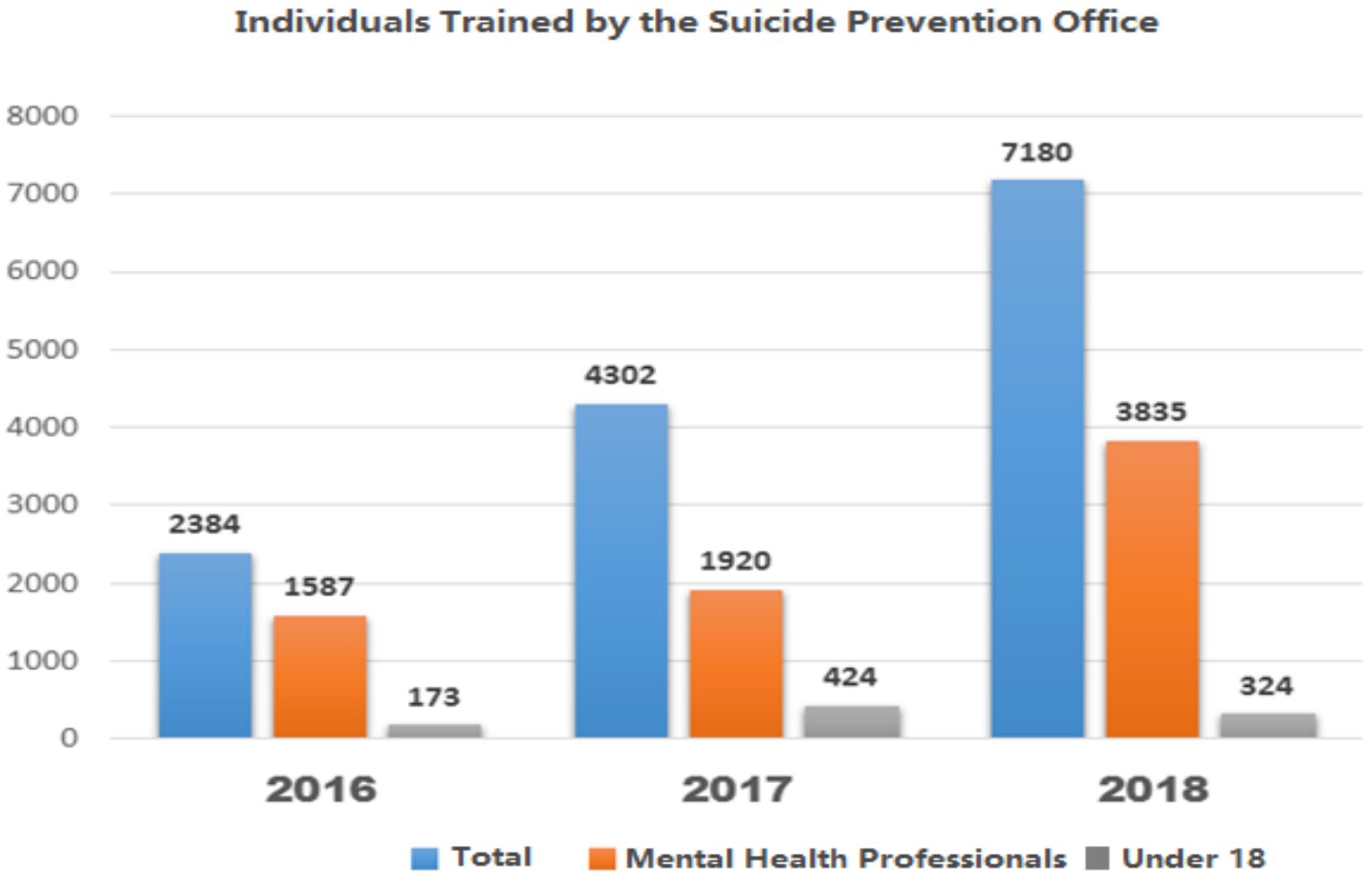
Zero Suicide (ZS) Programs

- **46%** increase in screening after implementation
- **95%** suicide screening rate across all DMH clinics
- SCDMH supports other agencies with ZS programming
  - *SC Department of Health and Environmental Control (DHEC)*
  - *Federally Qualified Health Centers (FQHCs)*
  - *SC Department of Juvenile Justice (DJJ)*
  - *SC Department of Corrections (SCDC)*

zero suicide



COMPARISON GRAPH OF INDIVIDUALS TRAINED 2016-2018



COMMUNITY CRISIS PROGRAMMING

- All 16 SCDMH CMHCs provide crisis services
- $6.2 million awarded annually to CMHCs
  - Local/Private Inpatient/Community Crisis Beds - 78% diverted out of EDs and 22% prevented an ED admission for Local/Private/Community Crisis beds
  - Crisis/Co-Occurring Teams

MOBILE CRISIS – A 24/7 CRISIS RESPONSE TEAM FORMED IN 1987 - 32 YEARS OF HISTORY INFORMING THE FUTURE



COMMUNITY CRISIS RESPONSE AND INTERVENTION

THE PURPOSE

To enhance the crisis services array to include a statewide community crisis on-site emergency psychiatric screening and assessment.

COMMUNITY CRISIS RESPONSE & INTERVENTION
SC Department of Mental Health

To provide services **24/7/365** within 60 minutes of contact with the CCRI team to meet the mental health needs of residents of South Carolina.

SCDMH

COMMUNITY CRISIS RESPONSE & INTERVENTION

Program Director:
Amanda Gilchrist

CCRI Access Line:
833-DMH-CCRI
833-(364-2274)

Email: ccri@scdmh.org

www.state.sc.us/dmh/

DMH South Carolina Department of Mental Health

COMMUNITY CRISIS RESPONSE & INTERVENTION

COMMUNITY MENTAL HEALTH SERVICES

- Operational 24/7/365
- Staffed by regional teams - Coastal, Pee Dee, Midlands, Upstate
- Requires strong partnerships with local law enforcement offices and probate courts, local emergency departments, and inpatient facilities



Amanda Gilchrist, LPC
Program Director,
Community Crisis Response & Intervention

ABOUT CCRI

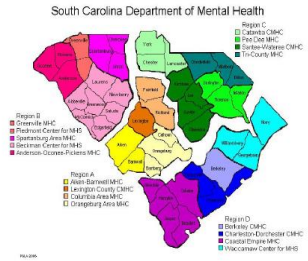
We provide adults and children with clinical screening either

- in person at the location of the crisis,
- in person at a community mental health center,
- via phone, or
- Telehealth Communication Software,

in order to de-esclate the crisis and provide linkage to ongoing treatment and other resources.

HOW IT WORKS

Each call that is received via the CCRI Access Line will be directed to the appropriate triage clinician based on geographical location (region).



Region A: Midlands
Region B: Upstate
Region C: Pee-Dee
Region D: Coastal

PROGRAM GOALS

Provide access and link patients to appropriate levels of care and divert from unnecessary hospitalizations and incarcerations.

Build partnerships with local law enforcement, hospitals, judges, community partners, and local mental health providers.

WHEN IS IT AVAILABLE?

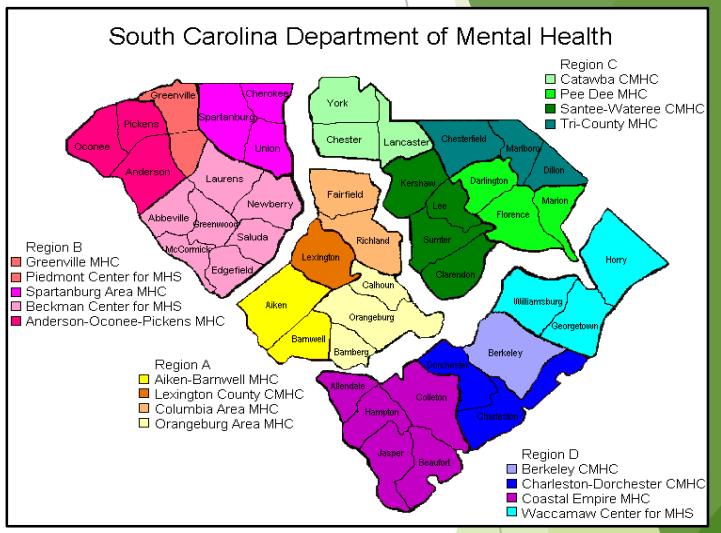
Each region will be phased in. The local DMH centers are available for services to the community based on their current county of residence.

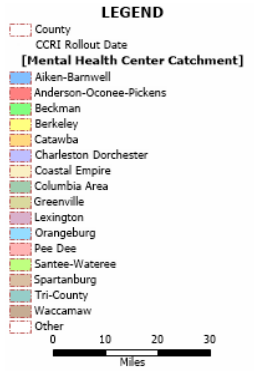
- Rollout began May 1, 2018 in the Coastal region and is active in 29 counties to date
- The toll free line to access services is 833-364-2274 (833-DMH-CCRI)

COMMUNITY CRISIS RESPONSE INITIATIVE (CCRI) ROLLOUT DATES, BY COUNTY



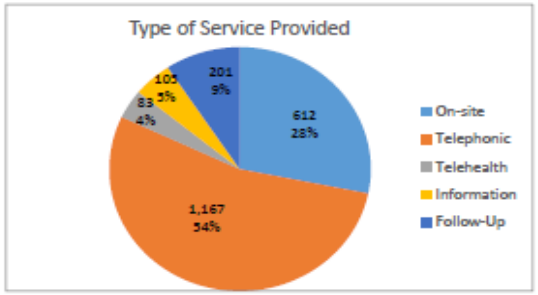
REGIONAL MAP





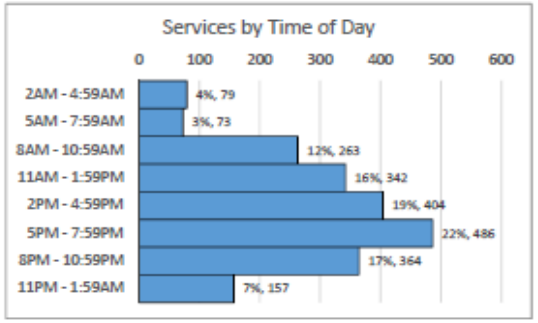
DMH South Carolina Department of Mental Health

CCRI DATA



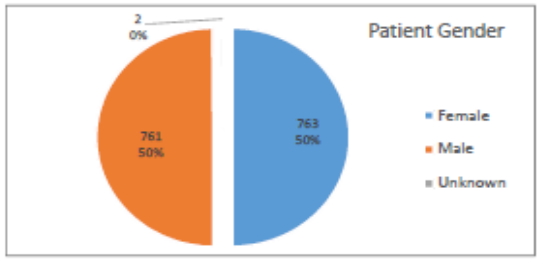
Service Type	Patients		Services	
	#	%	#	%
On-site	550	31%	612	28%
Telephonic	893	50%	1,167	54%
Telehealth	83	5%	83	4%
Information	101	6%	105	5%
Follow-Up	169	9%	201	9%
Total	1,796	100%	2,168	100%

* Patient totals unduplicated for each reporting category



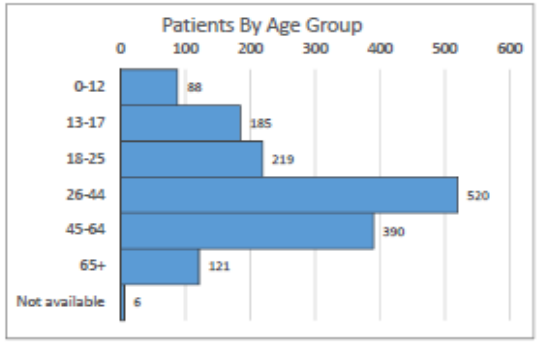
Service Type	Patients		Services	
	#	%	#	%
2AM - 4:59AM	70	4%	79	4%
5AM - 7:59AM	69	4%	73	3%
8AM - 10:59AM	237	12%	263	12%
11AM - 1:59PM	305	16%	342	16%
2PM - 4:59PM	357	18%	404	19%
5PM - 7:59PM	430	22%	486	22%
8PM - 10:59PM	326	17%	364	17%
11PM - 1:59AM	151	8%	157	7%
Total	1,945	100%	2,168	100%

* Patient totals unduplicated for each reporting category



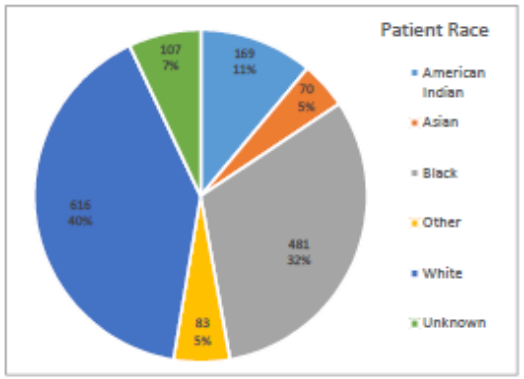
Gender	Patients		Services	
	#	%	#	%
Female	763	50%	1,042	48%
Male	761	50%	1,124	52%
Unknown	2	0%	2	0%
Total	1,526	100%	2,168	100%

* Patient totals unduplicated for each reporting category



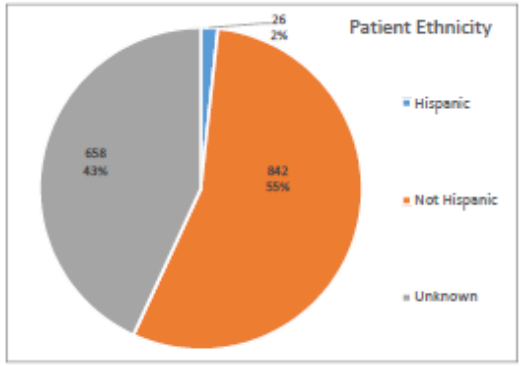
Age Group	Patients		Services	
	#	%	#	%
0-12	88	6%	127	6%
13-17	185	12%	235	11%
18-25	219	14%	317	15%
26-44	520	34%	727	34%
45-64	390	26%	595	27%
65+	121	8%	161	7%
Not available	6	0%	6	0%
Total	1,529	100%	2,168	100%

* Patient totals unduplicated for each reporting category



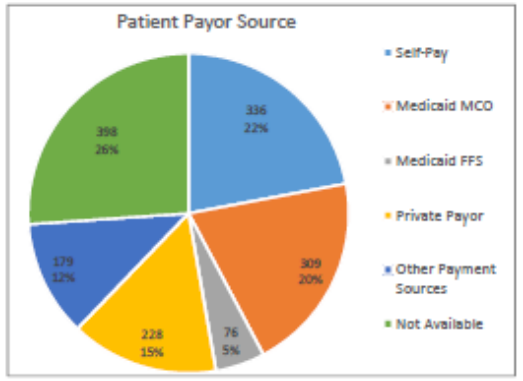
Race Group	Patients		Services	
	#	%	#	%
American Indian	169	11%	204	9%
Asian	70	5%	84	4%
Black	481	32%	685	32%
Other	83	5%	128	6%
White	616	40%	933	43%
Unknown	107	7%	134	6%
Total	1,526	100%	2,168	100%

* Patient totals unduplicated for each reporting category



Hispanic Ethnicity	Patients		Services	
	#	%	#	%
Hispanic	26	2%	43	2%
Not Hispanic	842	55%	1,265	58%
Unknown	658	43%	860	40%
Total	1,526	100%	2,168	100%

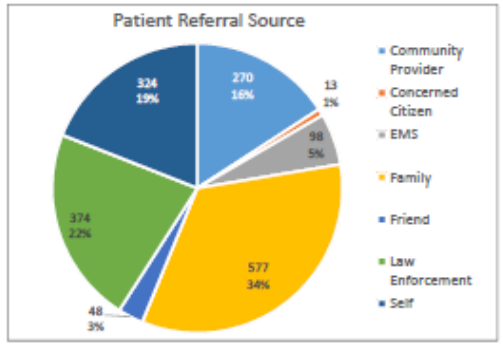
* Patient totals unduplicated for each reporting category



Payment Source	Patients		Services	
	#	%	#	%
Self-Pay	336	22%	507	23%
Medicaid MCO	309	20%	451	21%
Medicaid FFS	76	5%	97	4%
Private Payor	228	15%	326	15%
Other Payment Sources	179	12%	285	13%
Not Available	398	26%	502	23%
Total	1,526	100%	2,168	100%

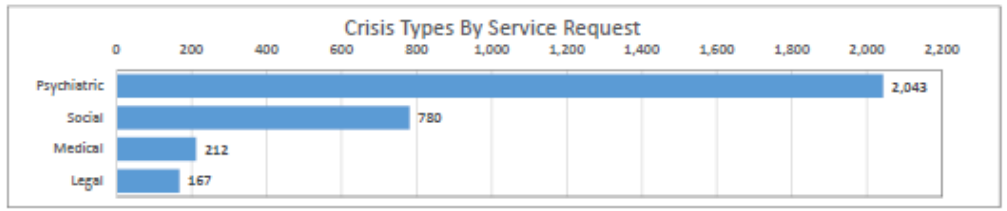
* Patient totals unduplicated for each reporting category

CCRI DATA

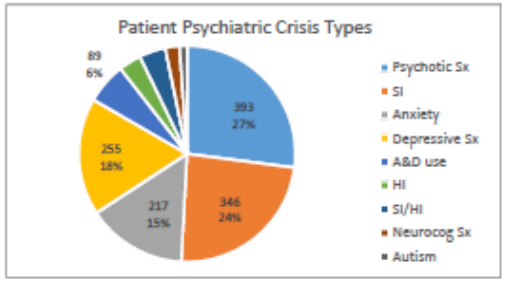


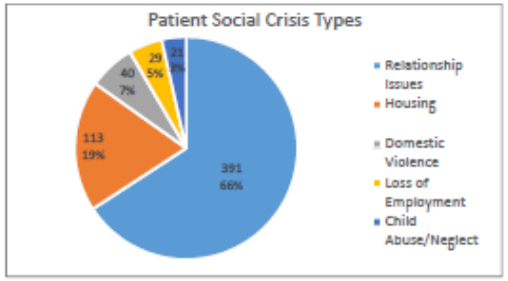
Referral Source	Patients		Services	
	#	%	#	%
Community Provider	270	16%	302	14%
Concerned Citizen	13	1%	17	1%
EMS	98	6%	104	5%
Family	577	34%	757	35%
Friend	48	3%	56	3%
Law Enforcement	374	22%	442	20%
Self	324	19%	490	23%
Total	1,704	100%	2,168	100%

* Patient totals unduplicated for each reporting category



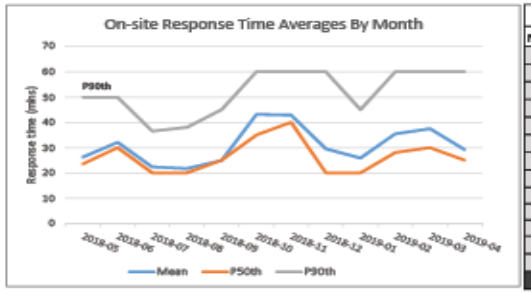
* Crisis type categories not mutually exclusive



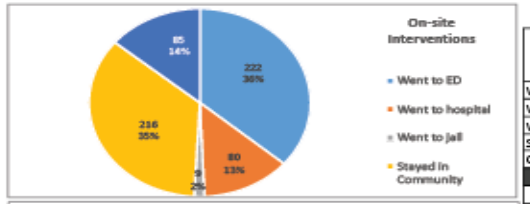


Crisis Type	Patients		Services	
	#	%	#	%
Psychatric	1,453	95.2%	2,043	94.2%
Psychotic Sx	393	27.0%	573	26.4%
SI	346	23.8%	454	20.9%
Anxiety	217	14.9%	346	16.0%
Depressive Sx	255	17.5%	334	15.4%
A&D use	89	6.1%	130	6.0%
HI	49	3.4%	67	3.1%
SI/HI	57	3.9%	77	3.6%
Neurocog Sx	31	2.1%	37	1.7%
Autism	16	1.1%	25	1.2%
Social	594	38.9%	780	36.0%
Relationship Issues	391	65.8%	522	66.9%
Housing	113	19.0%	148	19.0%
Domestic Violence	40	6.7%	48	6.2%
Loss of Employment	29	4.9%	37	4.7%
Child Abuse/Neglect	21	3.5%	25	3.2%
Medical	164	10.7%	212	9.8%
Legal	141	9.2%	167	7.7%

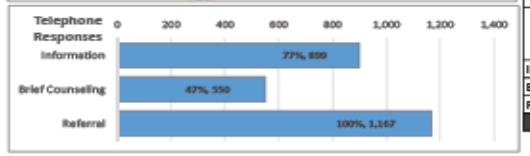
* Patient totals unduplicated for each reporting category



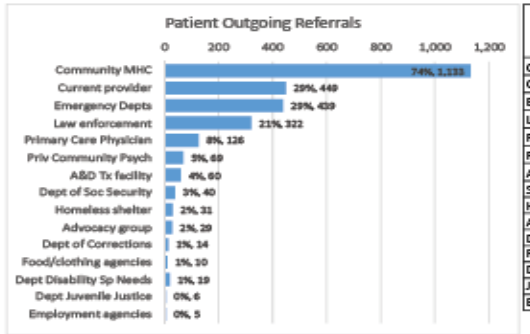
On-Site Response Times By Month and Minutes			
Month	Mean	P50th	P90th
2018-05	26	24	50
2018-06	32	30	50
2018-07	22	20	37
2018-08	22	20	38
2018-09	25	25	45
2018-10	43	35	60
2018-11	43	40	60
2018-12	30	20	60
2019-01	26	20	45
2019-02	35	28	60
2019-03	37	30	60
2019-04	29	25	60
2019-05	31	30	60
Total	31	25	60



Status	On-Site Response Times By Month and Minutes			
	Patients		Services	
	#	%	#	%
Went to ED	211	36%	222	36%
Went to hospital	73	13%	80	13%
Went to jail	9	2%	9	1%
Stayed in Community	208	36%	216	35%
Other	83	14%	85	14%
Total	584	100%	612	100%

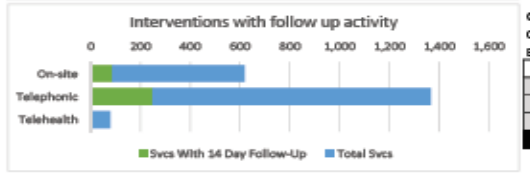


Telephonic Intervention Content	Telephonic Responses			
	Patients		Services	
	#	%	#	%
Information	721	81%	899	77%
Brief Counseling	426	48%	550	47%
Referral	893	100%	1,167	100%
Total	893		1,167	



Referrals	Outgoing Referrals			
	Patients		Services	
	#	%	#	%
Community MHC	1,133	74%	1,567	72%
Current Provider	449	29%	550	25%
Emergency Depts.	439	29%	520	24%
Law Enforcement	322	21%	391	18%
Primary Care Physician	126	8%	148	7%
Priv Community Psych	69	5%	80	4%
A&D Tx facility	60	4%	69	3%
Social Services	40	3%	45	2%
Homeless Shelter	31	2%	34	2%
Advocacy Group	29	2%	32	1%
Dept. of Corrections	14	1%	15	1%
Food/Clothing Agencies	10	1%	11	1%
Disability and Sp. Needs	19	1%	24	1%
Juvenile Justice	6	0%	8	0%
Employment Agencies	5	0%	5	0%

Patients may receive more than one referral



Crisis intervention follow up activity

Count of svcs with 2nd svc within 14 days

Excludes svcs resulting in psych hospitalization

Service Type	# of svcs	With F/U	% W F/U
On-site	532	87	16.4%
Telephonic	1118	248	22.2%
Telehealth	71	8	11.3%
Total	1,721	343	19.9%

OTHER CMHS PROGRAMS AND INITIATIVES

FIRST EPISODE PSYCHOSIS (FEP)

- Evidence-based model called NAVIGATE
- Tailored to young adults experiencing their first episode of psychosis and their families
- Model focuses on psycho-education, acceptance, medication management, and navigation of expectations

NAVIGATE

INTENSIVE COMMUNITY TREATMENT (ICT) TEAMS

- Multidisciplinary teams provide intensive treatment services to patients
- Patients are offered appointments at least weekly
- Staff to patient ratio not to exceed 1:35
- Patients are seen in community

MULTIDIMENSIONAL FAMILY THERAPY (MDFT)

- Intensive services for children and their families in the community
- Large emphasis on family engagement
- Staff to patient ratio not to exceed 1:15

multidimensional
FAMILY THERAPY

PEER SUPPORT SERVICES

Certified Peer Support Specialists are self-identified staff recovering from a mental illness who are willing to share their lived experiences to help others on their road to recovery!

SOUTH CAROLINA CERTIFIED
PEER SUPPORT SPECIALIST
OFFERING HOPE THROUGH LIVED EXPERIENCE



SOUTH CAROLINA LEADERSHIP ACADEMY FOR TOBACCO-FREE RECOVERY STATE STRATEGY SESSION

2018 South Carolina State Strategy Session

- SCDMH, DHEC, SC Department of Alcohol and Other Drug Abuse Services, and SC Department of Health and Human Services (DHHS) have partnered with SAMHSA, Centers for Disease Control's National Behavioral Health Network, and Smoking Cessation Leadership Center from University of California, San Francisco
- Partners held 2018 summit to address high prevalence of smoking among adults with behavioral health disorders in SC

Goals of State Strategy Session

- Reduce tobacco use by Medicaid-eligible adults with mental health diagnoses from 32.2% to 23.0% by 2023
- Reduce tobacco use by Medicaid-eligible adults with substance abuse diagnoses from 62.3% to 53.0% by 2023

PRIMARY CARE INTEGRATION

- Some centers have staff embedded in Federally Qualified Health Centers (FQHCs).
- Some centers have FQHCs embedded in our mental health centers.
- One center provides primary care with its own staff.

HOLISTIC CARE - COLLECTING FOOD AND TOYS FOR THE HOLIDAYS FOR PATIENTS





HOLISTIC APPROACH - *CAF HOLIDAY PARTY FOR PATIENTS*











CARE COORDINATION

- SCDMH operates a separate arm of support for patients known as Care Coordination.
- Care Coordinators help patients find and access resources such as primary care, housing, entitlement programs, etc.
- Care Coordination is operated by SCDMH's Division of Medical Affairs (to be discussed in more detail during a future presentation).

CRISIS STABILIZATION UNITS AND TELEPSYCHIATRY FOR JAIL/EMERGENCY DEPARTMENT DIVERSON

CRISIS STABILIZATION UNITS

Tri-County Crisis Stabilization Center (TCSC)
(Charleston-Dorchester and Berkeley CMHCs)







CRISIS STABILIZATION DATA

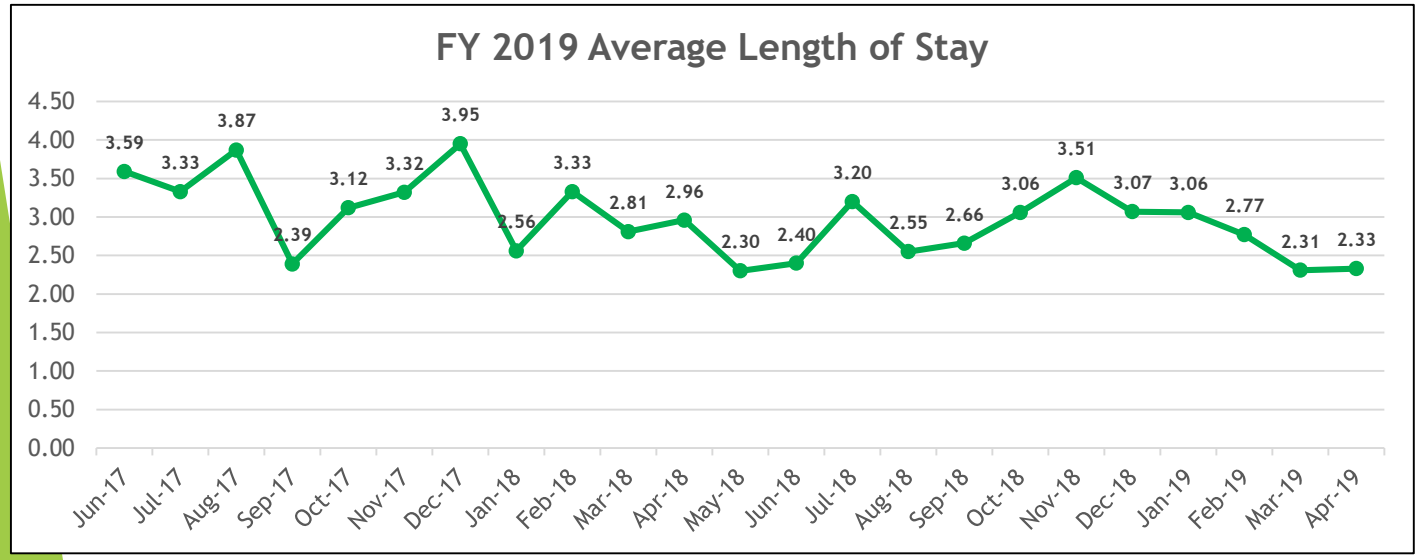
Tri-County Crisis Stabilization Center
(Charleston-Dorchester and Berkeley CMHCs)

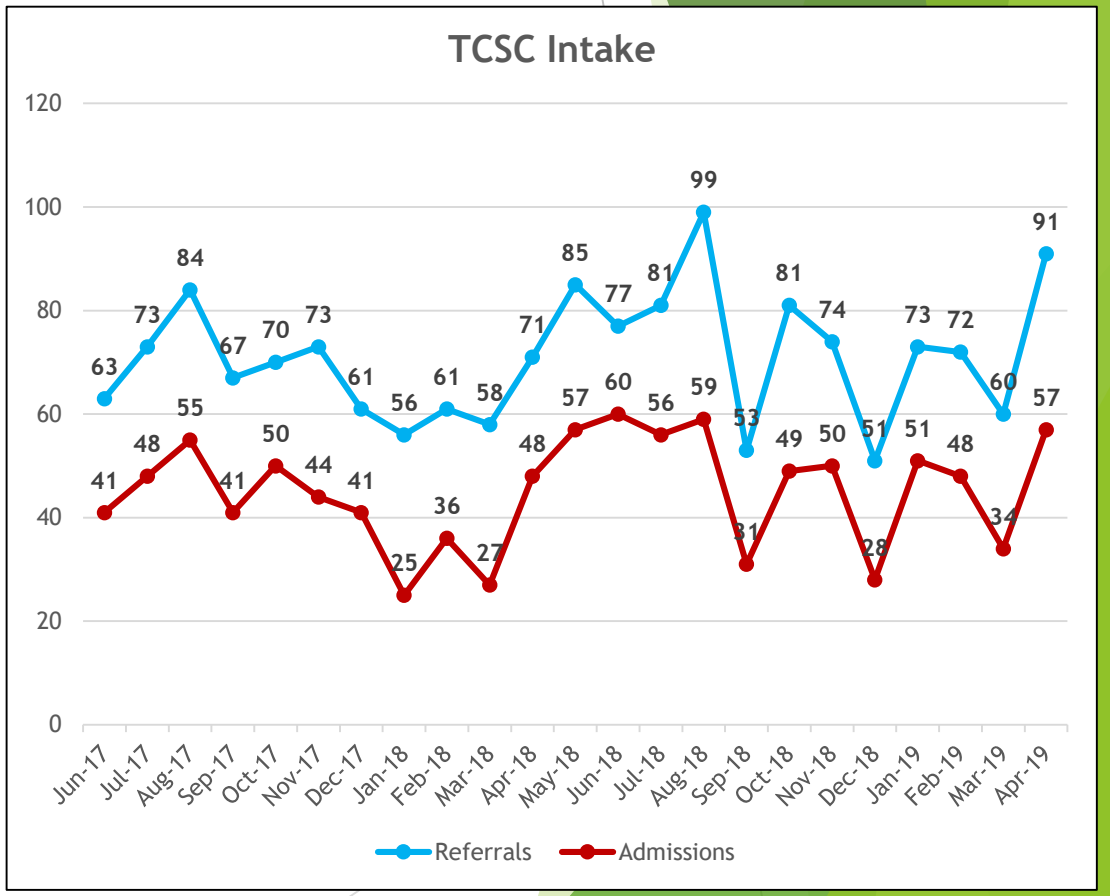
Tri-County Crisis Stabilization Center Data

June 5, 2017 to April 30, 2019

Time frame	Referrals	Admissions	Triage	Diversions		
				MH hosp	ED	Jail
6/5/17 to 4/30/19	1634	1036	124	987	365	20

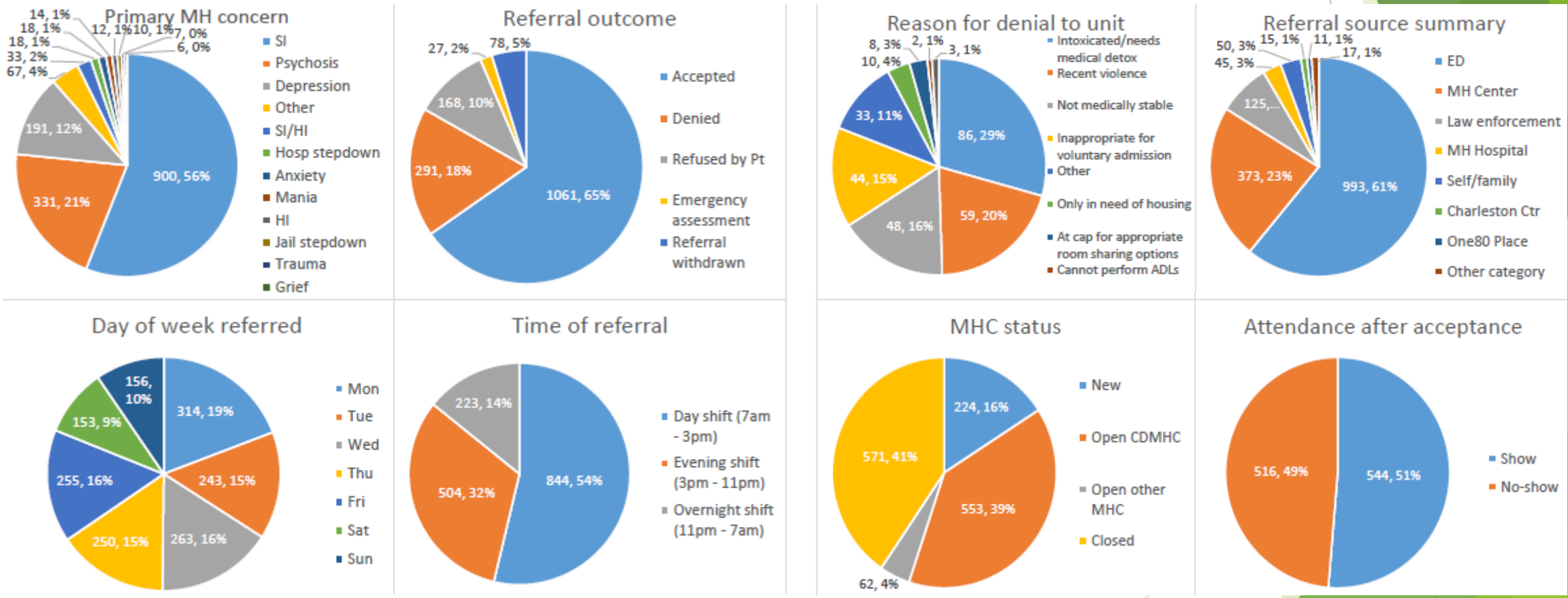
2.89	Avg length of stay
4.15	Avg daytime census





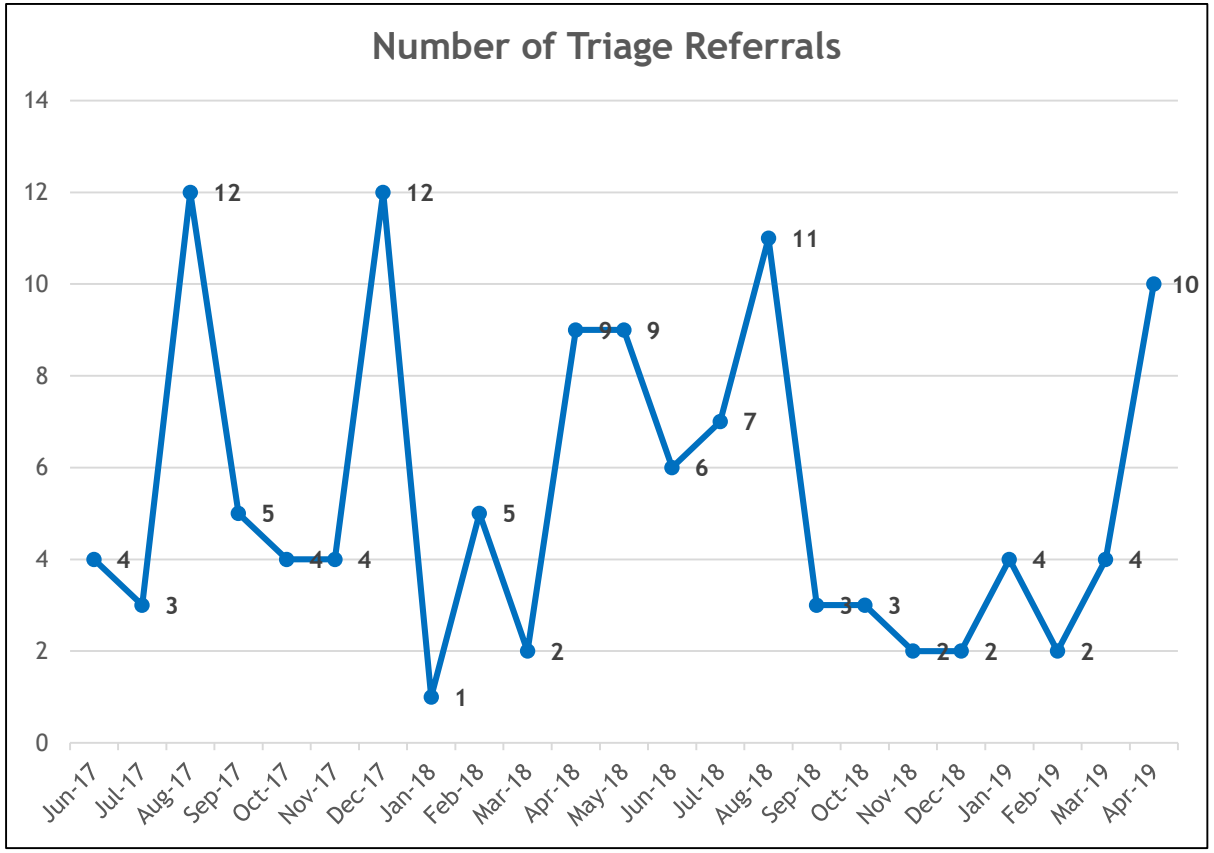
CRISIS STABILIZATION DATA

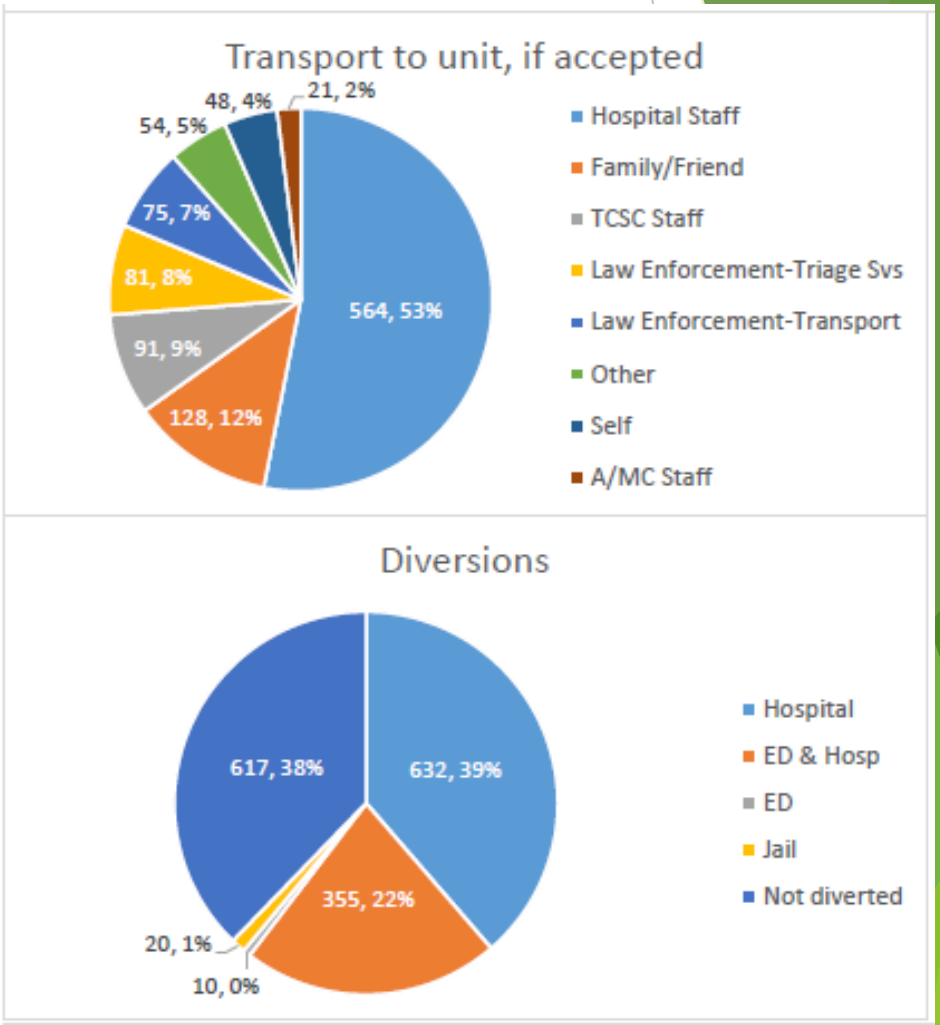
Tri-County Crisis Stabilization Center (Charleston-Dorchester and Berkeley CMHCs)



CRISIS STABILIZATION UNITS

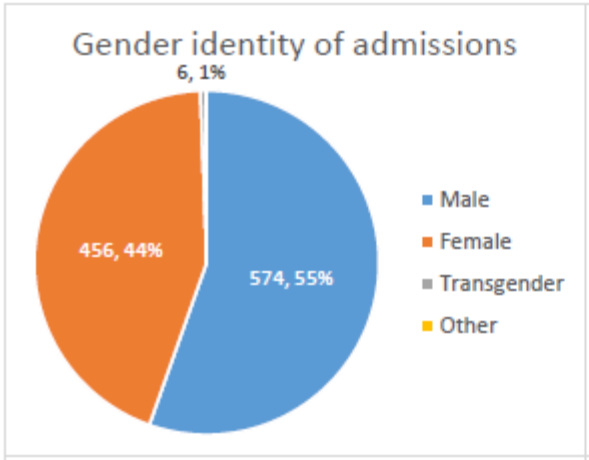
Tri-County Crisis Stabilization Center (Charleston-Dorchester and Berkeley CMHCs)

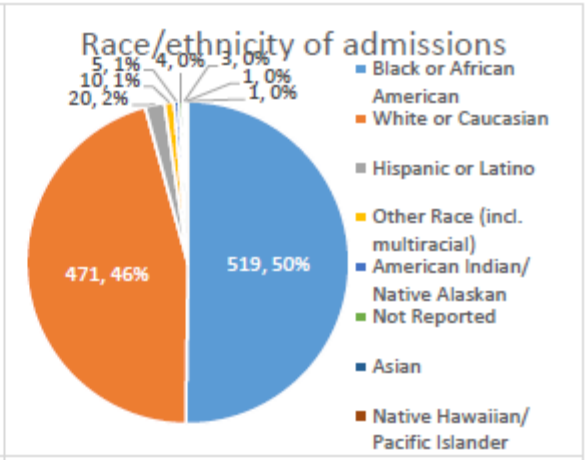


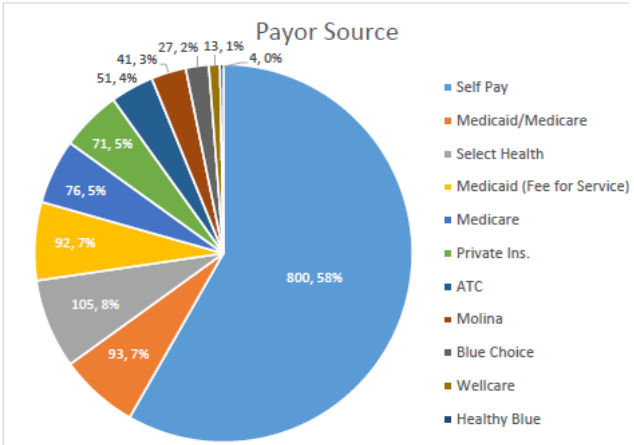


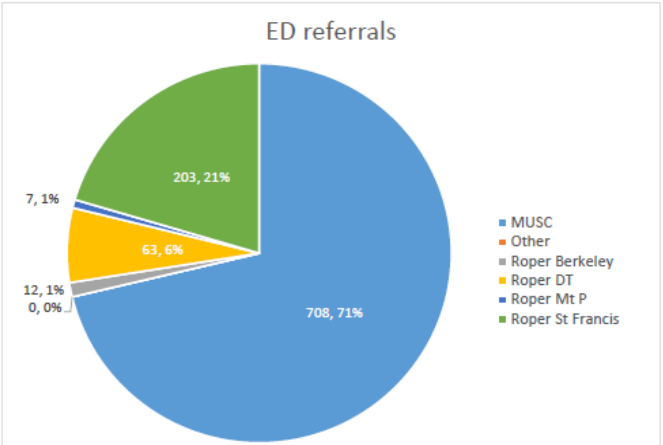
CRISIS STABILIZATION DATA

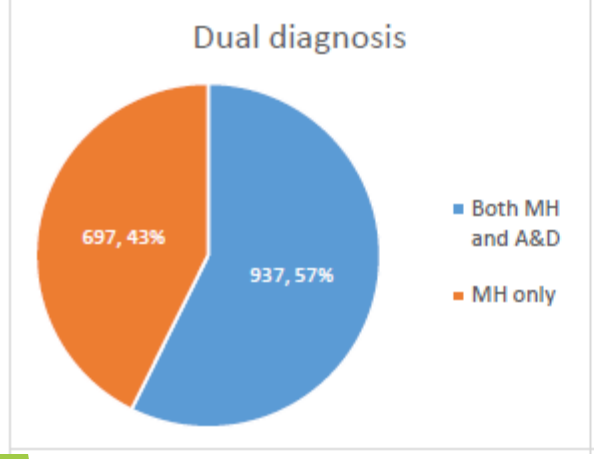
Tri-County Crisis Stabilization Center
(Charleston-Dorchester and Berkeley CMHCs)

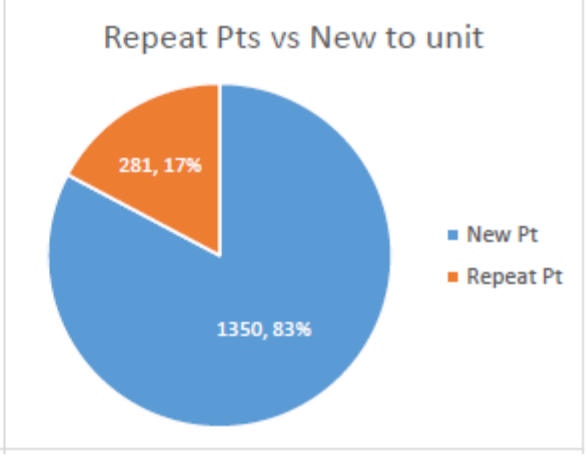


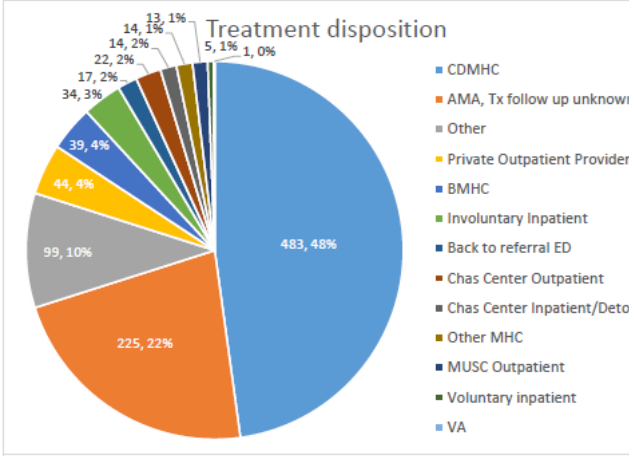


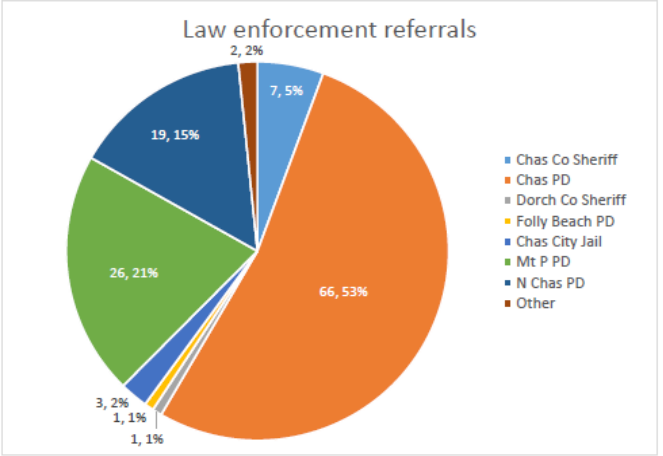








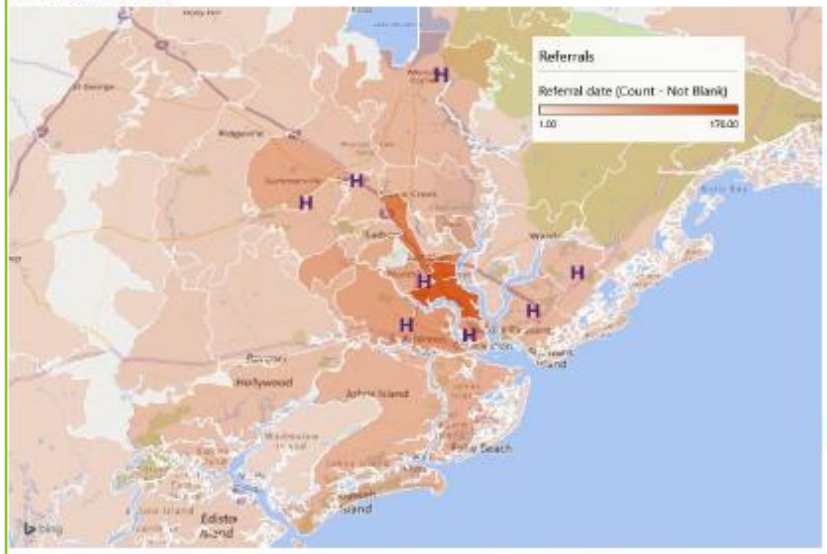




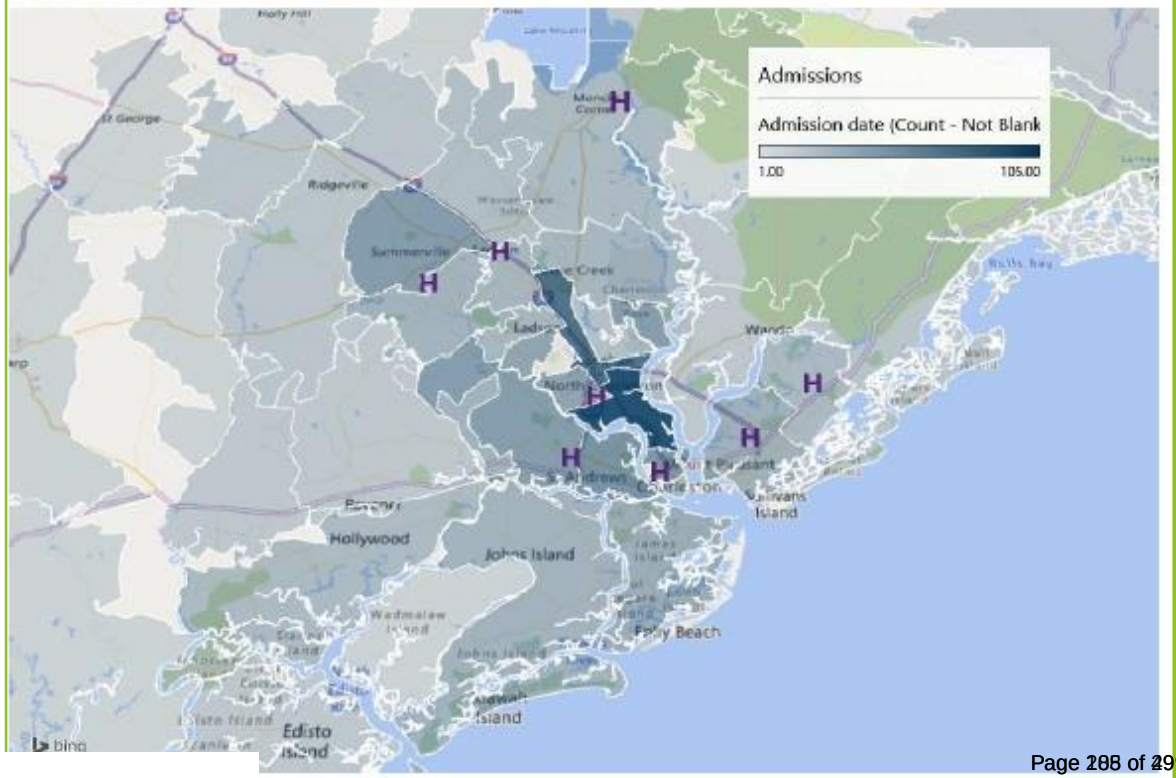
CRISIS STABILIZATION UNIT - PATIENT UTILIZATION MAP

Tri-County Crisis Stabilization Center (Charleston-Dorchester and Berkeley CMHCs)

Service area



Area of residence	Referrals	Admissions
Homeless	523	364
N Charleston	353	226
W Ashley	140	83
Summerville	92	66
Downtown	94	55
Mt Pleasant	46	31
Johns Island	35	18
James Island	40	24
Moncks Corn	29	12
Ladson	27	16
Goose Creek	24	15
Hollywood	19	12
Out of state	11	5



CRISIS COLLABORATION WITH THE CHARLESTON CENTER, A 301 ALCOHOL AND DRUG TREATMENT AGENCY – CO-LOCATED WITH THE TRI-COUNTY CRISIS STABILIZATION CENTER – TO OPEN SUMMER OF 2019





Charleston Center's Sobering Center

CRISIS STABILIZATION UNITS

Spartanburg's Ray C. Eubanks, Jr. Support Center – opened in October 2018



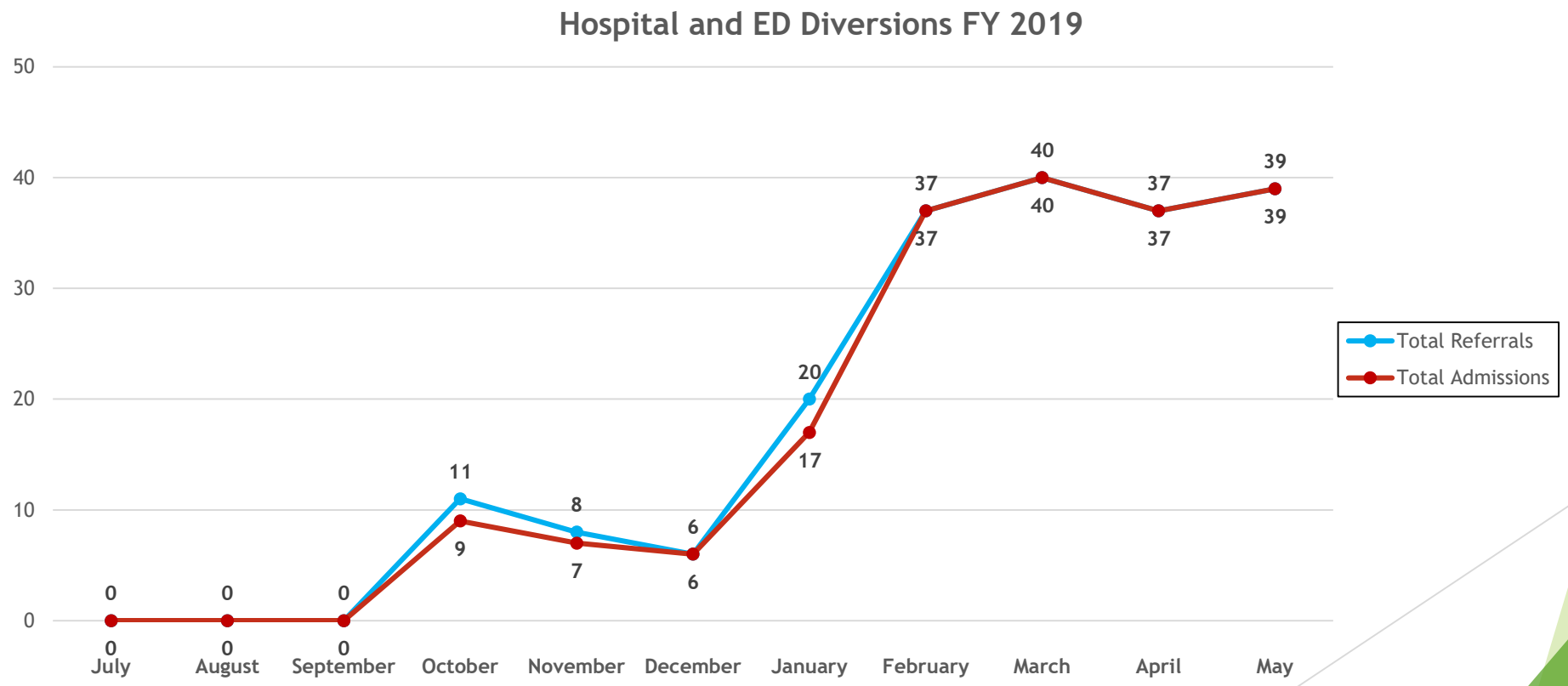


- Peer drop-in "living room" concept hospital diversion program
  - Provides individuals with mental illness an additional support system outside of clinical setting
  - 3 Peer Support Specialists, 2 clinicians, 1 part-time care coordinator
  - 44 individuals diverted from emergency room or hospital
- Housing subsidies
- Automated appointment reminder system
- IPS
- Advance Practice Registered Nurses
- ICT
- Intensive Family Support

CRISIS STABILIZATION UNITS

Eubanks Center
Spartanburg Area Mental Health Center
FY'19 YTD

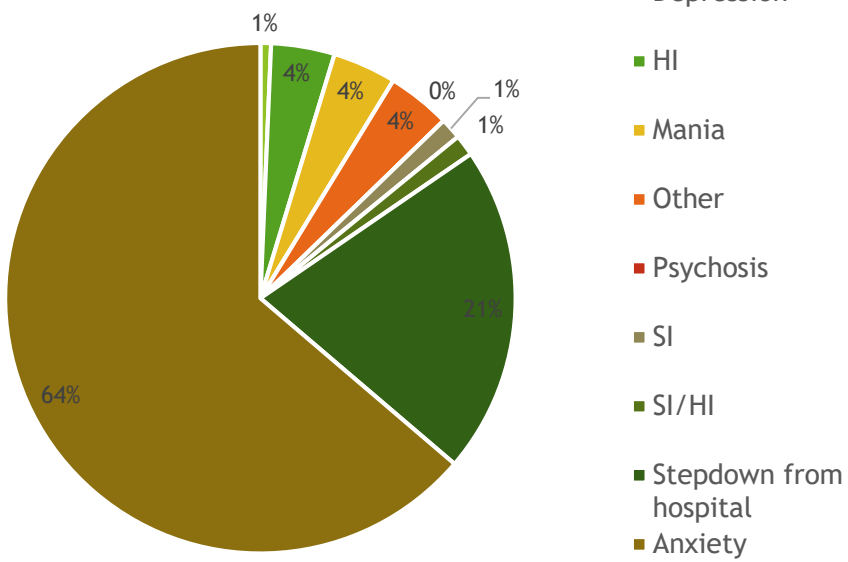
					Diversions from:			Patients	
Referrals:	198			ED:	42		Unduplicated:	118	
Admissions:	192			Hospital:	32		Repeat Patients:	32	



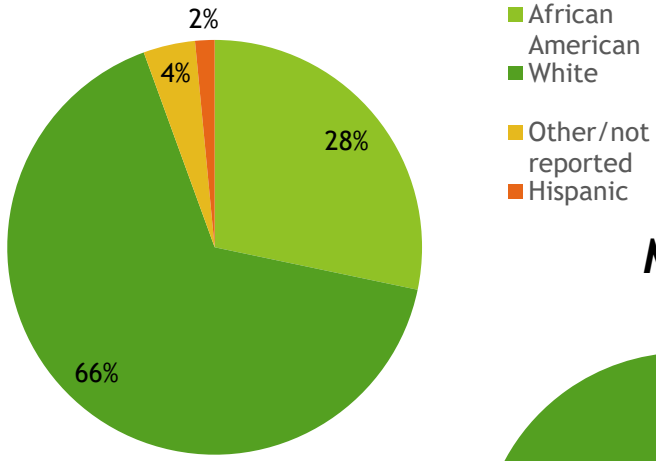
CRISIS STABILIZATION UNITS

Eubanks Center
Spartanburg Area Mental Health Center
FY'19 YTD

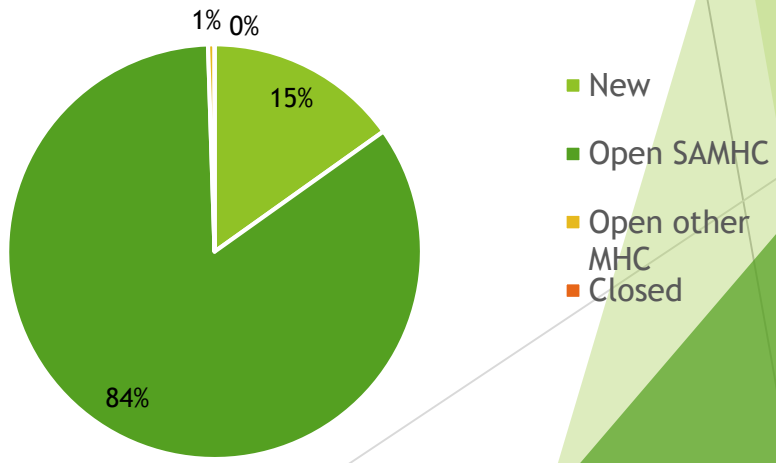
Reason for Referral



Race of referrals



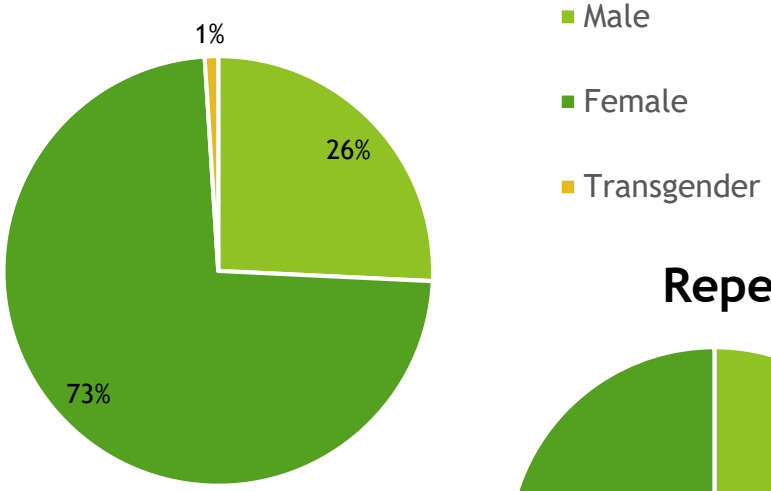
MH Center status



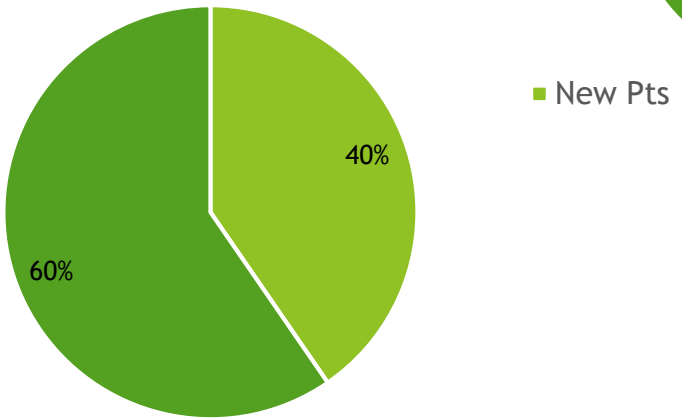
CRISIS STABILIZATION DATA

Eubanks Center
Spartanburg Area Mental Health Center
FY'19 YTD

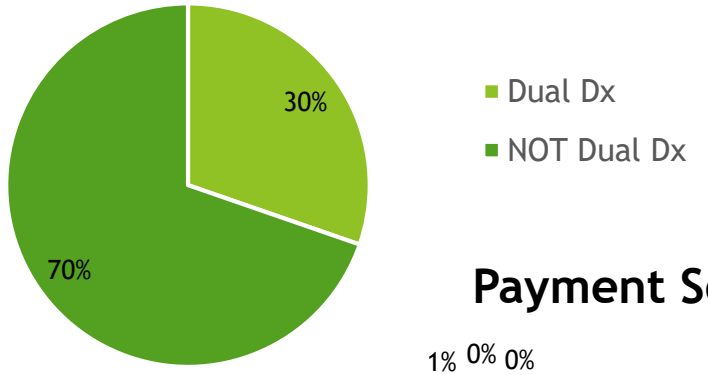
Gender of referrals



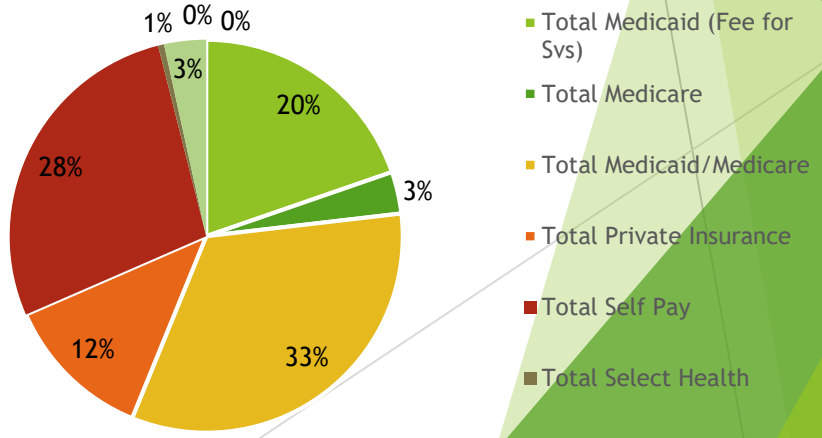
Repeat Patients



A & D and Mental Health Dx



Payment Source

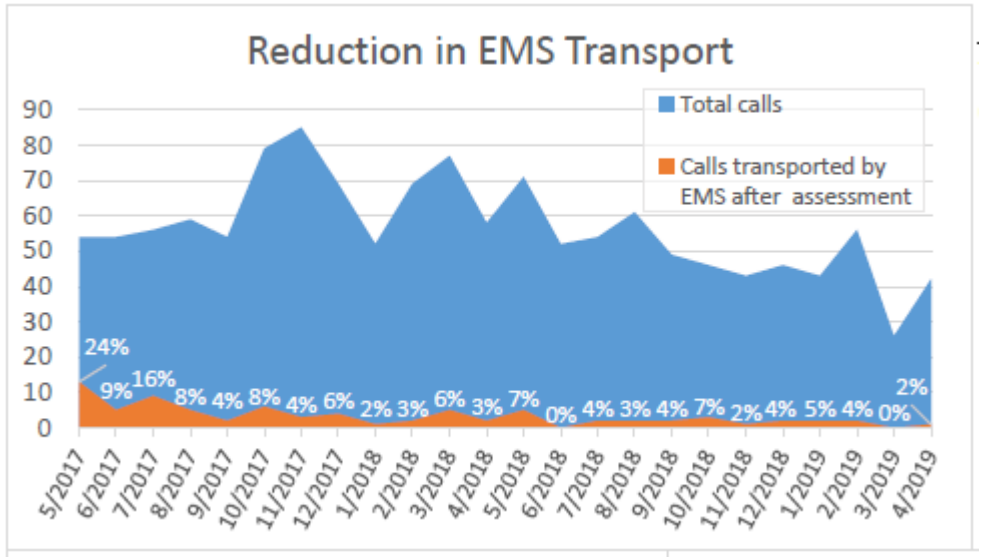


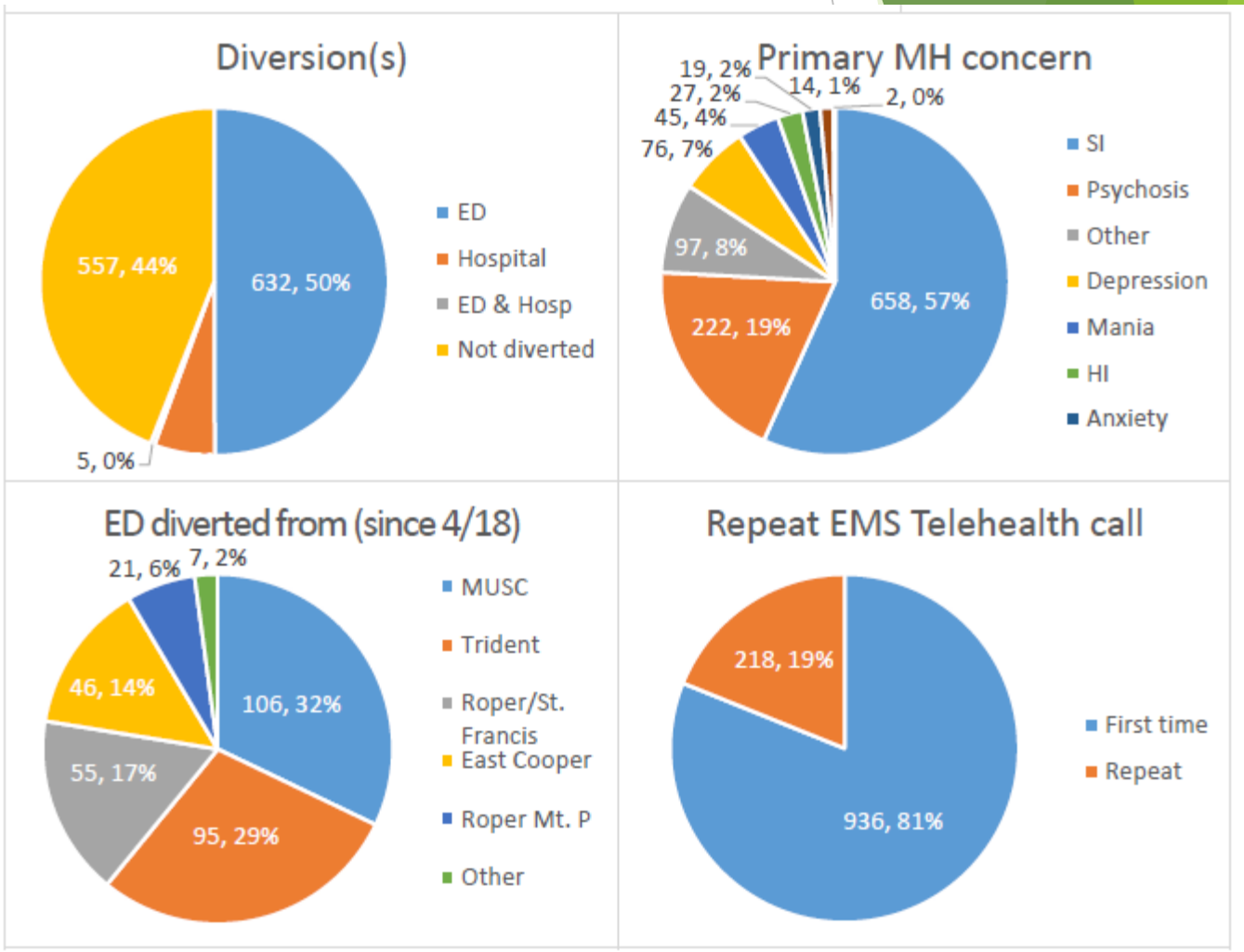
EMS/MOBILE CRISIS TELE-PSYCHIATRY EMERGENCY DEPARTMENT (ED) AND JAIL DIVERSION PROJECT



EMS/MOBILE CRISIS TELE-PSYCHIATRY ED/JAIL DIVERSION PROJECT

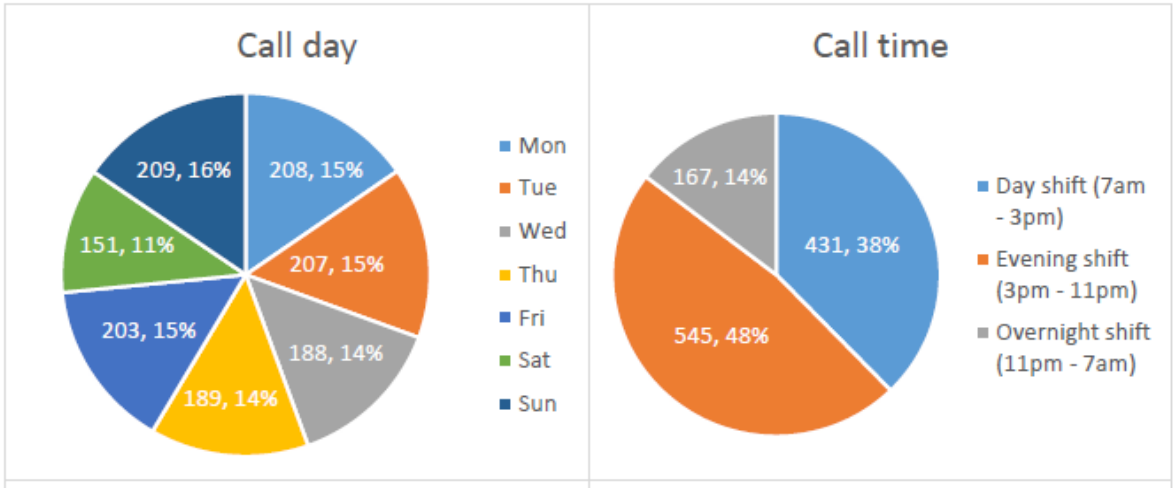
Charleston-Dorchester Mental Health Center

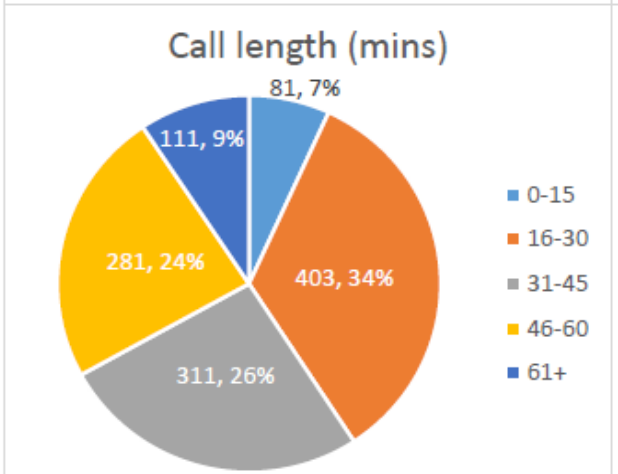


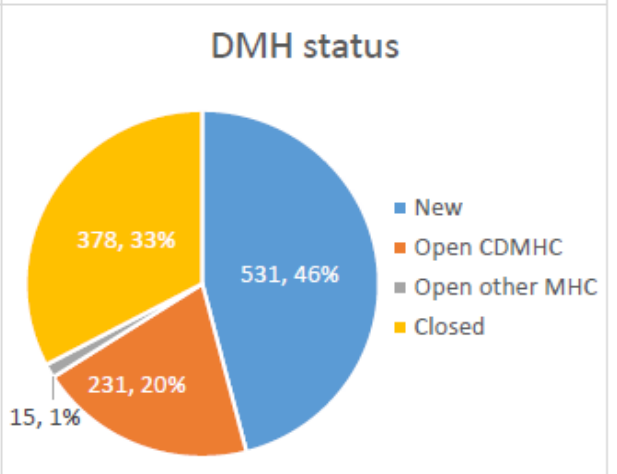


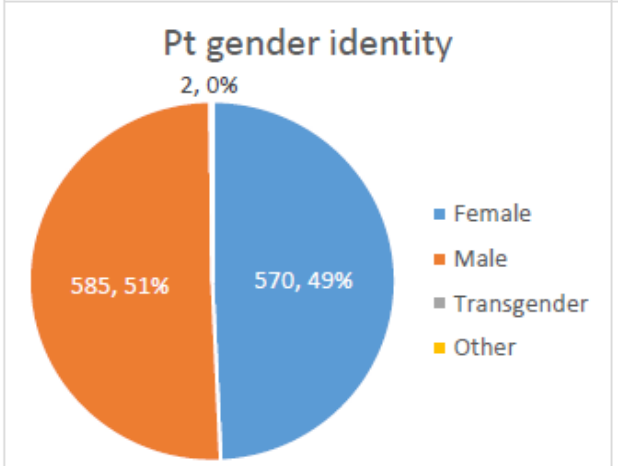
EMS/MOBILE CRISIS TELE-PSYCHIATRY ED/JAIL DIVERSION PROJECT

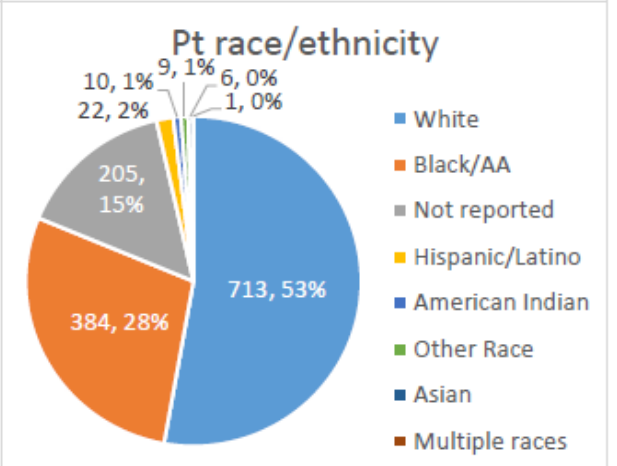
Charleston-Dorchester Mental Health Center





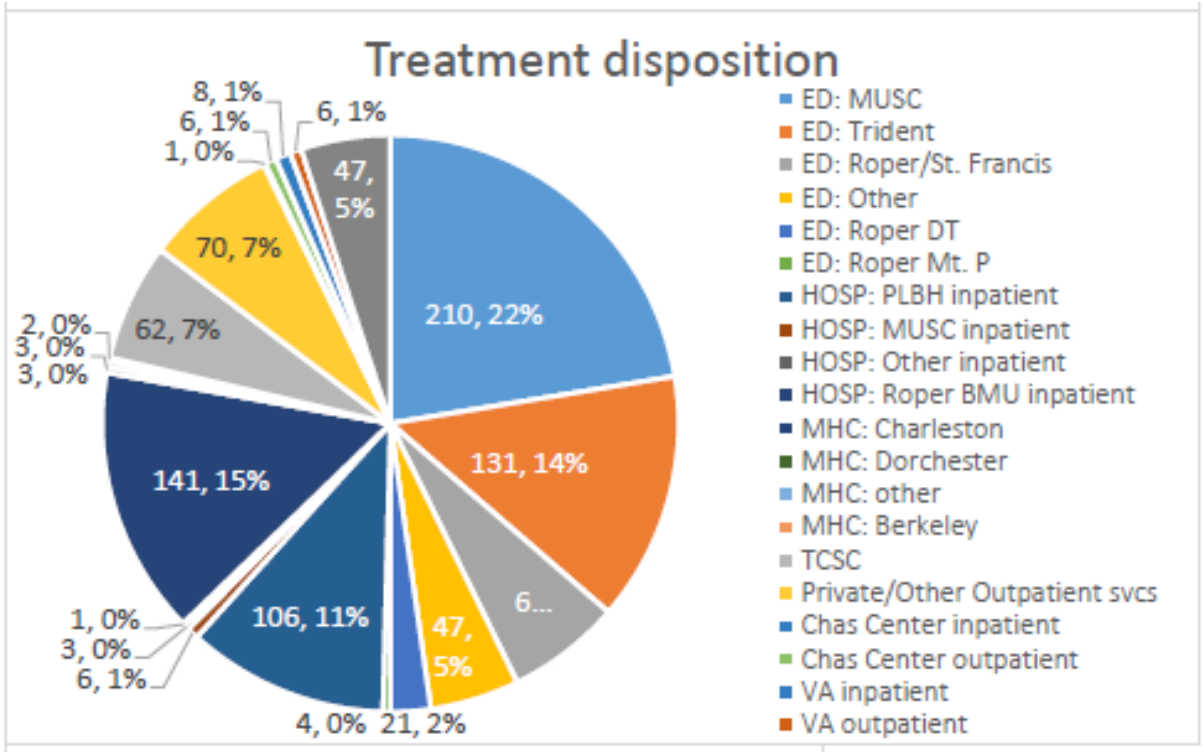


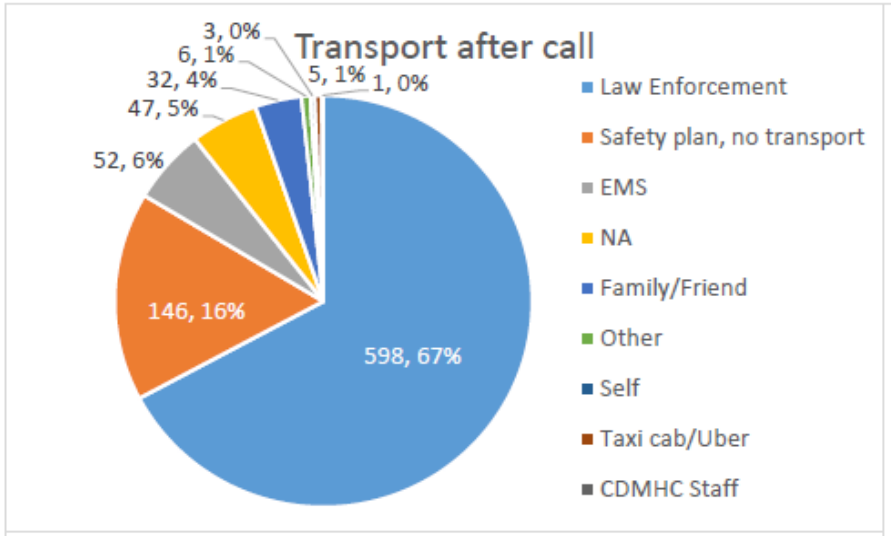


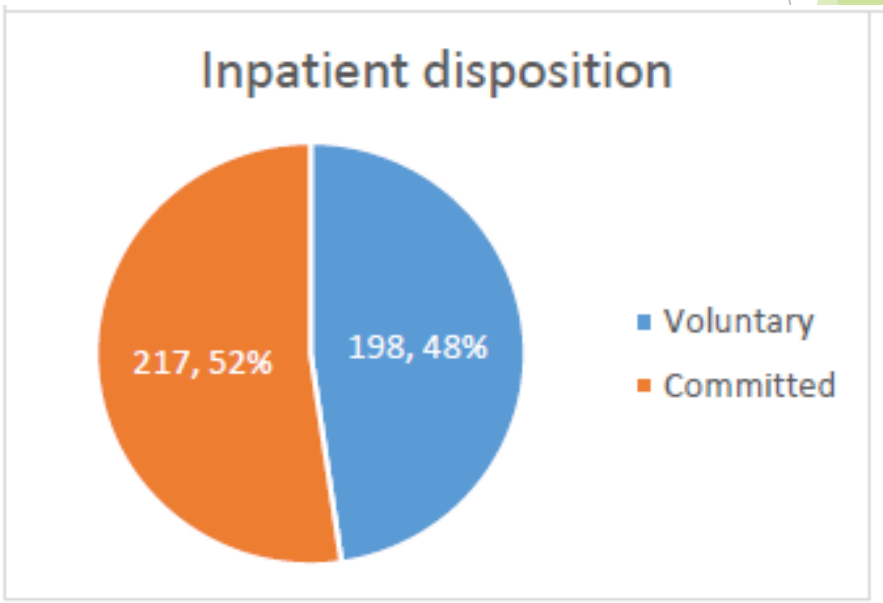


EMS/MOBILE CRISIS TELE-PSYCHIATRY ED/JAIL DIVERSION PROJECT

Charleston-Dorchester Mental Health Center







WHEN THE UNTHINKABLE HAPPENS – HOW MENTAL HEALTH CENTERS RESPOND TO THEIR COMMUNITIES' NEEDS

HOW DO WE BEST RESPOND?

- QUICKLY, BUT THOUGHTFULLY – DAY OF; INVITED IN; RIGHT STAFF
- GATHER ALL AVAILABLE AGENCY RESOURCES – SISTER CENTERS, GO TEAMS, DEAF SERVICES, PSOs, ETC.
- CONNECT WITH OTHER COMMUNITY RESOURCES – LE, NCVC, VICTIMS' ADVOCATES, COURTS, EMS, CORONER'S OFFICE, ETC.
- BE PREPARED FOR LONG HAUL – OUR COMMUNITY, OUR RESPONSIBILITY
- STAY FOCUSED ON MISSION

SOFA SUPER STORE FIRE AND THE CHARLESTON 9 – JUNE 18, 2007



AS A RESULT OF THE FIRE, A CLINICAL TEAM TO ONLY SERVE FIRST RESPONDERS WAS DEVELOPED AND IS EXPANDING ACROSS THE STATE.





THE MOTHER EMANUEL MASSACRE & THE EMANUEL 9 – JUNE 17, 2015





CREATED A TEAM TO SERVE VICTIMS, FAMILIES, AND AFFECTED COMMUNITIES



Tywanza Sanders





Sharonda Coleman-Singleton



Rev. Senator Clementa Pinckney



Susie Jackson



Rev. Depayne Middleton-Doctor



Myra Thompson



Ethel Lance



Cynthia Hurd



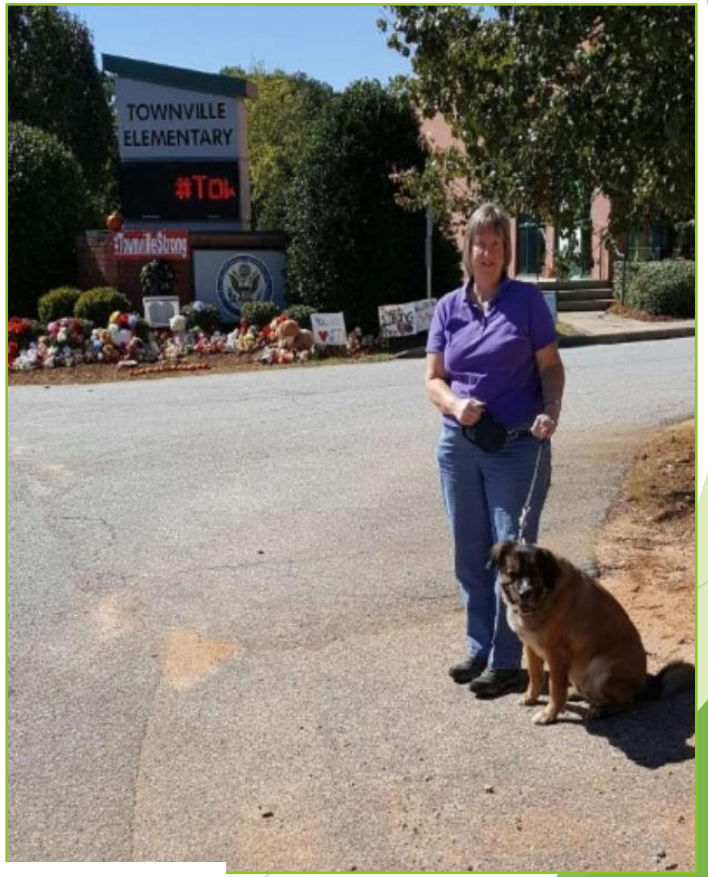
Rev. Daniel Simmons

SCHOOL SHOOTING AT TOWNVILLE ELEMENTARY SCHOOL – SEPTEMBER 28, 2016

CMHS staff supported Townville Community for weeks after shooting







RESPONDING TO THE HISTORIC FLOODS IN 2015 AND 2018

SCDMH WAS AWARDED A FEMA/SAMHSA GRANT TO SERVE VICTIMS.

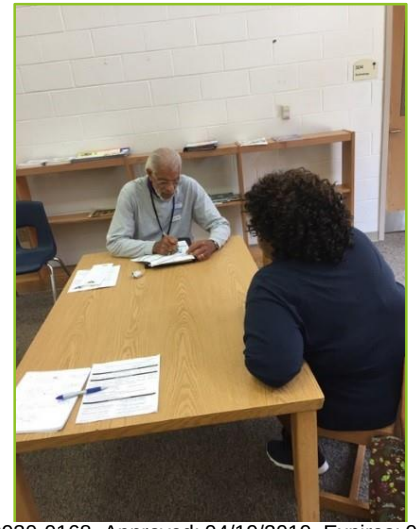
















HOW DO WE KNOW WHAT WE ARE DOING? MEASURING WHAT WE DO

MEASURING - OUR OUTPUTS AND OUTCOMES

- **CENTER DIRECTORS' PERFORMANCE EVALUATIONS** – To receive "successful" or "exceptional" rating, center directors must ensure their centers meet specific deliverables (e.g., designated rates for access, productivity, and collaborative documentation; adherence to maximum caseload size; number of outreach and anti-stigma events; budget management; etc.)
- **MONTHLY METRICS/MEASUREMENT OF OUTCOMES** – Monthly data dashboards showing performance of all CMHCs and reflecting all Evidence-Based Practices and center programs
- **BOARD REPORTS** – Dashboards and other CMHC operating/financial reports shared with each center board on monthly basis

APRIL 2019 CMHC DASHBOARD - Page 1

Center	FY 2019 Budget Forecast (Projected Revenue)	FY 2019 Projected County Appropriations	Per Capita - State Contribution $	Per Capita Rank	FY 2019 Projected Forecast Center End	FY 2019 Projected Forecast DOFS End	FY 2018 Year-End Earned Revenue (Medicaid, MCO, Other Fees)	FY 2018 Original Earned Revenue Forecast	Difference Year End - Original	Percentage	Number of FTEs (includes clinical and administrative staff)
Aiken-Barnwell	$6,434,161	$1,000	$18.83	6	$242,136	$73,426	$2,341,076	$2,537,275	-$196,199	92%	82
Anderson-Oconee-Pickens	$11,985,848	$111,725	$14.84	15	$61,972	$159,821	$5,065,127	$4,793,767	$271,360	106%	137
Beckman	$8,333,493	$19,635	$14.84	14	$369,144	$371,936	$3,892,497	$3,711,436	$181,061	105%	100
Berkeley	$5,602,743	$40,000	$16.68	12	$38,809	-$75,080	$2,090,560	$2,010,356	$80,204	104%	70
Catawba	$9,696,686	$3,750	$14.14	17	$293,259	$438,067	$4,001,874	$3,854,000	$147,874	104%	95
Charleston-Dorchester	$20,659,218	$62,247	$18.46	8	$75,710	$59,595	$10,355,800	$9,693,605	$662,195	107%	254
Coastal	$8,625,557	$96,534	$18.09	10	$162,264	$213,703	$3,727,635	$3,610,522	$117,113	103%	88
Columbia	$16,514,464	$2,223,501	$21.99	5	$162,816	$295,878	$5,065,143	$5,554,550	-$489,407	91%	156
Greenville	$11,951,573	$95,013	$18.15	9	$109,510	$163,138	$6,600,077	$6,290,259	$309,818	105%	154
Lexington	$9,533,856	$0	$17.07	11	-$224,613	-$194,349	$4,462,462	$4,568,910	-$106,448	98%	119
Orangeburg	$5,943,558	$19,770	$26.29	2	$13,777	-$28,773	$2,543,865	$2,703,949	-$160,084	94%	66
Pee Dee	$12,092,242	$6,315	$24.58	3	$294,955	$326,673	$5,494,892	$4,937,499	$557,393	111%	138
Piedmont	$8,572,591	$58,245	$18.74	7	$257,758	$291,343	$4,800,201	$4,867,718	-$67,517	99%	94
Santee-Wateree	$10,171,508	$34,160	$23.81	4	$21,413	$45,513	$4,376,917	$4,206,825	$170,092	104%	120
Spartanburg	$11,800,002	$312,640	$15.87	13	$320,510	$329,645	$5,092,160	$4,622,882	$469,278	110%	133
Tri-County	$5,186,456	$0	$29.06	1	$203,216	$283,695	$2,003,811	$1,963,500	$40,311	102%	46
Waccamaw	$11,313,448	$80,100	$14.43	16	$1,196	$11,053	$5,376,195	$5,157,473	$218,722	104%	133
Total/Overall Measure	**$174,417,404**	**$3,164,635**	*Mar. DOFS data*		**$2,403,834**	**$2,765,286**	**$77,290,293**	**$75,084,525**	**$2,205,767**	**103%**	**1,985**
Date/Source of Measurement	*Mar. DOFS report*				*Mar. DOFS report*		*DOFS FY18 year-end financial report*				*2/20/2019 HR report; does not include temporary staff; update from HR not provided for April*

APRIL 2019 CMHC DASHBOARD - Page 2

Center	FY 2018 Earned Revenue	FY 2018 Total Expenditures	Percentage	Rank	FY 2018 Cancellations by Staff	FYTD 2019 Cancellations by Staff	FY 2018 No Show Rate	FYTD 2019 No Show Rate	Annual Turnover Rate (6/2/2017-6/1/2018)	Q3 FY 2019 Turnover Rate	Licensed Staff/ All Master's Level Staff
Aiken-Barnwell	$2,341,076	$5,544,428	42.22%	15	2.0%	1.4%	15.7%	16.6%	23.9%	1.3%	21 / 34 = 61.8%
Anderson-Oconee-Pickens	$5,065,127	$10,936,264	46.31%	9	1.4%	1.2%	12.3%	12.0%	19.7%	1.5%	25 / 61 = 41.0%
Beckman	$3,892,497	$7,535,918	51.65%	4	2.4%	2.0%	16.7%	14.0%	19.8%	5.0%	16 / 54 = 29.6%
Berkeley	$2,090,560	$4,807,021	43.49%	14	5.1%	5.6%	14.4%	13.7%	21.7%	4.3%	15 / 34 = 44.1%
Catawba	$4,001,874	$8,666,405	46.18%	10	2.1%	2.0%	13.7%	12.8%	17.6%	4.2%	18 / 60 = 30.0%
Charleston-Dorchester	$10,355,800	$19,515,297	53.07%	3	2.0%	2.7%	13.1%	12.3%	14.9%	5.1%	77 / 159 = 48.4%
Coastal	$3,727,635	$8,020,071	46.48%	8	2.7%	2.8%	12.1%	12.6%	32.4%	6.8%	24 / 46 = 52.2%
Columbia	$5,065,143	$15,497,305	32.68%	17	1.1%	1.4%	11.1%	11.5%	17.3%	2.6%	23 / 74 = 31.1%
Greenville	$6,600,077	$11,147,275	59.21%	1	0.4%	0.4%	4.2%	3.8%	20.8%	7.6%	23 / 81 = 28.4%
Lexington	$4,462,462	$9,437,924	47.28%	7	1.4%	1.4%	12.6%	13.2%	22.9%	4.3%	52 /69 = 75.4%
Orangeburg	$2,543,865	$5,715,505	44.51%	12	4.3%	4.3%	15.8%	16.5%	13.6%	4.9%	6 / 33 = 18.2%
Pee Dee	$5,494,892	$10,308,408	53.30%	2	2.9%	3.3%	15.7%	14.6%	11.1%	0.7%	12 / 80 = 15.0%
Piedmont	$4,800,201	$12,248,472	39.19%	16	1.7%	1.5%	8.9%	8.5%	23.6%	7.8%	16 / 42 = 38.1%
Santee-Wateree	$4,376,917	$9,661,300	45.30%	11	1.1%	1.6%	12.5%	14.0%	10.1%	2.5%	18 / 58 = 31.0%
Spartanburg	$5,092,160	$10,012,168	50.86%	5	1.6%	1.6%	15.3%	14.2%	13.6%	3.1%	28 / 54 = 51.9%
Tri-County	$2,003,811	$4,552,104	44.02%	13	2.2%	3.7%	16.6%	17.9%	17.1%	4.2%	7 / 24 = 29.2%
Waccamaw	$5,376,195	$11,178,645	48.09%	6	1.9%	3.4%	11.5%	11.5%	17.3%	1.5%	27 / 85 = 31.8%
Total/Overall Measure	**$77,290,293**	**$164,784,511**	**46.90%**		**1.9%**	**2.2%**	**12.6%**	**12.4%**	**18.3%**	**3.9%**	**408 / 1,048 = 38.9%**
Date/Source of Measurement	*DGF SFY18 year end financial report*				*7/31/2018 CMIT report*	*5/31/2018 CMIT report*	*7/31/2018 CMIT report*	*5/31/2018 CMIT report*	*7/31/2018 information provided by Payroll; Rate = ((FY18 Terminations / FY18 Employee Average) × 100*	*5/31/2018 information provided by Payroll; Rate = ((Q3 Terminations / Q3 Employee Average) × 100*	*April 2019 credentialing report*

APRIL 2019 CMHC DASHBOARD - Page 3

Center	Jul. 2018 (Non-Adjusted) Productivity	Aug. 2018 (Non-Adjusted) Productivity	Sep. 2018 (Adjusted) Productivity	Oct. 2018 (Adjusted) Productivity	Nov. 2018 (Non-Adjusted) Productivity	Dec. 2018 (Adjusted) Productivity	Jan. 2019 (Non-Adjusted) Productivity	Feb. 2019 (Non-Adjusted) Productivity	Mar. 2019 (Non-Adjusted) Productivity	Apr. 2019 (Non-Adjusted) Productivity	FYTD 2019 Productivity	Adjusted* FYTD 2019 Productivity	FYTD 2019 Productivity excluding no charge (07) services
Aiken-Barnwell	900.33	814.21	922.21	895.18	868.16	802.62	876.62	904.94	863.73	831.21	842.83	850.30	839.95
Anderson-Oconee-Pickens	752.00	793.37	817.12	855.97	840.11	729.44	865.30	847.37	835.29	803.74	820.30	821.57	811.23
Beckman	720.00	706.00	753.00	815.13	792.53	688.01	811.86	793.09	756.00	774.00	767.00	778.33	762.00
Berkeley	737.00	672.00	742.95	750.07	885.37	778.00	864.80	905.87	910.33	866.41	791.48	803.35	766.00
Catawba	673.00	847.12	850.90	863.29	822.09	685.73	926.25	875.99	806.50	731.00	771.00	777.15	763.00
Charleston-Dorchester	603.00	656.00	771.91	822.48	794.81	723.00	774.00	829.32	767.00	779.00	719.00	729.89	716.00
Coastal	635.00	671.00	695.24	737.39	754.00	641.00	753.00	817.15	732.00	776.00	683.00	693.35	677.00
Columbia	721.00	694.00	768.40	735.25	753.00	703.49	777.00	802.16	745.00	707.00	720.00	731.08	718.00
Greenville	830.10	703.00	794.99	762.00	718.00	688.62	830.15	828.47	831.36	769.00	767.00	770.13	767.00
Lexington	663.00	698.00	699.42	782.55	782.22	668.00	837.31	833.99	844.17	738.00	756.00	766.92	750.00
Orangeburg	693.00	704.00	828.76	831.52	877.29	824.90	880.97	889.22	817.87	763.00	779.00	795.77	774.00
Pee Dee	824.68	790.38	848.69	875.38	872.88	792.22	874.00	957.16	882.24	861.57	833.62	848.73	829.70
Piedmont	717.00	647.00	722.00	704.00	766.00	658.46	776.00	815.64	771.00	731.00	728.00	731.66	727.00
Santee-Wateree	743.00	719.00	803.48	861.61	828.18	758.00	792.70	837.08	868.01	810.17	822.09	834.42	812.04
Spartanburg	786.62	731.00	834.82	798.21	851.36	678.60	802.15	861.90	758.00	704.00	771.00	773.67	756.00
Tri-County	734.00	780.00	886.65	813.40	880.97	744.00	901.23	897.35	786.05	738.00	793.42	812.89	774.00
Waccamaw	644.00	634.00	774.60	835.76	831.39	761.00	908.86	927.57	869.57	807.58	732.00	752.18	728.00
Total/Overall Measure	*4 ctrs. meeting std.*	*5 ctrs. meeting std.*	*9 ctrs. meeting std.*	*12 ctrs. meeting std.*	*13 ctrs. meeting std.*	*3 ctrs. meeting std.*	*13 ctrs. meeting std.*	*17 ctrs. meeting std.*	*11 ctrs. meeting std.*	*6 ctrs. meeting std.*	*6 ctrs. meeting std.*	*7 ctrs. meeting std.*	*4 ctrs. meeting std.*
Date/Source of Measurement	*Official ONIT reports; standard is 730 annualized average hours*		*Oct. CMHS report, adjusted for Hurricane Florence closure hours*	*Nov. CMHS report, adjusted for Hurricane Michael closure hours*	*Official ONIT report*	*Dec. CMHS report, adjusted for inclement weather closure hours*	*Official ONIT reports and current CMHS reports for Orangeburg and Piedmont*			*Official ONIT reports and current 5/15/2019 CMHS report for Orangeburg and Piedmont; *indicator number adjusted to account for all weather closures during the period*			*5/15/2019 CMHS report*

APRIL 2019 CMHC DASHBOARD - Page 4

Center	Military/Veterans Served - Percent of Open Cases	FYTD 2019 New Cases/ Readmissions	FYTD 2019 CD%	FYTD 2019 Access	FYTD 2019 # Patients Served	FYTD 2019 # Services	Homeshare	Apartment $	Community Housing Units Currently Assisted/# Units Funded	Extended Office Hours	Crisis Stabilization Unit
Aiken-Barnwell	73/1.7%	2,322	97%	99%	3,733	31,430	✓	✓	35 / 36 = 97%	✓	X
Anderson-Oconee-Pickens	93/1.4%	3,096	85%	91%	5,682	86,212	X	✓	26 / 29 = 90%	By request	In progress, TBD
Beckman	46/0.8%	2,281	82%	96%	4,717	44,354	✓	✓	N/A	✓	X
Berkeley	33/1.1%	1,619	88%	93%	2,666	25,893	✓	✓	N/A	✓	X
Catawba	25/0.4%	2,523	93%	96%	4,918	44,607	X	✓	14 / 16 = 88%	✓	X
Charleston-Dorchester	74/0.7%	4,934	85%	95%	9,364	101,551	✓	✓	19 / 20 = 95%	✓	✓
Coastal	55/1.2%	2,084	96%	88%	3,963	45,638	✓	✓	14 / 16 = 88%	?	X
Columbia	42/0.5%	3,346	84%	79%	6,522	66,454	✓	✓	41 / 46 = 89%	?	X
Greenville	93/1.4%	2,198	61%	98%	5,609	84,697	X	✓	24 / 24 = 100%	X	In progress, TBD
Lexington	40/0.6%	2,569	84%	93%	5,267	44,934	✓	✓	16 / 16 = 100%	Limited basis	X
Orangeburg	17/0.6%	1,053	82%	99%	2,450	24,304	✓	✓	25 / 25 = 100%	?	X
Pee Dee	34/0.8%	1,790	93%	100%	3,773	68,218	✓	✓	20 / 25 = 80%	✓	X
Piedmont	25/0.5%	1,710	77%	96%	4,436	46,514	X	✓	N/A	?	X
Santee-Wateree	73/1.1%	2,072	71%	99%	5,453	45,452	✓	✓	4 / 6 = 67%	✓	X
Spartanburg	72/1.0%	1,931	71%	86%	6,114	55,823	X	✓	15 / 14 >100%	✓	✓
Tri-County	27/1.1%	927	94%	100%	1,977	22,476	✓	✓	3 / 4 = 75%	X	X
Waccamaw	62/0.9%	2,478	81%	90%	5,218	49,084	✓	✓	25 / 27 = 93%	X	X
Total/Overall Measure	**877/0.9%**	**38,933**	**82%**	**94%**	**80,438	**887,641**	**12**	**17**	**281 / 304 = 92%**	**10**	**2**
Date/Source of Measurement	*SMH 2018 point-in-time CMHS report*	*FYTD 2018 CMHS data*	*FYTD 2018 CMHS data; standard is 85%*	*FYTD 2018 CMHS data; standard is 95%*	*FYTD 2018 CMHS data; **indicator unduplicated number of patients*	*FYTD 2018 CMHS data*	*Information provided by center*		*SMH 2018 CMHS Housing Report*	*Information provided by center*	

APRIL 2019 CMHC DASHBOARD - Page 5

Center	Military/Veterans Served - Percent of Open Cases	FYTD 2019 New Cases/ Readmissions	FYTD 2019 CD%	FYTD 2019 Access	FYTD 2019 # Patients Served	FYTD 2019 # Services	Homeshare	Apartment $	Community Housing Units Currently Assisted/# Units Funded	Extended Office Hours	Crisis Stabilization Unit	# of Schools
Aiken-Barnwell	73/1.7%	2,322	97%	99%	3,733	31,430	✓	✓	35 / 36 = 97%	✓	X	16
Anderson-Oconee-Pickens	93/1.4%	3,096	85%	91%	5,682	86,212	X	✓	26 / 29 = 90%	By request	In progress, TBD	34
Beckman	46/0.8%	2,281	82%	96%	4,717	44,354	✓	✓	N/A	✓	X	47
Berkeley	33/1.1%	1,619	88%	93%	2,666	25,893	✓	✓	N/A	✓	X	17
Catawba	25/0.4%	2,523	93%	96%	4,918	44,607	X	✓	14 / 16 = 88%	✓	X	59
Charleston-Dorchester	74/0.7%	4,934	85%	95%	9,364	101,551	✓	✓	19 / 20 = 95%	✓	✓	111
Coastal	55/1.2%	2,084	96%	88%	3,963	45,638	✓	✓	14 / 16 = 88%	?	X	43
Columbia	42/0.5%	3,346	84%	79%	6,522	66,454	✓	✓	41 / 46 = 89%	?	X	31
Greenville	93/1.4%	2,198	61%	98%	5,609	84,697	X	✓	24 / 24 = 100%	X	In progress, TBD	52
Lexington	40/0.6%	2,569	84%	93%	5,267	44,934	✓	✓	16 / 16 = 100%	Limited basis	X	52
Orangeburg	17/0.6%	1,053	82%	99%	2,450	24,304	✓	✓	25 / 25 = 100%	?	X	27
Pee Dee	34/0.8%	1,790	93%	100%	3,773	68,218	✓	✓	20 / 25 = 80%	✓	X	51
Piedmont	25/0.5%	1,710	77%	96%	4,436	46,514	X	✓	N/A	?	X	44
Santee-Wateree	73/1.1%	2,072	71%	99%	5,453	45,452	✓	✓	4 / 6 = 67%	✓	X	36
Spartanburg	72/1.0%	1,931	71%	86%	6,114	55,823	X	✓	15 / 14 >100%	✓	✓	63
Tri-County	27/1.1%	927	94%	100%	1,977	22,476	✓	✓	3 / 4 = 75%	X	X	14
Waccamaw	62/0.9%	2,478	81%	90%	5,218	49,084	✓	✓	25 / 27 = 93%	X	X	38
Total/Overall Measure	**877/0.9%**	**38,933**	**82%**	**94%**	****80,438**	**887,641**	**12**	**17**	**281 / 304 = 92%**	**10**	**2**	**735**
Date/Source of Measurement	*SHV2019 point-in-time CMHS report*	*FYTD 2019 CMHS data*	*FYTD 2019 CMHS data; standard is ##x*	*FYTD 2019 CMHS data; standard is 95x*	*FYTD 2019 CMHS data; **indicates unduplicated number of patients.*	*FYTD 2019 CMHS data*	*Information provided by centers*		*SHV2019 CMHS Housing Report*	*Information provided by centers*		*SY2019-2019 CMHT report (update not available at time of dashboard creation)*

APRIL 2019 CMHC DASHBOARD - Page 6

Center	PAC	Jail	Integrated Primary Care	Smoke/Tobacco Free Campus	Mobile Team/CCRI	CIT	# ED Staff	CAC	Entitlement Specialists	ICT	PS	Peer Support FTEs
Aiken-Barnwell	✓	✓	X	✓	✓	X	0	MOA w/ CAC	Yes/FT	✓	✓	5.0
Anderson-Oconee-Pickens	✓	✓	X	X	X	✓	2	10% Psychiatrist	No	✓	✓	3.8
Beckman	✓	X	✓	To start 10/31/2019	X	X	2	Contract w/CAC	No	✓	✓	1.0
Berkeley	✓	X	✓	✓	✓	X	0	MOA w/ CAC	Yes/PT	✓	✓	1.6
Catawba	✓	✓	✓	X	X	X	0	2 MHPs	Yes/FT	✓	✓	1.0
Charleston-Dorchester	✓	✓	✓	X	✓	✓	0	2 MHPs/Charleston CAC	Yes/FT	✓	✓	3.5
Coastal	✓	✓	X	✓	✓	✓	0	X	No	✓	✓	1.5
Columbia	✓	✓	X	X	✓	✓	1	6 MHPs/MetCAC	No	✓	✓	3.0
Greenville	✓	✓	X	✓	X	X	1	2 MHPs/Julie Valentine	coming soon/TBD	✓	✓	3.0
Lexington	✓	✓	X	✓	✓	✓	1	X	No	✓	✓	2.0
Orangeburg	✓	X	X	X	✓	X	1	X	Yes/FT	✓	✓	1.0
Pee Dee	✓	X	X	✓	✓	✓	<1	0.75 FTE, shared w/Tri-County	No	✓	✓	2.0
Piedmont	✓	✓	X	X	X	X	0	X	Yes/FT	X	✓	1.0
Santee-Wateree	X	✓	✓	✓	X	X	0	X	coming soon/FT	✓	✓	5.0
Spartanburg	✓	✓	X	To start 7/1/2019	X	✓	1	X	Yes/FT	✓	✓	4.5
Tri-County	X	X	coming soon	✓	✓	X	1	0.25 FTE, shared w/Pee Dee	No	coming soon	✓	1.0
Waccamaw	X	X	✓	✓	✓	✓	3	X	Yes (MOA)/FT	✓	✓	2.0
Total/Overall Measure	**14**	**11**	**6**	**9**	**10**	**8**	**<14**	**13, plus MOA/contract staff**	**8, either PT or FT**	**15**	**17**	**41.9**
Date/Source of Measurement	*Information provided by centers*											

APRIL 2019 CMHC DASHBOARD - Page 7

Center	CBT	DBT	EMDR	IPS	MI	MDFT	PCIT	TF-CBT
Aiken-Barnwell	✓	✓	X	✓	✓	✓	X	✓
Anderson-Oconee-Pickens	✓	✓	X	✓	✓	✓	X	✓
Beckman	✓	✓	✓	✓	✓	✓	✓	✓
Berkeley	✓	✓	✓	✓	✓	✓	X	✓
Catawba	✓	✓	✓	coming soon	✓	✓	X	✓
Charleston-Dorchester	✓	✓	✓	✓	✓	✓	✓	✓
Coastal	✓	✓	X	✓	✓	✓	✓	✓
Columbia	✓	✓	X	✓	X	✓	✓	✓
Greenville	✓	✓	✓	✓	X	✓	✓	✓
Lexington	✓	✓	✓	coming soon	✓	✓	X	✓
Orangeburg	✓	✓	X	coming soon	✓	✓	X	✓
Pee Dee	✓	✓	X	✓	✓	✓	X	✓
Piedmont	✓	✓	✓	X	X	✓	X	✓
Santee-Wateree	✓	✓	X	✓	X	✓	X	✓
Spartanburg	✓	✓	✓	✓	✓	✓	X	✓
Tri-County	✓	✓	X	coming soon	✓	✓	✓	✓
Waccamaw	✓	✓	X	✓	X	✓	X	✓
Total/Overall Measure	**17**	**17**	**8**	**12**	**12**	**17**	**6**	**17**
Date/Source of Measurement	*Information provided by centers*							

ACRONYMS/DEFINITIONS

CAC - Child Advocacy Center
CBT - Cognitive Behavioral Therapy
CCRI - Community Crisis Response & Intervention
CD - Collaborative Documentation
CIT - Crisis Intervention Team
CMHS - Community Mental Health Services Division
CRS - Call Reminder System
DBT - Dialectical Behavior Therapy
DOFS - Division of Financial Services at SCDMH
ED - Emergency Department
EMDR - Eye Movement Desensitization & Reprocessing Therapy
FTE - Full Time Equivalent
FY - Fiscal Year (State)
FYTD - Fiscal Year to Date
HR - Human Resources
ICT - Intensive Community Treatment
IPS - Individual Placement and Support
MCO - Managed Care Organization
MDFT - Multidimensional Family Therapy
MI - Motivational Interviewing
MST - Multi-Systemic Therapy
ONIT - Office of Network Information Technology
PAC - Patient Affairs Coordinator
PCIT - Parent-Child Intervention Therapy
PS - Peer Support
TBD - To be determined
TF-CBT - Trauma-Focused Cognitive Behavioral Therapy

IMPROVED OUTCOMES, INCREASED PATIENT SATISFACTION, AND COMMITMENT TO EXCELLENCE

- ***Tools and Practices***
  - Use Levels of Care and DLA-20 to assess patient improvement as a result of treatment
  - Employ variety of Evidence-Based Practices to provide most appropriate treatment techniques for patients
- ***Patient Satisfaction***
  - Administer annual Patient Satisfaction Surveys; received 97% overall positive rating based on 33,017 responses received in FY 2018
  - Survey school administrators at schools with mental health programs; in FY 2018, 91% believe having DMH counselors onsite is beneficial, and 87% believe students would not otherwise receive counseling
- ***Achievements in FY 2018***
  - 95% services offered within appointment time standards; walk-ins taken at all centers and extended office hours offered at more than half
  - CMHCs provided 1M+ services and served more than 80K patients
  - Productivity hours exceeded established standard of 780 annualized average hours
  - More than 80% patient notes done collaboratively with patients

NATIONAL AWARDS and ACCREDITATIONS

- International IPS Learning Community Program Awards - IPS Supported Employment Leaning Community comprise of 24 States and 5 Counties outside of the US
  - *2008 Achievement Award* - Charleston-Dorchester Community Mental Health Center and Vocational Rehabilitation, Charleston, South Carolina
  - *2014 Achievement Awar*d - Greenville Mental Health Center and Vocational Rehabilitation, Greenville, South Carolina
  - *2016 Achievement Award* - PEE DEE Mental Health (Florence) and Vocational Rehabilitation, South Carolina
  - *2019 Rick Martinez Leadership Award* - Demetrius Henderson, South Carolina Department of Mental Health
- SAMHSA 2014 Excellence In Innovation Award – CDMHC's Mobile Crisis
- VIDYO 2017 Leadership in Technology Award – CDMHC's EMS/Mobile Crisis Telepsychiatry Program
- Association for Behavioral and Cognitive Therapies - Champions of Evidence-Based Interventions awarded to Andrea (Lanalle) Darden, CAF Director, Santee-Wateree Mental Health
- Every MHC is CARF accredited





FUTURE PLANS FOR CMHS

- Better developed co-occurring treatment programs
- Better developed early infant and child mental health programs
- More primary care integration programming
- More justice-involved programming
- Meeting the 2022 school mental health vision of every public school having an embedded clinician in at least the 1:2 model
- Improving evidenced-based practice fidelity with more monitoring and evaluation
- Intensifying bridge between inpatient and outpatient divisions to ensure seamless transitions

QUESTIONS?



CMHS GRANTS AND CONTRACTS

CMHS GRANTS AND CONTRACTS

Grants

- Total amount awarded for 29 open grants (federal and private) = **$63,066,190**
- Enhanced services for children, youth, and young adults; supported housing/mental health services for homeless; crisis counseling for those affected by disaster; transportation for seniors/disabled; expanded telehealth/telepsychiatry services; increase in number of mental health courts; integration of primary care; assistance for victims of crime; enhanced school mental health partnerships; public safety equipment; expanded suicide prevention programming; improved information technology infrastructure

Contracts

- Currently have 35 contracts with total revenue of **$6,739,677**
- We contract with hospitals, counties, municipalities, detention centers, institutes of higher education, medical practices, and civic organizations

South Carolina Dept. of Mental Health

DIVISION OF MEDICAL AFFAIRS

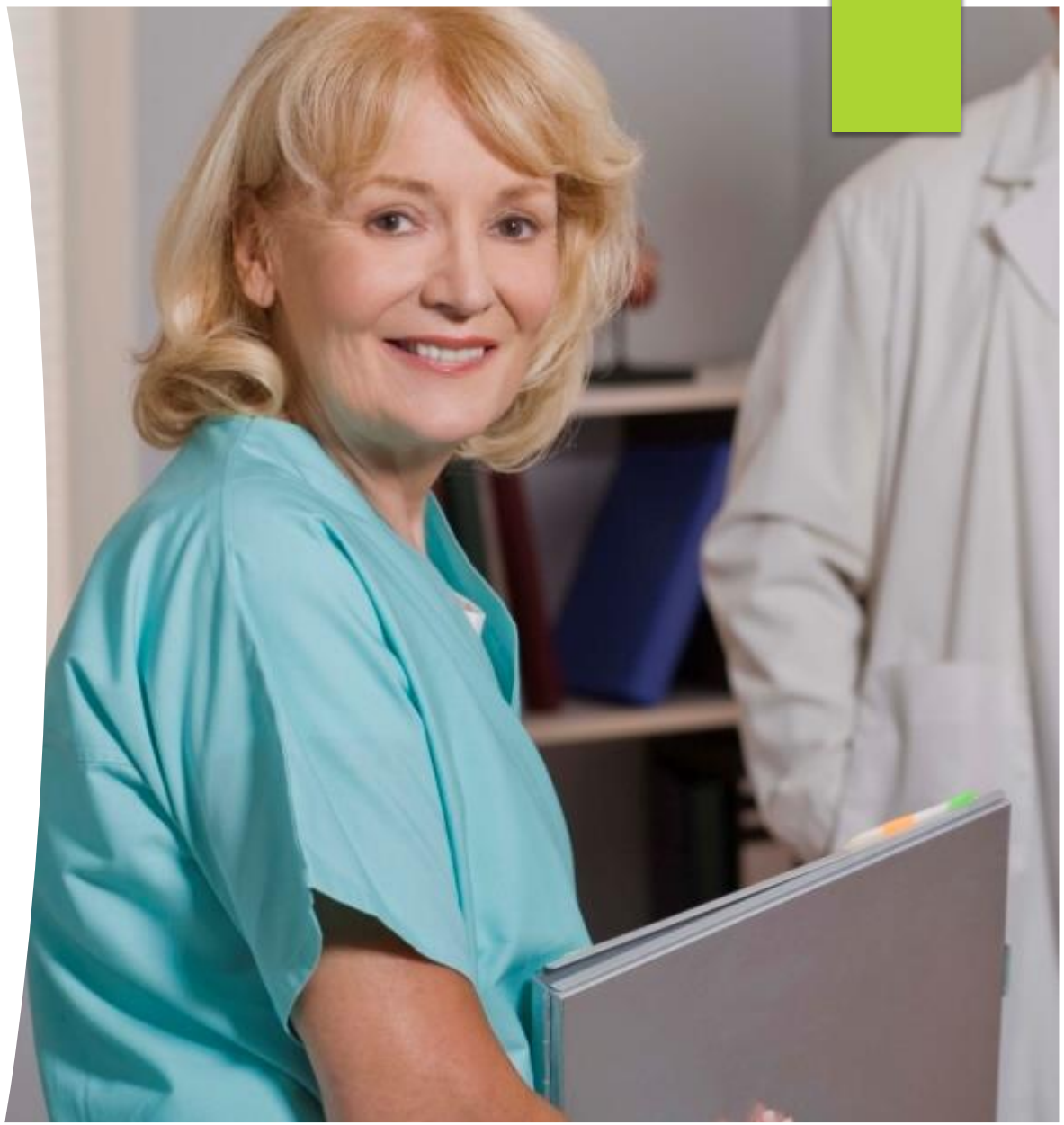
ROBERT BANK, MD
STATE MEDICAL DIRECTOR

Division of Medical Affairs

- Office of Quality Management and Organizational Improvement
- Telepsychiatry
- Transition and Care Coordination Programs
- Evaluation, Training & Research
- Emergency Preparedness and Response

Services at SCDMH are Medically directed.

- All services are Medically necessary.
- Physicians direct treatment teams and authorize treatment plans.



Patients Served

Population:

Child (0-17) 34%

Adult (18-64) 61%

Senior (64+) 5%

Gender:

Female 53%

Male 47%

Diagnostic Categories:

Schizophrenia & Related Disorders 22%

Bipolar and Mood Disorders 49%

Other Diagnosis 29%

Service Locations

Community Mental Health Centers & Clinics

(On-site & Telepsychiatry)

Inpatient Hospitals & Nursing Homes

(On-site & Telepsychiatry)

Emergency Departments (Telepsychiatry)

Schools (On-site & Telepsychiatry)

Physician Staffing

Physician, APRN, and Nursing Services

SCDMH Full Time Physicians

Approx. 73

Individual Contract (LLC) and Part-Time Physicians

Approx. 35

Vendor Contract Physicians

Approx. 36

Psychiatric Medical Assessments

Approx. 164,000/yr.

Nursing Medication Management

Approx. 106,000/yr.

Prescriptions
Approx. 520,000/yr.

Injections
Approx. 64,000/yr.

Electronic Health Record

University Affiliations and Collaboration

Impact on Medical Service Delivery

University of South Carolina (USC)

Medical University of South Carolina (MUSC)

South Carolina Telehealth Alliance (SCTA)

Questions?

Robert L. Bank, M.D.
Deputy Director
SCDMH Division of Medical Affairs
Phone: 803.898.8339



SCDMH Division of Medical Affairs

Quality Management And Organizational Improvement

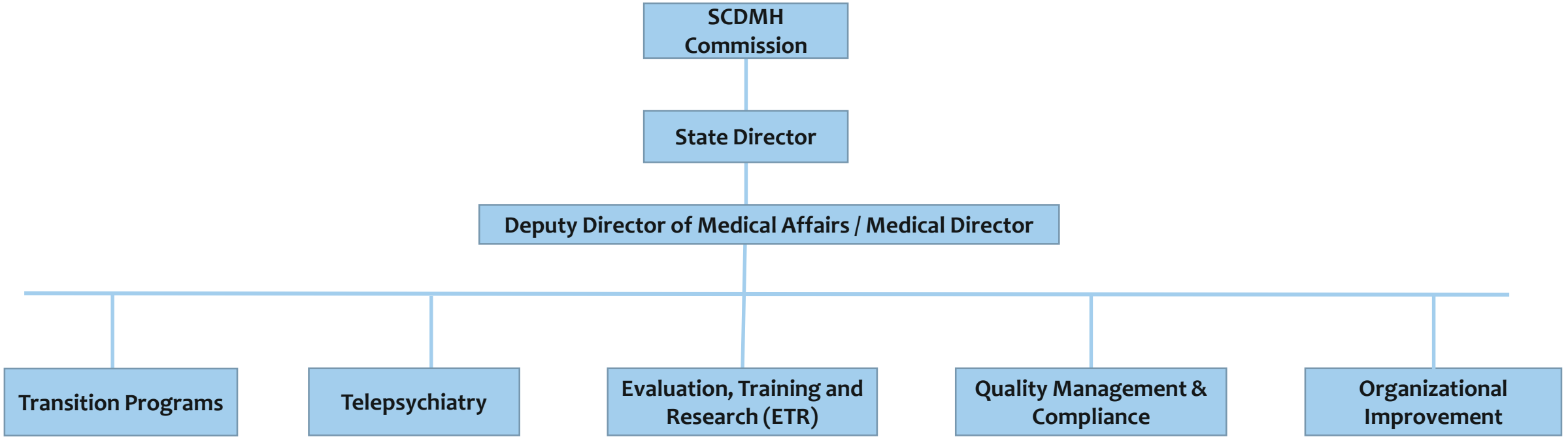
Melba Arthur, M.Ed., CPHQ
Director of Organizational Improvement

July 2019

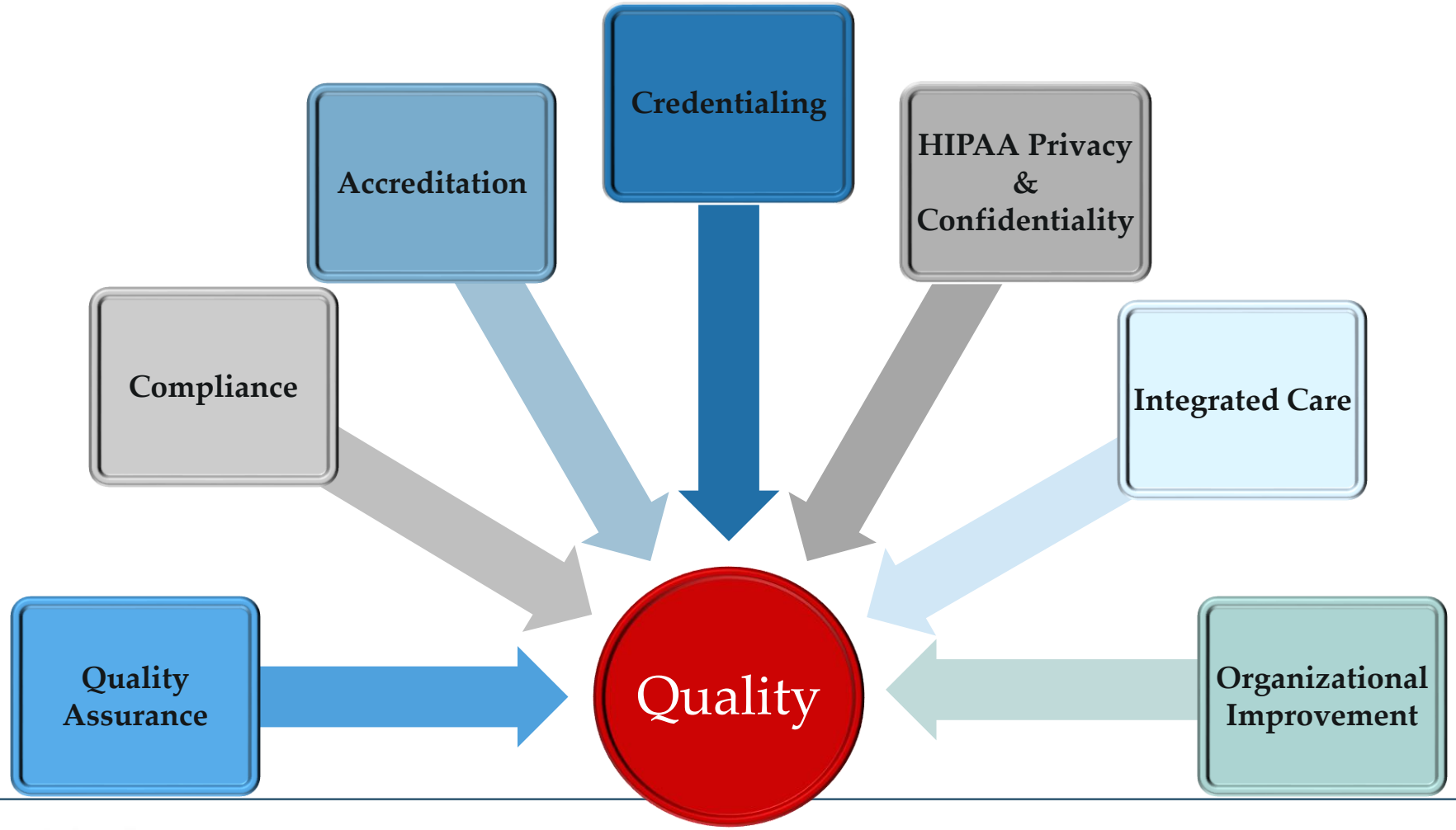
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SCDMH Division of Medical Affairs

Organizational Structure



Quality Management and Organizational Improvement



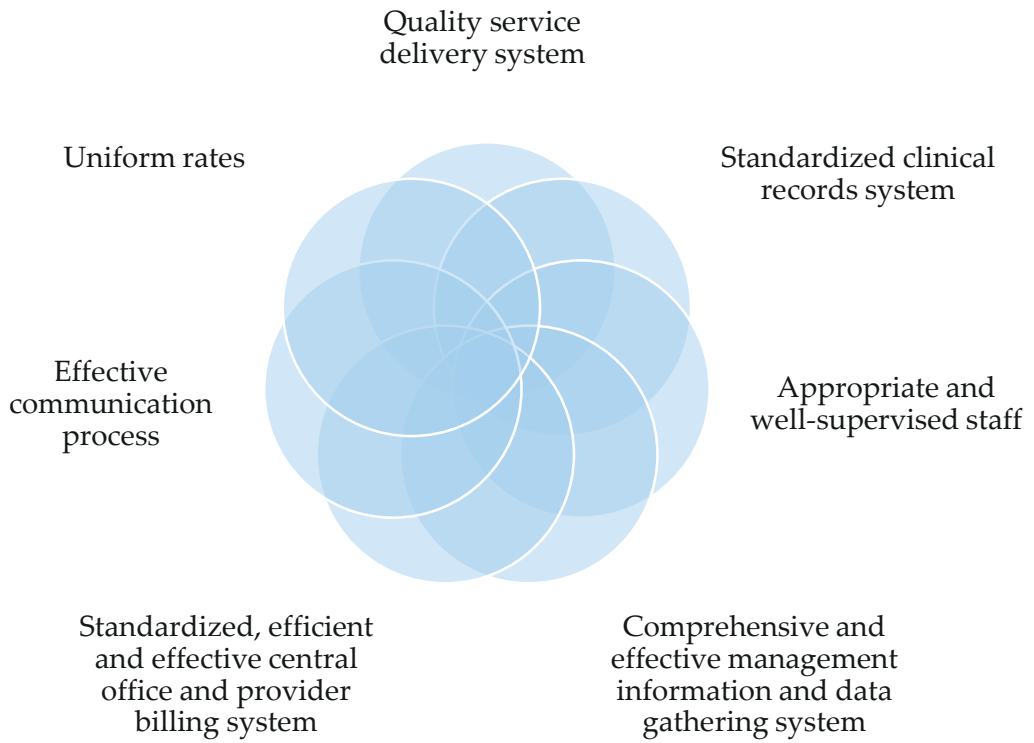
Quality Assurance

- **Quality Assurance**
- Compliance
- Accreditation
- Credentialing
- HIPAA Privacy
- Integrated Care
- Organizational Improvement

- SCDMH / DHHS Medicaid Contract Compliance
- DHHS Liaison
- Quality Assurance Audits
  - Audits for Quality, Appropriateness and Medical Necessity
- Managed Care Organizations (MCO) Prior Authorizations
- Staff Training

Quality Assurance

Provides consultation and technical assistance to the CMHC/programs to ensure:



Quality Assurance Audits

- Community Mental Health Centers
- Medicaid Targeted Case Management
- SCDMH Inpatient Facilities
- Credentialing and Privileging
- Special Focus Audits as Needed
- DHHS Regulatory Manuals:
  - Community Mental Health Services
  - Rehabilitative Behavioral Health Services
  - Targeted Case Management
  - SC Medicaid Policy and Procedures Manual

Compliance



- Quality Assurance
- **Compliance**
- Accreditation
- Credentialing
- HIPAA Privacy
- Integrated Care
- Organizational Improvement

- SCDMH Office of Corporate Compliance established in 1998
- Federal Mandates
  - Office of Inspector General
  - Deficient Reduction Act
  - False Claims Act
  - Affordable Care Act
  - Whistleblower Protection
- Goal to Prevent Fraud, Waste and/or Abuse and Prevent Improper Billing

Compliance Program Components

- SCDMH Compliance Plan and Policy
- Auditing and Monitoring
- Billing and Coding
- Compliance Reporting
- Education
- Enforcement
- Investigation and Remediation
- SCDMH Compliance Committee

"SCDMH is committed to ensure the promotion of full compliance and the prevention and detection of accidental and intentional noncompliance with all applicable legal and ethical responsibilities."

FY'19 Accomplishments

- Improved Community Mental Health Center Compliance Audit Efficiency
- Improved Accountability for Follow up and Corrective Action Planning (Compliance Report and Compliance Audit follow up)
- Improved Timeliness of Resolution of Compliance Reports
- Improved Annual Training Compliance
- Division of Inpatient Services (DIS) Compliance Audit
- Billing System Enhancements

Accreditation

- Quality Assurance
- Compliance
- **Accreditation**
- Credentialing
- HIPAA Privacy
- Integrated Care
- Organizational Improvement

- CARF Accreditation Consultation
- CARF Survey Support and Tracking
- Annual CARF Training
- Integration of CARF Standards with SCDMH Policy and Quality Initiatives

Office of Credentialing & Privileging

- Quality Assurance
- Compliance
- Accreditation
- **Credentialing**
- HIPAA Privacy
- Integrated Care
- Organizational Improvement

- Community Mental Health Center Credentialing
- National Committee for Quality Assurance (NCQA) Accreditation since January 2017
- Primacy Source Verifications & Background Checks
- Provider Eligibility Qualifications
- Facility Credentialing

Community Mental Health Center (CMHC)

Credentialed and Licensed Professionals

CMHC	MD/DO	APRN	PhD	LISW	LMFT	LMSW	RN	LPC	*TOTALS*
Aiken-Barnwell MHC	2	1		2		5	5	14	***29***
Anderson-Oconee-Pickens MHC	7	2				4	10	20	***43***
Beckman MHC	5	2		1	1	6	5	10	***30***
Berkeley MHC	3	1		1		3	3	11	***22***
Care Coordination	5	2		5	1	4	7	8	***32***
Catawba MHC	21	2		16		10	16	44	***109***
Coastal Empire MHC	6			1	1	10	6	12	***36***
Columbia Area MHC	27	7	4	3		7	19	13	***80***
Greenville MHC	5	3		3	2	7	14	12	***46***
Lexington County MHC	7	1		9		23	6	17	***63***
Orangeburg Area MHC	3	1				4	3	2	***13***
Pee Dee MHC	3	2				3	7	10	***25***
Piedmont MHC	8	1		2		4	6	12	***33***
Santee-Wateree MHC	6	2		1		9	8	8	***34***
Spartanburg Area MHC	11	3		1	7	4	11	14	***51***
Tri-County MHC	4	1				1	3	6	***15***
Waccamaw MHC	11					13	9	14	***47***
Telepsych Community	13								***13***
Deaf Services	1							1	***2***
Care Coordination				1		1			***2***
CCRI				2		1		3	***6***
Totals	***148***	***31***	***4***	***48***	***12***	***119***	***138***	***231***	***731***

- ✓ 1752 Active Credentialed Staff (CMHC as of June 2019)
- ✓ 42% Licensed (731)

HIPAA Privacy

- Quality Assurance
- Compliance
- Accreditation
- Credentialing
- **HIPAA Privacy**
- Integrated Care
- Organizational Improvement

- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Health Information Technology for Economic and Clinical Health Act (HITECH)
- HIPAA Event Reporting and Tracking

Integrated Care

- Quality Assurance
- Compliance
- Accreditation
- Credentialing
- HIPAA Privacy
- **Integrated Care**
- Organizational Improvement

- Managed Care Organization (MCO) Carve In:
  - Community Mental Health Centers July 2016
  - Division of Inpatient Services Anticipated 2019
- Healthcare Effectiveness Data and Information Set (HEDIS) Quality Measures, such as:
  - Follow-Up After Hospitalization for Mental Illness
  - Metabolic Monitoring for Children/Adolescents on Antipsychotics
- Primary Care Integration Initiatives

Organizational Improvement

- Quality Assurance
- Compliance
- Accreditation
- Credentialing
- HIPAA Privacy
- Integrated Care
- **Organizational Improvement**

- Quality Management Advisory Committee (QMAC)
- Quality Improvement Projects:
  - Level of Care Protocol & Implementation
  - Training Task Force
  - Risk Assessment Protocol & Implementation

Mandatory Training Project

Total Mandatory Training Modules

	Jan 2018	Jun 2019	% Reduction
CMHC's			
RN	80	31	61%
Clinical	81	32	60%
Admin	65	28	57%
DIS			
RN	73	28	62%
Clinical	65	26	60%
Admin	45	22	51%


Thank You!



South Carolina Department of Mental Health Telepsychiatry Programs

Driving the Future of Psychiatric Service Delivery

June
2019

Telehealth, Telemedicine, and Telepsychiatry

- The terms "telehealth" and "telemedicine" are often used interchangeably, but that is not exactly accurate.
- "Telehealth" is a broader range of services such as video conferencing, remote monitoring, online medical evaluations, and transmission of still images.[1]
  - Telehealth is the interaction of patient and clinician via electronic communications to improve a patient's clinical status.[1]
  - Telehealth includes a growing variety of applications and services using two-way video, email, smartphones, wireless tools and other forms of telecommunication.[1]
- "Telemedicine" refers specifically to the subset of telehealth represented by the delivery of clinical services via synchronous, interactive audio and video telecommunications systems.[1] Telepsychiatry is one such clinical service.
- Several key features of "Telepsychiatry" are:
  - High definition
  - HIPAA compliant
  - Encrypted
  - Real-time

Source: [1]Blue Cross Blue Shield Association

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2025

- In 2015, every state in the United States was experiencing at least a high shortage of practicing child and adolescent psychiatrists.[1]
  - In South Carolina, 4 counties had a high shortage, 12 counties had a severe shortage, and 29 counties had no child and adolescent psychiatrists at all. Only one county had a mostly moderate supply of child and adolescent psychiatrists.[1]
- The pool of psychiatrists working with public sector and insured populations declined by 10 percent from 2003-2013.[2]
  - 77% percent of counties in the United States are underserved.[2]
  - Due to efficient screening for mental health and suds in primary care, there will be growing demand for access to psychiatric services.[2]
- In 2025, it is projected that the supply of full-time equivalent psychiatrists will equal 45,210. In 2025, it is projected that the demand for full-time equivalent psychiatrists will range from 51,290 to 60,610.[3]
  - In 2025, the shortage of full-time equivalent psychiatrists in the United States could exceed 15,000.[3]

Sources: [1]American Academy of Child & Adolescent Psychiatry
[2]National Council for Behavioral Health
[3]Health Resources and Services Administration

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2030

- By 2030, there will be a **shortage** of **121,300** physicians in the United States.
  - 66,000 in the South.
- Currently, there is a **need** for **13,800** primary care providers and **5,500** psychiatrists in the United States just to meet the current demand.
- By 2030, demand for healthcare will increase **15%**.
- While supply continues to lag behind demand, methods to address the shortfall will become more imperative.



Source: The Greenville News, April 2018

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One Such Solution

- The solutions depend on a combination of interrelated activities. One such solution: improved efficiency of service delivery.[1]
- There are two distinct conclusions that can be drawn from the information.[2]
  - The introduction of telepsychiatry as a method of service delivery for psychiatric services at the South Carolina Department of Mental Health (SCDMH) provides both a recruitment incentive to psychiatrists and a resource deployment tool for operations.[2]
  - Recruitment Incentive…[2]
    - Geographic area
    - Opportunity to mix practice environments
    - Flexible schedule
  - Resource Deployment Tool…[2]
    - System-wide utilization and scheduling
    - Load balancing of need
    - Rapid relocation of services

Sources: [1]National Council for Behavioral Health
[2]2017 SCDMH Executive Leadership Development Program

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Partners in Behavioral Health Emergency Services



S.C. Emergency Departments Tap Into Tele-Psychiatry for Mental Health Treatment (https://www.scetv.org/stories/telehealth/2016/sc-emergency-departments-tap-tele-psychiatry-mental-health-treatment)

(5:48)

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The Five Programs

Today, SCDMH has five (5) telepsychiatry programs…

- Deaf Services Telepsychiatry Program
- Emergency Department Telepsychiatry Program
- Community Telepsychiatry Program
- EMS Telehealth Pilot Project
- Inpatient Services Telepsychiatry Program

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Deaf Services Telepsychiatry Program

- The Deaf Services Program at the South Carolina Department of Mental Health (SCDMH) was one of the earliest adopters of video technology, starting in 1996 to use telepsychiatry to meet the needs of patients who wanted direct communication with their doctor or counselor.
- The pool of available clinicians who are fluent in American Sign Language is very small and, as SCDMH serves the entire state, requires that either the patient or the staff drive great distances to deliver services. Providing services to a linguistic minority like the Deaf community requires specialized skills.
- Telepsychiatry allows SCDMH to expand the reach of its staff, enabling it to serve more patients, more frequently, and on a more flexible schedule.
- When given a choice, patients consistently say they would rather see a clinician who can communicate with them directly over the video system than use an interpreter.

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Emergency Department Telepsychiatry Program

- In a collaboration of historic significance, the South Carolina Department of Mental Health partnered with The Duke Endowment to create in December 2007 an innovative solution to the overcrowding of psychiatric patients in local hospital emergency departments.
- The solution was called “Partners in Behavioral Health Emergency Services.” Informally, it is referred to as the “SCDMH Emergency Department Telepsychiatry Program.”
- It is a cutting-edge statewide service delivery model that provides remote access for emergency departments in South Carolina to psychiatrists whenever a psychiatric consultation is required.
- With on-going program evaluation from the University of South Carolina, School of Medicine, early financial support from the South Carolina Department of Health and Human Services, and initial program support from the South Carolina Hospital Association, the Program is a critical component to meeting the increased demand on emergency departments to treat psychiatric and co-occurring disorder patients.
- The approach is to impact the demand for services at the service-delivery point with a product that will augment the limited resources available in the emergency departments.
- It is the first of its kind nationally.



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Community Telepsychiatry Program

- The Community Telepsychiatry Program started because of the need for full spectrum community mental health services in rural areas across the state.
- Built on the success of the SCDMH Emergency Department Telepsychiatry Program, SCDMH has equipped its community mental health centers and mental health clinics to provide psychiatric treatment services to its patients via telepsychiatry.
- Many SCDMH community mental health centers operate mental health clinics in rural counties that are distant from the main center. The use of telepsychiatry within catchment networks allows psychiatrists based at the main center to serve outlying satellite clinics without having to travel to those locations. This technology provides patients in need of mental healthcare both scheduled and urgent access to psychiatric services.
- SCDMH has also recruited agency psychiatrists to supplement catchment areas experiencing a shortage of available psychiatric time by utilizing telepsychiatry. These psychiatrists are located in a central geographic location and provide telepsychiatry services from that central location to locations across the state.
- Recruiting psychiatrists is challenging in many locations, especially rural areas. Driving to remote rural clinics consumes valuable time better spent serving patients.

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Emergency Management Services Telehealth Pilot Project

- On May 1, 2017, the Assessment Mobile Crisis (AMC) team at Charleston Dorchester Mental Health Center (CDMHC) began a Telehealth Pilot Project with Charleston County EMS (CCEMS).
- Funded by an MUSC Telehealth Grant, the pilot project was created in an effort to appropriately divert behavioral health patients from local Emergency Departments and hospitals.
- CCEMS uses the telehealth technology on all 911 calls which are identified as psychiatric in nature. It first sends a staffed ambulance to evaluate the individual for medical needs for emergency transport. If there are no medical concerns, a CCEMS supervisor, with the telehealth equipment, is dispatched to the scene. AMC is contacted by the supervisor, and they establish a video connection using HIPAA compliant software.
- Using telehealth assessments has significantly decreased the amount of time needed to complete the intervention, and has allowed for the ambulance to quickly return to service without transporting to the ED.
- The estimated cost savings for the healthcare system in the first 3 months (cost of ambulance transport and a basic ED visit) was approximately $206,600.

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Inpatient Services Telepsychiatry Program

- The Inpatient Services Telepsychiatry Program started because of the periodic need for psychiatric services in SCDMH's inpatient facilities across the state – specifically, neurology.
- Also built on the success of the SCDMH Emergency Department Telepsychiatry Program, SCDMH is equipping its inpatient facilities to provide psychiatric evaluation and treatment services to its patients via telepsychiatry.
- With full implementation of telepsychiatry in SCDMH's Division of Inpatient Services, SCDMH will have deployed telepsychiatry across the spectrum of its psychiatric services and locations.



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Timeline

The South Carolina Department of Mental Health is the largest provider of telepsychiatry services in South Carolina. It shares the distinction of "largest provider of telehealth services" in South Carolina.

1996

The Deaf Services Program is one of the earliest adopters of video technology in psychiatric service delivery.

2007

SCDMH enters into a collaboration of historical significance with The Duke Endowment – the Emergency Department Telepsychiatry Program.

2009

On March 29, 2009, the first wireless video cart was activated in a hospital emergency department.

2013

The Community Telepsychiatry Program began in August 2013.

2017

On May 1, 2017, the Assessment Mobile Crisis (AMC) team began a Telehealth Pilot Project in Charleston County.

2018

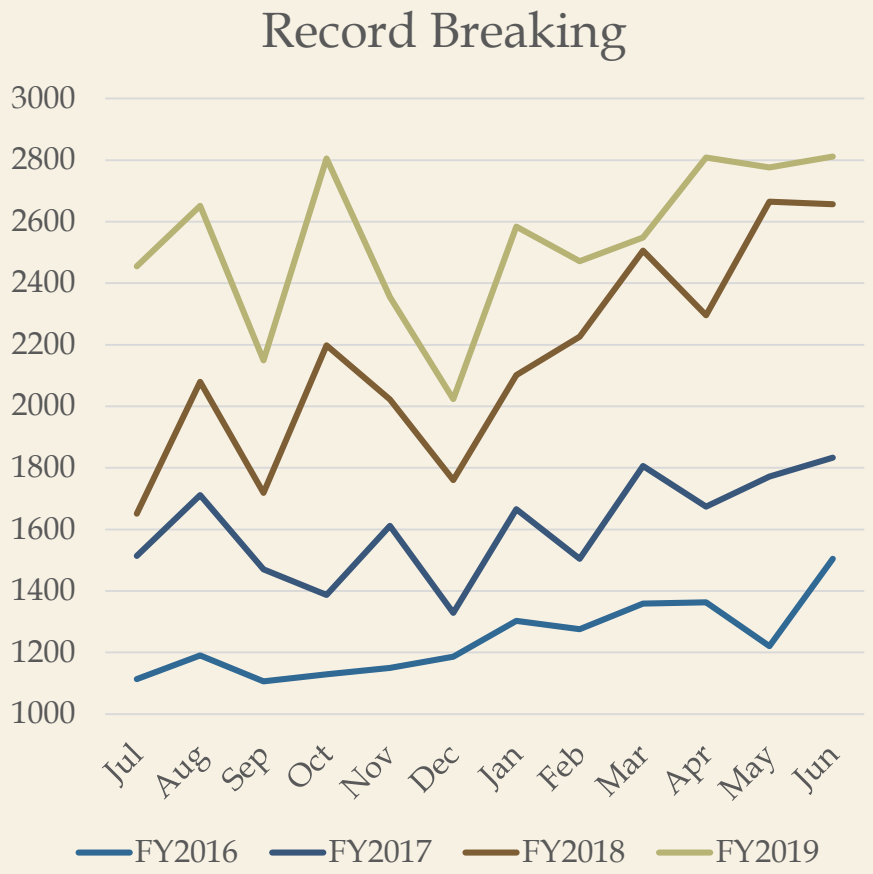
In October 2018, SCDMH delivered its 100,000th psychiatric service rendered via telehealth.

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122,000*

Comprehensive Evaluations and Treatment Services Rendered Via Telehealth

- FY2016 - 14,902
- FY2017 - 19,279
- FY2018 - 25,881
- FY2019- 30,436



*Approximation based on date of reporting.

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The Two Largest Telepsychiatry Programs

The Emergency Department Telepsychiatry Program and the Community Telepsychiatry Program comprise the largest contributors to the number of psychiatric services rendered via telehealth.

Emergency Department Telepsychiatry

- More than 50,000 comprehensive evaluations provided since inception
- Approximately 700 comprehensive evaluations provided per month
- More than 20 telepsychiatrists in full and part-time capacities
- Operating hours: 7:00AM-12:00AM; 365 days a year
- 23 participating hospitals
- 5 state/regional/national awards

Community Telepsychiatry

- More than 70,000 psychiatric treatment services provided since inception
- Approximately 1,800 psychiatric treatment services provided per month
- More than 50 telepsychiatrists in full and part-time capacities
- 16 participating community mental health centers and 43 mental health clinics

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Emergency Department Telepsychiatry Program

- Primary Goals
  - Achieve timely mental health comprehensive evaluations and recommendations
  - Initiate quality treatment services
  - Reduce overall hospital length of stay
  - Affect return on investment through hospital savings
  - Provide successful post-emergency department transfer to aftercare services in community settings

- Clinical Services
  - Evaluations are provided by licensed and board certified psychiatrists
  - Patient-personal treatment and comprehensive discharge care plan is developed
  - Electronic medical record (EMR) is utilized
  - EMR is electronically transferred to hospital
  - Follow-up comprehensive evaluations are provided by ED Telepsychiatry Program telepsychiatrists

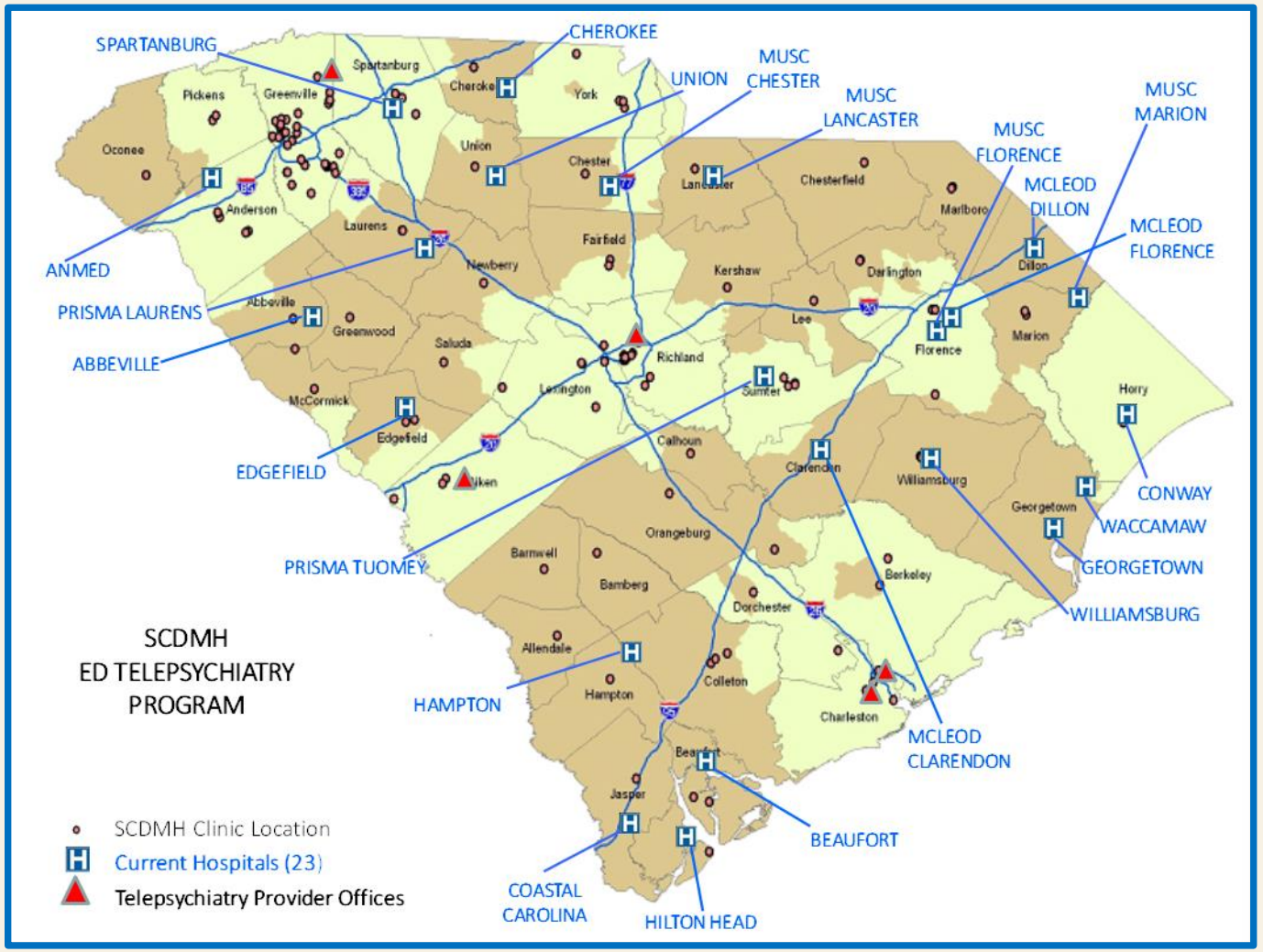
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Emergency Department Telepsychiatry Program

- Program Outcomes
  - An R01 grant awarded to the University of South Carolina, School of Medicine by the National Institutes of Health has demonstrated that this unique program has improved access, improved affordability, and provided quality care to citizens of the state with mental illnesses.
    - What is an R01 Grant?

      The Research Project Grant (R01) is the original and historically oldest grant mechanism used by National Institutes of Health (NIH). The R01 provides support for health-related research and development based on the mission of the NIH – to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability.
  - Since 2012, longitudinal results demonstrate:
    - Higher follow-up and retention of patients seen with the telepsychiatry group compared to controls in an outpatient setting
    - Shorter lengths of stay
    - Fewer inpatient admissions
    - Total charges at encounter level for the index emergency department visit including subsequent inpatient admission that were significantly lower for the telepsychiatry group.

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Participating Hospitals

There are twenty-three (23) participating hospitals in the Emergency Department Telepsychiatry Program.

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Evaluation and Return on Investment

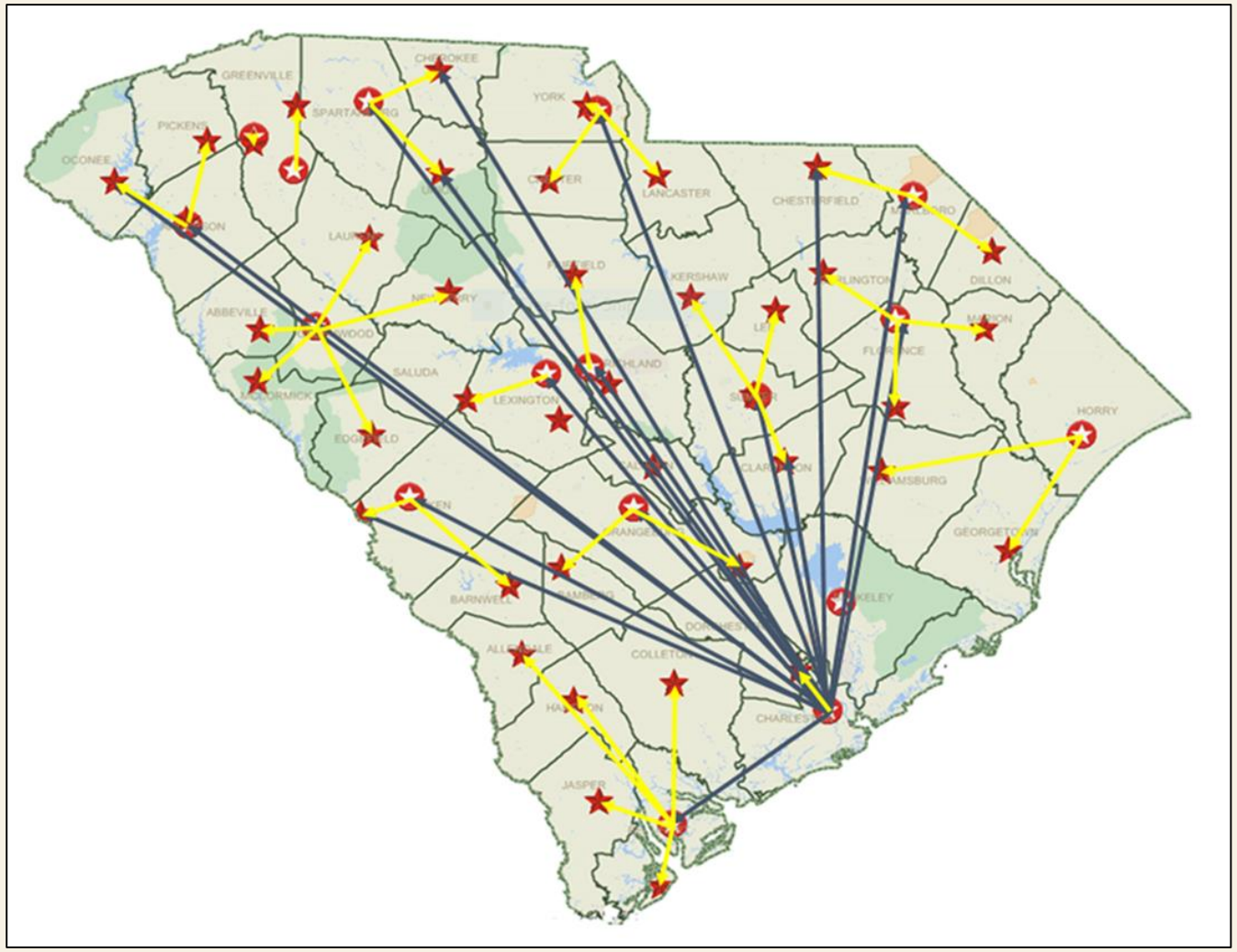
- South Carolina Telehealth Alliance Evaluation: Direct to Consumer and Telepsychiatry Programs, 2018-2019 Report, SCTA Evaluation Team, University of South Carolina, School of Medicine
  - Access
    - Access for treatment was improved for traditionally marginalized groups
  - Value
    - 29% lower average in lengths of stays when remaining in same facility
    - 97% lower cost when considering length of stay costs 90 days after initial encounter
    - 33% lower inpatient hospital charges on average for telepsychiatry vs. non-telepsychiatry comparison group
    - 15% lower total hospital charges on average for telepsychiatry vs. non-telepsychiatry comparison group
  - Quality
    - 71% higher rate of transfer to other facilities for inpatient care from the ED for telepsychiatry vs. non-telepsychiatry comparison group
    - 70% lower rate of inpatient admission to the same hospital from the ED for telepsychiatry vs. non-telepsychiatry comparison group
    - 51% higher follow-up rate for telepsychiatry patients for both 30-day and 90-day outpatient follow-up appointments

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Community Telepsychiatry Program

- Primary Goals
  - Improve access and timeliness of clinical services
  - Improve clinical workflows and efficiencies
  - Provide collaborative care
  - Increase patient engagement
- Clinical Services
  - Evaluations are provided by licensed and board certified psychiatrists
    - Initial Psychiatric Medical Assessment (PMA)
    - Follow-up care
    - Treatment team participation
  - Patient-personal treatment and comprehensive discharge care plan is developed and monitored
  - Electronic medical record (EMR) is utilized
    - System-wide EMR application increases service delivery effectiveness via timely, accessible clinical information
  - Effects continuity of care

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State-wide Interconnectivity

The interconnectivity of SCDMH's Telepsychiatry Programs creates state-wide access to care and efficiently deploys limited clinical resources.

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Evaluation and Return on Investment

- South Carolina Telehealth Alliance Evaluation: Direct to Consumer and Telepsychiatry Programs, 2018-2019 Report, SCTA Evaluation Team, University of South Carolina, School of Medicine
  - Access
    - Access for treatment was improved for traditionally marginalized groups
  - Value
    - 16% of patients with at least one ED visit for behavioral health vs. 11% post Community Telepsychiatry Program (CTP) – ED visits for behavioral health were significantly reduced after CTP
  - Quality
    - 66% had a Psychiatric Medical Assessment (PMA) visit vs. 78% in the year after a patient's first CTP visit – Significantly more clients received their assessment after receiving CTP
    - Patients had their psychotropic medication filled and available for them to take for significantly more days after CTP, increasing the probability they will adhere to taking their medication as prescribed

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The Factors for Success in the SCDMH Telepsychiatry Programs

- Integrated Mental Health System and the State Mental Health Authority
- Centralized Electronic Health Record (EHR)
- Bank of Physicians Dedicated to Telepsychiatry
- Popular Geographic Locations for Physician Recruitment
- Interconnectivity of Information Technology Network
- Home Offices and Telecommuting
- Low Access Fees (ED Telepsychiatry Program)
- Hours of Operation (ED Telepsychiatry Program)
- Telehealth Champion for Rural Area Access (Palmetto Care Connections)
- Large Statewide Contingent Focused on Telehealth (South Carolina Telehealth Alliance (SCTA))

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The South Carolina Telehealth Alliance

- The SCTA is a statewide collaboration of many organizations that have joined forces to expand telehealth services across the State of South Carolina.
- Led by the SCTA Advisory Council, it provides guidance, assists with strategic development, and advises on technology and standards. It is co-chaired by MUSC and Palmetto Care Connections.
- The SCTA was formed with founding strategic providers, Greenville Health, McLeod Health, Medical University of South Carolina and Palmetto Health – known as The Hubs – providing telehealth care services. SCDMH was the fifth Hub and is the only provider with a statewide emphasis.
- The SCTA is funded by the S.C. State Legislature, via the House Ways & Means Committee and the S.C. Department of Health and Human Services. The Medical University of South Carolina, an agency of the State of South Carolina, serves as the fiscal agent and headquarters of the SCTA.

GREENVILLE HEALTH SYSTEM

DMH South Carolina Department of Mental Health

MUSC Health Medical University of South Carolina

McLeod Health The Choice for Medical Excellence

PALMETTO HEALTH

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The 2019 SCTA Strategic Plan

SOUTH CAROLINA Telehealth ALLIANCE

Mission

Improve the health of all South Carolinians through telehealth.

Values

Patient centered
Quality
Collaboration
Sustainability
Accountability

Vision

Telehealth will grow to support delivery of health care to all South Carolinians with an emphasis on underserved and rural communities. It will facilitate, coordinate and make more accessible quality care, education and research that are patient centered, reliable and timely. Our state will become recognized nationally for telehealth that is uniquely collaborative, valuable and cost effective.

Value Proposition

Telehealth in South Carolina will deliver high value through productive collaboration.

The 2018 Annual Report



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The South Carolina Telehealth Alliance Strategic Plan

Strategies and Tactics

- 1. Open Access
- 2. Rural Focus
- 3. Service Development
- 4. Mental Health
  - Tactic 4.1: Support rural hospitals with the availability of mental health and related clinical services and programs.
  - Tactic 4.2: Support primary and ambulatory care providers with efficient access to specialty care.
  - Tactic 4.3: Establish telepsychiatry as recruitment tool for providers.
  - Tactic 4.4: Develop a best practice for medical information sharing across disparate medical service delivery organizations.
  - Tactic 4.5: Identify, support, and coordinate other statewide telehealth initiatives that address mental health and related clinical services and programs.
- 5. Education and Training
- 6. SCTA Collaboration
- 7. Outcomes
- 8. Promotions and Sustainability

Source (Slides 24-26): South Carolina Telehealth Alliance

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The Keys to Future Success in Telehealth

- Broadband Access Expansion within Rural Communities
- Enhanced Information Sharing Platforms
- Service-Sustaining Reimbursement (Services, Providers, Locations)
- Telehealth in Strategic Planning
- Partnerships with Non-Traditional Healthcare Organizations to Provide Better Care
- Partnerships with Non-Traditional Healthcare Locations to Provide Access to Care
- Continuous Adaptability



Citation: Dr. Michael Christopher Gibbons, Chief Health Innovation Officer, The Greystone Group, Connect2Health FCC Task Force: remarks at the 7th Annual Telehealth Summit (2019), South Carolina

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Leveraging Available Resources

- Since 2015, SCDMH has participated in the Federal Communications Commission's (FCC) Healthcare Connect Fund (HCF). It is an FCC Rural Health Care program that is administered by Universal Service Administrative Company (USAC).
- The HCF provides a 65% discount for eligible broadband expenses and network equipment. Its target recipients are rural healthcare providers (HCP) and consortia of HCPs. SCDMH participates in the HCF as part of a consortia.
- The vast majority of benefit to SCDMH is associated with circuits on its wide-area network.
- To date, SCDMH has received offsets to its AT&T bills through the HCF of more than $2.7 million.

Federal Communications Commission

USAC
Universal Service Administrative Company

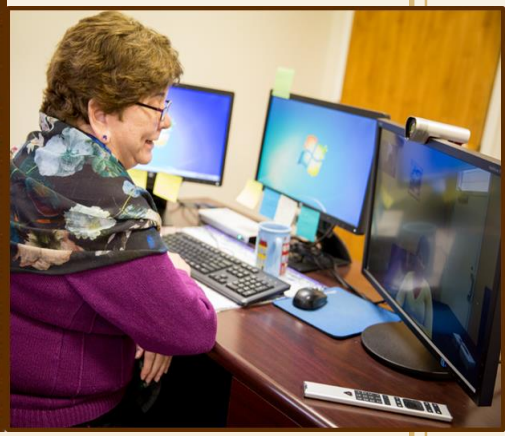
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Telepsychiatry at the South Carolina Department of Mental Health

Anytime, Anywhere, Anyhow







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Where Do We Go From Here?

- Program Expansion: Emergency Department Telepsychiatry Program
- Program Expansion: Inpatient Services Telepsychiatry Program
- New Program Pilot: Geriatric Telepsychiatry
- New Program Pilot: FQHC Partnership/Primary Care Alignment
- School Mental Health Program with Telepsychiatry Support
- Utilization of Nurse Practitioners (APRN) and Physician Assistants (PA)

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Ancillary Telepsychiatry Activities

- Patient Centered Outcomes Research Institute (PCORI): Engaging Patients in Care (EPIC) Program
- Zero Suicide Initiative
- Centralized Credentialing
- Healthy Transitions
- Ensor Grant

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The Most Important Part of Telepsychiatry – the Patient



Deaf Resident Strikes the Right Note with Telemedicine (https://www.scetv.org/stories/telehealth?page=2)
(4:20)

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Telepsychiatry

Part of SCDMH's more than 900 portals of access to services

- SCDMH Vision: As the State's Mental Health Authority, SCDMH will be the provider and employer of choice.
- SCDMH Mission: To support the recovery of people with mental illnesses.
  - Telepsychiatry is the future of SCDMH's mission.

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Additional Resources

https://www.scetv.org/telehealth
http://www.sctelehealth.org/
https://scdmh.net/telepsychiatry/



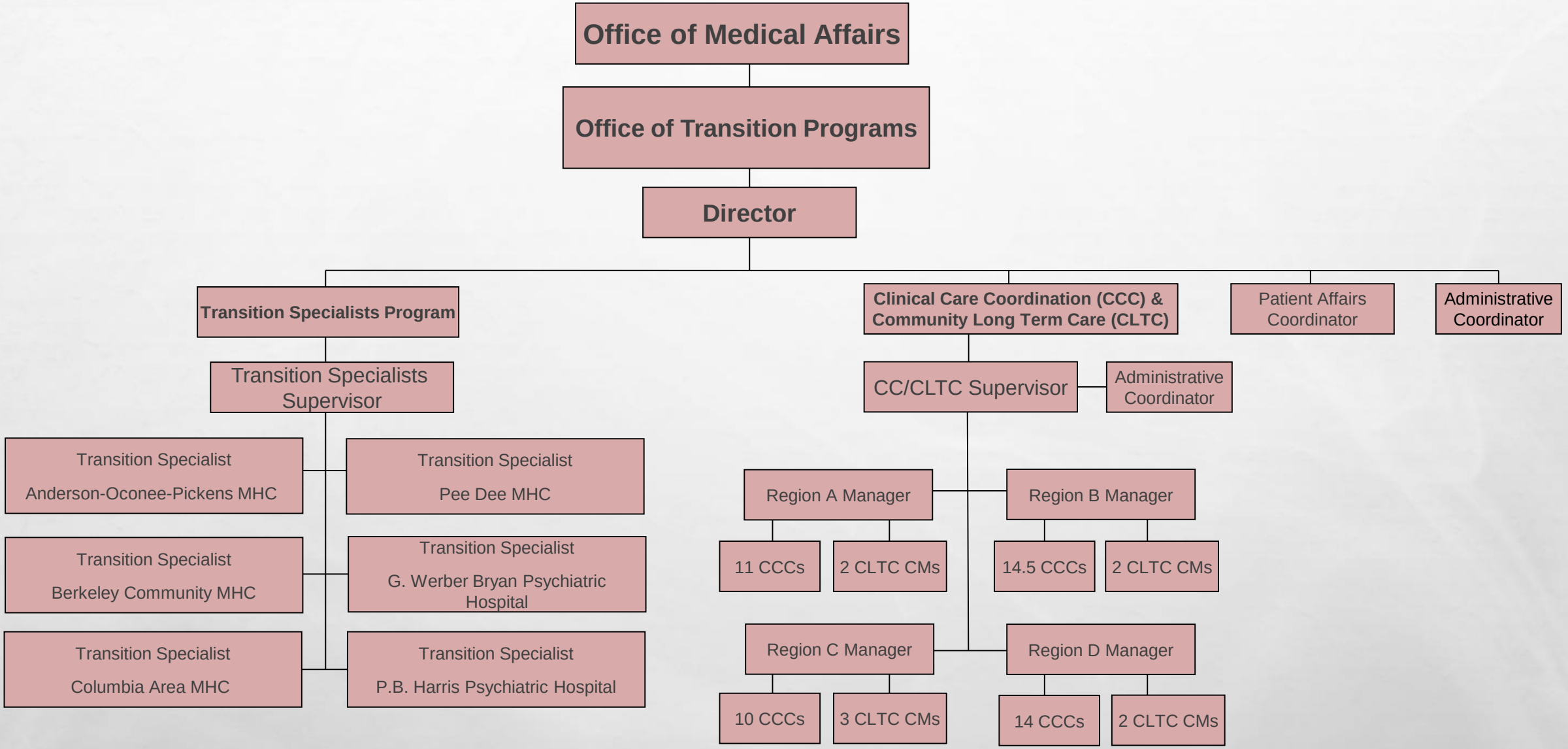

Thank You!
Stewart Cooner, Director of Special Programs & Telepsychiatry
Phone
803-898-8632
Email
stewart.cooner@scdmh.org

OFFICE OF TRANSITION PROGRAMS

BUILDING BRIDGES TO THE COMMUNITY



SLIDE 1


Office of Medical Affairs
Office of Transition Programs
Director
Transition Specialists Program
Transition Specialists Supervisor
Transition Specialist
Anderson-Oconee-Pickens MHC
Transition Specialist
Pee Dee MHC
Transition Specialist
Berkeley Community MHC
Transition Specialist
G. Werber Bryan Psychiatric Hospital
Transition Specialist
Columbia Area MHC
Transition Specialist
P.B. Harris Psychiatric Hospital
Clinical Care Coordination (CCC) & Community Long Term Care (CLTC)
Patient Affairs Coordinator
Administrative Coordinator
CC/CLTC Supervisor
Administrative Coordinator
Region A Manager
Region B Manager
11 CCCs
2 CLTC CMs
14.5 CCCs
2 CLTC CMs
Region C Manager
Region D Manager
10 CCCs
3 CLTC CMs
14 CCCs
2 CLTC CMs

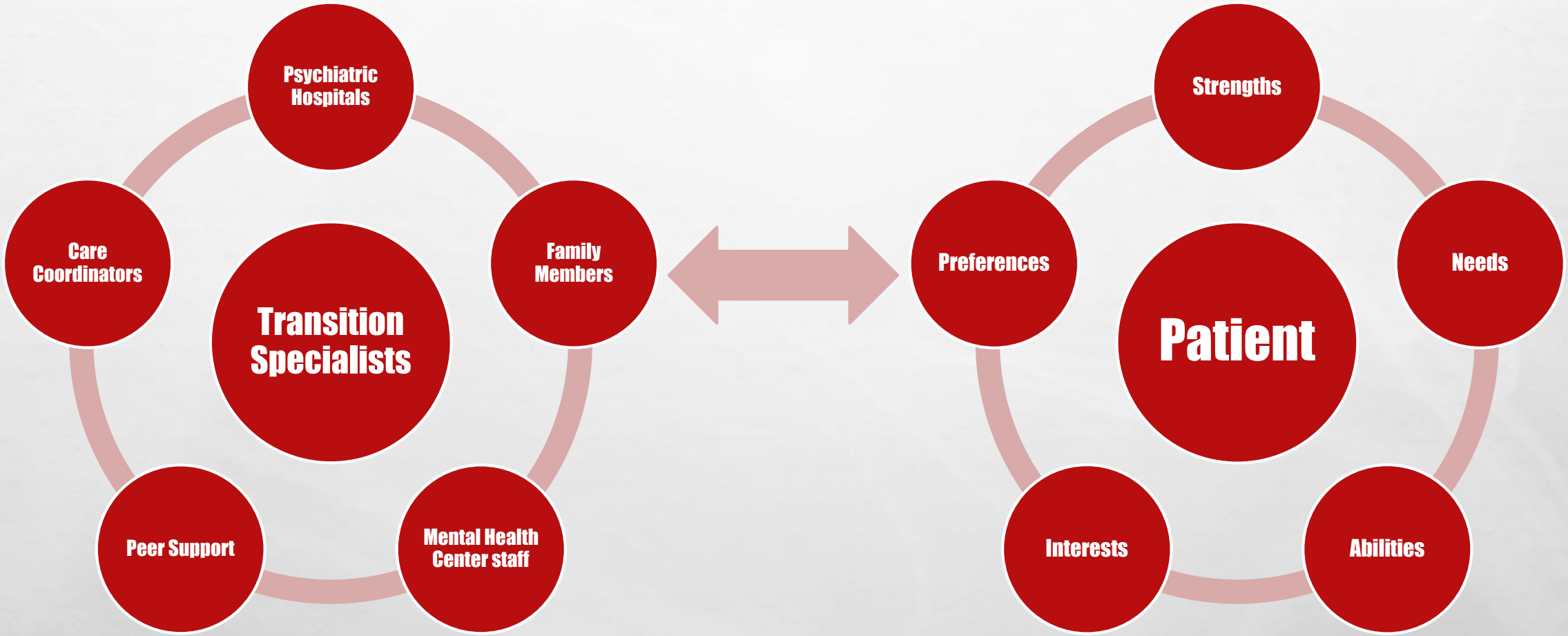
SLIDE 2

TRANSITION SPECIALISTS



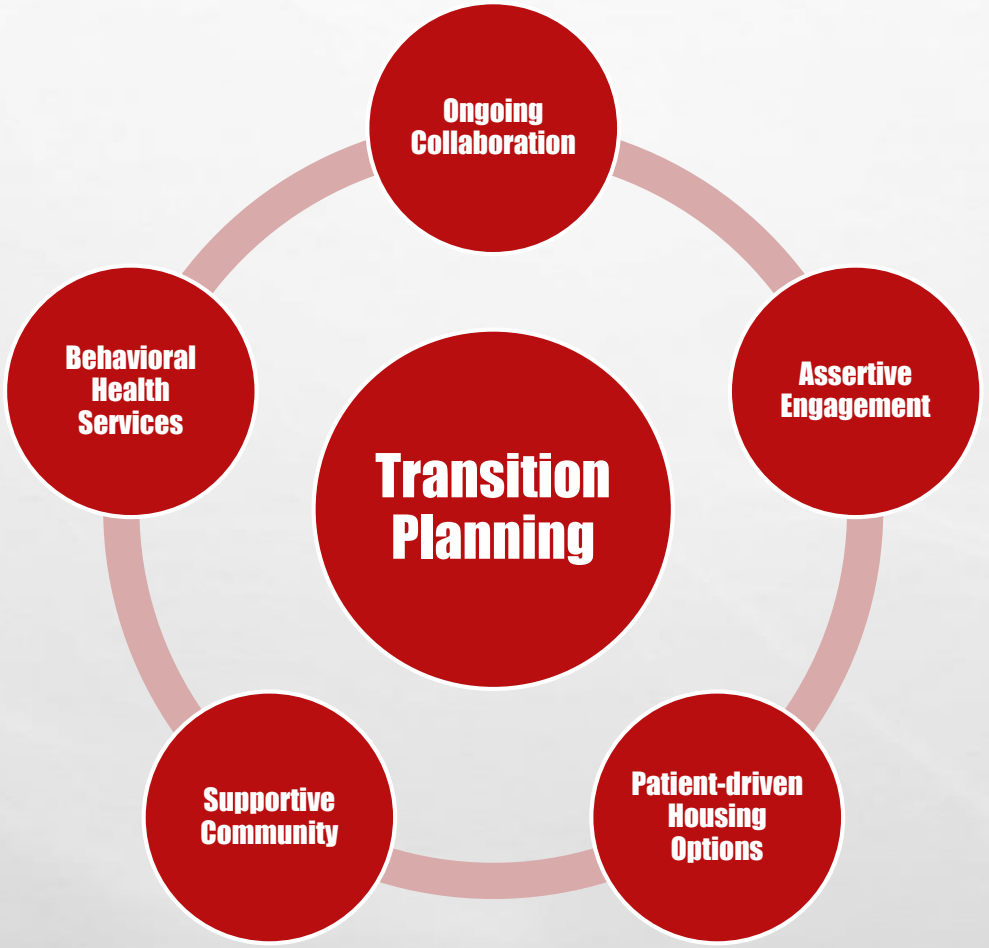
SLIDE 3

COLLABORATION



SLIDE 4

TRANSITION PLANNING



SLIDE 5

TREATMENT ACCESSIBILITY



SLIDE 6

OUTCOMES

GOALS	MEASUREMENTS
SUCCESSFUL COMMUNITY PLACEMENT/TENURE	# DAYS IN COMMUNITY
TIMELY DISCHARGE SERVICES	# DAYS BETWEEN DISCHARGE/1ST TREATMENT SERVICE
TREATMENT ENGAGEMENT	TREATMENT COMPLIANCE
IMPROVED LEVEL OF FUNCTIONING	DAILY LIVING ASSESSMENT
REDUCTION IN INPATIENT LENGTH OF STAY	BRYAN & HARRIS LENGTH OF STAY
REDUCTION IN INPATIENT READMISSION RATES	BRYAN & HARRIS READMISSION RATES
TRACKING COMMUNITY RESOURCE NEEDS	MET/UNMET NEEDS

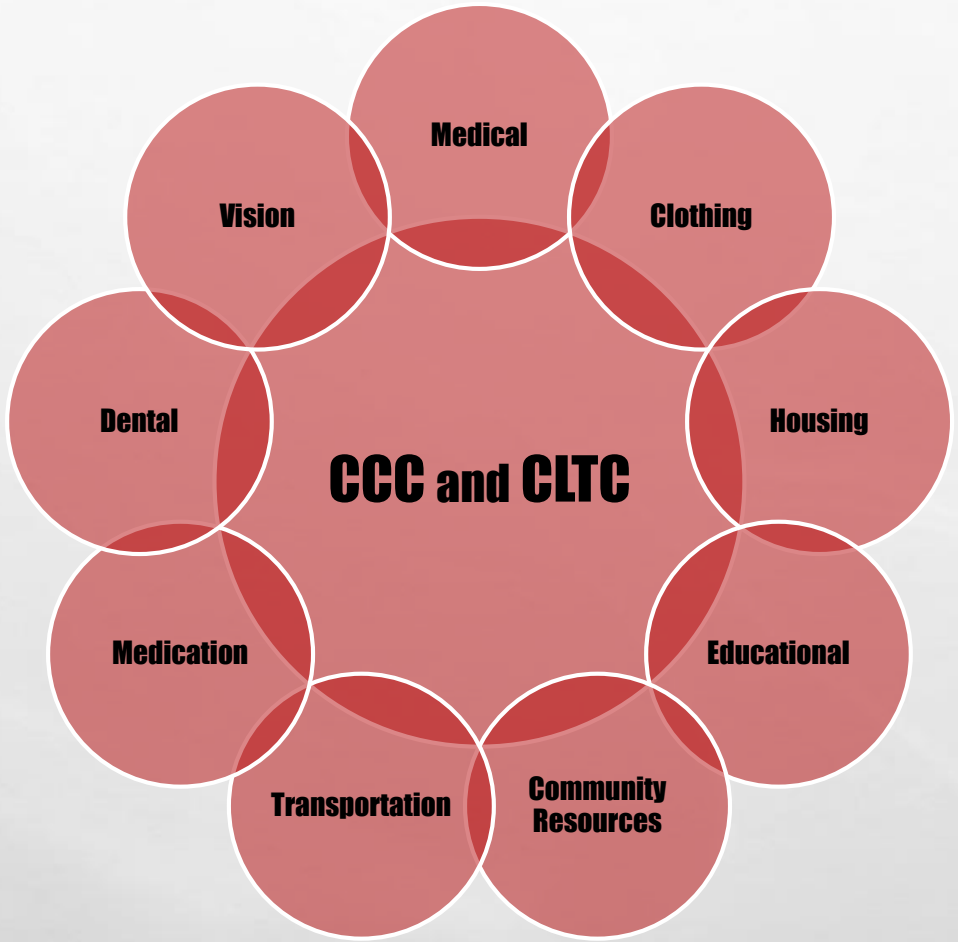
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OUTCOMES

- HOUSING TYPES
  - INDEPENDENT LIVING
  - SUPERVISED APARTMENTS
  - CRCFS
  - BOARDING HOMES
- GEOGRAPHICAL AREA DISCHARGED
  - TREATMENT CATCHMENT AREA
- ENGAGE PEER SUPPORT SERVICES (PSS)
  - PSS LINKAGE
- ENGAGE CARE COORDINATION (CC)
  - LINKAGE TO CC INPATIENT/OUTPATIENT

SLIDE 8

OFFICE OF CLINICAL CARE COORDINATION AND COMMUNITY LONG TERM CARE



SLIDE 9

OFFICE OF CLINICAL CARE COORDINATION AND COMMUNITY LONG TERM CARE

Community Care Coordination

Assisted 52,000 Care Coordination patients since 1/2013 (through 6/01/19)
(approx. 45% self-pay)

Hospital Care Coordination

Assisted 610 patients discharge to community settings including smooth hand-off to community Clinical Care Coordinator since 7/1/16

Community Long Term Care

Assisted 600 participants to remain in their homes since January 2015

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PATIENT AFFAIRS COORDINATOR



SLIDE 11

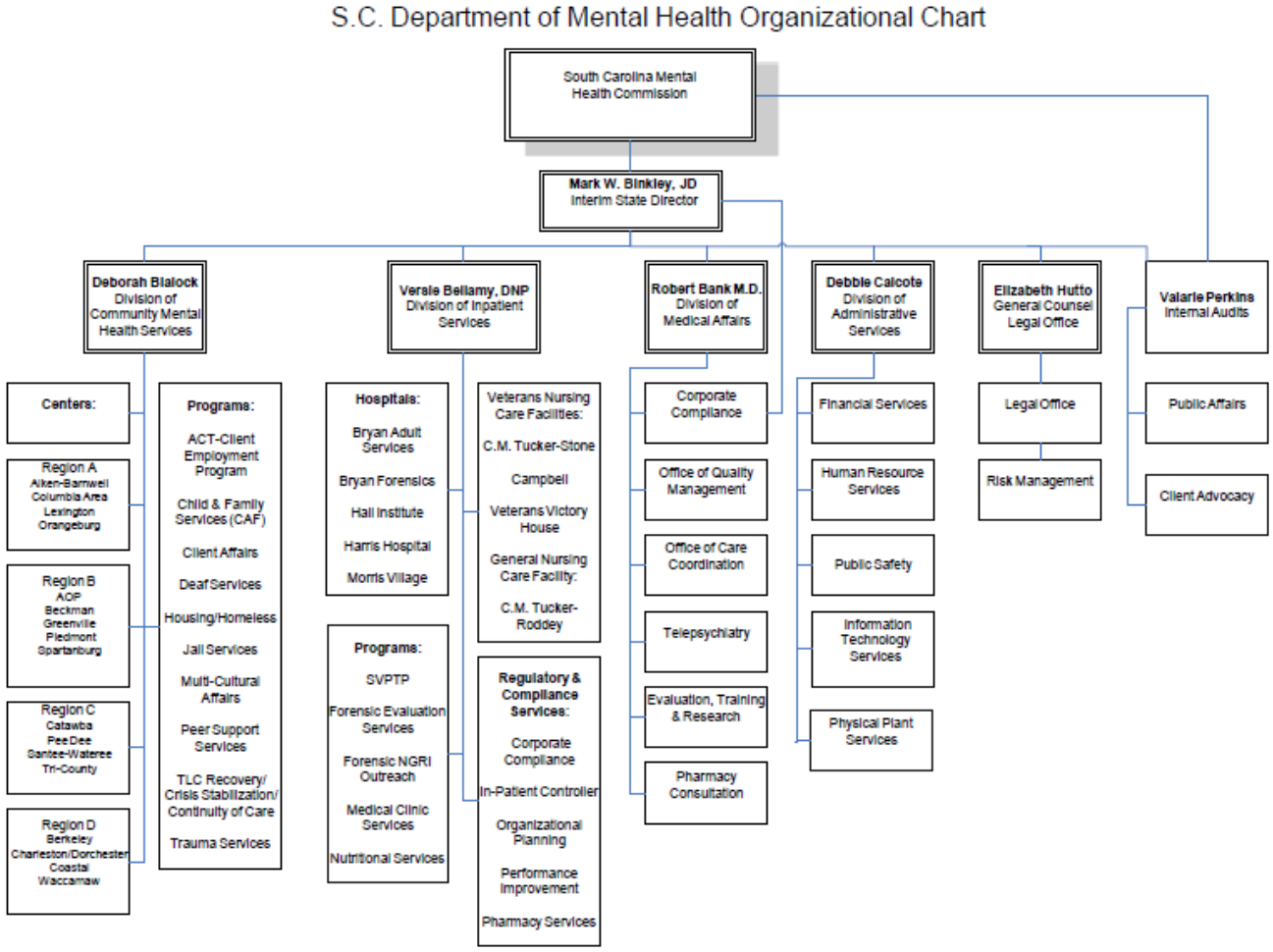


SLIDE 12

Planning Steps – Step 1– Assess the Strengths and Organizational Capacity of the Service System to Address the Specific Populations Revision Request – November 12, 2019 (Supplemental Information)

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

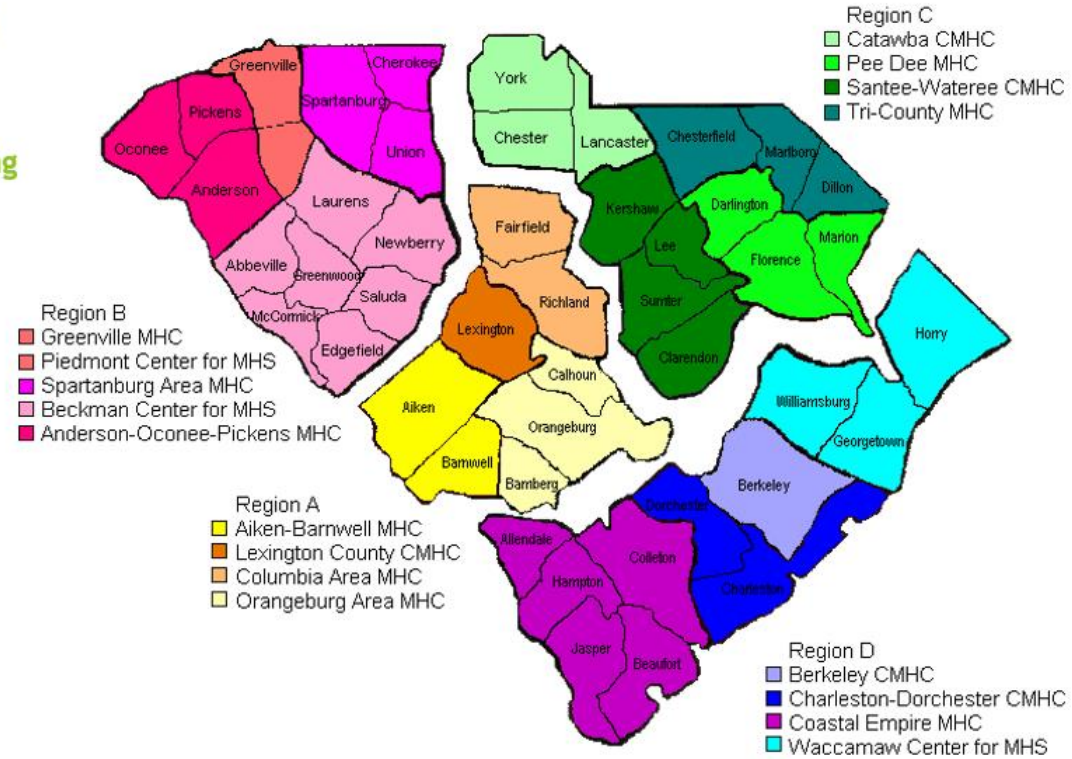
The South Carolina Department of Mental Health's (SCDMH) mission is to support the recovery of people with mental illnesses, giving priority to adults with serious and persistent mental illness and children and adolescents with serious emotional disturbances. The Agency serves approximately 100,000 citizens with mental illnesses, approximately 30,000 of whom are children and adolescents. Child and adolescent services are provided by SCDMH's Child, Adolescent & Family Services (CAF) within the Division of Community Mental Health Services. Inpatient services for children and adolescents are provided at SCDMH's William S. Hall Psychiatric Institute.



SCDMH is the mental health authority in the State of South Carolina and the lead state agency in the provision of mental health services to the citizens of the State (see S.C. Department of Mental Health Organizational Chart). SCDMH partners with the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) to support DAODAS' role as the lead state agency for funding SUD services – services that are provided by local non-profits known as "301s" for ACT 301 that facilitated their establishment.

Each of SCDMH's 16 community mental health centers (see SCDMH Mental Health Centers and Regions – note that the map lists 17 community mental health centers, but as of June 30, 2019, Greenville Mental Health Center and Piedmont Center for Mental Health Services merged to consolidate operations across Greenville County – resulting in 16 community mental health centers) is accredited by CARF International, an independent, nonprofit accreditor of human service providers. CARF International also accredits Morris Village Treatment Center, the Agency's inpatient drug and alcohol hospital. SCDMH's psychiatric hospitals (see DMH Inpatient Hospitals and Nursing Homes) are accredited by The Joint Commission, which aims to improve healthcare by evaluating healthcare providers and inspiring them to excel in the provision of safe, effective care of the highest quality and value. Each of SCDMH's four nursing homes is licensed by DHEC and certified by CMS. Three of the four nursing homes (530 beds) exclusively serve veterans; they are certified by the Department of Veterans Affairs. The Tucker Nursing Care Facility (Roddey-General Nursing Home and Stone-Veterans Nursing Home) is nationally accredited by The Joint Commission and is one of only six nursing homes in the State of South Carolina to hold this distinction.

SCDMH MENTAL HEALTH CENTERS AND REGIONS
(Greenville and Piedmont are merging into Greater Greenville - fully effective 6/30/19)



In addition, SCDMH has more than 1,000 portals by which citizens can access mental health services, including: a network of 16 outpatient community mental health centers – 64 total clinics covering all 46 counties; three psychiatric hospitals – one specifically for children, one community nursing care center, and three veterans' nursing homes; more than 20 specialized clinical service sites (SCDMH offices that provide some type of clinical care, but do not offer a full array of services found in a center or clinic); 23 South Carolina hospitals with SCDMH

Telepsychiatry services; more than 150 community sites (non-SCDMH entities or businesses where SCDMH staff regularly and routinely provide clinical services); and more than 750 school mental health service sites.

DMH Inpatient Hospitals and Nursing Homes



Richard M. Campbell Veterans Nursing Home
Skilled nursing care facility for SC veterans in Anderson



Patrick B. Harris Psychiatric Hospital
Adult psychiatric care hospital in Anderson.



G. Werber Bryan Psychiatric Hospital

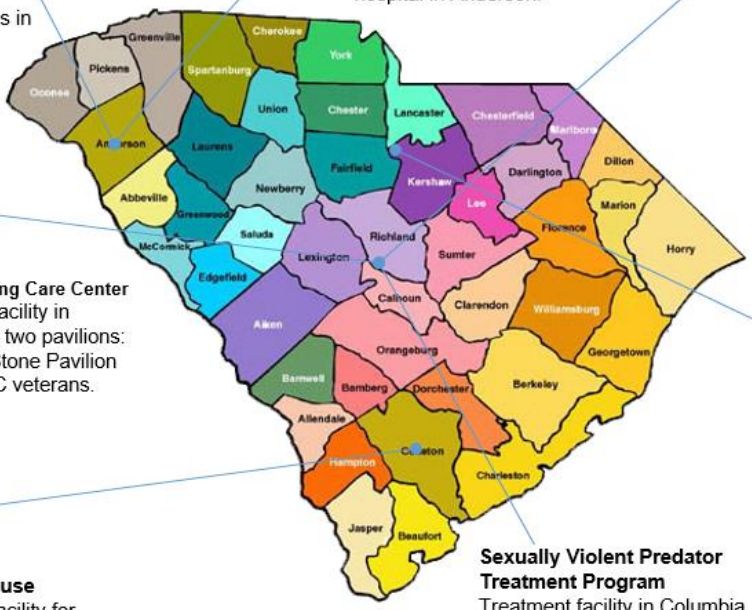
Adult Services - Adult psychiatric care hospital in Columbia.

Forensics - Court-ordered stabilization, restoration, evaluation, and ongoing treatment for people found not competent to stand trial or Not Guilty by Reason of Insanity. Located in Columbia.

William S. Hall Psychiatric Institute
Child and Adolescent psychiatric hospital on the Bryan Campus with acute, residential and alcohol and drug addiction treatment.



C.M. Tucker, Jr. Nursing Care Center
Skilled nursing care facility in Columbia comprising two pavilions: Roddey and Stone. Stone Pavilion specifically serves SC veterans.





Morris Village Alcohol and Drug Addiction treatment Center
Alcohol and drug addiction treatment hospital in Columbia.



Veterans Victory House
Skilled nursing care facility for SC veterans in Walterboro.

Sexually Violent Predator Treatment Program
Treatment facility in Columbia for persons adjudicated as sexually violent predators.

Community services offered to adults and children ages 0-100+ include assessments, individual therapy, group therapy, family therapy, psychiatric medical assessment (PMA), nursing services, medication administration, medication monitoring, psychosocial rehabilitation services, certified peer support services, crisis intervention, and care coordination (see SCDMH – A True System of Care (A Brief Overview)).

It is the mission of SCDMH to support Recovery Initiatives through the development of empowered patient leadership for persons served through the agency. SCDMH empowers patients by hiring them to be: planners; policy makers; program evaluators; service providers. SCDMH also supports recovery through training and education on recovery principles and recovery-oriented practice and systems, including the role of peers in care; required peer accreditation or certification; block grant funding of recovery support services; involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the mental health system; and measurement of the impact of consumer and recovery community outreach activities. SCDMH partners with the local advocacy group SC SHARE to certify Peer Support Specialists for the State.

SCDMH maintains partnerships with the South Carolina Department of Education, South Carolina Department of Health and Human Services, South Carolina Department of Juvenile Justice, South Carolina Department of Social Services, South Carolina Department of Vocational Rehabilitation, South Carolina State Housing Finance and Development Authority, and many other state agencies, universities, non-profits, and other stakeholder organizations, such as counties – some of which provide funding to support SCDMH operations – to ensure a comprehensive mental health continuum and supporting services for the citizens SCDMH serves.

SCDMH's treatment continuum is best illustrated by the following graphic.



An unmet service need and a gap in the current system is the inclusion of consultation sessions – government-to-government interaction – with the State of South Carolina's only federally recognized tribe: the Catawba Indian Nation. SCDMH has attempted, however, since 2012, to obtain, at least, tribal input – the South Carolina Mental Health State Planning Council secured representation from the State Commission for Minority Affairs by means of a state employee who is not only employed by the State Commission for Minority Affairs, but who also serves as a liaison to the Native American Indian Advisory Committee.

Regarding how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the state –

- SCDMH tracks access or enrollment in services, types of services received and outcomes for said services by race, ethnicity, gender, gender identity, and age. It does not track sexual orientation.
- SCDMH has a data-driven plan to address and reduce disparities in access, service use, and outcomes for the above sub-populations.
- SCDMH has a plan to identify, address, and monitor linguistic disparities.
- SCDMH has a workforce-training plan to build the capacity of mental health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations.
- SCDMH has established directives related hereto.
    - Directive 839-03 – Culturally and Linguistically Appropriate Services to Consumers who have Limited English Proficiency (LEP), or are Hard of Hearing or Deaf – The purpose of this Directive is to ensure each Facility and Community Mental Health Center has a policy and procedure to provide culturally and linguistically appropriate services to its consumers who are not proficient in the English language, to the extent that they cannot access the services or programs offered by the agency without language assistance.

It is the policy of the Department of Mental Health (DMH) to recognize and respect the cultural diversity of its consumers and to provide culturally and linguistically appropriate services to all of its consumers. Moreover, it is the policy of the Department to provide services to those needing them without regard to national origin or disabilities. Included are individuals who have limited English proficiency, or are hard-of-hearing or deaf. The Department recognizes that in order to provide meaningful access to its behavioral health services to consumers who have limited English proficiency, or are hard-of-hearing or deaf, DMH facilities and community mental health centers must have procedures in place to provide communication services, including interpreter services at no cost to the consumer. Accurate and adequate communication between consumers and providers is a necessary element for providing good quality care, and it is a recognized right of consumers. The treatment staff needs to have the capability to effectively communicate with and relate to the experiences of consumers from diverse cultures, as this is an important component of culturally competent treatment.

- Directive 894-09 – Cultural Competence – This directive establishes the policy for the creation and maintenance of culturally and linguistically competent system of care at the South Carolina Department of Mental Health (SCDMH).

  The Department recognizes that culture is dynamic and that cultural competence must be an ongoing process, believing that valuing individual and group cultural differences is critical to achieving the organizational goals. SCDMH considers cultural competence a necessary part of good clinical services. Organized under the Division of Community Mental Health Services the Statewide Multi-Cultural Council and Center/Facility Multi-Cultural Committees are charged with the responsibility to advise and guide SCDMH leadership in the creation and maintenance of a linguistically and culturally competent workforce, service divisions, programs, and collaborative endeavors reflective of the diversity of the population served and the community. Administrative Services, Centers and Facilities will refer to the Departmental Directive No. 839-03 Culturally and Linguistically Appropriate Services to Consumers who have Limited English Proficiency (LEP), or are Hard of Hearing or Deaf for compliance procedures.

Public Mental Health in South Carolina

As referenced herein, the attached PowerPoint presentations provide a comprehensive overview of the mental health service system in South Carolina. Each also details the methods by which SCDMH meets the expectation that it will not only offer a core array of usual and customary psychiatric services, but that it will also be the leader in innovative and technologically-advanced approaches to the delivery of mental health and other ancillary and support services.

[End]

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the **National Survey on Drug Use and Health** (NSDUH), the **Treatment Episode Data Set** (TEDS), the **National Facilities Surveys on Drug Abuse and Mental Health Services**, and the **Uniform Reporting System** (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several **other data sets** that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[16] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[16] **http://www.healthypeople.gov/2020/default.aspx**

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Footnotes:

Planning Steps – Step 2– Identify the Unmet Service Needs and Critical Gaps within the Current System

Identifying Unmet Service Needs and Critical Gaps

In order to identify the unmet service needs and critical gaps within the current system to address the specific populations of children with SED, adults with SMI, and older adults with SMI, among other identified groups, the South Carolina Department of Mental Health (SCDMH) systematically reviews its programs and services throughout the fiscal year. As a result of such reviews, SCDMH is able to determine the areas in which it particularly excels and subsequently share such excellence with its partners and stakeholders. Similarly, SCDMH is also able to determine the areas in which gaps or needs have arisen and subsequently address such shortages with its Senior Leadership and staff. Based on data-driven analyses, performance measurements, and feedback mechanisms, SCDMH is able to articulate its competence as the mental health authority in the State of South Carolina while continually evaluating, assessing, and refining its programs, services, and service delivery systems for its patients.

An External Comprehensive Review

In May 2018, SCDMH began a formalized review of its operations under Chapter 2, Title 2 of the 1976 Code (Legislative Oversight of Executive Departments) as the South Carolina House of Representatives exercised its option to conduct an information request under the authority of an oversight review. The specific task of the South Carolina House of Representatives, House Legislative Oversight Committee, Healthcare and Regulatory Subcommittee is to conduct legislative oversight studies and investigations of state agencies at least once every seven years.

"The purpose of legislative oversight is to determine if agency laws and programs are being implemented and carried out in accordance with the intent of the General Assembly and whether or not they should be continued, curtailed or even eliminated. Any House Member may file legislation to implement the Legislative Oversight Committee's recommendations."

Information regarding SCDMH's participation in the oversight process can be found at the following link: https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyPHPFiles/MentalHealth.php.

During this formalized review process, SCDMH provided an abbreviated list of agency challenges. Many of the articulated challenges illuminated unmet service needs and critical gaps within the current system.

- Increasing Access to Veterans Nursing Home Beds – Based on a formula promulgated by the Department of Veterans Affairs, there exists in South Carolina the need for additional veterans long-term beds. Title 38, Part 59 provides the total number of allowed State Home beds, which, when netted with the number of current State Home beds (530), indicates a need for an additional 559 veterans nursing home beds.

- Reducing the Time for Forensics Admissions – By law, criminal defendants found incompetent to stand trial due to a mental illness must go through a commitment process to a SCDMH hospital. Because of a significant increase in commitment orders, the length of time that defendants must wait for admission substantially increased. As a result, in June, 2016, SCDMH made reducing the wait time for forensic admissions its first priority and developed a multi-faceted Action Plan.

- Increasing Hospital Capacity without Increasing Hospital Beds – If SCDMH is able to increase the availability of intensive community mental health services and increase the availability of supported community housing, it will lead to shorter hospital lengths of stay. In effect, expanding community housing and intensive mental health services will result in SCDMH being able to hospitalize more patients with its

current number of beds. The challenge is to fund increased community housing and additional mental health services delivered at a patient's residence. SCDMH has requested recurring appropriations to support these services.

- Addressing Crisis Stabilization – It is critical the SCDMH be able to partner with local hospitals and other community officials to increase residential crisis stabilization programs. Such programs help divert individuals in a psychiatric crisis who can be safely cared for outside of a hospital from emergency departments. Charleston has opened a 10-bed Crisis Stabilization Center and discussions are ongoing with other communities.

- Addressing Workforce Recruitment and Retention - Like many healthcare providers, SCDMH is faced with enormous challenges in recruiting and retaining all of the healthcare professionals it needs, including competing with other public and private healthcare providers for a limited supply of psychiatrists, nurses, and counselors. SCDMH is pursuing a number of new measures to reach prospective employees, including dedicating recruiting staff to attend job fairs, expanding its presence on social media, and placing job announcements in professional publications. SCDMH's Human Resources office is also streamlining the hiring process with the goal of significantly shortening the time between receiving job applications and being able to offer positions.

This list of significant challenges that SCDMH will encounter in the future is not complete. However, the items listed above are ongoing and, consequently, require ongoing consideration.

SCDMH also provided an abbreviated list of emerging issues agency representatives anticipate having an impact on agency operations in the upcoming five (5) years. Many of the articulated issues also illuminated unmet service needs and critical gaps within the current system.

- Changes continue to occur throughout healthcare regarding third party payors and proposed models of reimbursement. Whether this will increase the demand on the Department or possibly increase services by private sector is uncertain.

- Population growth, especially along coast, is increasing demand for services in those areas.

- Cost of housing and appropriate services affects the ability of people to remain in their home communities and will continue to bring challenges.

Upon conclusion of the legislative oversight process, the Healthcare and Regulatory Subcommittee will produce a report with recommendations concerning SCDMH. SCDMH expects that the oversight process will continue into late 2019.

FY2020 Budget Requests

SCDMH's FY2020 budget requests to the Governor of the State of South Carolina and the General Assembly of South Carolina, which were submitted in September 2018 and were requests for additional state appropriations, validate the strength of its performance measurement/system oversight capacity by consistently identifying and consequently formulating systemic needs into requests for appropriated funding. The budget requests reflect SCDMH's acknowledgement of the unmet service needs and critical gaps in the current system and the possibility that other unmet service needs and gaps could develop. SCDMH's FY2020 budget requests are listed below.

Crisis Stabilization Units

- The requested funds would enable the agency to continue to partner with local hospitals and other community officials to increase residential crisis stabilization programs beyond the four (4) currently in existence or in the planning stages. Such programs help divert individuals in a psychiatric crisis who can be safely cared for outside of a hospital emergency department.

Improving Local Access

- Patients in need of psychiatric hospitalization generally are best served if they can be hospitalized as close to their homes and families as possible. Receiving hospital services locally enables patients to maintain contact with family and other existing community support systems, and frequently results in shorter lengths of stay.
- Hospitalizing patients in need of emergency admission locally also reduces the transportation requirements for local law enforcement and improves safety for both the patient and law enforcement officers.
- The requested funds would enable SCDMH to identify 2 or 3 willing community hospitals with which to pilot the establishment of small psychiatric units for patients in a psychiatric crisis needing stabilization in a hospital setting. The funds would enable the Department to purchase a minimum of 1,535 bed days for uninsured patients.
- Current State Health Plan provisions permit hospitals partnering with SCDMH to receive a Certificate of Need for a small number of psychiatric beds designated for crisis stabilization.
- The goals of the pilot units would be to demonstrate:
    - An increase in the number of community hospitals with psychiatric beds able to provide short-term acute care for psychiatric admissions;
    - Improvement in the timeliness of admission for patients presenting in hospital emergency departments in need of psychiatric hospitalization;
    - Reductions in the lengths of stay for patients needing psychiatric hospitalization, both in emergency departments and following admission; and
    - Reductions in the demands on local law enforcement agencies for out-of-county transports of patients requiring an involuntary emergency admission.

Sexually Violent Predator Treatment Program

- The requested amount would enable the Department to fund a CPI increase for its contractor operating its Sexually Violent Predator Treatment Program (SVPTP), as well as pay for anticipated increased costs due to an increasing census of residents.
- The contractor's labor, pharmacy and medical costs have all been increasing.
- The request is based on an assumed Southeast Medical CPI of 3% and estimate of the cost per resident of a census which is projected to increase by 12 additional residents.

Contractual Adjustment – Inpatient Services

- The requested amount represents expected contractual obligations in FY2020 related to CPI adjustments for the Department's forensics program and veterans' nursing homes.
- Forensics (CPI): $604,481; Contracted Veterans Nursing Homes (CPI): $361,387 and $368,556

School Mental Health Services

- SCDMH school mental health services improve access to needed mental health services for children and their families.
- The requested funding would enable the agency to increase by at least 50 the number of school mental health therapists based on the average State support needed to sustain a position being $25,000 per school-based therapist.
- A shared goal of SCDMH and the Department of Education is to have school mental health therapists serving the students and families in every public school by 2022.

Psychiatric Medical Services

- The requested funding will support recruitment and retention for psychiatrists, psychiatric Advanced Practice Nurses (APRNs) and Physician Assistants (PAs).
- SCDMH is committed to providing outstanding mental health services to residents of this state. The Statewide and nationwide shortages of psychiatrists has already adversely affected a number of State agencies.

- In addition to its hospitals, the Department has 60 community mental health clinics throughout South Carolina. The Department's use of telehealth technology has enabled it to more efficiently and effectively use its limited number of psychiatrists by doing away with the need for its psychiatrists to travel between the Agency's multiple outpatient locations. Utilizing Advanced Practice Nurses (APRNs) and Physician Assistants (PAs) with the authority to prescribe medication under the supervision of a psychiatrist is another established method that SCDMH has been pursuing to serve the increasing numbers of citizens in need of psychiatric care.
- While technology has been helpful, market competition for psychiatrists, psychiatric APRNs and PAs has reached the point where SCDMH must increase compensation for these scarce professionals in order to recruit and retain a sufficient number to meet the growing demand and sustain its effective public mental health system.

First Episode Psychosis (FEP) Programs

- Funds will support two (2) programs for individuals who have experienced the early onset of a psychotic disorder, such as Schizophrenia.
- The first symptoms of psychotic disorders typically manifest in individuals between the ages of 16 and 25. Young adults are a challenging population to engage and stay in treatment. FEP programs are 2 year intensive programs with small caseloads using a person-centered team approach. Also known as "Coordinated Specialty Care," FEP programs are aimed at guiding young adults experiencing psychosis (and their families) toward mental, physical and functional health.
- Studies have shown that Coordinated Specialty Care programs improve treatment engagement and adherence and substantially reduce the likelihood that patients' psychotic disorders will lead to long-term disability. The majority of patients are able to stay in school or remain employed, and remain connected to family, friends and social supports. Correspondingly, patient's use of emergency services, such as hospital Emergency Departments and calls to law enforcement is significantly reduced.
- Despite the clear benefits of these programs for patients and for reducing long-term care costs, neither public nor private insurance currently reimburse many of the services provided by Coordinated Specialty Care programs.

Additional community supportive housing

- DMH has a long history of making efforts to foster more supportive community housing for its patients, including permanent independent housing. Appropriate housing is often the single biggest factor in determining whether a patient with serious psychiatric impairments is able to remain successful in their recovery in the community.
- The Department since 1990 has funded various types of supported community housing, recognizing that patients are individuals whose support needs differ, and includes:
    - Homeshare;
    - Community Residential Care Facilities (CRCFs);
    - Supported apartments.
- Funds will be used to expand all types of supported community housing options for long-term patients who have presented as discharge challenges at Bryan Psychiatric Hospital -- both civil and forensic patients -- as well as Harris Psychiatric Hospital.
- Goal would be to increase availability of CRCF beds as well as Homeshare settings and supported apartments.
- Funds would also be used for rental assistance in supported apartments and for transitioning patients into independent living.
- The expected outcomes will be reduced lengths of hospitalization and longer, hopefully permanent, community tenure.
- Successful discharges of long-term patients will also result in additional inpatient capacity as lower lengths of stay and bed turnover will result in increased bed availability for new patients in need of hospitalization.

Information Technology

- The requested funds will replace one-time funds to support the Department's operations, including its expanding telepsychiatry network, its Inpatient Services and Community Mental Health Services electronic health records, information technology support, and its network infrastructure support, including contractual services maintenance, software product costs, training, and funds associated with vacant and requested Information Technology staff positions.

DMH Crime Victims Counseling Support

- The program would be based on a successful partnership between mental health and law enforcement agencies in Charleston and Dorchester counties.
- The funds would be used to station 20 DMH Mental Health Professionals (MHPs) in South Carolina police and sheriffs' departments to provide direct services to adults and children who are identified as victims of crime, in addition to other adults and children identified by law enforcement as potentially needing mental health care.
- In 2014, the Department's Charleston Dorchester mental health center embedded a MHP in the Charleston Police Department's headquarters to create a "Family Violence Unit." The purpose of the Unit was to immediately respond to domestic violence scenes and to screen children witnessing violence for mental health needs related to the potentially traumatic event. Therapy services are offered to 100% of the victims at the time of the first meeting/intervention.
- The Family Violence Unit was modeled after a similar project in New Haven, Connecticut addressing the needs of children who were present when police responded to domestic violence in the home.
- A high percentage of children exposed to domestic violence are removed by the Department of Social Services (DSS). Over the past three years, in cases in which the Family Violence Unit responds, families are more likely to contact police regarding further incidents involving violence, families feel safer and more positive about the police, and families are more likely to engage in mental health treatment and other family support services.
- The MHPs stationed on-site at the Police/Sheriff's Departments will provide mental health assessments and evidence-based Trauma-Informed therapy for victims and others as identified. The therapists may also participate in weekly case reviews where their input is presented regarding the ongoing investigation of child abuse cases, if applicable. Detectives will be able to regularly staff a variety of victim cases with the MHP for guidance.

Long Term Care Division

- The requested funds will enable the Department of Mental Health to add additional nursing and administrative staff to its Division of Long Term Care, to monitor and oversee the operation of its multiple long term care facilities, some of which are operated on a contractual basis by private companies.
- With the addition of 3 additional State Veterans Nursing Homes, expected to open in the latter part of Fiscal 2021, the agency's Long Term Care Division will encompass a total of 7 nursing homes, 6 of which will be for eligible State Veterans.
- The number of long term beds operated by SCDMH – 700 – currently equals the number of the Department's functional hospital beds. With the additional State Veteran Nursing Homes, the Long Term Care Division will be significantly larger in capacity than the agency's hospitals.
- The requested funds are based on estimated expenditures to employ 2 registered nurses, a program manager, and an administrative professional. This estimate includes fringe. This estimate also includes a factor for other recurring operational expenditures, such as travel, as the agency's current and future long term facilities are geographically spread throughout the State.

Funds for Appointed Counsel in Civil Commitment Proceedings

- By way of background, during the Recession of 2000 -2001 State agencies were required to cut their budgets. The Judicial Department made the decision to discontinue paying appointed counsel and private physician Designated Examiners who provided representation/examinations in civil commitment proceedings. The Chief Justice notified all the Probate Judges by letter to stop sending the Judicial Department the invoices of

appointed attorneys and private examiners. The Probate Judges were concerned and contacted SCDMH. In 2001, SCDMH and the Judicial Department reached an agreement to preserve some payment for appointed counsel in civil commitment hearings. Under the terms of the agreement, the Judicial Department dropped the reimbursement rate for attorneys from $75 to $50 per hearing, and completely eliminated reimbursement for private Designated Examiners (DEs). In return, DMH agreed to fund the payment of the appointed counsel by the Judicial Department, essentially to preserve the working of the judicial commitment process, especially the hybrid process of Special Probate Judges holding commitment hearings in psychiatric hospitals. The major reason the Department was willing to step in and replace a major part of the funding cut by the Judicial Department was the process created by SCDMH and Court Administration in the 1980s enabling the holding of civil commitment hearings in psychiatric hospitals. Without this measure, hospitals, including DMH hospitals, would have to transport patients and staff around the State for such hearings, which would both increase costs and create some safety issues.

- The amount of DMH funding annually sent to Court Administration for the payment of attorneys in civil commitment proceedings has been approximately $375,000.
- In discussions with Court Administration about the Judicial Department seeking funding from the General Assembly to replace the DMH funds, the Judicial Department wishes to discontinue its direct participation in the paying of attorney's fees for civil commitment representation. Following meetings with Court Administration, the Probate Judges Association and the Office of Indigent Defense, DMH agreed to seek funding from the General Assembly, as well as new Provisos, to take over the process of funding and administering the payment of attorney's vouchers via an agreement with the Office of Indigent Defense.
- The requested funds will enable the Department to not only continue paying appointed counsel at the rate which has been in effect since 2001, but increase the rate to $100 per hearing, which SCDMH and the Probate Judges Association believe is long overdue.

Capital Requests
Certification of State Match (VA Nursing Homes)
Suicide Prevention - Ligature Resistant Fixtures
Catawba Mental Health Center Construction
Anderson-Oconee-Pickens Mental Health Center Construction
NE Campus Electrical Distribution System Renovations
Community Buildings Deferred Maintenance
Columbia Area MHC Phase III Construction
Campbell Veterans Nursing Home Renovations
Roddey Pavilion Renovations (Flooring, Laundry)

One-Time Requests
Community Mental Health Services – Outpatient Electronic Medical Record

Decision-Support through Data Management
By means of consistent evaluation of data resources, and interpretation of the data related thereto, SCDMH is well-positioned to articulate its strengths, weaknesses, opportunities, and threats, and is well-positioned to measure its performance as it encounters and addresses unmet service needs and gaps. The key to SCDMH's successful evaluation was its data systems (listed below).

- CIS – The Client Information System (CIS) is SCDMH's outpatient fee-for-service billing system. It is utilized in the community mental health centers, Care Coordination, and Telepsychiatry.
- EMR – The outpatient EMR is an internally developed electronic medical record used in conjunction with CIS. SCDMH is evaluating replacement of this EMR.
- AvatarPM – AvatarPM is a vendor supported inpatient billing system used in SCDMH inpatient facilities.
- EHR - The inpatient EHR is a vendor supported electronic health record used in conjunction with AvatarPM.

- SCEIS – South Carolina Enterprise Information System: The South Carolina Enterprise Information System consolidated more than 70 state agencies onto a single, statewide enterprise system, built on SAP software, for finance, materials management and human resources/payroll.

The specific attention that has been placed by SCDMH Senior Leadership on data and its meaning, and the importance of usefulness that has been emphasized for the underlying electronic databases, document management systems, business intelligence systems, and associated programs has provided SCDMH with a means to effectively navigate current and future situations.

Tracking and Trending Identified Areas of Emphasis

SCDMH Senior Leadership has developed dashboard performance measures that it reviews and refines on a periodic basis. The measures are quick reference global indicators to evaluate actual performance against the strategic plan. While measurement of an activity does not indicate identification of an unmet service need, it could alert Senior Leadership to a potential or impending gap. The dashboard performance measures are part of the Inpatient Services Dashboard and the Community Mental Health Services Transparency Monthly Indicators (TMI).

In addition to the TMI, SCDMH Division of Community Mental Health Services tracks trends of certain data points. The following are examples of the types of trending that is monitored.

- Statewide Collaborative Documentation (Percentage of Notes Completed with 24 Hours of Appointment) with Prior Year and Current Benchmarks and Linear Trend Line
- Patients Served by Fiscal Year (Number of Patients) with Linear Trend Line
- Annual Access Rates Meeting Standards (Percentage) with Prior Year and Current Benchmarks and Linear Trend Line
- Average Annual Productivity (Hours) with Prior Year and Current Benchmarks and Linear Trend Line

Current Strategic Direction

As the mental health authority in South Carolina, SCDMH serves as the safety net provider for the current and potential prevalence of mental health patients in the state. As said safety net provider, SCDMH has identified a baseline of performance measures – informed by recurring areas of focus – which it consistently measures. However, SCDMH also monitors the current state of the mental health continuum for emerging issues and incorporates such into its strategic focus. As a result, SCDMH not only has core performance management measures, but augments such with emerging trends that also require review. As such, SCDMH has identified other needs and gaps requiring particular focus. Several are identified below.

- Recruitment and Retention
- State-of-the-Art Technology
- Consistently Applied Best Practices
- Organizational Adaptability and Resiliency

The items listed above were identified on May 30, 2018, when approximately 90 senior leaders at the South Carolina Department of Mental Health (SCDMH) met together in Columbia for the 2018 Leadership Assembly (Assembly). The Assembly served several purposes. One of the purposes was to participate in an open forum discussion related to future agency goals – those listed above.

That open forum discussion generated at least 10 objectives and action steps for each of the future agency goals.

- Recruitment and Retention
  - Examples: competitive pay; work with colleges to actively recruit; speed up job offers, etc.
  - 14 objectives and action steps noted
- State-of-the-Art Technology
  - Examples: connectivity of treatment team members; streamline administrative functions; technology as a recruiting tool
  - 18 objectives and action steps noted

- Consistently Applied Best Practices
    - Examples: centralized list of clinical best practices; managing risk of suicide across inpatient and outpatient; centralized billing
    - 17 objectives and action steps noted
- Organizational Adaptability and Resiliency
    - Examples: cross-training; succession planning; diversify grant portfolios
    - 12 objectives and action steps noted

The recommendations (objectives and action steps) have since guided and informed SCDMH's strategic planning process. Updates to the objectives and action steps have been completed as of October 2018 and May 2019.

Conclusion

A proactive healthcare continuum is constantly monitoring, controlling and reacting to the forces acting upon it. It creates key performance indicators and key results areas that measure activity and identify progress. It adjusts to unanticipated results and defines the measure of success in a changing environment. These are the fundamentals on which SCDMH has built its strategic direction. Its continuous systemic analysis provides a blueprint from which SCDMH can continue to positively impact the mental health service delivery system for the benefit of the citizens of the State of South Carolina, and especially to support the recovery of people with mental illnesses.

[End]

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Current Baseline Performance Measures

Priority Type: MHS

Population(s): SMI, SED, Other (Various)

Goal of the priority area:

The intent is to measure the activities and achievements of the Department and compare said measurements to internal and external benchmarks, as available and appropriate, established over time.

Objective:

The objective is to support the recovery of people with mental illnesses.

Strategies to attain the objective:

Given the comprehensiveness of the measurement tools, changes in results from one year to the next generally are a reasonable determinant of the effectiveness of the mental health continuum - understanding that South Carolina has an integrated system of care over which SCDMH has significant influence and control since it is the primary service provider for inpatient and community services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: SCDMH will increase the number of children and adolescents it serves.

Baseline Measurement: Number of Children and Adolescents Served (Baseline = 27,000)

First-year target/outcome measurement: 29,000

Second-year target/outcome measurement: 29,000

Data Source:

South Carolina Department of Mental Health (SCDMH)

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: SCDMH will maintain or increase the number of total patients seen in community settings.

Baseline Measurement: Number of Adults Served in Community Mental Health Centers (Baseline = 84,500)

First-year target/outcome measurement: 86,800

Second-year target/outcome measurement: 86,800

Data Source:

South Carolina Department of Mental Health (SCDMH)

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None

Indicator #: 3

Indicator: Inpatient "bed days" will remain constant or increase.

Baseline Measurement: Number of Inpatient Bed Days (Baseline = 553,000)

First-year target/outcome measurement: 556,000

Second-year target/outcome measurement: 556,000

Data Source:

South Carolina Department of Mental Health (SCDMH)

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None

Indicator #: 4

Indicator: Admissions to inpatient forensic facilities.

Baseline Measurement: Number of Admissions to Inpatient Forensics Facilities (Baseline = 297)

First-year target/outcome measurement: 236

Second-year target/outcome measurement: 236

Data Source:

South Carolina Department of Mental Health (SCDMH)

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None. Patients requiring or in potential need of mental health services benefit from appropriate hospital services as opposed to county correctional facilities. This performance measure is related to access to services, when services are appropriate and necessary.

Indicator #: 5

Indicator: Patients requiring CMHC appointments will be seen in a timely manner according to protocol (priority, urgent, or routine).

Baseline Measurement: Percent of Appointments Meeting Timeliness Expectations (Baseline = 95%)

First-year target/outcome measurement: 95%

Second-year target/outcome measurement: 95%

Data Source:

South Carolina Department of Mental Health (SCDMH)

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None

Indicator #: 6

Indicator: Patients will have scheduled appointments at CMHCs within median of 7 days of discharge from an inpatient psychiatric facility.

Baseline Measurement: Median Number of Days from Discharge to Appointment at Community Mental Health Center (Baseline = 3.72 Days)

First-year target/outcome measurement: Less Than or Equal to 7 Days

Second-year target/outcome measurement: Less Than or Equal to 7 Days

Data Source:

South Carolina Department of Mental Health (SCDMH)

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None

Indicator #: 7

Indicator: Percentage of patients requiring readmission within thirty days of discharge will be below 5%.

Baseline Measurement: Percentage of Patients Requiring Readmission within 30 Days of Discharge (Baseline = Less than 1.2%)

First-year target/outcome measurement: Less Than or Equal to 5%

Second-year target/outcome measurement: Less Than or Equal to 5%

Data Source:

South Carolina Department of Mental Health (SCDMH)

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None

Indicator #: 8

Indicator: Number of hours employees receive training via computer will increase or remain constant.

Baseline Measurement: Number of Hours Employees Receive Training via Computer (Baseline = 4,800)

First-year target/outcome measurement: 4,800

Second-year target/outcome measurement: 4,800

Data Source:

SCDMH – Division of Evaluation, Training, and Research (ETR) – Pathlore (SCDMH Training Database)

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None

Indicator #: 9

Indicator: The number of hospitals utilizing SCDMH Telepsychiatry services will remain constant or increase.

Baseline Measurement: Number of Participating Hospitals - ED Telepsychiatry Consultation Program (Baseline = 23)

First-year target/outcome measurement: 23

Second-year target/outcome measurement: 25

Data Source:

SCDMH – Office of Medical Affairs (Emergency Department Telepsychiatry Program)

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None

Indicator #: 10

Indicator: The number of Community Mental Health Centers utilizing Telepsychiatry services will remain constant or increase.

Baseline Measurement: Number of CMHCs Providing Services via Telepsychiatry (Baseline = 16)

First-year target/outcome measurement: 16

Second-year target/outcome measurement: 16

Data Source:

SCDMH – Office of Medical Affairs (Community Telepsychiatry Program)

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None

Indicator #: 11

Indicator: Percentage of SCDMH patients having competitive employment will increase.

Baseline Measurement: Percent Employed as Compared Internally and to National Average Low and National Average High (Baseline = 16%)

First-year target/outcome measurement: At Least 14%

Second-year target/outcome measurement: At Least 14%

Data Source:

SCDMH – Division of Community Mental Health Services

Description of Data:

Program Indicators Data

Data issues/caveats that affect outcome measures::

None. Targets are set to be at least equal to the average of the previous five years' value of the measure.

Indicator #: 12

Indicator: Percentage of patients participating in SCDMH employment programs, gaining meaningful employment, will meet or exceed national benchmark (40%).

Baseline Measurement: Percent of Patients Gaining Meaningful Employment (Baseline = 58%)

First-year target/outcome measurement: At Least 57%

Second-year target/outcome measurement: At Least 57%

Data Source:

SCDMH – Division of Community Mental Health Services

Description of Data:

Program Indicators Data

Data issues/caveats that affect outcome measures::

None. Targets are set to be at least equal to the average of the previous five years' value of the measure.

Indicator #: 13

Indicator: Life expectancy at Roddy Pavilion (skilled nursing facility) will exceed national average (1.2 years).

Baseline Measurement: Life Expectancy as Compared Internally and to National Average (Baseline = 6.8 Years)

First-year target/outcome measurement: At least 6.0 Years

Second-year target/outcome measurement: At least 6.0 Years

Data Source:

SCDMH – Division of Inpatient Services

Description of Data:

Client-Level Data Summarized Into Aggregate Outcomes

Data issues/caveats that affect outcome measures::

None. Targets are set to be at least equal to the average of the previous five years' value of the measure.

Indicator #: 14

Indicator: Life expectancy at Stone Pavilion (skilled nursing facility for veterans) will exceed national average (1.2 years).

Baseline Measurement: Life Expectancy as Compared Internally and to National Average (Baseline = 1.8 Years)

First-year target/outcome measurement: At least 2.0 Years

Second-year target/outcome measurement: At least 2.0 Years

Data Source:

SCDMH – Division of Inpatient Services

Description of Data:

Client-Level Data Summarized Into Aggregate Outcomes

Data issues/caveats that affect outcome measures::

None. Targets are set to be at least equal to the average of the previous five years' value of the measure.

Indicator #: 15

Indicator: Use of restraints in SCDMH inpatient facilities will remain below of national average). (0.62 hours per 1,000 hours of inpatient service).

Baseline Measurement: Inpatient Restraint Rate as Compared Internally and to National Average (Baseline = 0.18)

First-year target/outcome measurement: Less Than or Equal to 0.17 Hours Per 1,000 Hours of Inpatient Service

Second-year target/outcome measurement: Less Than or Equal to 0.17 Hours Per 1,000 Hours of Inpatient Service

Data Source:

SCDMH – Division of Inpatient Services

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None. Targets are set to be at least equal to the average of the previous five years' value of the measure.

Indicator #: 16

Indicator: Use of seclusion rooms in SCDMH inpatient facilities will remain below of national average). (0.49 hours per 1,000 hours of inpatient service).

Baseline Measurement: Inpatient Seclusion Rate as Compared Internally and to National Average (Baseline = 0.22)

First-year target/outcome measurement: Less Than or Equal to 0.22 Hours Per 1,000 Hours of Inpatient Service

Second-year target/outcome measurement: Less Than or Equal to 0.22 Hours Per 1,000 Hours of Inpatient Service

Data Source:

SCDMH – Division of Inpatient Services

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None. Targets are set to be at least equal to the average of the previous five years' value of the measure.

Indicator #: 17

Indicator: Percentage of adults expressing satisfaction with SCDMH services will meet or exceed national averages (US average 88%).

Baseline Measurement: Percent of Adults Expressing Satisfaction with SCDMH Services (Baseline = 92%)

First-year target/outcome measurement: At Least 91%

Second-year target/outcome measurement: At Least 91%

Data Source:

SCDMH – Division of Evaluation, Training, and Research (ETR)

Description of Data:

Compilation of Survey Results

Data issues/caveats that affect outcome measures::

Limited by Actual Percentage and Number of Responses. Targets are set to be at least equal to the average of the previous five years' value of the measure.

Indicator #: 18

Indicator: Percentage of youths receiving SCDMH services will remain consistent with satisfaction of parents of youth (no national average available for youth satisfaction rates).

Baseline Measurement: Percent of Youths Expressing Satisfaction with SCDMH Services (Baseline = 91.7%)

First-year target/outcome measurement: At Least 89%

Second-year target/outcome measurement: At Least 89%

Data Source:

SCDMH – Division of Evaluation, Training, and Research (ETR)

Description of Data:

Compilation of Survey Results

Data issues/caveats that affect outcome measures::

Limited by Actual Percentage and Number of Responses. Targets are set to be at least equal to the average of the previous five years' value of the measure.

Indicator #: 19

Indicator: All Community Mental Health Centers will meet Centers for Medicare and Medicaid Studies' rules for emergency preparedness when surveyed for compliance (at least once every three years).

Baseline Measurement: CMHCs will Meet the New Regulatory Requirements for Emergency Preparedness as Per 42 CFR-485.920 (Baseline = 100%)

First-year target/outcome measurement: 100%

Second-year target/outcome measurement: 100%

Data Source:

South Carolina Department of Mental Health (SCDMH)

Description of Data:

Program Indicators Data

Data issues/caveats that affect outcome measures::

None

Indicator #: 20

Indicator: SCDMH will have trained personnel prepared to staff the State Emergency Operation's Center (SEOC) throughout all drills and "real world" emergency situations.

Baseline Measurement: SCDMH will have Staff Available to Assist State and County Emergency Operations Centers (EOC) (Baseline = 75%)

First-year target/outcome measurement: 100%

Second-year target/outcome measurement: 100%

Data Source:

South Carolina Department of Mental Health (SCDMH)

Description of Data:

Program Indicators Data

Data issues/caveats that affect outcome measures::

None

Indicator #: 21

Indicator: Number of people awaiting beds will be reduced. (Data is based upon a "Monday morning snapshot" of hospital emergency departments).

Baseline Measurement: Number of Individuals Waiting in ER (Baseline = 2,428 Annually)

First-year target/outcome measurement: Less Than 2,250

Second-year target/outcome measurement: Less Than 2,250

Data Source:

SCDMH – Division of Community Mental Health Services

Description of Data:

Compilation of Externally-Sourced Data

Data issues/caveats that affect outcome measures::

None

Indicator #: 22

Indicator: Patients awaiting beds, at time of Monday snapshot, will be appropriately placed within 24 hours of their emergency room arrival.

Baseline Measurement: Number of Individuals Waiting in ER Longer than 24 Hours (Baseline = 1,919)

First-year target/outcome measurement: Less Than 1,750

Second-year target/outcome measurement: Less Than 1,750

Data Source:

SCDMH – Division of Community Mental Health Services

Description of Data:

Compilation of Externally-Sourced Data

Data issues/caveats that affect outcome measures::

None

Indicator #: 23

Indicator: The number of schools in South Carolina with a school based counselor will increase.

Baseline Measurement: Number of Schools in School Mental Health Program (Baseline = 738)

First-year target/outcome measurement: At Least 900

Second-year target/outcome measurement: At Least 900

Data Source:

SCDMH – Division of Community Mental Health Services

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None

Priority #: 2

Priority Area: New Performance Measures Under Consideration

Priority Type: MHS

Population(s): SMI, SED, Other (Various)

Goal of the priority area:

The intent is to evaluate the measurement of certain activities and achievements of the Department and compare said measurements to internal and external benchmarks, as available and appropriate, established over time.

Objective:

The objective is to support the recovery of people with mental illnesses.

Strategies to attain the objective:

Given the comprehensiveness of the measurement tools, changes in results from one year to the next generally are a reasonable determinant of the effectiveness of the mental health continuum - understanding that South Carolina has an integrated system of care over which SCDMH has significant influence and control since it is the primary service provider for inpatient and community services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: South Carolina Youth Suicide Prevention Initiative (SCYSPI) will partner with an increasing number of schools in SC.

Baseline Measurement: Number of Schools Partnered with SCYSPI (Baseline = 25)

First-year target/outcome measurement: 50

Second-year target/outcome measurement: 50

Data Source:

SCDMH – Division of Community Mental Health Services

Description of Data:

Program Indicators Data

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: SCYSPI will be in partnerships with a CMHC, Federally Qualified Health Center, a hospital ED, and an inpatient hospital. Each partnership will be 25% of achieving goal.

Baseline Measurement: Partnerships as a Percent of the Total By Organizational Type (Baseline = 75%)

First-year target/outcome measurement: 100%

Second-year target/outcome measurement: 100%

Data Source:

SCDMH – Division of Community Mental Health Services

Description of Data:

Program Indicators Data

Data issues/caveats that affect outcome measures::

None

Indicator #: 3

Indicator: Percent of SC Schools with School Mental Health Counselors.

Baseline Measurement: Percent of South Carolina Schools with Access to a School Mental Health Program Counselor (Baseline = 58.06%)

First-year target/outcome measurement: At Least 66.88%

Second-year target/outcome measurement: At Least 66.88%

Data Source:

SCDMH – Division of Community Mental Health Services

Description of Data:

Program Indicators Data

Data issues/caveats that affect outcome measures::

None

Indicator #: 4

Indicator: Percentage of inpatient bed days used compared to bed days available.

Baseline Measurement: Percent of Bed Day Use (Baseline = Not Calculated)

First-year target/outcome measurement: At Least 90%

Second-year target/outcome measurement: At Least 90%

Data Source:

South Carolina Department of Mental Health (SCDMH)

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None

Indicator #: 5

Indicator: Demonstrate effectiveness and/or efficiency of telepsychiatry.

Baseline Measurement: Specific Measures to be Identified

First-year target/outcome measurement: To Be Determined

Second-year target/outcome measurement: To Be Determined

Data Source:

SCDMH – Office of Medical Affairs (SCDMH Telepsychiatry Programs) with Evaluation by the South Carolina Telehealth Alliance (SCTA), SCTA Evaluation Team, University of South Carolina, School of Medicine

Description of Data:

Program Indicators Data

Data issues/caveats that affect outcome measures::

In previous research studies, telepsychiatry has shown to produce higher follow-up and retention (for community treatment), shorter lengths of stay in emergency departments, fewer inpatient admissions, and total charges in the emergency department that were significantly lower. SCDMH will attempt to acquire similar data in future reports.

Indicator #: 6

Indicator: Percentage of Under 18 Year Old Population in SC Served by SCDMH will be within 0.1% of Previous Year's Percentage

Baseline Measurement: Percent of Under 18 Year Old Population Served (Baseline = 2.38%)

First-year target/outcome measurement: At Least 2.38%

Second-year target/outcome measurement: At Least 2.38%

Data Source:

South Carolina Department of Mental Health (SCDMH)

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None

Indicator #: 7

Indicator: Percentage of Adult Population in SC Served by SCDMH will be within 0.1% of Previous Year's Percentage

Baseline Measurement: Percent of Adult Population Served (Baseline = 1.46%)

First-year target/outcome measurement: At Least 1.46%

Second-year target/outcome measurement: At Least 1.46%

Data Source:

South Carolina Department of Mental Health (SCDMH)

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None

Priority #: 3

Priority Area: First Episode Psychosis Program

Priority Type: MHS

Population(s): ESMI

Goal of the priority area:

The intent is to address the needs of persons with early psychotic disorders, specifically first episode psychosis, either through enhancing existing program activities or development of new activities.

Objective:

Given that FEP typically occurs while a person is between the ages of 16-25, the Department will expand the target population to ages 15-30 under the program(s) funded by the Ten Percent Set-Aside in order to capture as many persons most likely to experience FEP. However, when appropriate, it will serve other persons experiencing FEP, even if said persons fall outside of the prescribed age range.

Strategies to attain the objective:

The Department has specifically cited Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT) as the treatment modalities it will deploy utilizing a portion of the Ten Percent Set Aside. These treatment modalities have been identified as appropriate and effective for persons experiencing First Episode Psychosis (FEP). It has also been found that maximum effectiveness is attainable when the two modalities are deployed together. MI serves as the engagement modality and CBT serves as the therapy modality.

SCDMH will also deploy NAVIGATE as its CSC (Coordinated Specialty Care) program utilizing a portion of the Ten Percent Set Aside.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: First Episode Psychosis Program

Baseline Measurement: Total Number of Patients Served (Baseline = 260)

First-year target/outcome measurement: At Least 370

Second-year target/outcome measurement: At Least 400

Data Source:

South Carolina Department of Mental Health (SCDMH)

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None. Note that the intent in measuring the total number of patients served is to increase, as funding permits, the number of evidence-based interventions utilized to engage and appropriately serve this population.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

SCDMH is reviewing the Current Baseline Performance Measures with consideration to include not only the absolute number but also the percentage as an indicator of performance and a measure of constancy based upon a percentage of the whole.

The 2nd Year Targets will be evaluated in 2020 for FY2021 based upon FY2020 actual results. Therefore, the FY2020 Mental Health Block Grant Uniform Application 2nd Year Targets match the 1st Year Targets.

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention*		$0	$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		$2,057,224	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$98,124,974	$0	$180,731,474	$2,921,650	$12,161,336
7. Other 24 Hour Care		$0	$33,613,110	$52,677,532	$51,378,928	$0	$11,331,794
8. Ambulatory/Community Non-24 Hour Care		$18,372,492	$116,860,900	$11,612,764	$192,840,318	$6,238,502	$57,664,682
9. Administration (Excluding Program and Provider Level)***		$142,522	$0	$84,082	$75,959,352	$0	$3,501,362
10. Total	**$0**	**$20,572,238**	**$248,598,984**	**$64,374,378**	**$500,910,072**	**$9,160,152**	**$84,659,174**

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

Footnotes:

1 – ESTIMATES ONLY: The information presented above represents a 24-month period (July 1, 2019 – June 30, 2021). Note that SCDMH only budgets for a 12-month period based on the prevailing Appropriations Act for the applicable fiscal year.

2 – Note that as in previous Uniform Applications, estimates are based on Allocations and Revenues from SCDMH's Financial Reports. Allocations and Revenues are more easily cross-referenced with SCDMH's program areas in its Financial Reports. This update includes consideration for Supplemental Funding.

3 – Note that Allocations, Revenues, Expenditures, and Supplemental Funding – as represented in SCDMH's Financial Reports – are based on forecasts for the applicable fiscal year with the expectation that as changes occur to the operations of SCDMH said changes may be reflected in changes to forecasts; therefore, amounts provided at the beginning of a fiscal year may not be the actual result presented at the end of the fiscal year. Consequently, this 24-month budget is subject to variations, especially based on the date of reporting.

4 - Related to the total amount reported for the Mental Health Block Grant (MHBG), due to having three (3) MHBGs active during any given state fiscal year for SCDMH - July 1 through June 30 - it is possible that the amount associated with MHBG expenditures may vary from the actual amount of a single year award.

5 – As per SAMHSA's instruction, SCDMH used the "FY 2020 Mental Health Block Grant Estimated Allotments" file for purposes of completing the FY2020-2021 MHBG planned expenditures (Table 2) and related planned expenditures.

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 07/01/2019 MHBG Planning Period End Date: 06/30/2021

Activity	FFY 2020 Block Grant
1. Information Systems	$0
2. Infrastructure Support	$140,522
3. Partnerships, community outreach, and needs assessment	$0
4. Planning Council Activities (MHBG required, SABG optional)	$2,000
5. Quality Assurance and Improvement	$0
6. Research and Evaluation	$0
7. Training and Education	$0
8. Total	**$142,522**

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Footnotes:
ESTIMATES ONLY: The information presented above represents a 24-month period (July 1, 2019 – June 30, 2021). Note that SCDMH only budgets for a 12-month period based on the prevailing Appropriations Act for the applicable fiscal year.

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

[22] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102-123 **http://www.who.int/bulletin/volumes/91/2/12-108282.pdf**; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52-77

[23] Research Review of Health Promotion Programs for People with SMI, 2012, **http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper**; About SAMHSA's Wellness Efforts, **https://www.samhsa.gov/wellness-initiative**; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Hearts, **https://www.samhsa.gov/health-care-health-systems-integration**; Schizophrenia as a health disparity, **http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml**

[24] Comorbidity: Addiction and other mental illnesses, **http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses** Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, JAMA Psychiatry. 2014; 71 (3):248-254. doi:10.1001/jamapsychiatry.2013.3726; **http://www.samhsa.gov/co-occurring/**

[25] Social Determinants of Health, Healthy People 2020, **http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39**; **https://www.cdc.gov/nchhstp/socialdeterminants/index.html**

[26] **http://www.samhsa.gov/health-disparities/strategic-initiatives**

[27] **http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/**

[28] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. **https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf**; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, **https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf**; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. **http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf**; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, **http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf**; American Psychiatric Association, **http://www.psych.org/practice/professional-interests/integrated-care**; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, **http://books.nap.edu/openbook.php?record_id=11470&page=210**; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, **http://nasadad.org/nasadad-reports**

[29] Health Care Integration, **http://samhsa.gov/health-reform/health-care-integration**; SAMHSA-HRSA Center for Integrated Health Solutions, (**http://www.integration.samhsa.gov/**)

[30] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, **https://www.integration.samhsa.gov/operations-administration/telebehavioral-health**; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, **http://www.americantelemed.org/home**; National Telehealth Policy Resource Center, **http://telehealthpolicy.us/medicaid**;

[31] Health Homes, **http://www.integration.samhsa.gov/integrated-care-models/health-homes**

[32] New financing models, **https://www.integration.samhsa.gov/financing**

[33] Waivers, **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html**; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, **http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf**

[34] What are my preventive care benefits? **https://www.healthcare.gov/what-are-my-preventive-care-benefits/**; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); **http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html**

[35] Medicare-Medicaid Enrollee State Profiles, **http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html**; About the Compact of Free Association, **http://uscompact.org/about/cofa.php**

[36] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, **http://www.cbo.gov/publication/44308**

[37] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

[38] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

[39] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, **http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf**; Creating jobs by addressing primary care workforce needs, **https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n**

[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**; National Behavioral Health Quality Framework, Draft, August 2013, **http://samhsa.gov/data/NBHQF**

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

SCDMH provides strategic leadership throughout its delivery systems of care for the expansion of the agency's partnership with public and private primary healthcare providers and mental health and substance abuse stakeholders. Under SCDMH's leadership, a number of alignment care initiatives were implemented and expanded to support the identification of need and the provision of primary care services for its patients with both public and private primary care stakeholders. SCDMH continues to strengthen its existing bi-directional service alignment partnerships with both public and private primary healthcare providers. Designated community mental health centers have maintained longstanding alignment care arrangements to include: facilitated referrals, co-location and bi-directional partnerships with Federally Qualified Health Centers.
public and private primary healthcare providers and mental health and substance abuse stakeholders. Under SCDMH’s leadership, a number of alignment care initiatives were implemented and expanded to support the identification of need and the provision of primary care services for its patients with both public and private primary care stakeholders. SCDMH continues to strengthen its existing bi-directional service alignment partnerships with both public and private primary healthcare providers. Designated community mental health centers have maintained longstanding alignment care arrangements to include: facilitated referrals, co-location and bi-directional partnerships with Federally Qualified Health Centers.

SCDMH partners with publicly-funded provider entities and payors for the development of local collaborative and outcomes based models of primary/behavioral health alignment service delivery, to include Medicaid Managed Care Organizations, primary care network providers and care management staff. In addition, SCDMH has undertaken the implementation of transitional care management partnerships between the Medicaid MCOs, acute care inpatient facilities, community mental health centers and SCDMH's inpatient facilities in accordance with patient privacy/confidentiality requirements.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

The agency participates in ongoing multi-agency stakeholder policy platforms, which includes medical service providers, behavioral health entities and payors, in its efforts to support further expansion of service alignment capacity for systems of care for individuals with co-occurring mental and substance use disorders.

To further these efforts, key stakeholder partnerships are being sustained, to include the SC Rural Health Association, Federally Qualified Health Centers, Medicaid Managed Care Organizations, South Carolina Health Information Exchange Office, and SC Department of Health and Human Services-Medicaid Agency.

The agency has successfully continued its efforts to promote localized alignment care models and strengthen its workforce capacity to address co-occurring chronic medical and behavioral health conditions of our target population. Partnerships with Medicaid Managed Care Organizations in support of population health management models across the 16 CMHCs are being evaluated and recommended as a means to explore potential mechanisms for outcomes-based alignment care models.

SCDMH maintains active participation in the expansion of the South Carolina Health Information Exchange (SCHIEx) partnerships. This partnership provides enhanced capacity for health information exchange to ensure continuity of care for patients with co-occurring disorders. The strategic plan includes statewide rollout of the SCHIEx/DIRECT Messaging initiative among 16 CMHCs, the SCDMH Office of Clinical Care Coordination and local SCHIEx participating providers (e.g. hospitals, federally qualified health centers, rural health clinics, primary care partners and alcohol and other substance use disorder providers.)

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ○ Yes ◉ No

b) and Medicaid? ◉ Yes ○ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

The South Carolina Department of Mental Health is not responsible for monitoring access to M/SUD services by the QHP.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ◉ Yes ○ No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education ◉ Yes ○ No

b) Health risks such as

ii) heart disease ◉ Yes ○ No

iii) hypertension ◉ Yes ○ No

iv) high cholesterol ◉ Yes ○ No

v) diabetes ◉ Yes ○ No

c) Recovery supports ◉ Yes ○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ◉ Yes ○ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ○ Yes ◉ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

The South Carolina Department of Mental Health defers comment to those state agencies directly involved in the implementation and enforcement of parity protections for mental and substance use disorder services.

10. Does the state have any activities related to this section that you would like to highlight?

In January 2018, SCDMH joined the South Carolina Telehealth Alliance (SCTA) as a Service Specialty Telehealth Hub. SCDMH was already serving as a member of the SCTA Advisory Council.

The SCTA is a statewide collaboration of many organizations that have joined forces to expand telehealth services across the State of South Carolina.

Led by the SCTA Advisory Council, it provides guidance, assists with strategic development, and advises on technology and standards. It is co-chaired by MUSC and Palmetto Care Connections.

The SCTA was formed with founding strategic providers, Greenville Health, McLeod Health, Medical University of South Carolina and Palmetto Health – known as The Hubs – providing telehealth care services. SCDMH was the fifth Hub and is the only provider with a statewide emphasis.

The SCTA is funded by the S.C. State Legislature, via the House Ways & Means Committee and the S.C. Department of Health and Human Services. The Medical University of South Carolina, an agency of the State of South Carolina, serves as the fiscal agent and headquarters of the SCTA.

Each year, the SCTA produces a strategic plan. That strategic plan includes 8 primary areas of emphasis: Open Access; Rural Focus; Service Development; Mental Health; Education and Training; SCTA Collaboration; Outcomes; and Promotions and Sustainability. The strategic plan can be found at www.sctelehealth.org.

Of note, Strategy 4 - Mental Health includes the 5 tactics outlined below. Note that Tactic 4.2 specifically addresses alignment with primary care providers.

Tactic 4.1: Support rural hospitals with the availability of mental health and related clinical services and programs.
Tactic 4.2: Support primary and ambulatory care providers with efficient access to specialty care.
Tactic 4.3: Establish telepsychiatry as recruitment tool for providers.
Tactic 4.4: Develop a best practice for medical information sharing across disparate medical service delivery organizations.
Tactic 4.5: Identify, support, and coordinate other statewide telehealth initiatives that address mental health and related clinical services and programs.

Please indicate areas of technical assistance needed related to this section

Not Applicable

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for **Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	(•) Yes	( ) No
b) Ethnicity	(•) Yes	( ) No
c) Gender	(•) Yes	( ) No
d) Sexual orientation	( ) Yes	(•) No
e) Gender identity	(•) Yes	( ) No
f) Age	(•) Yes	( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? (•) Yes ( ) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? (•) Yes ( ) No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? (•) Yes ( ) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? ( ) Yes (•) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ( ) Yes (•) No

7. Does the state have any activities related to this section that you would like to highlight?

The following are two SCDMH Directives related to the subject matter.

Directive 839-03 – Culturally and Linguistically Appropriate Services to Consumers who have Limited English Proficiency (LEP), or are Hard of Hearing or Deaf.

The purpose of this Directive is to ensure each Facility and Community Mental Health Center has a policy and procedure to provide culturally and linguistically appropriate services to its consumers who are not proficient in the English language, to the extent that they cannot access the services or programs offered by the agency without language assistance.

It is the policy of the Department of Mental Health (DMH) to recognize and respect the cultural diversity of its consumers and to provide culturally and linguistically appropriate services to all of its consumers. Moreover, it is the policy of the Department to provide services to those needing them without regard to national origin or disabilities. Included are individuals who have limited English proficiency, or are hard-of-hearing or deaf. The Department recognizes that in order to provide meaningful access to its behavioral health services to consumers who have limited English proficiency, or are hard-of-hearing or deaf, DMH facilities and community mental health centers must have procedures in place to provide communication services, including interpreter services at no cost to the consumer. Accurate and adequate communication between consumers and providers is a necessary element for providing good quality care, and it is a recognized right of consumers. The treatment staff needs to have the capability to effectively communicate with and relate to the experiences of consumers from diverse cultures, as this is an important component of culturally competent treatment.

Directive 894-09 – Cultural Competence

This directive establishes the policy for the creation and maintenance of culturally and linguistically competent system of care at the South Carolina Department of Mental Health (SCDMH).

The Department recognizes that culture is dynamic and that cultural competence must be an ongoing process, believing that valuing individual and group cultural differences is critical to achieving the organizational goals. SCDMH considers cultural competence a necessary part of good clinical services. Organized under the Division of Community Mental Health Services the Statewide Multi-Cultural Council and Center/Facility Multi-Cultural Committees are charged with the responsibility to advise and guide SCDMH leadership in the creation and maintenance of a linguistically and culturally competent workforce, service divisions,

programs, and collaborative endeavors reflective of the diversity of the population served and the community. Administrative Services, Centers and Facilities will refer to the Departmental Directive No. 839-03 Culturally and Linguistically Appropriate Services to Consumers who have Limited English Proficiency (LEP), or are Hard of Hearing or Deaf for compliance procedures.

Please indicate areas of technical assistance needed related to this section

Not Applicable

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** [x] Leadership support, including investment of human and financial resources.
- **b)** [x] Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** [ ] Use of financial and non-financial incentives for providers or consumers.
- **d)** [ ] Provider involvement in planning value-based purchasing.
- **e)** [ ] Use of accurate and reliable measures of quality in payment arrangements.
- **f)** [x] Quality measures focus on consumer outcomes rather than care processes.
- **g)** [ ] Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** [ ] The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Evidence-based practices provide proven tools to help patients achieve the goal of recovery. As the field moves forward, demand for EBPs by patients and other stakeholders have increased. Evidence-based practices do not exist for every problem nor do they work for every person. However, they do exist for certain conditions and they have been demonstrated by research to be effective. As resources continue to shrink, providing care that is proven effective seems an optimal way to stretch these resources.

In order to understand what services and treatments work best and for whom, and to build public support, it is essential that data on outcomes be measured and the results reported and used to inform decision making. This activity is achieved through the combined efforts of internal programmatic resources and external program evaluators.

Providing evidence-based practices is essential to any plan striving to improve the quality of mental health treatment. Patients, family members, other stakeholders, and funders want to ensure that mental health practices with a strong evidence base are available. Evidence-based practices offer the greatest hope yet, through new treatments and services that have been proven to be effective through scientific evidence and research.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

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Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ○ Yes ◉ No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? ◉ Yes ○ No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

Initially, States were permitted to address the needs of persons with early psychotic disorders, specifically first episode psychosis, either through enhancing existing program activities or development of new activities. SCDMH's approach was to enhance existing program activities.

After several discussions with the Substance Abuse and Mental Health Services Administration (SAMHSA), and based on its guidance, the Department specifically cited Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT) as the treatment modalities it would deploy utilizing the Set Aside funds. These treatment modalities were identified as appropriate and effective for persons experiencing First Episode Psychosis (FEP). This initial pathway became The Traditional Program.

In subsequent communications, SAMHSA indicated that its preference for the use of the Set-Aside funds was to implement Coordinated Specialty Care programs. Consequently, all future programs funded with Set-Aside funds will reflect

SAMHSA's current preference.

Therefore, SCDMH's approach with future funds for First Episode Psychosis (FEP) is the development of an additional Coordinated Specialty Care (CSC) Program at a new CMHC site. As with the Charleston/Dorchester CSC Program, this program will be referred to as The CSC Program.

The current SCDMH-funded FEP Programs are listed below:

The Traditional Program
Charleston/Dorchester Community Mental Health Center
Pee Dee Mental Health Center
Lexington County Community Mental Health Center

The CSC Program
Charleston/Dorchester Community Mental Health Center (NAVIGATE)

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

Given the geographic specificity of the deployment of SCDMH's First Episode Psychosis (FEP) programs, promotion and outreach for the programs are unique to each SCDMH Community Mental Health Center (CMHC) offering an FEP program. The CMHC's efforts are outlined below.

Charleston-Dorchester Mental Health Center (Traditional Program and CSC Program): The NAVIGATE and New Directions programs promote the use of EBP by using the NAVIGATE model. This model has an Individual Resiliency Trainer (therapist) that is assigned to each patient. The treatment is individualized with the completion of a goal setting chart with the patient. Once this is completed, all of the services that the patient receives by the treatment team are centered on the patient's determined goal. There are many modules in the NAVIGATE manual that have been deemed effective with the patients meeting their goals. Some of the modules include education on psychosis, gaining resiliency, nutrition, coping with stress, barriers to meeting goals, relapse prevention, processing the psychotic episode, building on one's strengths and dealing with negative feelings. There is also a NAVIGATE Family Education Manual that is used with the family member and/or support systems in the patient's life. This has assisted the patient's supports by increasing education about psychosis, coping with stress skills, communication skills to use with the patient, ways to assist the patient with meeting their goal and participating in their relapse prevention plan. Once the patient is in the program for 6 months, a treatment team meeting is scheduled with the patient and their family. This meeting focuses on the patient's goal. The barriers to the goal are discussed as well as the successes towards meeting the goal. All of these components of the NAVIGATE EBP have been very successful with the patient meeting their goal and ultimately supporting the mission of SCDMH.

There are continuous efforts to inform the intake staff and clinicians in the agency of the program criteria for both programs in order to assist with gaining new referrals. The Center promotes the program during the intake process. If a patient seems appropriate for the FEP teams, it is discussed with the patient at intake. The FEP staff also attend team meetings around the Center on a regular basis to talk about the program with staff, so they are aware of what the program offers, who is appropriate, etc. The Center also talks about the program at Mental Health Taskforce meetings with the community held every other month. Finally, the outreach team that works with mostly the homeless population also promotes the program in the community as they attend several community meetings and provide services at the homeless shelter.

For FY2020, Charleston-Dorchester Mental Health Center will incorporate an approved grant, EPINET, into the NAVIGATE program. This grant will focus on hiring one part-time staff to assist with research on medication adherence and engaging patients in the program. Also, the Peer Support Specialist for the program will be trained in Cognitive Adaptation Training (CAT) to assist with basic living skills for the patients. There will be an addition to the NAVIGATE EBP by providing Enhanced NAVIGATE services. This will assist with engaging current patients in the program and providing success for these patients.

Lexington County Community Mental Health Center (Traditional Program): Lexington County Community Mental Health Center offers training opportunities at the center throughout the year for evidence-based practices. Center clinicians are trained in TF-CBT and Motivational Interviewing. One Youth-In-Transition staff is also training now in DBT skills group. The Center also seeks resources from SAMSHA's website.

Regarding individualized treatment, the Center conducts a comprehensive assessment at the initiation of treatment and uses this information to develop an individualized collaborative treatment plan with each patient. The goal is for the treatment services to be catered to the individual patient and comprehensive in addressing needs.

The Center does not currently provide integrated care, although this is a goal for the future. The initial assessment with each patient does help to identify possible health needs or other services that may be indicated for the patient. Staff specifically ask patients if they have a primary care MD and if they need help getting connected to services. Staff then refer to SCDMH care coordinators onsite to help connect patients to physical health services.

In the past year, Lexington County CMHC has continued to target younger clients by working with our Child, Adolescent and Family clinic to transition to specialized services when psychosis is present. In September 2019, Lexington County CMHC launched an Individual Placement and Support Program (IPS) which is an evidenced-based practice for supported employment. The CMHC paired its IPS team with its FEP team to support CMHC client's efforts to obtain gainful employment. Lexington County CMHC is hoping these two teams working together will also promote more engagement with the FEP population as well as positive outcomes related to employment.

The Center has a short overview on its website with information (http://lexingtonmhc.org/my-new-page_4.html). It also engages in community outreach in working with other community partners who serve the same population to help build knowledge of this resource. If someone is interested in the program, then the Center typically has them meet with staff to discuss it. The intake office also screens for psychosis and will refer new patients to the program directly if they are within the appropriate age range.

Pee Dee Mental Health Center (Traditional Program): Pee Dee Mental Health Center does not deploy a particular evidence-based practice; however, it does utilize CBT, Focus Therapy, Exposure Therapy, Mindfulness Skills, and some DBT.

Pee Dee has developed marketing materials to promote the program. It has a short overview on its website with information about its program (https://www.peedeementalhealth.org/adult-outpatient-services/#adultservices). The Center receives referrals from intake and adult outpatient services. When the referral is received, an FEP staff will complete an in-house generated assessment with the patient to determine if the patient meets criteria. Generally, FEP staff may average one referral per week.

As awareness of the program increases, it is hoped that referrals from external sources will begin and more community resources will become available.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? (●) Yes ( ) No

5. Does the state collect data specifically related to ESMI? (●) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Initially, States were permitted to address the needs of persons with early psychotic disorders, specifically first episode psychosis, either through enhancing existing program activities or development of new activities. SCDMH's approach was to enhance existing program activities.

After several discussions with the Substance Abuse and Mental Health Services Administration (SAMHSA), and based on its guidance, the Department specifically cited Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT) as the treatment modalities it would deploy utilizing the Set Aside funds. These treatment modalities were identified as appropriate and effective for persons experiencing First Episode Psychosis (FEP). This initial pathway became The Traditional Program.

In subsequent communications, SAMHSA indicated that its preference for the use of the Set-Aside funds was to implement Coordinated Specialty Care programs. Consequently, all future programs funded with Set-Aside funds will reflect SAMHSA's current preference.

Therefore, SCDMH's approach with future funds for First Episode Psychosis (FEP) is the development of an additional Coordinated Specialty Care (CSC) Program at a new CMHC site. As with the Charleston/Dorchester CSC Program, this program will be referred to as The CSC Program.

The current SCDMH-funded FEP Programs are listed below:

The Traditional Program (Amount of Funds Allocated)
Charleston/Dorchester Community Mental Health Center ($125,408)
Pee Dee Mental Health Center ($123,320)
Lexington County Community Mental Health Center ($101,272)

The CSC Program
Charleston/Dorchester Community Mental Health Center (NAVIGATE) ($393,578)

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

On May 21, 2019, SCDMH initiated efforts to identify a new Community Mental Health Center (CMHC) site for implementation of a Coordinated Specialty Care (CSC) Program. It issued a Request for Funding (RFF) (see attached) to its CMHCs to facilitate an allocation of Mental Health Block Grant (MHBG) FEP funds.

Santee-Wateree Community Mental Health Center was awarded $238,855 to implement the NAVIGATE Program.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

SCDMH utilizes its ability to track client-level data via its electronic medical record to provide aggregated outputs (counts) and outcomes (results) in order to demonstrate the effective and efficient use of the Ten Percent Set-Aside for First Episode Psychosis funds. SCDMH is able to identify both the clinicians and the patients involved in the Program, so data specific to the Program can be reported.

10. Please list the diagnostic categories identified for your state's ESMI programs.

The CSC Program provides services to patients who have experienced an FEP and have a schizophrenia spectrum disorder and the Traditional Programs serve patients who have experienced an FEP with any mental health diagnosis.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
COMMUNITY MENTAL HEALTH CENTERS
COLUMBIA, SOUTH CAROLINA

MEMORANDUM

TO: Center Directors, Community Mental Health Centers

FROM: Deborah Blalock, Deputy Director
Division of Community Mental Health Services

DATE: May 21, 2019

SUBJECT: Request for Funding (RFF) for MHBG Ten Percent Set Aside

This notification is to encourage all community mental health centers (CMHC) to submit a proposal for funding in FY2020 for services related to the treatment of First Episode Psychosis (FEP). This funding is made available as part of a requirement of the Mental Health Block Grant: Ten Percent Set-Aside to support "evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders." This RFF satisfies this expectation from the Substance Abuse and Mental Health Services Administration (SAMHSA).

The attached Request for Funding for MHBG Ten Percent Set-Aside outlines the guidelines for submission of a proposal. The proposal is to be submitted **no later than 4:00PM on Friday, June 14, 2019.** The proposal should be submitted electronically to Stewart Cooner, stewart.cooner@scdmh.org.

Any questions should be directed to Stewart Cooner at 803-898-8632.

Your leadership and programmatic partnerships within the CMHC and the broader community are essential to broadening community mental health treatment for individuals in need of services related to FEP. Thank you for your commitment to providing quality services and programs to meet the needs of your catchment area.

DB/dsc

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
COMMUNITY MENTAL HEALTH CENTERS
COLUMBIA, SOUTH CAROLINA

REQUEST FOR FUNDING (RFF)

Source of Funds - Federal Community Mental Health Services Block Grant
The South Carolina Department of Mental Health annually receives Federal Mental Health Block Grant (MHBG) funds (CFDA 93.958) from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). The source of funds for this RFF is wholly the Community Mental Health Services Block Grant as provided for under CFDA 93.958.

In accordance with CFDA 93.958, Objectives (050), the intent of the Block Grants for Community Mental Health Services is:

> *"to provide financial assistance to States and Territories to enable them to carry out the State's plan for providing comprehensive community mental health services to adults with a serious mental illness and to children with a serious emotional disturbance; monitor the progress in implementing a comprehensive community based mental health system; and provide technical assistance to States and the Mental Health Planning Council that will assist the States in planning and implementing a comprehensive community based mental health system."*

The RFF funds will be recurring contingent upon federal appropriations, the term of this RFF, and any guidance provided during the Mental Health Block Grant Application process, or thereafter.

Note that funds awarded under this RFF are restricted from certain uses according to CFDA 93.958. For administrative purposes, sections of CFDA 93.958 are provided hereinafter; however, the sections provided below should not be considered as superseding any current, or future, language cited in CFDA 93.958 or other related documents.

CFDA 93.958 states, in part, under Uses and Use Restrictions (070) that:

> *"Funds may be used at the discretion of the State to achieve the described objectives except for certain requirements. State plans must meet prescribed criteria. Services under the plan will be provided only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs and mental-health primary consumer- directed programs). Services under the plan will be provided through community mental health centers only if the centers meet prescribed criteria. Up to 5 percent of grant funds may be used for administering the funds. Funds may not be used to provide inpatient services; to make cash payments to intended recipients of health services; to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment; to satisfy any requirement for the expenditure of nonfederal funds as a condition for the receipt of Federal funds; or to provide financial assistance to any entity other than a public or nonprofit private entity. States are required to provide systems of integrated services for children with SED. Each year the State shall expend not less than the amount expended in FY 1994. States are also required to set aside 10 percent of their allocation for implementing programs showing strong evidence of effectiveness that targets individuals with a first episode psychosis. Other statutory requirements also apply."*

Program Overview from SAMHSA

In its Fiscal Year 2014 appropriation, the United States Congress allocated additional funds to SAMHSA to support "evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders." States were required to set-aside five percent of their MHBG allocation to support this activity.

The Congressional language "notes that the majority of individuals with severe mental illness experience their first symptoms during adolescence or early adulthood." The language also noted that "[d]espite the existence of effective treatments, there are often long delays – years and sometimes decades – between the first onset of symptoms and when people receive help." While the Congressional language was broad enough to allow the use of the Five Percent Set-Aside for any evidence-based program addressing any type of serious mental illness, a specific "promising model" was mentioned: First Episode Psychosis (FEP).

In its Fiscal Year 2016 appropriation, the Substance Abuse and Mental Health Services Administration (SAMHSA) was directed by Congress through its Omnibus bill, Public Law 114-113, to set aside 10 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based programs that provide treatment for those with early serious mental illness (SMI) and a first episode psychosis (FEP) – an increase from the previous 5% set aside. This additional 5 percent increase to the set-aside was over the FY2015 level. The appropriation bill specifically required the 10 percent set-aside to fund only those evidence-based programs that target FEP.

"States can implement models which have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state should be able to begin to move their system toward earlier intervention, or enhance the early intervention services already being implemented."

Approach to Meeting MHBG Ten Percent Set-Aside

Initially, States were permitted to address the needs of persons with early psychotic disorders, specifically first episode psychosis, either through enhancing existing program activities or development of new activities. SCDMH's approach was to enhance existing program activities.

After several discussions with the Substance Abuse and Mental Health Services Administration (SAMHSA), and based on its guidance, the Department specifically cited Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT) as the treatment modalities it would deploy utilizing the Set Aside funds. These treatment modalities were identified as appropriate and effective for persons experiencing First Episode Psychosis (FEP). This initial pathway became *The Traditional Program*.

In subsequent communications, SAMHSA indicated that its preference for the use of the Set-Aside funds was to implement Coordinated Specialty Care programs. Consequently, all future programs funded with Set-Aside funds will reflect SAMHSA's current preference.

Therefore, SCDMH's approach with the FY2020 funds for First Episode Psychosis (FEP) is the development of an additional Coordinated Specialty Care (CSC) Program at a new CMHC site. As with the Charleston/Dorchester CSC Program, this program will be referred to as *The CSC Program*.

A description of Coordinated Specialty Care (CSC) as defined by the National Institute of Mental Health is provided below for ease of reference.

> "Coordinated specialty care (CSC) is a recovery-oriented treatment program for people with first episode psychosis (FEP). CSC uses a team of specialists who work with the client to create a personal treatment plan. The specialists offer psychotherapy, medication management geared to individuals with FEP, family education and support, case management, and work or education support, depending on the individual's needs and preferences. The client and the team work together to make treatment decisions, involving family members as much as possible. The goal is to link the individual with a CSC team as soon as possible after psychotic symptoms begin."
>
> "CSC" is a general term used to describe a certain type of treatment for FEP. There are many different programs that are considered CSC. In the United States, examples of CSC programs include (but are not limited to) NAVIGATE, the Connection Program, OnTrackNY, the Specialized Treatment Early in Psychosis (STEP) program, and the Early Assessment and Support Alliance (EASA). RAISE is not a CSC program. RAISE is the name of a research initiative developed and funded by NIMH to test CSC programs. (The two programs tested by the RAISE initiative were NAVIGATE and the Connection Program.)"

Given that SCDMH has already implemented the CSC Program NAVIGATE through the Charleston/Dorchester Community Mental Health Center, this RFF recommends the implementation of an additional NAVIGATE Program.

NAVIGATE (http://navigateconsultants.org/)
NAVIGATE is a comprehensive program designed to provide early and effective treatment to individuals who have experienced a first episode of psychosis. It was developed with support from NIMH and has been implemented at 20 sites throughout the U.S. and one in Canada, including urban, suburban, and rural settings, and has provided treatment to people from diverse ethnic and cultural backgrounds. NAVIGATE is one of the options for implementing Coordinated Specialty Care (CSC) for early psychosis, as described by SAMHSA's website.

The program is named "NAVIGATE" to convey our mission of helping individuals with a first episode of psychosis and their families to successfully find their way to psychological and functional well-being, and to access the services they need in the mental health system.

Here's How NAVIGATE Works:
When individuals are enrolled in the program, they and their families first meet with the Program Director, who explains the program and answers any of their questions. The program director then introduces them to the other team members, and first appointments are set up with each of them. The individual then begins to work with the prescriber to evaluate the role of medication, with the Individual Resiliency Trainer (IRT) to promote individual resiliency by enhancing illness management and building strengths, with the Family Education (FE) clinician to learn how to work together as a family to support the individual's recovery, and with the Supported Employment and Education (SEE) specialist to pursue employment and educational goals.

On average, individuals and families usually work closely (e.g., weekly) with one of more members of the team for 6 to 12 months, followed by less frequent services (e.g., monthly for 12-18 months. After two years, the team, the individual and his or her family usually work together to decide on the next best steps to continue their recovery. Some individuals stay with the NAVIGATE team at the same levels or a less intensive basis (e.g., monthly check-ins), some transfer treatment to a non-NAVIGATE team, and others may no longer be involved in treatment.

NAVIGATE is a team-based approach, including the following members:

- ✓ Program director, who educates the community, recruits individuals who have begun to experience psychosis, and leads the team;
- ✓ Prescriber, trained in using low doses of medications and addressing special issues of clients with first episode psychosis;
- ✓ Individual Resiliency Trainer (IRT), who helps individuals identify and work towards their goals, teaching them strategies and skills to build their resiliency in coping with psychosis while staying on track with their lives;
- ✓ Family Education (FE) Clinician, who helps the whole family learn about psychosis and how to manage it, and also how to support each other and build family resiliency;
- ✓ Supported Employment and Education (SEE) Specialist, who helps people identify and achieve their educational and/or employment goals;
- ✓ Case Management, provided either by a separate case manager or by a specified NAVIGATE team member.

FY2020 Funding

The South Carolina Department of Mental Health (SCDMH, Department) has set aside $399,140.00 to fund this RFF. This level of funding will support one (1) FEP CSC Program.

Current and Future SCDMH Funded FEP Programs

The current and future SCDMH funded FEP Programs are listed below.

The Traditional Program	Budget
Charleston/Dorchester Community Mental Health Center	$ 149,521.00
Pee Dee Mental Health Center	$ 123,320.00
Lexington County Community Mental Health Center	$ 125,385.00
	$ 398,226.00

The CSC Program	Budget
Charleston/Dorchester Community Mental Health Center (NAVIGATE)	$ 393,578.00
New CSC Program	$ 399,140.00
	$ 792,718.00

Total	Total Budget
Total Expenditures for Set Aside for First Episode Psychosis	$1,190,944.00

Award

The Department will award the Ten Percent Set-Aside funds in an RFF process for the purpose of establishing an additional CSC Program. This award approach provides an opportunity for each of the Department's 16 CMHCs to respond with a proposal, including a statement of need based on demand, and ensures that the funds are allocated to the communities with the greatest need and to the CMHCs offering the greatest return on investment.

The Ten Percent Set-Aside funds will not be used to supplant existing positions. While current staff may assume the proffered roles, Federal funds may not be used to replace state, or other funds.

The Ten Percent Set-Aside funds may be used to fully implement a CSC Program, which includes costs for staff salary and benefits, travel and training, and other required expenses. Any other ancillary expenses will also be the responsibility of the responding CMHC. To the extent practical, the Ten Percent Set-Aside funds must be used to primarily fund salaries and fringe benefits.

Upon award of the Ten Percent Set-Aside funds to one of the CMHCs, the Department will utilize its ability to track client-level data via its electronic medical records to provide aggregated outputs (counts) and outcomes (results) to SAMHSA to demonstrate the effective and efficient use of the Ten Percent Set-Aside funds.

Proposal Guidelines

A) Proposals must **not exceed four (4) pages in length including budget.** Submit the proposal electronically to Stewart Cooner, stewart.cooner@scdmh.org.

B) Proposals should include the following:
   a. Identify the contact person for the proposal.
   b. Describe the program model and justify the need for the proposed position(s) as supported by data substantiating the lack of services, or the need for services.
   c. Identify operational/resource needs to create the current program of services with a projected timeline of full operation of the proposed position(s).
   d. Identify expected aggregated outputs (counts) and outcomes (results) to demonstrate the effective and efficient use of the Ten Percent Set-Aside funds.
   e. Provide position(s) budget and demonstrate the methodology by which position(s) will be readily identifiable as funded by the Ten Percent Set-Aside funds.
   f. Provide a summary position description (job description) under which the position(s) will operate that defines the role as one established to provide psychiatric services to persons experiencing FEP, adhering to the age range of the program model.

C) Proposals should commit to provide quarterly reports and other ad hoc data as requested. Quarterly reports should include:
   a. Actual aggregated outputs (counts) and outcomes (results) to demonstrate the effective and efficient use of the Ten Percent Set-Aside funds.
   b. Actual expenditures associated with the position(s) designated as participating in this program and funded by the Ten Percent Set-Aside funds.
   c. A description of the methodology by which position(s) are identifiable as funded by the Ten Percent Set-Aside funds.

Proposals are to be submitted to Stewart Cooner, Director of Special Programs & Telepsychiatry via email at stewart.cooner@scdmh.org no later than 4:00PM on Friday, June 14, 2019. Confirmation of receipt of proposal will be provided via email.

Review/Selection

The SCDMH Division of Community Mental Health Services will review all proposals based upon the respective CMHC's responses to the proposal guidelines provided above, including determinations of greatest need. One (1) proposal will be awarded. Each responding CMHC will be notified via email of the disposition of its proposal. The CMHC selected for funding will also receive written notification indicating the award amount.

[End]

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person?s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person?s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person?s needs and desires.

1. Does your state have policies related to person centered planning? ○ Yes ◉ No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

SCDMH does not use the term "person-centered planning" but refers to its internal process as an Individualized Plan of Care.

SCDMH Community Mental Health Centers (CMHCs) provide training and education initially, and on-going thereafter, in order to communicate how to embody individualized care that includes families/supports. The CMHCs also teach how clinical documents from the Initial Clinical Assessment (ICA), to Individualized Plan of Care (POC), to 90-Day POC Summaries, to Service Notes, to Physician Medical Orders (PMO), to Nursing Notes all must reflect the patient's unique needs, progress, and other considerations.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Please see answer to Question 4.

4. Describe the person-centered planning process in your state.

Following are components of the "person-centered planning" process for the South Carolina Department of Mental Health.
- SCDMH offers psychiatric advanced directive information and assistance.
- SCDMH offers at admission the opportunity for the patient to identify family/supports to be involved in treatment.
- SCDMH offers at admission the opportunity for the patient to identify any designee(s) to have access to treatment information.
- SCDMH employs family-based care for children and adolescents in order to facilitate achievement of goals.
- SCDMH utilizes its Continuity of Care Manual to inform "Family Inclusion" in care treatment for adults.
- SCDMH uses the ICA, which is strengths-based. It identifies goals, preferences, needs, desired outcomes in numerous dimensions.
- SCDMH uses initial individualized POC with patient and family/support input, documented collaboratively, and patient signature.
- SCDMH uses POC to identify discharge/transition parameters for each patient.
- SCDMH collaboratively documents at any time, but at least each 90 days, an updated POC based on progress and changes.
- SCDMH focuses services on the whole person, including social, health, living, education, spirituality, employment, etc.
- SCDMH Care Coordinators identify options and resources and link patients to such.
- SCDMH Peer Support Specialists use Recovery for Life and WHAM to promote/support balanced lives and skills for patients.
- SCDMH utilizes Engagement Specialists for outreach to patients who miss appointments.
- SCDMH uses Levels of Care - a tool to communicate to patient and families/support movement toward desired outcomes.
- SCDMH uses Collaborative Documentation to ensure patient and families/support contribute to information input into EMR.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

In the life cycle of a MHBG award, expenditures related thereto may be reviewed by any combination of SCDMH's Office of Special Programs, Office of Grants Administration, Office of Budgeting, Accounts Payable, Office of Procurement and Internal Audits, among others. It is also subject to the scrutiny of other state government agencies, including the Office of the State Auditor, Office of the Comptroller General, and the Materials Management Office.

SCDMH has established internal controls sufficient to institute preventive controls - designed to discourage errors or fraud - and detective controls - designed to identify an error or fraud after it has occurred. It is also subject to external controls established by the State of South Carolina. It is, therefore, reasonable to assert that SCDMH has instituted measures that provide for appropriate separation of duties, assignment of roles and responsibilities to appropriately qualified staff, establishment of sound business practices, and sustainability to a system that ensures proper authorization and recordation of procedures for financial transactions (Literature reference: AICPA).

Beginning in FY2018, SCDMH implemented an oversight procedure for non-profit organizations - sub-recipients of MHBG funds through a Request for Proposal (RFP) process administered by SCDMH. Attached is the Monitoring Tool used for said procedure. The implementation of this procedure was based on a recommendation from SAMHSA.

Please indicate areas of technical assistance needed related to this section

Not Applicable

Footnotes:

Mental Health Block Grant (MHBG) Program Monitoring Tool
(Four (4) Pages Including Cover Sheet)

Monitor Name:

Date of Monitoring Activity:

Applicable Monitoring Period:

Sub-recipient Organization Name:

Program Name:

Is the Sub-recipient familiar with CFDA 93.958, Objectives (050): Yes / No

Is the Sub-recipient familiar with CFDA 93.958, Use and Restrictions (070): Yes / No

Is the Sub-recipient familiar with CFDA 93.958, Post Assistance Requirements (110): Yes / No

Is the Sub-recipient familiar with CFDA 93.958, Audits (112): Yes / No

Is the Sub-recipient aware that available funding for this program is subject to the enactment of a final federal budget or an annualized Continuing Resolution (CR)? Offerors/Contractors should be aware that SCDMH cannot guarantee that sufficient funds will be appropriated to fully fund this program? Yes / No

Is the Sub-recipient aware that should SCDMH receive guidance from SAMHSA/CMHS that the services provided as a result of this request for proposal no longer satisfy the requirements of the Community Mental Health Services Block Grant State Behavioral Health Assessment and Plan as Administered by the Center for Mental Health Services, Division of State and Community Systems Development, or its designee, that based on its interpretation of said guidance, SCDMH may discontinue future funding for any awards made as a result of this request for proposal within the applicable terms set forth herein? Yes / No

Indicate the Type of Monitoring Activity
(Circle One)

Onsite Review **Onsite Visit**

Onsite Review (Includes Programmatic, Financial, and/or Other Related Information): Yes / No

Location:
Programmatic Review: Yes / No
Financial Review: Yes / No
Other Related Information Review: Yes / No

[Programmatic Review]

1. Does all information related to program(s) support the assertion that the program(s) support mental health transformation activities such as: expansion of access to mental health services; advancement of evidence-based practices; promotion of early screening, assessment, referral, and treatment; and/or promotion of consumer and family driven mental health care?

2. Is the program able to provide the dates and types of services provided, including the number of clients served (duplicated and unduplicated)?

3. Is the program able to provide a categorization of adult versus child persons served, the number of units of service provided within said categories, and the county of origin of service recipient?

4. Is the program able to describe evaluation activities including outcomes data collected and methods of collection?

5. Is the program able to quantify the actual outcomes versus proposed outcomes?

6. Does the organization maintain personnel files on its employees who provide services for which MHBG are used (neither visual nor independent verification is required)?

7. Have MHBG funds been used only for purposes supported by MHBG statutes, regulations, etc.?

[Financial Review]

1. Is the program able to provide the amount expended for direct services and the amount expended for indirect services, including the amount expended for administration?

2. Is the program able to provide an itemized income statement for activities associated with the use of MHBG funds, exclusive of any other activities?

3. Choosing one invoice, is the program able to provide supporting documentation for all expenditures for which it requested reimbursement?
    a. Date of Invoice:
    b. Date of Service Period:
    c. Amount of Invoice:

[Other Related Information]

1. Are there any other activities funded by the grant for which a quantitative measure is not feasible?

2. Are there any other relevant statistical measurements implemented by the entity that substantiates its eligibility for MHBG funds?

Sub-Recipient Organization Name:
Date of Monitoring Activity:

Onsite Visit (Includes Staff Interviews and/or Program Observation): Yes / No

Location:
Staff Interview: Yes / No
Program Observation: Yes / No
Is it possible for program activity to be observed: Yes / No
If No, provide reason why (e.g. privacy, confidentiality, etc.):

[Staff Interview]

1. Describe how the program(s) support mental health transformation activities such as: expansion of access to mental health services; advancement of evidence-based practices; promotion of early screening, assessment, referral, and treatment; and/or promotion of consumer and family driven mental health care.

2. Describe evaluation activities including outcomes data collected and methods of collection.

3. Quantify the actual outcomes versus proposed outcomes.

4. Describe any outreach, marketing, or other activities used to make others aware of the program.

5. Describe any program eligibility requirements.

6. What are the strengths of the program?

7. What are the areas of growth for the program?

8. What training and/or technical assistance does the program need?

[Program Observation]

1. How many individuals participated in the program?

2. Were the objectives of the training clearly defined?

3. Did the presenter have a good understanding of the subject matter?

4. Did the presentation include appropriate teaching strategies (handouts, lecture, group participation, etc.)?

5. Were the distributed materials helpful?

6. Was the content organized and easy to follow?

7. Were the topics relevant to the purpose of the award… to support mental health transformation activities such as: expansion of access to mental health services; advancement of evidence-based practices; promotion of early screening, assessment, referral, and treatment; and/or promotion of consumer and family driven mental health care?

8. Were the training objectives met?

9. Was the time allotted for the training sufficient?

Sub-Recipient Organization Name:
Date of Monitoring Activity:

WORKSHEET

Sub-Recipient Organization Name:
Date of Monitoring Activity:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state?s plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

As per SAMHSA's view of "consultation" as a government-to-government interaction that is distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands where such consultation is attended by elected officials of the tribe or their designees and by the highest possible state officials, the South Carolina Department of Mental Health has not conducted consultation sessions with the State of South Carolina's only federally recognized tribe: the Catawba Indian Nation.

2. What specific concerns were raised during the consultation session(s) noted above?

Not Applicable

3. Does the state have any activities related to this section that you would like to highlight?

The promulgation of regulations regarding State Recognition of Native American Indian entities in the State of South Carolina resides in the purview of the State Commission for Minority Affairs (SC Code of Laws Section 1-31-40(A)(10)). The purpose of the Commission is “to study the causes and effects of the socio-economic deprivation of minorities in the State and to implement programs necessary to address inequities confronting minorities in the State.”

Pursuant to SC Code of Laws Section 1-31-40(A)(10) and SC Code of Regulations 139, which also falls under the purview of the State Commission for Minority Affairs, the State of South Carolina recognizes three categories of Native American Indian entities in South Carolina: Native American Indian Tribes, Native American Indian Groups, and Native American Indian Special Interest Organizations.

As a part of SC Code of Regulations 139, there is established a Native American Indian Advisory Committee whose purpose is “to preserve the true aboriginal culture of the Americas in the State of South Carolina and to advance the Native American Indian

culture." The Committee advises the State Commission for Minority Affairs by apprising it of matters regarding Native American Indian Affairs, identifying the needs and concerns of the Native American Indian people of South Carolina by bringing such needs and concerns to the attention of the Commission, making recommendations to the Commission to address the needs and concerns of Native American Indian people, and inviting individuals recognized as specialists in Native American Indian Affairs and representatives of the state and federal agencies to present information to members of the Advisory Committee.

The Native American Affairs Division Advisory Committee is comprised of representatives from the following: Catawba Indian Nation, Beaver Creek Indians, Chaloklowa Chickasaw Indian People, Eastern Cherokee, Southern Iroquois and United Tribes of SC, Edisto Natchez Kusso Tribe of South Carolina, Natchez Tribe of South Carolina, Native American Studies Program, Office of the Governor, University of South Carolina-Lancaster Native American Studies Center, Office of the State Archaeologist, Pee Dee Indian Nation of Upper South Carolina, South Carolina Institute of Archaeology and Anthropology, Pee Dee Indian Tribe of Beaver Creek, Pee Dee Indian Tribe, Piedmont American Indian Association (PAIA), Santee Indian Organization, Lower Eastern Cherokee Nation of South Carolina, Sumter Tribe of Cheraw Indians, The Waccamaw Indian People and the Wassamasaw Tribe of Varnertown Indians.

As of 2012, the South Carolina Mental Health State Planning Council secured representation from the State Commission for Minority Affairs by means of a state employee who is not only employed by the State Commission for Minority Affairs, but who also serves as a liaison to the Native American Indian Advisory Committee.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Services include assessment, crisis intervention, and individual and group therapy using evidenced based practices including CBT, TFCBT, AFCBT, DBT, EMDR, PCIT. PMA and nursing services are provided to monitor/reduce symptoms. Patients are offered PSS and PRS to assist in job placement, linking to the Vocational Rehabilitation Department, learning job and other skills to maintain stability in the community. Housing programs assist with placement and subsidy of rent to help patients maintain independent living. Mental Health Court programs, clinicians embedded at Department of Juvenile Justice sites, and the local jail provide interventions to engage patients in treatment and reduce recidivism. The EBP, NAVIGATE model, is used with patients in the FEP programs, as well.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	(•) Yes ( ) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Best Practice Examples:
Telepsychiatry
School Mental Health Services
Assessment/Mobile Crisis
Metropolitan Children's Advocacy Center (MetCAC)
Child and Family Services
Parent-Child Interaction Therapy
Clinical Care Coordination
Deaf Services
Peer Support Services
Housing and Homeless Services
Individual Placement and Supported Employment Program (IPS)
Trauma Initiative

Dialectical Behavior Therapy
Towards Local Care (TLC)
Jail Diversion/Forensic Services
The Art of Recovery

3. Describe your state's case management services

Care Coordinators provide targeted case management services to qualifying individuals beginning with a comprehensive needs assessment. In the needs assessment, medical, dental, housing, employment, education, behavioral, and other community support needs are identified. Working collaboratively with the client, a Care Coordinator, who is knowledgeable about the local community resources, links the client to those resources. The Care Coordinator continues to monitor the services until goals are met and needs are resolved. Successful transition to community settings and access to needed services are focus points for Clinical Care Coordination services.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Examples include:

SCDMH Office of Transition Programs - Begun in 2019, the goals of the Office of Transition Programs are to provide for collaborations, community resources, transition planning, and treatment accessibility in the context of psychosocial needs and patient preferences for those patients being discharged from an SCDMH Inpatient Facility.

SCDMH Emergency Department Telepsychiatry Program - Begun in 2008, the goals of the ED Telepsychiatry Program are to achieve timely mental health comprehensive evaluations and recommendations; initiate quality treatment services; reduce overall hospital length of stay; affect return on investment through hospital savings; and, provide successful post-emergency department transfer to aftercare services in community settings.

SCDMH Emergency Management Services Telehealth Pilot Project - Begun in 2017, the goal of the EMS Telehealth Pilot Project is to appropriately divert behavioral health patients from local Emergency Departments and hospitals.

SCDMH Tri-County Crisis Stabilization Unit - Charleston-Dorchester Community Mental Health Center's (CDMHC) 10-bed Tri-County Crisis Stabilization Unit serves as an ED/hospital, and jail diversion program accepting patients that are voluntary for a brief stay to stabilize symptoms.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	209,587	Not Indicated
2.Children with SED	73,664	Not Indicated

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

SCDMH participates in the Substance Abuse and Mental Health Services Administration's (SAMHSA) Uniform Reporting System (URS). From said system, SCDMH extracts a statewide estimate of the prevalence of SMI among adults and SED among children (URS Table 1).

SCDMH uses this comparative data in conjunction with community-centric feedback to evaluate and substantiate planning and implementation activities for its mental health system of care.

The community-centric feedback is based on dashboard performance measures that SCDMH Senior Management reviews and refines on a periodic basis. The measures are quick reference global indicators to evaluate actual performance against the strategic plan. The dashboard measures rely on a response to demand approach that seeks to refine the efficiency of the service delivery system in order to create capacity to meet demand as it presents itself. Within the Community Mental Health Centers, the dashboard measures are evaluated by CMHC individually and by SCDMH as a system.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDE	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	(•) Yes ( ) No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

The Highway to Hope RV of the Charleston-Dorchester CMHC (launched in 2010) provides immediate psychiatric care to adults and children in the Charleston and Dorchester counties in a mobile setting. It visits rural areas that are known as underserved.

The RV functions as a mobile mental health clinic, providing a full range of services, including: Crisis intervention; Assessment; Case management; Individual and family therapy; and, Medication management. Staff include 2 counselors and a psychiatrist.

Services are available Monday through Friday from 8am to 4pm; the Center posts a schedule of days and locations.

Fees are based on an individual's and family's ability to pay. Third party payments through private insurance, Medicaid, Medicare, and self-pay are accepted. As with all services provided by DMH, no one is turned away due to the inability to pay.

SCDMH's telepsychiatry programs have provided more than 122,000 psychiatric services.

As of June 2019, SCDMH's innovative and award winning Emergency Department Telepsychiatry Program has provided more than 50,000 psychiatric comprehensive evaluations in emergency departments across South Carolina. The Program was developed to meet the critical shortage of psychiatrists in South Carolina's underserved areas, and assist hospital emergency rooms by providing appropriate treatment to persons in a behavioral crisis, using real-time, state-of-the-art video-and-voice technology that connects SCDMH psychiatrists to hospital emergency departments throughout the state.

Built on the success of telepsychiatry services to emergency departments, SCDMH has equipped its hospitals, mental health centers, and clinics to provide psychiatric treatment services to its patients via telepsychiatry. Since August 2013, the Community Telepsychiatry Program has provided more than 70,000 psychiatric treatment services to SCDMH patients throughout South Carolina.

b. Describe your state's targeted services to the homeless population.

Statewide Housing Units For Persons With Mental Illnesses
- Since FY '92, SCDMH has invested agency funds to develop over 1,100 housing units
- Proceeds from sale of Bull Street property used to fund new housing developments in partnership with private non-profit and for-profit organizations

Community Housing Rental Assistance Program
- Program began in 2015 using SCDMH funding of $1.5M provided through agreement with DHHS, as well as $400,000 in funds from General Assembly
- Currently, SCDMH is assisting 293 units/496 patients and family members at average annual cost/unit of <$6,500

HUD Continuum of Care Permanent Supportive Housing Programs
- Provide >$1.1M annually for rental assistance for formerly homeless patients and their families in 5 counties
- Currently assisting 135 units/174 patients and family members

Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH)
- Formula grant program funds enable SCDMH to provide outreach and clinical services to people with serious mental illnesses/co -occurring disorders who are experiencing homelessness
- Programs currently based in Columbia, Greenville, Myrtle Beach, and Charleston areas
- PATH programs served >2,000 individuals in FY '18

Supplemental Security Income/Social Security Disability Insurance Outreach, Access, and Recovery (SOAR) Initiative
- SOAR is SAMHSA best practice that increases access to SSA disability programs for individuals with serious mental illnesses who are experiencing homelessness
- SCDMH serves as lead agency and partners with SSA and SC Disability Determination Services
- SC SOAR initiative achieved a 69% approval rate for initial SOAR applications in FY '18 with average decision time of 78 days, exceeding national outcomes

Treatment for Adults Experiencing Homelessness in SC
- SAMHSA grant to assist homeless persons in receiving mental health services
- In 2018, SCDMH received 5-year award of $1M/year

c. Describe your state's targeted services to the older adult population.

Examples of SCDMH's targeted services to older adults include Pee Dee Mental Health Center's Silver Years Program and Santee-Wateree Community Mental Health Center's Elder Services Program.

The Silver Years Program is for elderly adults with symptoms of early Dementia and/or Alzheimer's. The program maximizes the abilities of patients in order to delay or prevent a long-term stay at a specialized facility.

The Elder Services Program provides for a staff psychiatrist who oversees all patient services. The Program works closely with each patient's personal physician and other community and support agencies to ensure the highest quality of care. The staff works with the "whole person." Services include: problem assessment, to include full psychological and cognitive assessment; psychiatric assessment for treatment planning; medication intervention and management and medical referral as needed; individual, family and group counseling; medication monitoring by nurses; and case management, to assist the client in accessing both mental health and appropriate health and social services.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

The South Carolina Department of Mental Health (SCDMH) has a comprehensive Staff Development and Training Program. It is housed in the Office of Evaluation, Training and Research (ETR).

Evaluation, Training and Research (ETR)
- Reports directly to the SCDMH Medical Director.
- Provides education and training for the entire agency though the traditional class room approach and an on-line learning management system.
- Videoconferencing of trainings is also used for centers and facilities outside of Columbia. This saves on the cost of travel and allows the staff member to remain on site and be available before and after the training. This enhances their ability to continue to provide billable services.
- An annual needs assessment is conducted agency wide to determine training needs of the staff.
- All of the training provided is evaluated by class participants and the results are used to improve existing training and/or create new training offerings to meet identified needs.
- The majority of the training is done using in house topic experts which makes them budget neutral.

Mentoring/Succession Program
- The purpose of this 10 month long program is to develop a cadre of potential leaders within SCDMH to relieve the void of those retiring. It is also designed to provide participants with sage advice from their mentors, focused feedback and networking resources, thereby enhancing collegiality and building greater loyalty to SCDMH.
- Each participant referred to as a mentee, attends class in Columbia one day a month. They are assigned a mentor that they meet with regularly and are given opportunities to attend management meetings and other leadership activities at their center or facility.
- Since its start in 2004, the program has been successful in graduating over 300 mentees, some of which have been promoted to Center and Facility Directors, Assistant Center Directors and Directors of Divisions within their Center or Facility.
- Leadership remains committed to this program as we continue to see the benefit to SCDMH from it.
- This year there are 32 participants.

Supervisory Mini Series
- Designed for individuals in SCDMH who were promoted to a supervisory role and new hires who will be in a supervisory role.
- Since its start in 2008, over 400 individuals have completed the program.
- This program is offered live and via video conferencing.
- It started out as a three part mini series but has grown to four parts based on identified needs of class participants and/or their supervisors.

Executive Leadership Development Program
- Designed for individuals in the agency who may serve in Executive Leadership roles in the future. The program was implemented in 2008.
- Since that time there has been a total of seven classes.
- Another class will start in September 2019.
- Class participants are required to complete a written Management Improvement Project. The purpose of this project is to give the program candidates the opportunity to use this experience to identify an area in SCDMH for targeted improvement and formulate a document about the improvement for all class participants. The project is required to focus on methods to create a new management initiative or improve or add value to one that is already in place in SCDMH.
- All of the current Deputy Directors are graduates of the program.

Certified Nursing Assistant Training Program
- Designed for individuals who will work at C. M. Tucker Nursing Care Center.
- The Program began in 2011 and is certified by Health & Human Services.
- This program is 120 hours long. Sixty hours are spent in the classroom and 60 hours are spent on the nursing units. Health and Human Services only requires 100 hours of instruction in order to take the certification exam.
- We elected to make our program longer and believe that our residents will benefit from this.
- Since its start, over 300 individuals have completed the program. Unfortunately, the retention rate is very low as most leave SCDMH for higher paying positions in the local community.

Psychiatric Grand Rounds
- Designed for physicians and other clinical staff.

- This program is offered monthly live and via video conferencing.
- Participants receive continuing education credit that they can use toward re-licensure.
- The topics are selected based on the results of the Needs Assessment that is sent out to the clinical staff each year.
- Is done in collaboration with the faculty of the Palmetto Health Medical Group at the University of South Carolina Department of Neuropsychiatry and Behavioral Science.

Annual Psychiatric Update Conference
- Conducted in September of each year.
- Offered to Physicians and other Clinical Staff.
- Has been held every year for the past 19 years. This is our largest training event of the year and is done with minimal cost.
- Faculty from USCSOM and the residents all participate in the program.
- Topics all address current evidence based Psychiatric BEST practices.
- Post training evaluations always give this event the highest ratings.
- Close to 200 attend either in person or by video conferencing each year.

Continuing Education Offerings
- ETR provides Continuing Medical Education (CME) for physicians. It also provides Continuing Education for Social Workers (SW), Licensed Professional Counselors (LPC) and Marriage & Family Therapist's (MFT). SCDMH is also an approved provider of Continuing Nursing Education through the South Carolina Nurses Association. In 2018 SCDMH was reapproved for three years.
- Number of hours awarded depends on the program offering. In order to receive continuing education credit for programs, the programs must meet specific criteria and an application requesting the credit must be completed and approved prior to the event.
- For FY2019, the following credits were awarded:
- CME 39.5 hours
- Nursing CE 36 hours
- CEUs 4.05 or 40.5 Contact hours
- SW 11.25 or 112.5 Contact hours
- LPC/MFT 10 or 100 Contact hours
- These credits can be used by staff to meet the requirements for re-licensure at no cost to them.

On-Line Learning Modules
- SCDMH has an On-line Learning Management System which staff use to take training that is required to meet regulatory and accrediting standards.
- All of the learning modules are designed and created in house by topic experts.
- If the modules were not available staff would be required to attend the training in person. This would greatly reduce the number of billable hours for clinical staff.
- In 2018 a Training Task Force was convened to conduct an extensive review of over 100 on-line learning modules. 46 were removed. 19 were combined with other modules. An elective curriculum was developed. This was all done in order to meet current best practices and regulatory and accrediting standards.
- The task force continues its work to ensure all on-line learning modules remain current and relevant.

Psychiatric Residency/Fellowship Training Programs
- SCDMH has a long standing agreement with Prisma Health (formerly Palmetto Health) for Psychiatric Residents to rotate in its facilities to gain hands-on psychiatric experience.
- There are four Residency/Fellowship training programs at the School of Medicine. They are General Psychiatry, Child and Adolescent, Forensics and Geropsychiatry. All use SCDMH as part of their clinical rotation.
- SCDMH Clinical psychiatrists provide supervision to the residents while in SCDMH.
- This has proven to be an excellent recruiting tool for the agency as psychiatrists are in high demand nationwide.
- ETR provides orientation to all residents who rotate in SCDMH facilities or centers.

Distance Learning
- SCDMH recognizes that staff may not always be able to attend training offerings due to scheduling conflicts but still require continuing education credits for re-licensure.
- Each month ETR researches on-line learning sites that offer high quality, evidenced based best practice training that staff can take at home or work as their time permits.
- ETR emails staff the monthly offerings which include no cost or low cost trainings that provide continuing education credit.
- This has been well received by staff.

Nursing Orientation & Training
- Nursing is a large and integral part of SCDMH. They have very stringent training requirements to meet regulatory and accrediting standards.
- ETR provides an extensive and in-depth classroom orientation for all new hires in nursing.
- ETR also provides annual competency verification of all nursing staff. This is an accrediting standard to ensure that staff remains qualified to perform the essential elements of their job duties.
- Nursing staff must take and pass written tests and also demonstrate ability to perform identified nursing skills in order to be deemed competent to perform their job duties.

Employees of SCDMH also participate in the South Carolina Certified Public Manager (CPM) Program. CPM is a "Nationally Accredited management development program for managers and supervisors in South Carolina state government. The program was initially accredited by the National CPM Consortium in 1996 and was reaccredited in 2006, 2011 and 2016.

Philosophically, the South Carolina CPM Program strives to encourage innovative management practices and high ethical standards. The mission of the CPM Program is to provide quality training for public administrators, to assist agencies in developing future leaders, and to recognize management as a profession in the public sector. The CPM Program promotes on-the-job application of learning, gives participants experience in solving agency problems, develops human resources and encourages networking with CPM graduates in other states."

Additional examples include use by Prisma Upstate and the Medical University of South Carolina of SCDMH Community Mental Health Centers as residency rotation sites, and provision by SCDMH of CMEs, RN CEUs. and other CEUs as a part of the Lowcountry Mental Health Conference (https://www.lowcountrymhconference.com/).

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? (●) Yes ( ) No

Please indicate areas of technical assistance needed related to this section.

Not Applicable

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? (●) Yes ( ) No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? (●) Yes ( ) No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? (●) Yes ( ) No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight.

SAMHSA Definition of Trauma
- A widespread, harmful, and costly public health problem, which occurs as a result of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful experiences
- Has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation

SCDMH Trauma-Informed Systems
- Support development and implementation of policies, procedures, and practices

- All patients offered evidence-based trauma assessments
- Patients experiencing trauma-related symptoms are offered evidence-based treatment options
- Practices in CMHCs and facilities do not create, nor recreate, traumatizing events for patients

FY 2019 Trauma-Informed Systems Trainings
- 69 SCDMH clinicians completed 3-day Trauma Focused-Cognitive Behavioral Therapy (CBT) for children, adolescents and their families training
- 48 SCDMH clinicians graduated from 3-day Cognitive Behavioral Therapy for Post-Traumatic Stress Disorder (PTSD) Therapy for Adults training
- 100+ SCDMH staff have participated in Trauma-Informed Care trainings

Please indicate areas of technical assistance needed related to this section.

Not Applicable

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: *: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**
[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? (●) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? (●) Yes ( ) No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? (●) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

Training for Law Enforcement and Emergency Medical Services
- Formulated in 1988 by Major Sam Cochran of Memphis Police Department
- Program designed to teach law enforcement about mental illnesses and de-escalation techniques
- These 40-hour classes are taught by mental health staff, National Alliance on Mental Illness (NAMI), law enforcement peers, and sometimes other community providers (e.g., 301 providers)

Mental Health Courts Initiative
- Goal - Diversion of non-violent, adult offenders with serious mental illness from criminal justice system
- Five County Courts in SC - Charleston, Greenville, Horry, Richland, and York
- Funding - $400,000 in recurring State appropriations, as well as $1,220,000 3-year grant from The Duke Endowment to standardize existing courts, establish two new courts, and conduct research study on outcomes

SCDMH has also established a Law Enforcement Liaison - Director of Justice-Involved Programming - within its Division of

Community Mental Health Services. The position assumes responsibility for the design, implementation and evaluation of the state program of services to patients who are involved in the Justice System. This includes adults with severe mental illness and who are justice involved. Activities include policy development, grant development, budget oversight, and program design. It is also responsible for coordinating programs and acting as a liaison to all State Law Enforcement entities.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

Footnotes:

MHBG Services in Jails and Prisons

Guidance Letter from SAMHSA to States
On February 11, 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a guidance letter related to the use of Mental Health Block Grant (MHBG) funds for services related to individuals with Serious Mental Illness (SMI) in jails and prisons. The letter served "to clarify that treatment during incarceration is an allowable use of the MHBG, provided that the treatment services as well as provider of such services meets the statutory requirements of the MHBG." The letter then addressed [paraphrased]: the purpose of the MHBG is to provide community mental health services; one of the primary aims of these funds is to provide for care and treatment of those living with serious mental illness who may face severe limitations on their ability to successfully navigate community living as a result of the severity of their mental illness, which, with worsening symptoms, could lead to infractions of criminal codes that lead to the arrest and incarceration of the seriously mentally ill; and that it is imperative that MHBG funds to the states be used to serve those in greatest need – the most vulnerable Americans with serious mental illness.

Revision Request to FY2020-2021 MHBG Application
On February 18, 2020, SAMHSA issued a Revision Request to the FY2020-2021 MHBG Application. The Revision Request indicated the following.

> Per the guidance letter dated February 11 to the state Mental Health Commissioners and the conference call held with Assistant Secretary Dr. McCance Katz on February 14, states can submit a modification to their MHBG Application for 2020-21 related to services for individuals with SMI in Jails/Prisons.

SCDMH Response to Revision Request
While the South Carolina Department of Mental Health (SCDMH) does not specifically target MHBG funds for services related to individuals with Serious Mental Illness (SMI) in jails and prisons, the SCDMH Division of Community Mental Health Services and its 16 Community Mental Health Centers and 48 Mental Health Clinics, along with other SCDMH statewide programs, has for many years addressed the needs of individuals with SMI in jails and prisons. SCDMH has a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to mental health/substance use disorder (M/SUD) services. It has a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms. It provides cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system. It also has an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances.

As outlined in the FY2020-2021 MHBG Application, Environmental Factors and Plan, Section 13. Criminal and Juvenile Justice, SCDMH also has an initiative focused on Mental Health Courts with the goal to divert non-violent, adult offenders with SMI from the criminal justice system and has established a Law Enforcement Liaison – Director of Justice-Involved Programming, who is responsible for the design, implementation and evaluation of the state program of services to patients who are involved in the Justice System.

Conclusion
For many years, SCDMH has addressed the needs of individuals with SMI in jails and prisons. Even as of recent, efforts are afoot to expand such services. While SCDMH does not specifically target MHBG funds for services related to individuals with SMI in jails and prisons, this population is considered in SCDMH ongoing efforts to address the recovery of people with mental illnesses.

[End]

Environmental Factors and Plan

15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☐ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☑ Psychiatric Advance Directives
- **c)** ☐ Family Engagement
- **d)** ☑ Safety Planning
- **e)** ☐ Peer-Operated Warm Lines
- **f)** ☐ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☑ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ Peer Support/Peer Bridgers
- **b)** ☐ Follow-up Outreach and Support
- **c)** ☐ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis

- **e)** ☑ Follow-up crisis engagement with families and involved community members
- **f)** ☐ Recovery community coaches/peer recovery coaches
- **g)** ☐ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

SCDMH has a number of crisis services initiatives, throughout the state, with a variety of funding streams, that are operational or in various phases of implementation. Please see the following pages.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

COMMUNITY CRISIS PROGRAMMING

- All 16 SCDMH CMHCs provide crisis services
- $6.2 million awarded annually to CMHCs
  - Local/Private Inpatient/Community Crisis Beds - 78% diverted out of EDs and 22% prevented an ED admission for Local/Private/Community Crisis beds
  - Crisis/Co-Occurring Teams

MOBILE CRISIS – A 24/7 CRISIS RESPONSE TEAM FORMED IN 1987 - 32 YEARS OF HISTORY INFORMING THE FUTURE



COMMUNITY CRISIS RESPONSE AND INTERVENTION

THE PURPOSE

To enhance the crisis services array to include a statewide community crisis on-site emergency psychiatric screening and assessment.

COMMUNITY CRISIS RESPONSE & INTERVENTION
SC Department of Mental Health

To provide services **24/7/365** within 60 minutes of contact with the CCRI team to meet the mental health needs of residents of South Carolina.

SCDMH

Program Director:
Amanda Gilchrist

CCRI Access Line:
833-DMH-CCRI
833-(364-2274)

Email: ccri@scdmh.org

www.state.sc.us/dmh/

COMMUNITY CRISIS RESPONSE & INTERVENTION

DMH South Carolina Department of Mental Health

COMMUNITY CRISIS RESPONSE & INTERVENTION

COMMUNITY MENTAL HEALTH SERVICES

- Operational 24/7/365
- Staffed by regional teams - Coastal, Pee Dee, Midlands, Upstate
- Requires strong partnerships with local law enforcement offices and probate courts, local emergency departments, and inpatient facilities



Amanda Gilchrist, LPC
Program Director,
Community Crisis Response & Intervention

ABOUT CCRI

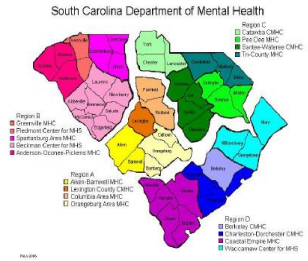
We provide adults and children with clinical screening either

- in person at the location of the crisis,
- in person at a community mental health center,
- via phone, or
- Telehealth Communication Software,

in order to de-esclate the crisis and provide linkage to ongoing treatment and other resources.

HOW IT WORKS

Each call that is received via the CCRI Access Line will be directed to the appropriate triage clinician based on geographical location (region).



Region A: Midlands
Region B: Upstate
Region C: Pee-Dee
Region D: Coastal

PROGRAM GOALS

Provide access and link patients to appropriate levels of care and divert from unnecessary hospitalizations and incarcerations.

Build partnerships with local law enforcement, hospitals, judges, community partners, and local mental health providers.

WHEN IS IT AVAILABLE?

Each region will be phased in. The local DMH centers are available for services to the community based on their current county of residence.

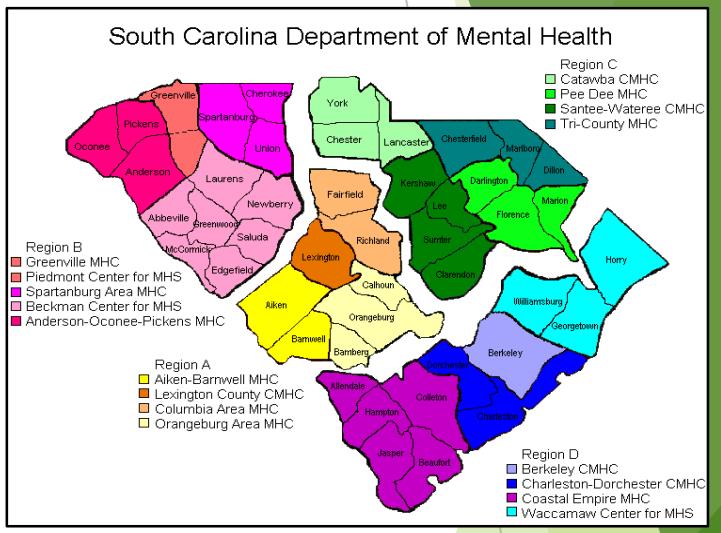
- Rollout began May 1, 2018 in the Coastal region and is active in 29 counties to date
- The toll free line to access services is 833-364-2274 (833-DMH-CCRI)

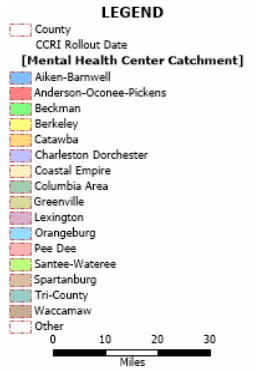
COMMUNITY CRISIS RESPONSE INITIATIVE (CCRI) ROLLOUT DATES, BY COUNTY



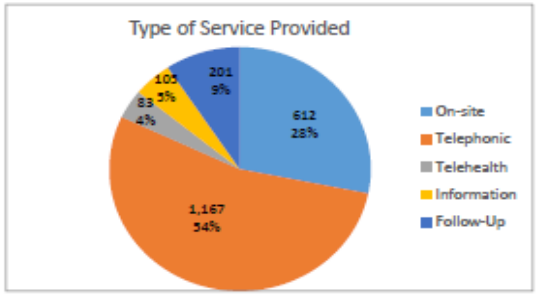
DMH South Carolina Department of Mental Health

REGIONAL MAP



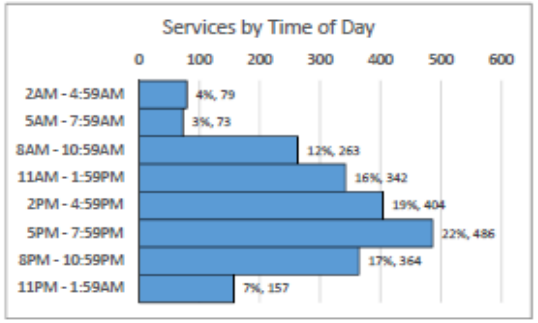


CCRI DATA



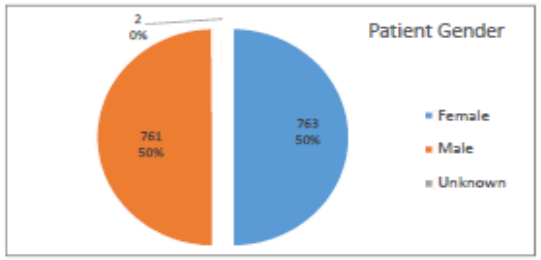
Service Type	Patients		Services	
	#	%	#	%
On-site	550	31%	612	28%
Telephonic	893	50%	1,167	54%
Telehealth	83	5%	83	4%
Information	101	6%	105	5%
Follow-Up	169	9%	201	9%
Total	1,796	100%	2,168	100%

* Patient totals unduplicated for each reporting category



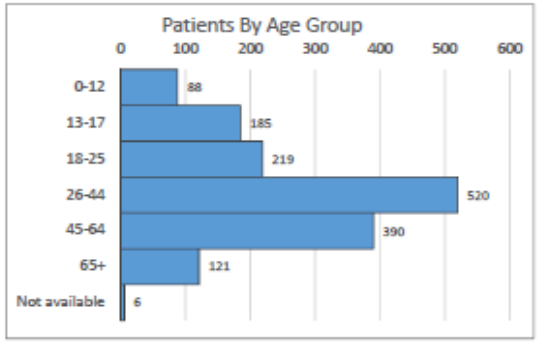
Service Type	Patients		Services	
	#	%	#	%
2AM - 4:59AM	70	4%	79	4%
5AM - 7:59AM	69	4%	73	3%
8AM - 10:59AM	237	12%	263	12%
11AM - 1:59PM	305	16%	342	16%
2PM - 4:59PM	357	18%	404	19%
5PM - 7:59PM	430	22%	486	22%
8PM - 10:59PM	326	17%	364	17%
11PM - 1:59AM	151	8%	157	7%
Total	1,945	100%	2,168	100%

* Patient totals unduplicated for each reporting category



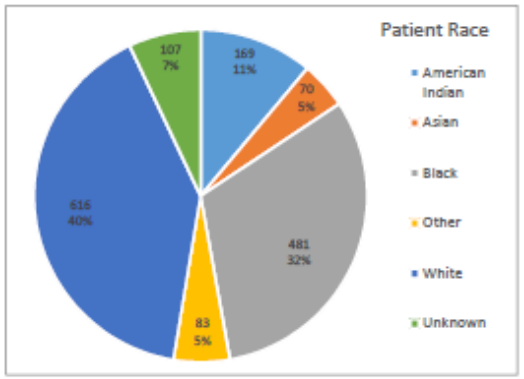
Gender	Patients		Services	
	#	%	#	%
Female	763	50%	1,042	48%
Male	761	50%	1,124	52%
Unknown	2	0%	2	0%
Total	1,526	100%	2,168	100%

* Patient totals unduplicated for each reporting category



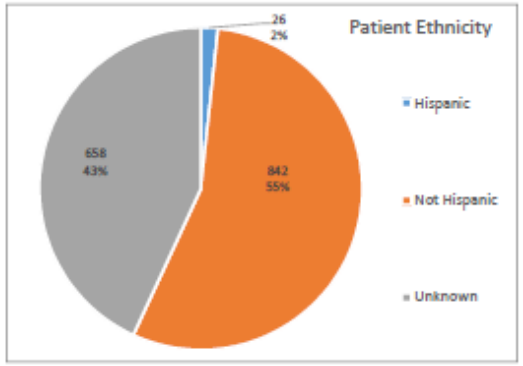
Age Group	Patients		Services	
	#	%	#	%
0-12	88	6%	127	6%
13-17	185	12%	235	11%
18-25	219	14%	317	15%
26-44	520	34%	727	34%
45-64	390	26%	595	27%
65+	121	8%	161	7%
Not available	6	0%	6	0%
Total	1,529	100%	2,168	100%

* Patient totals unduplicated for each reporting category



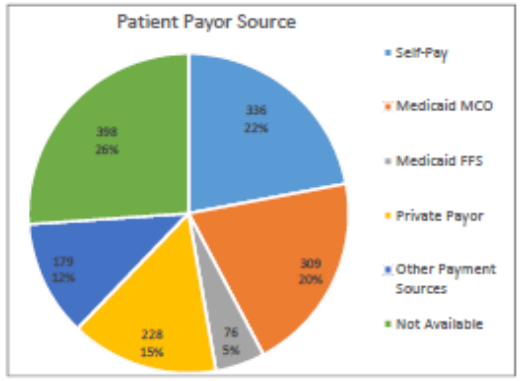
Race Group	Patients		Services	
	#	%	#	%
American Indian	169	11%	204	9%
Asian	70	5%	84	4%
Black	481	32%	685	32%
Other	83	5%	128	6%
White	616	40%	933	43%
Unknown	107	7%	134	6%
Total	1,526	100%	2,168	100%

* Patient totals unduplicated for each reporting category



Hispanic Ethnicity	Patients		Services	
	#	%	#	%
Hispanic	26	2%	43	2%
Not Hispanic	842	55%	1,265	58%
Unknown	658	43%	860	40%
Total	1,526	100%	2,168	100%

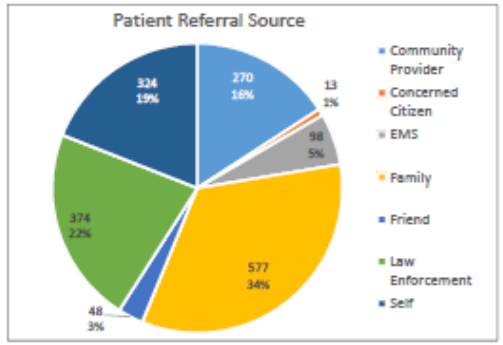
* Patient totals unduplicated for each reporting category



Payment Source	Patients		Services	
	#	%	#	%
Self-Pay	336	22%	507	23%
Medicaid MCO	309	20%	451	21%
Medicaid FFS	76	5%	97	4%
Private Payor	228	15%	326	15%
Other Payment Sources	179	12%	285	13%
Not Available	398	26%	502	23%
Total	1,526	100%	2,168	100%

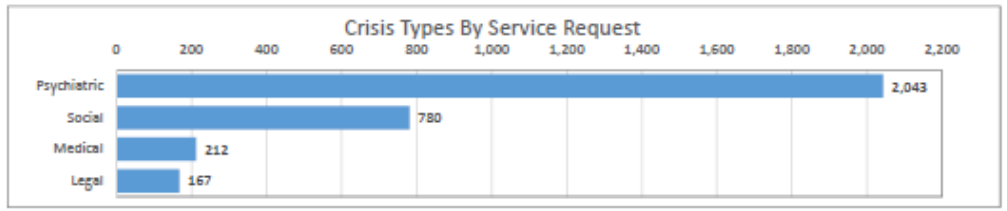
* Patient totals unduplicated for each reporting category

CCRI DATA

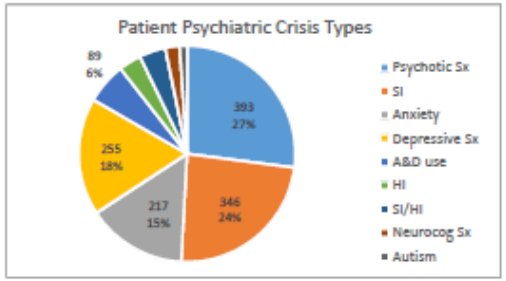


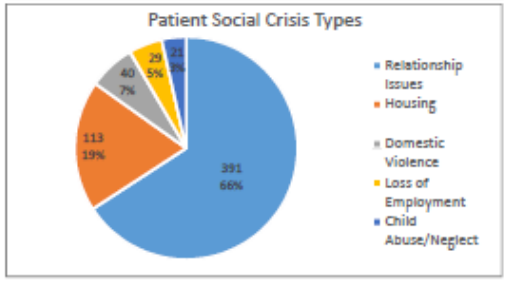
Referral Source	Patients		Services	
	#	%	#	%
Community Provider	270	16%	302	14%
Concerned Citizen	13	1%	17	1%
EMS	98	6%	104	5%
Family	577	34%	757	35%
Friend	48	3%	56	3%
Law Enforcement	374	22%	442	20%
Self	324	19%	490	23%
Total	1,704	100%	2,168	100%

* Patient totals unduplicated for each reporting category



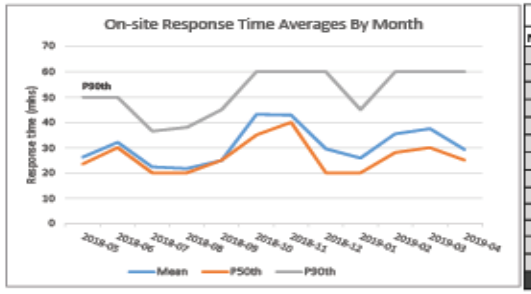
* Crisis type categories not mutually exclusive



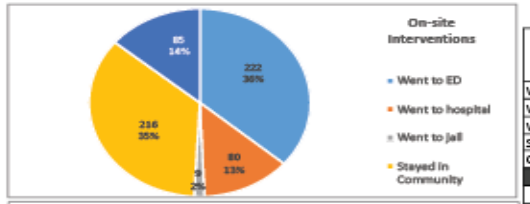


Crisis Type	Patients		Services	
	#	%	#	%
Psychatric	1,453	95.2%	2,043	94.2%
Psychotic Sx	393	27.0%	573	26.4%
SI	346	23.8%	454	20.9%
Anxiety	217	14.9%	346	16.0%
Depressive Sx	255	17.5%	334	15.4%
A&D use	89	6.1%	130	6.0%
HI	49	3.4%	67	3.1%
SI/HI	57	3.9%	77	3.6%
Neurocog Sx	31	2.1%	37	1.7%
Autism	16	1.1%	25	1.2%
Social	594	38.9%	780	36.0%
Relationship Issues	391	65.8%	522	66.9%
Housing	113	19.0%	148	19.0%
Domestic Violence	40	6.7%	48	6.2%
Loss of Employment	29	4.9%	37	4.7%
Child Abuse/Neglect	21	3.5%	25	3.2%
Medical	164	10.7%	212	9.8%
Legal	141	9.2%	167	7.7%

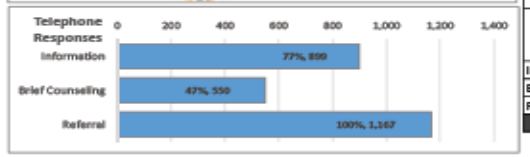
* Patient totals unduplicated for each reporting category



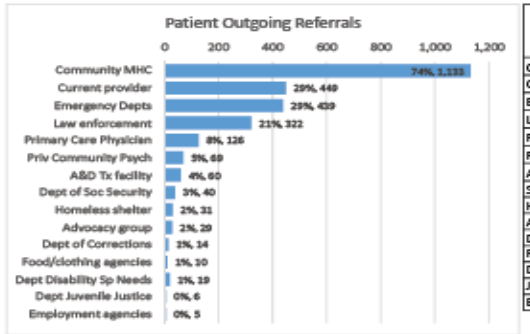
On-Site Response Times By Month and Minutes			
Month	Mean	P50th	P90th
2018-05	26	24	50
2018-06	32	30	50
2018-07	22	20	37
2018-08	22	20	38
2018-09	25	25	45
2018-10	43	35	60
2018-11	43	40	60
2018-12	30	20	60
2019-01	26	20	45
2019-02	35	28	60
2019-03	37	30	60
2019-04	29	25	60
2019-05	31	30	60
Total	31	25	60



Status	On-Site Response Times By Month and Minutes			
	Patients		Services	
	#	%	#	%
Went to ED	211	36%	222	36%
Went to hospital	73	13%	80	13%
Went to jail	9	2%	9	1%
Stayed in Community	208	36%	216	35%
Other	83	14%	85	14%
Total	584	100%	612	100%

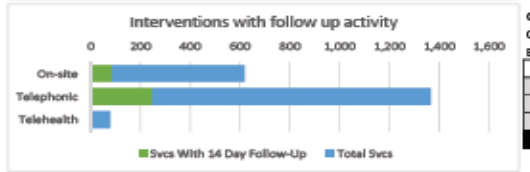


Telephonic Intervention Content	Telephonic Responses			
	Patients		Services	
	#	%	#	%
Information	721	81%	899	77%
Brief Counseling	426	48%	550	47%
Referral	893	100%	1,167	100%
Total	893		1,167	



Referrals	Outgoing Referrals			
	Patients		Services	
	#	%	#	%
Community MHC	1,133	74%	1,567	72%
Current Provider	449	29%	550	25%
Emergency Depts.	439	29%	520	24%
Law Enforcement	322	21%	391	18%
Primary Care Physician	126	8%	148	7%
Priv Community Psych	69	5%	80	4%
A&D Tx facility	60	4%	69	3%
Social Services	40	3%	45	2%
Homeless Shelter	31	2%	34	2%
Advocacy Group	29	2%	32	1%
Dept. of Corrections	14	1%	15	1%
Food/Clothing Agencies	10	1%	11	1%
Disability and Sp. Needs	19	1%	24	1%
Juvenile Justice	6	0%	8	0%
Employment Agencies	5	0%	5	0%

Patients may receive more than one referral



Crisis intervention follow up activity

Count of svcs with 2nd svc within 14 days

Excludes svcs resulting in psych hospitalization

Service Type	# of svcs	With F/U	% W F/U
On-site	532	87	16.4%
Telephonic	1118	248	22.2%
Telehealth	71	8	11.3%
Total	1,721	343	19.9%

CRISIS STABILIZATION UNITS AND TELEPSYCHIATRY FOR JAIL/EMERGENCY DEPARTMENT DIVERSON

CRISIS STABILIZATION UNITS

Tri-County Crisis Stabilization Center (TCSC)
(Charleston-Dorchester and Berkeley CMHCs)







CRISIS STABILIZATION DATA

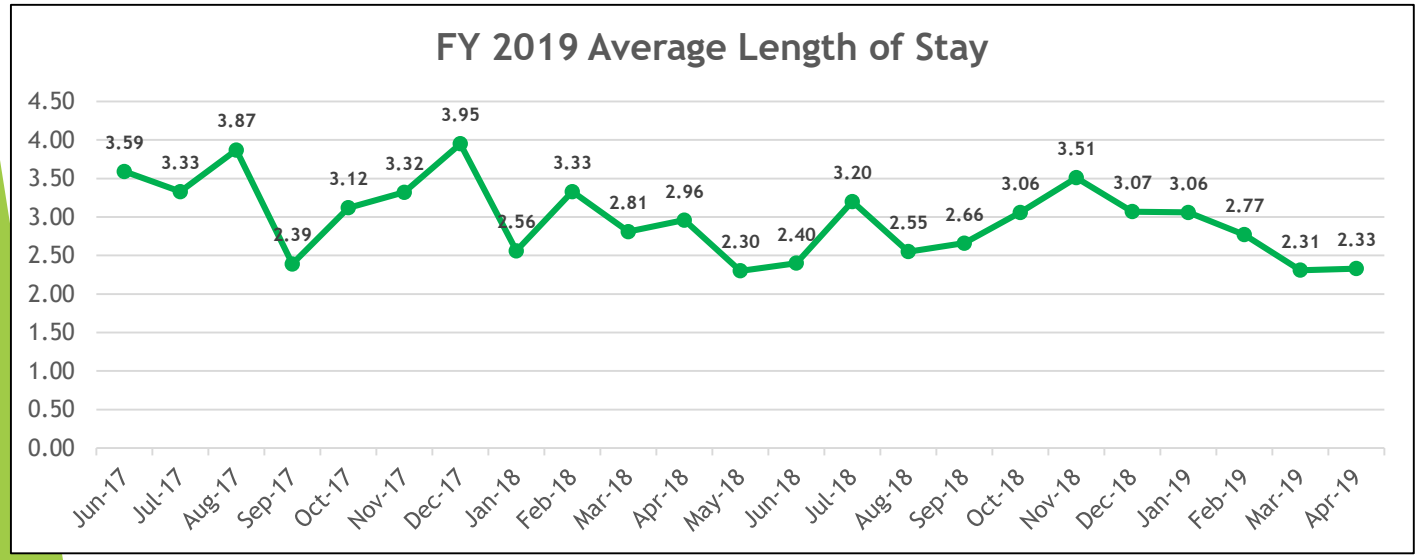
Tri-County Crisis Stabilization Center
(Charleston-Dorchester and Berkeley CMHCs)

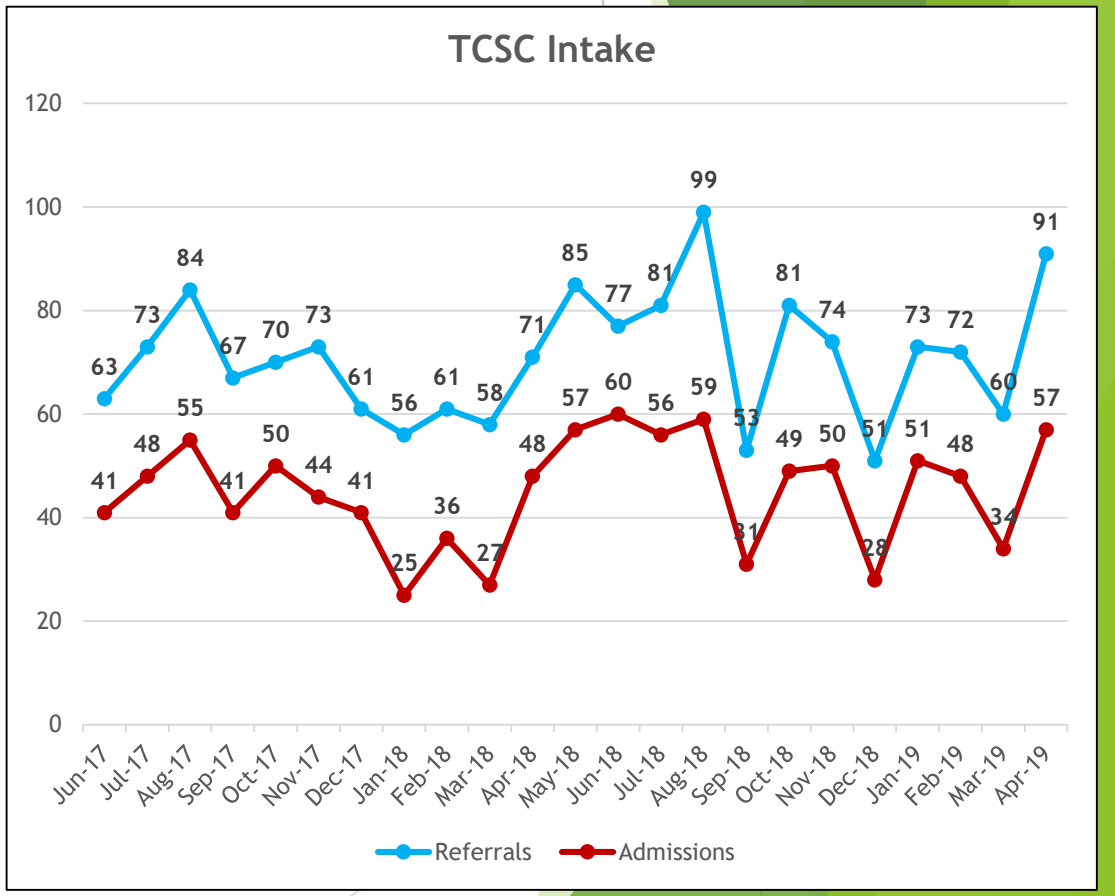
Tri-County Crisis Stabilization Center Data

June 5, 2017 to April 30, 2019

Time frame	Referrals	Admissions	Triage	Diversions		
				MH hosp	ED	Jail
6/5/17 to 4/30/19	1634	1036	124	987	365	20

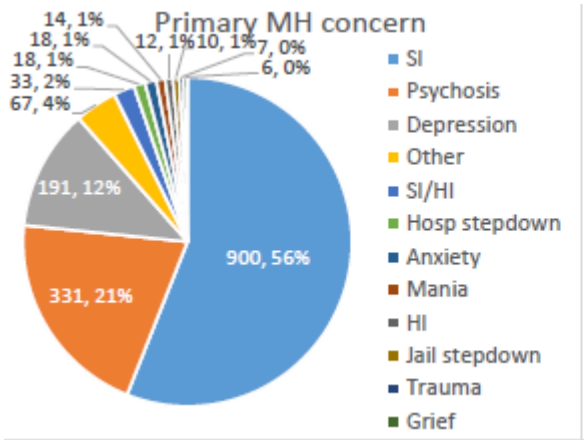
2.89	Avg length of stay
4.15	Avg daytime census

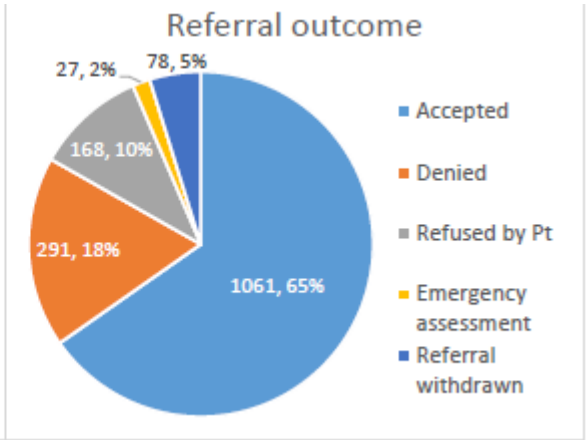


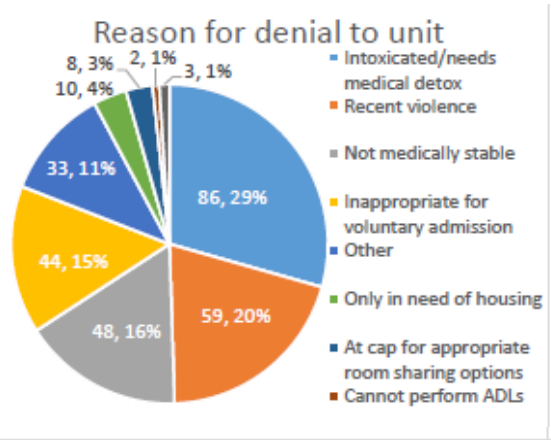


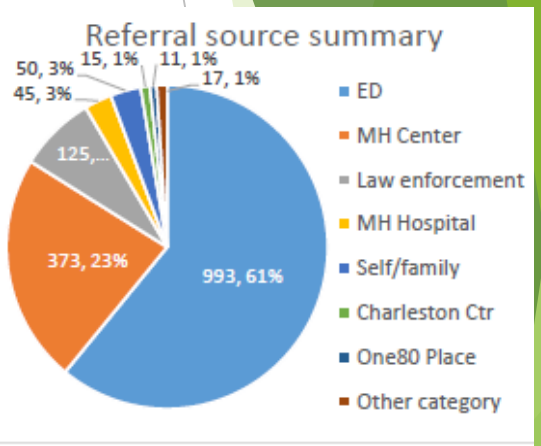
CRISIS STABILIZATION DATA

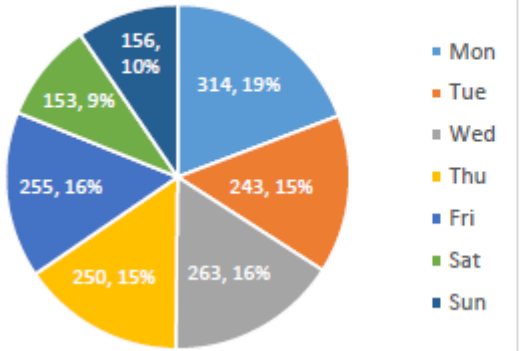
Tri-County Crisis Stabilization Center (Charleston-Dorchester and Berkeley CMHCs)

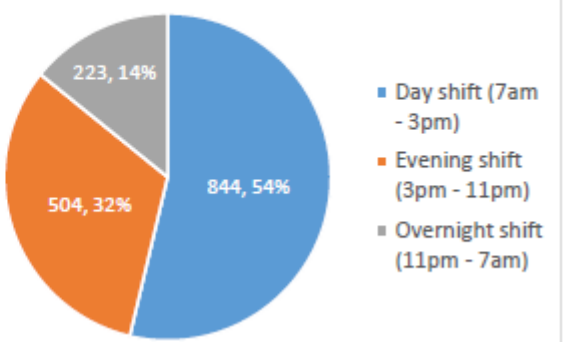


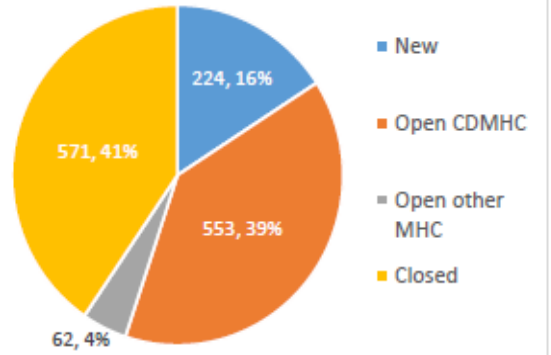


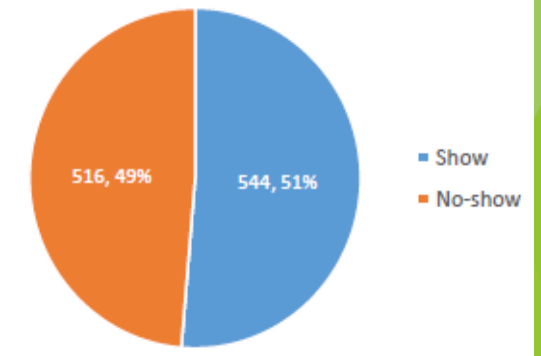






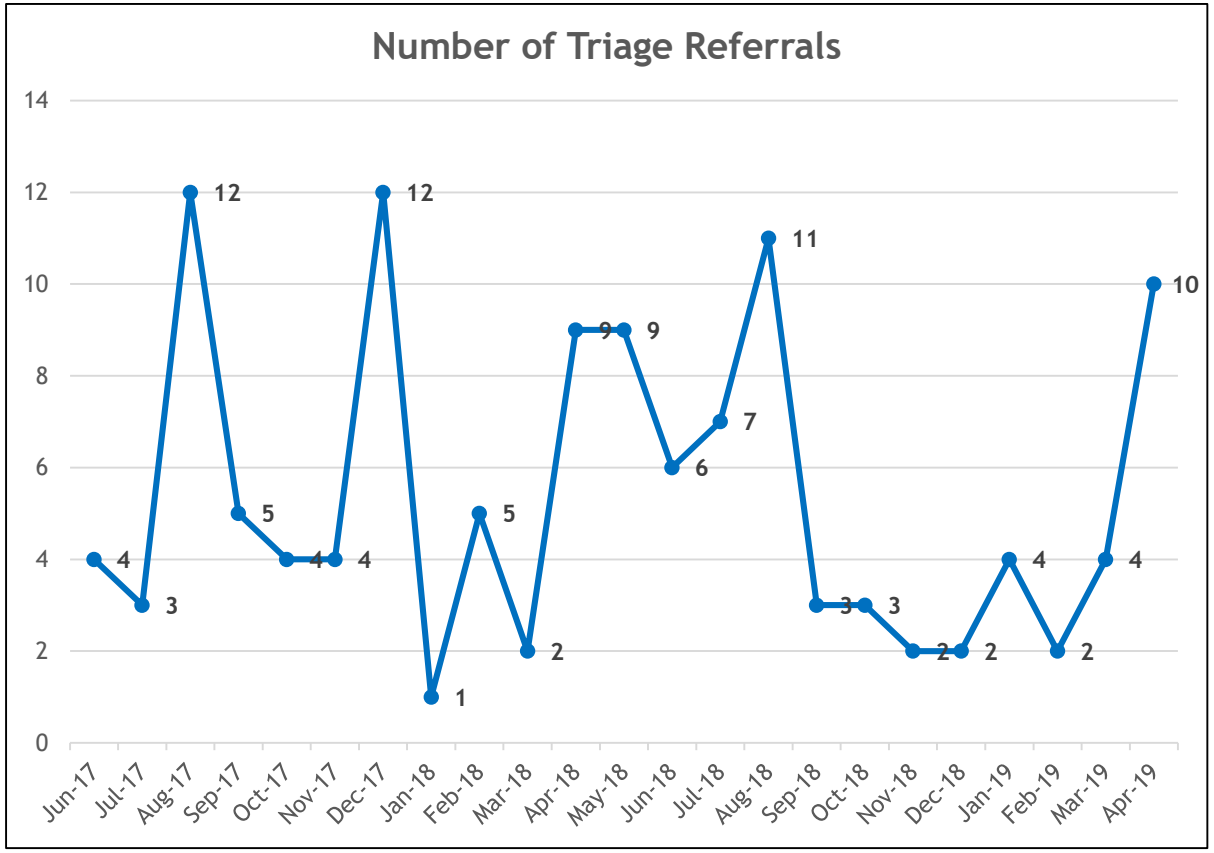


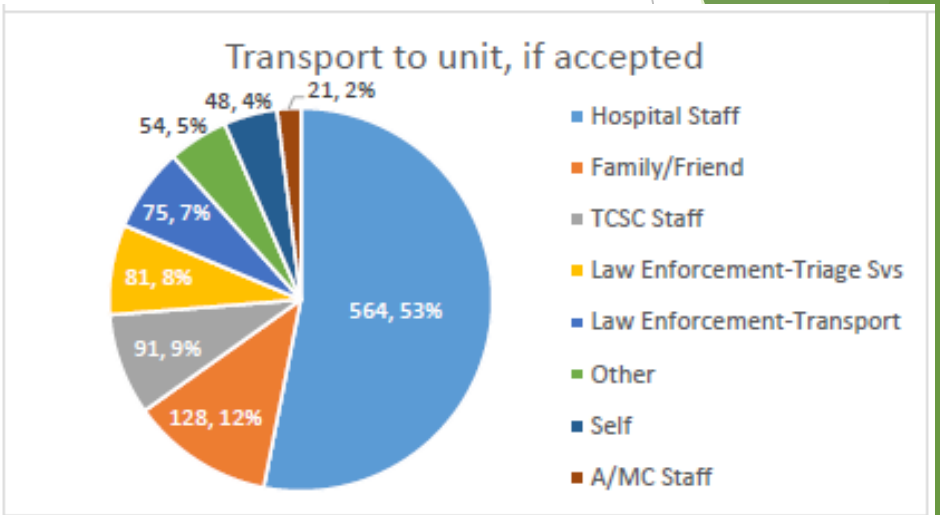


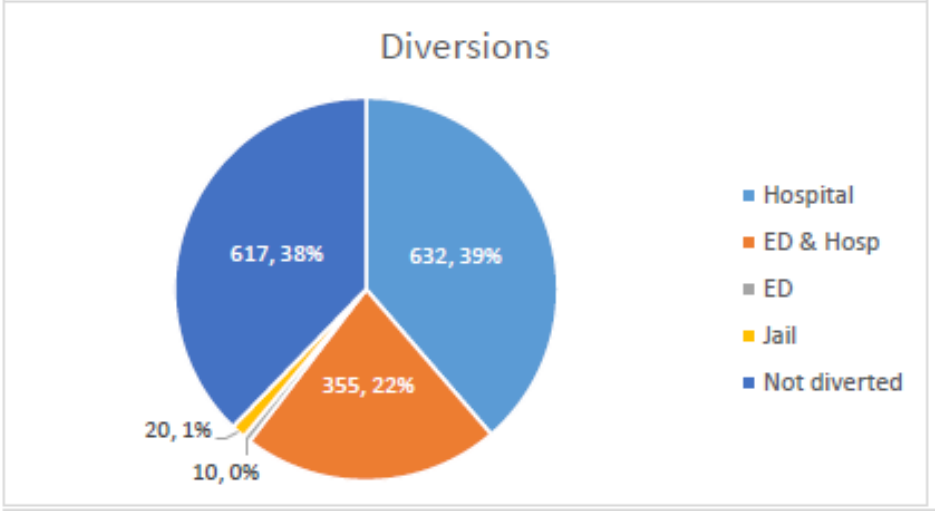


CRISIS STABILIZATION UNITS

Tri-County Crisis Stabilization Center (Charleston-Dorchester and Berkeley CMHCs)

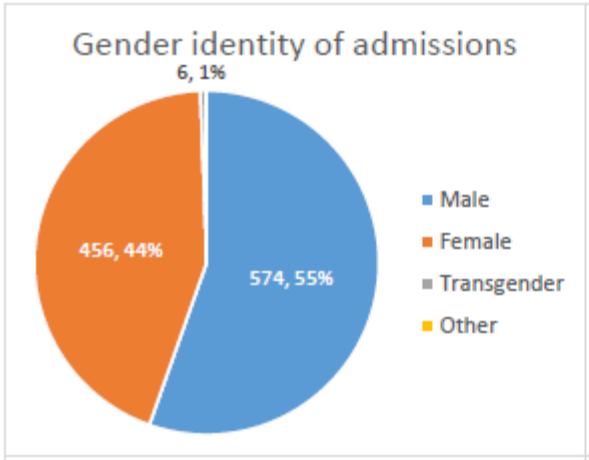


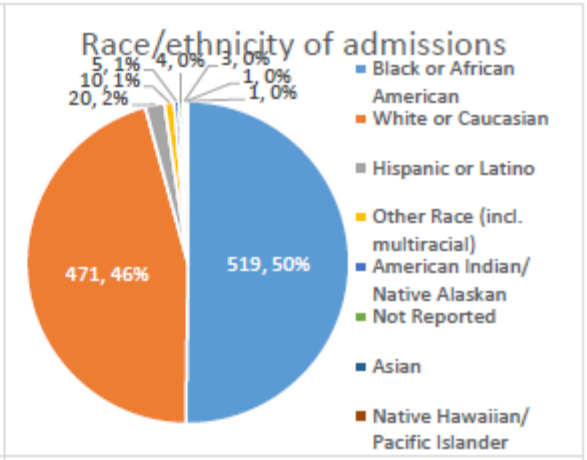


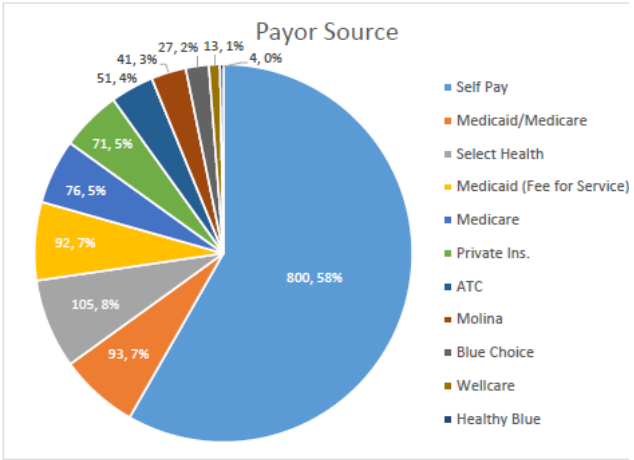


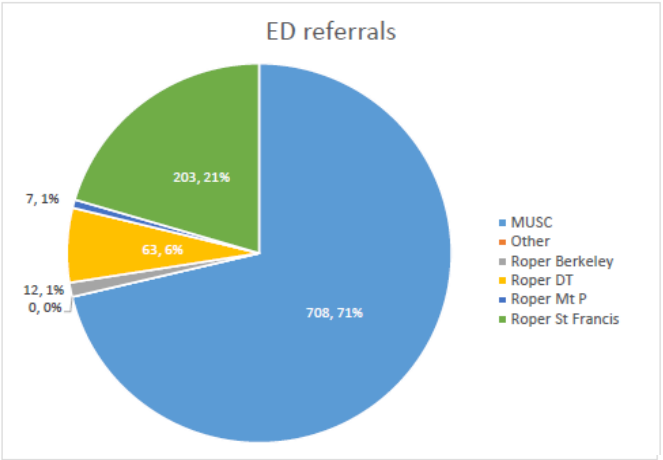
CRISIS STABILIZATION DATA

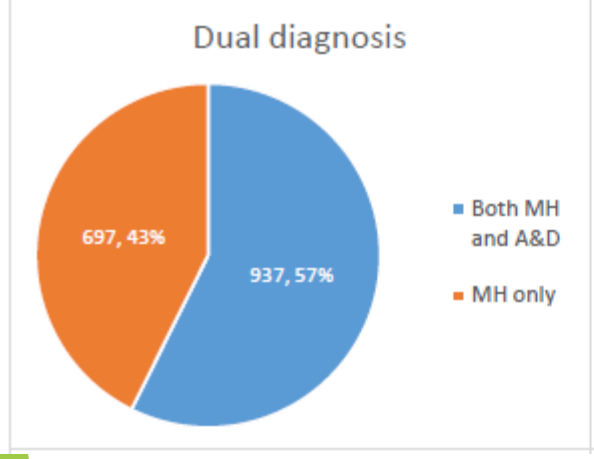
Tri-County Crisis Stabilization Center
(Charleston-Dorchester and Berkeley CMHCs)

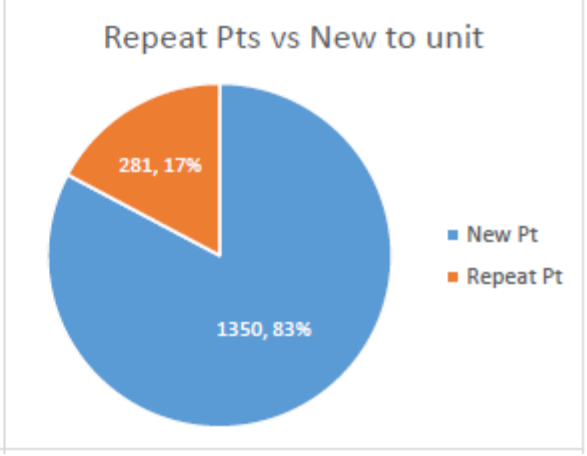


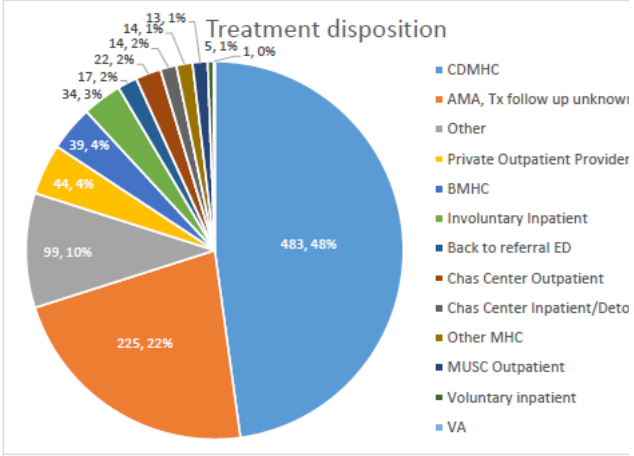


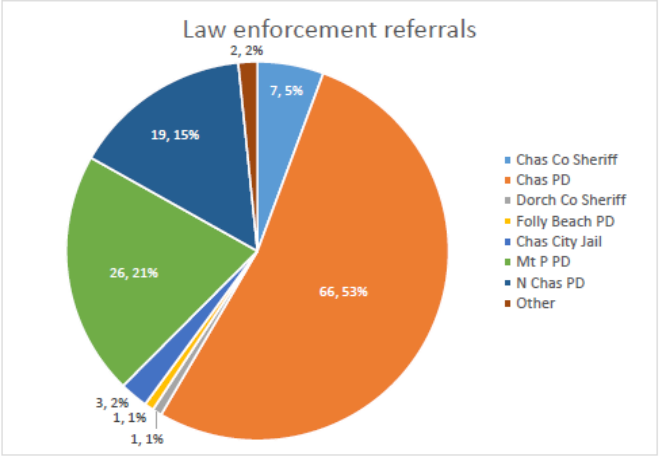








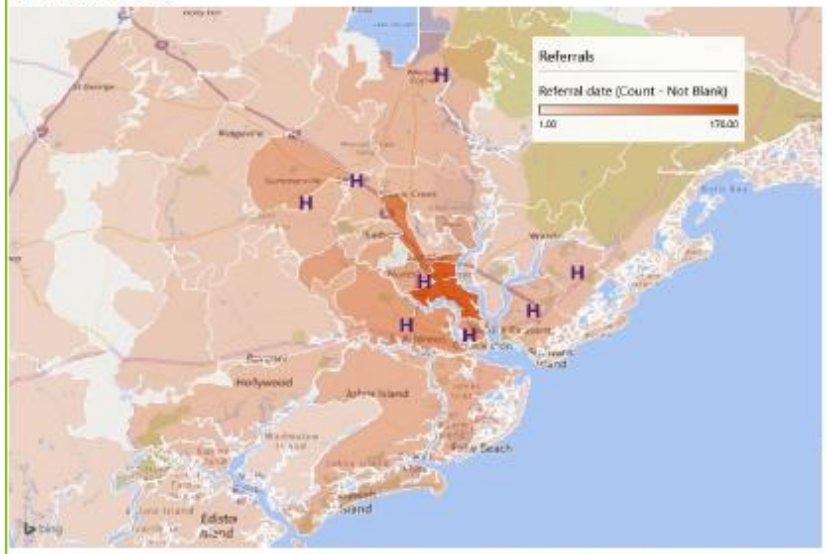




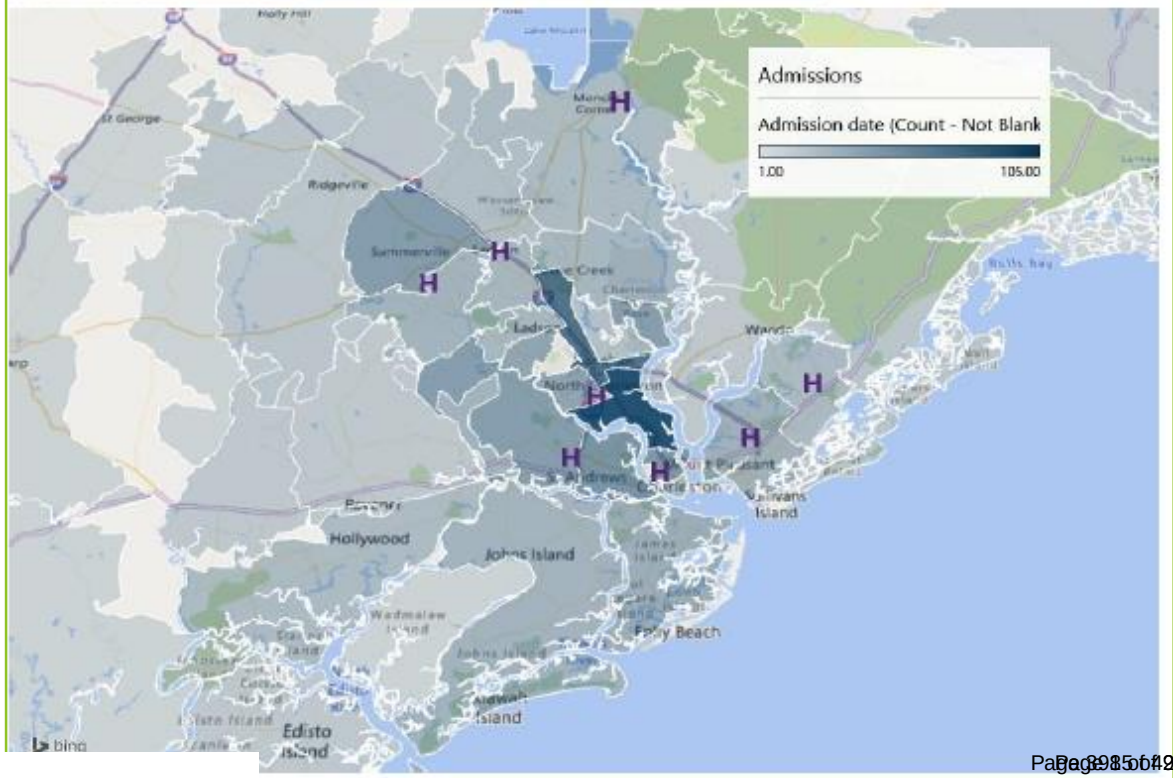
CRISIS STABILIZATION UNIT - PATIENT UTILIZATION MAP

Tri-County Crisis Stabilization Center (Charleston-Dorchester and Berkeley CMHCs)

Service area



Area of residence	Referrals	Admissions
Homeless	523	364
N Charleston	353	226
W Ashley	140	83
Summerville	92	66
Downtown	94	55
Mt Pleasant	46	31
Johns Island	35	18
James Island	40	24
Moncks Corn	29	12
Ladson	27	16
Goose Creek	24	15
Hollywood	19	12
Out of state	11	5



CRISIS COLLABORATION WITH THE CHARLESTON CENTER, A 301 ALCOHOL AND DRUG TREATMENT AGENCY – CO-LOCATED WITH THE TRI-COUNTY CRISIS STABILIZATION CENTER – TO OPEN SUMMER OF 2019





Charleston Center's Sobering Center

CRISIS STABILIZATION UNITS

Spartanburg's Ray C. Eubanks, Jr. Support Center – opened in October 2018



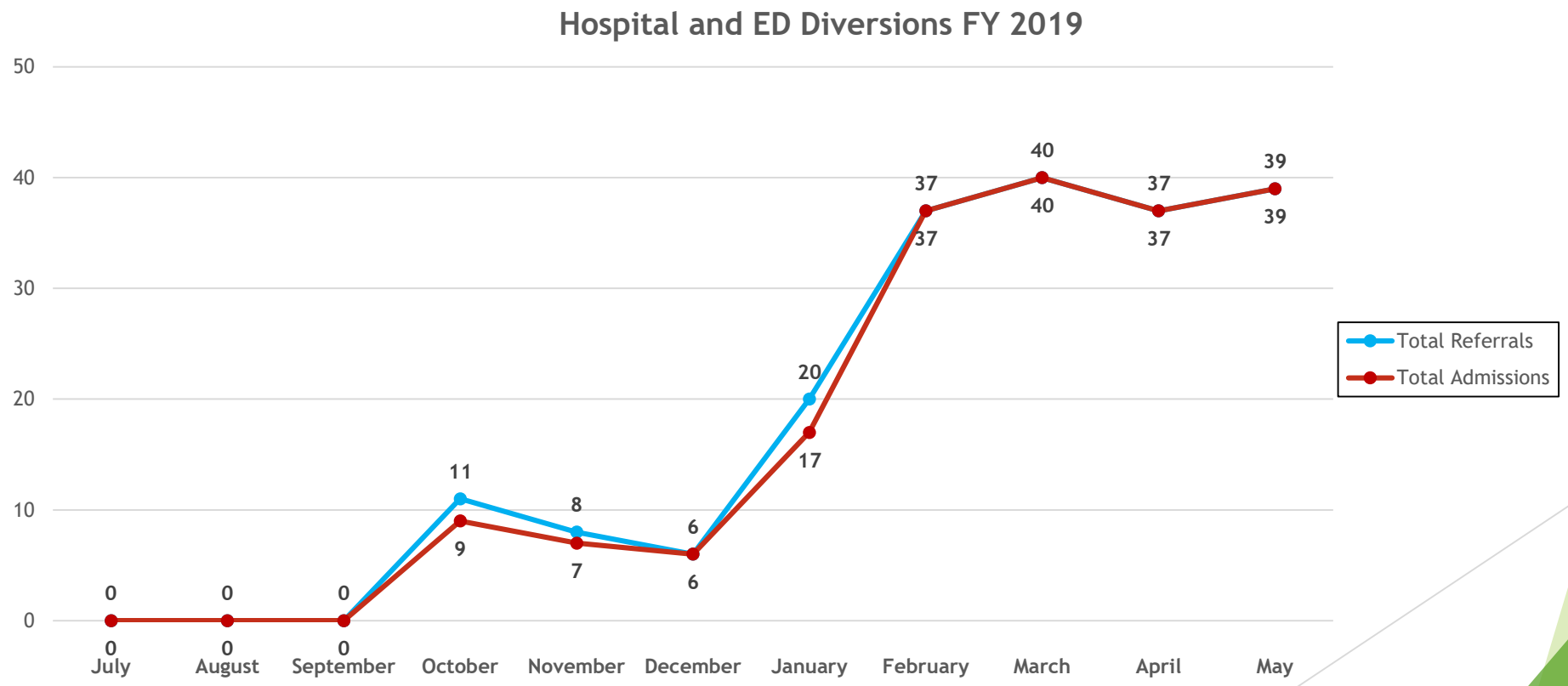


- Peer drop-in "living room" concept hospital diversion program
  - Provides individuals with mental illness an additional support system outside of clinical setting
  - 3 Peer Support Specialists, 2 clinicians, 1 part-time care coordinator
  - 44 individuals diverted from emergency room or hospital
- Housing subsidies
- Automated appointment reminder system
- IPS
- Advance Practice Registered Nurses
- ICT
- Intensive Family Support

CRISIS STABILIZATION UNITS

Eubanks Center
Spartanburg Area Mental Health Center
FY'19 YTD

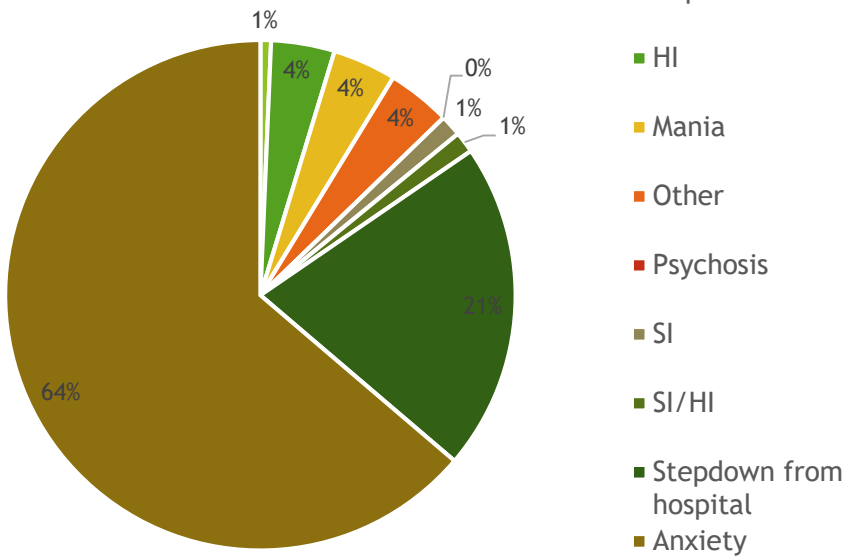
					Diversions from:			Patients	
	Referrals:	198			ED:	42		Unduplicated:	118
	Admissions:	192			Hospital:	32		Repeat Patients:	32



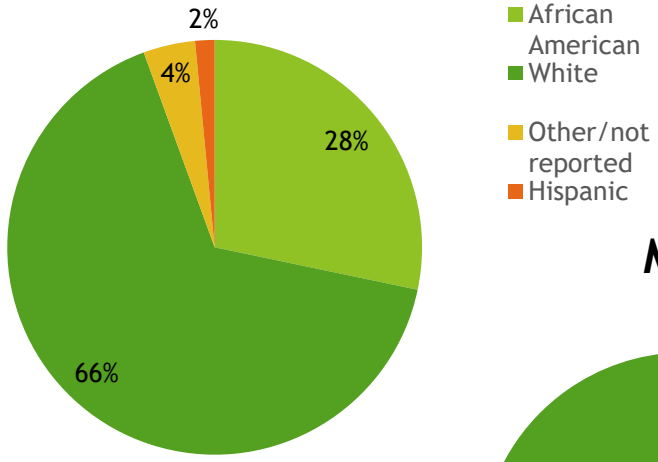
CRISIS STABILIZATION UNITS

Eubanks Center
Spartanburg Area Mental Health Center
FY'19 YTD

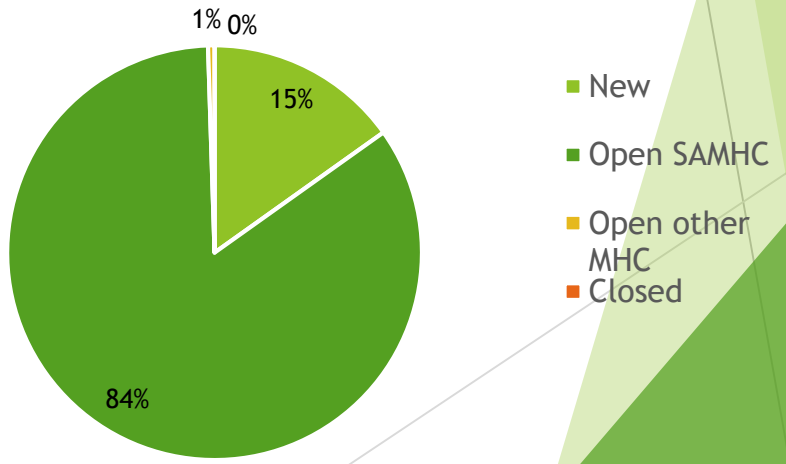
Reason for Referral



Race of referrals



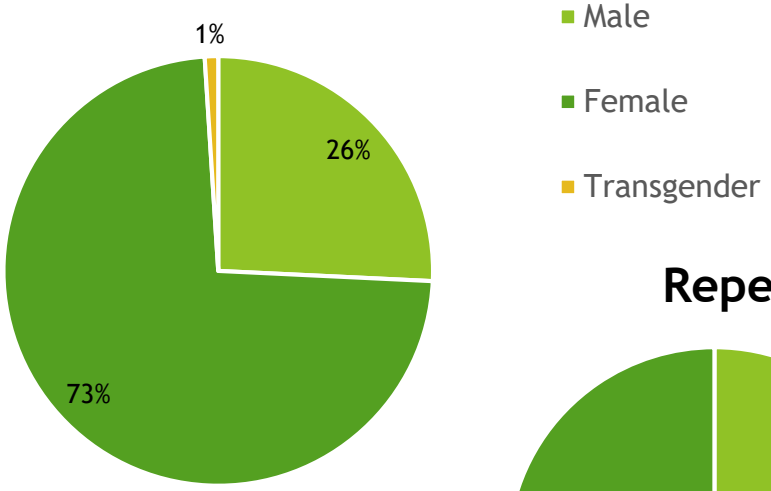
MH Center status



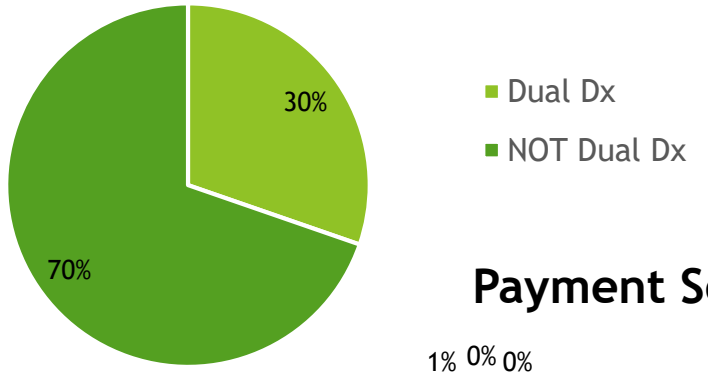
CRISIS STABILIZATION DATA

Eubanks Center
Spartanburg Area Mental Health Center
FY'19 YTD

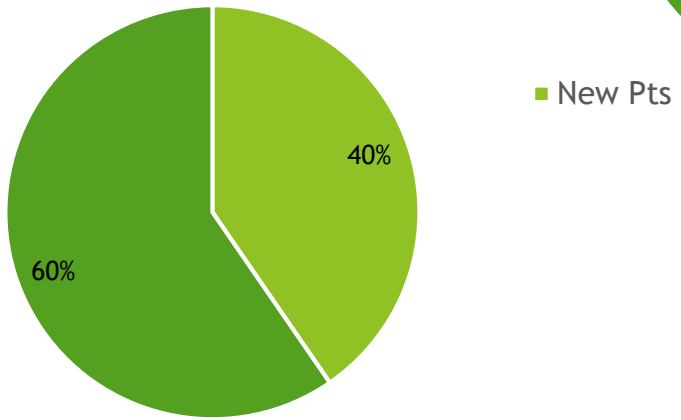
Gender of referrals



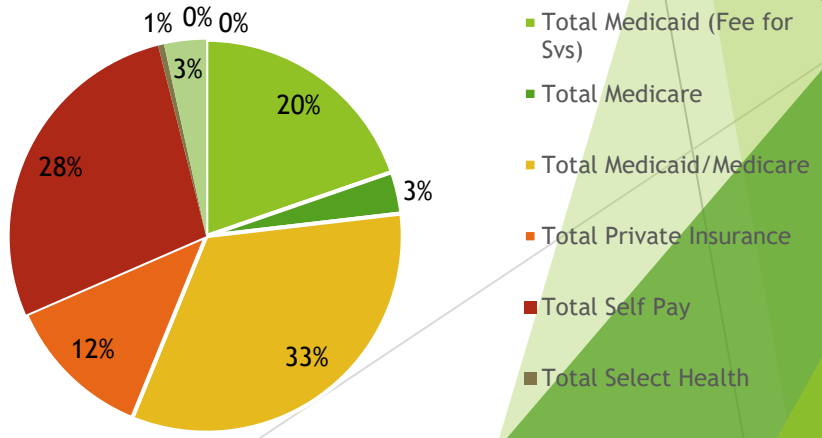
A & D and Mental Health Dx



Repeat Patients



Payment Source

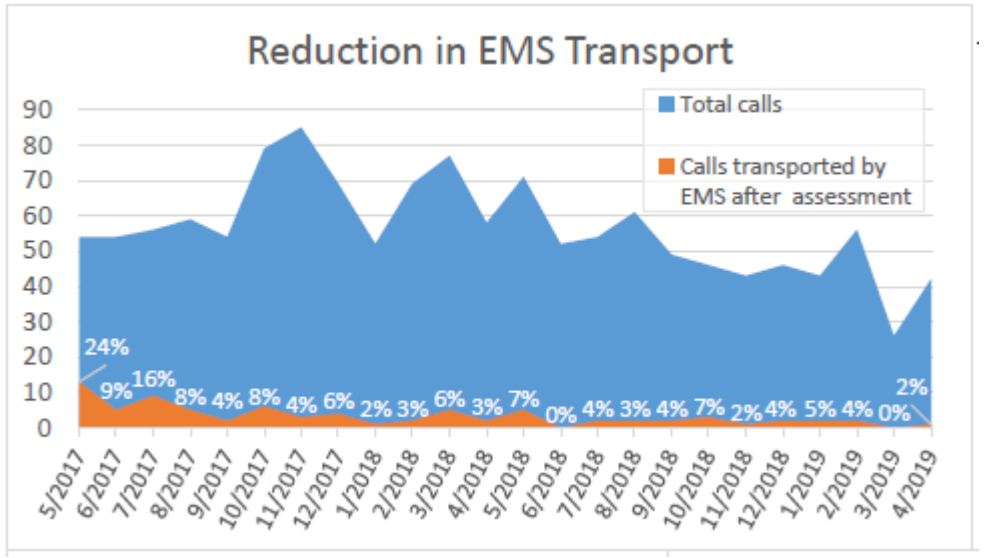


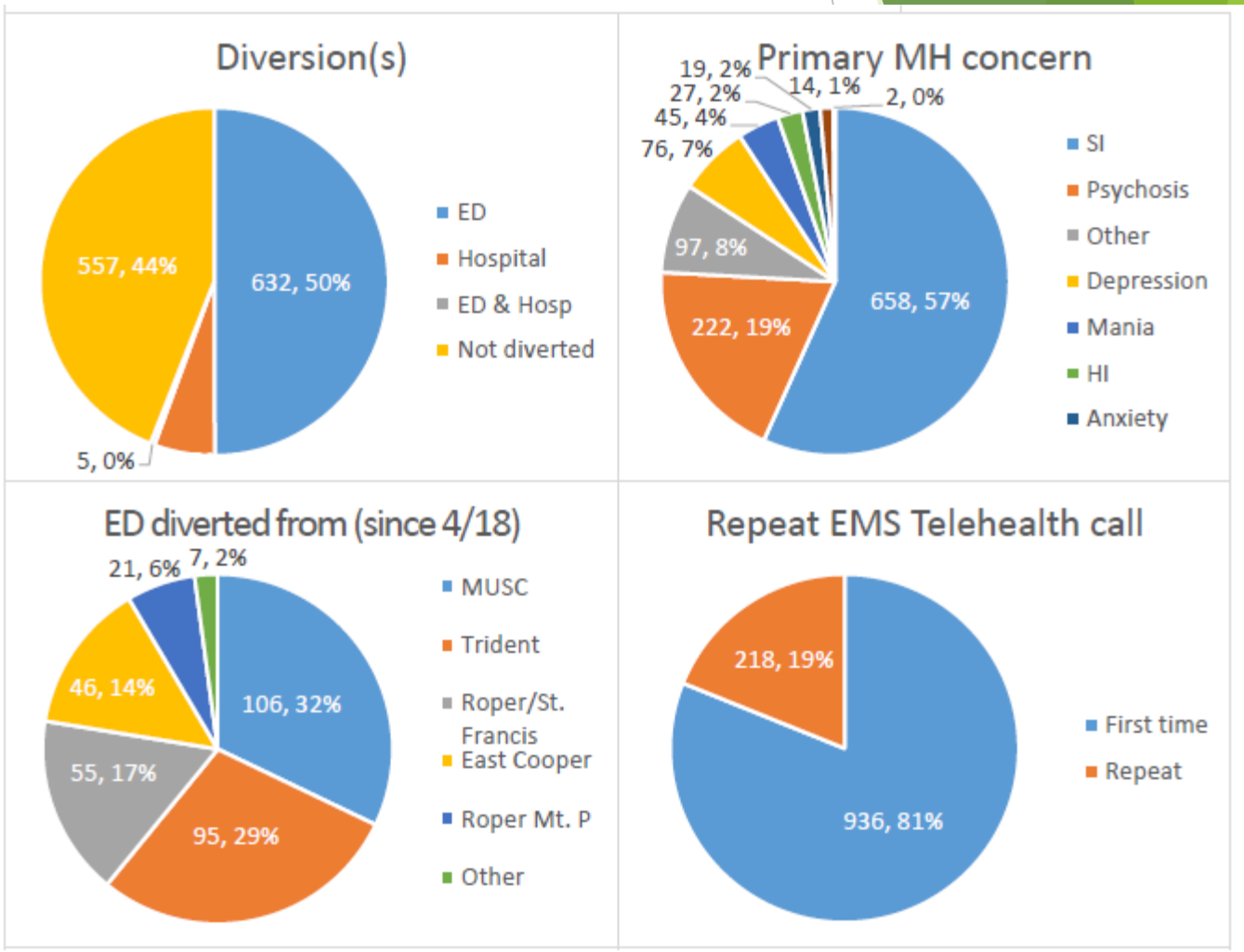
EMS/MOBILE CRISIS TELE-PSYCHIATRY EMERGENCY DEPARTMENT (ED) AND JAIL DIVERSION PROJECT



EMS/MOBILE CRISIS TELE-PSYCHIATRY ED/JAIL DIVERSION PROJECT

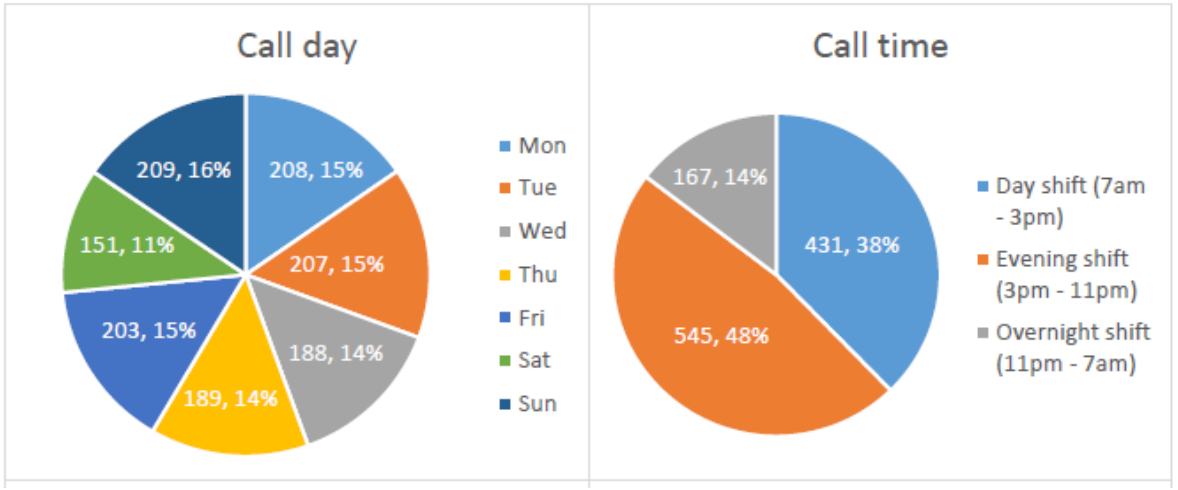
Charleston-Dorchester Mental Health Center

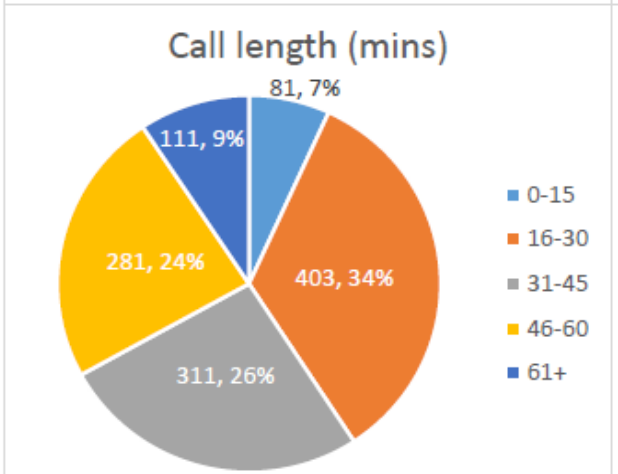


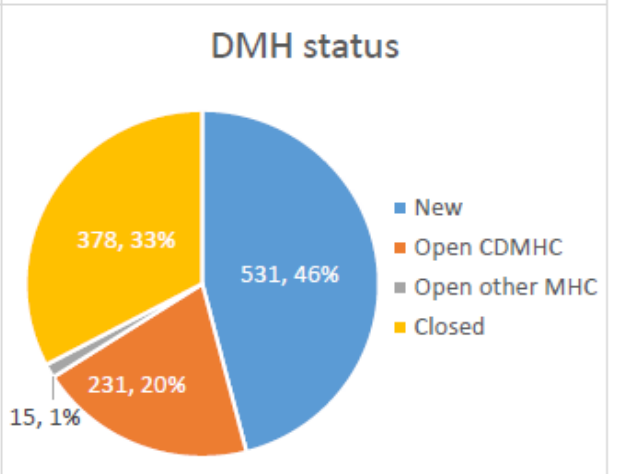


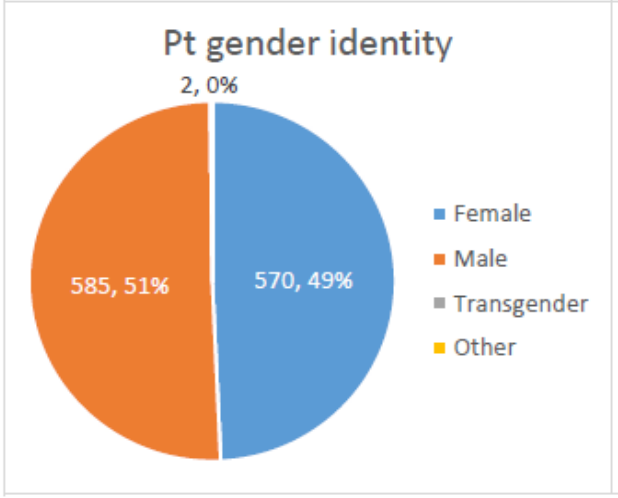
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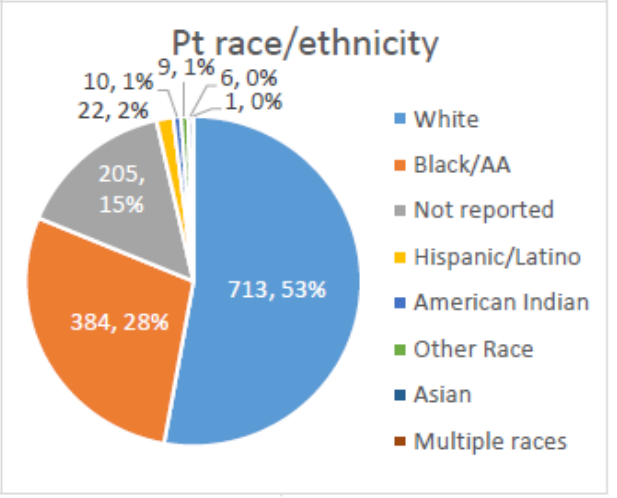
Charleston-Dorchester Mental Health Center





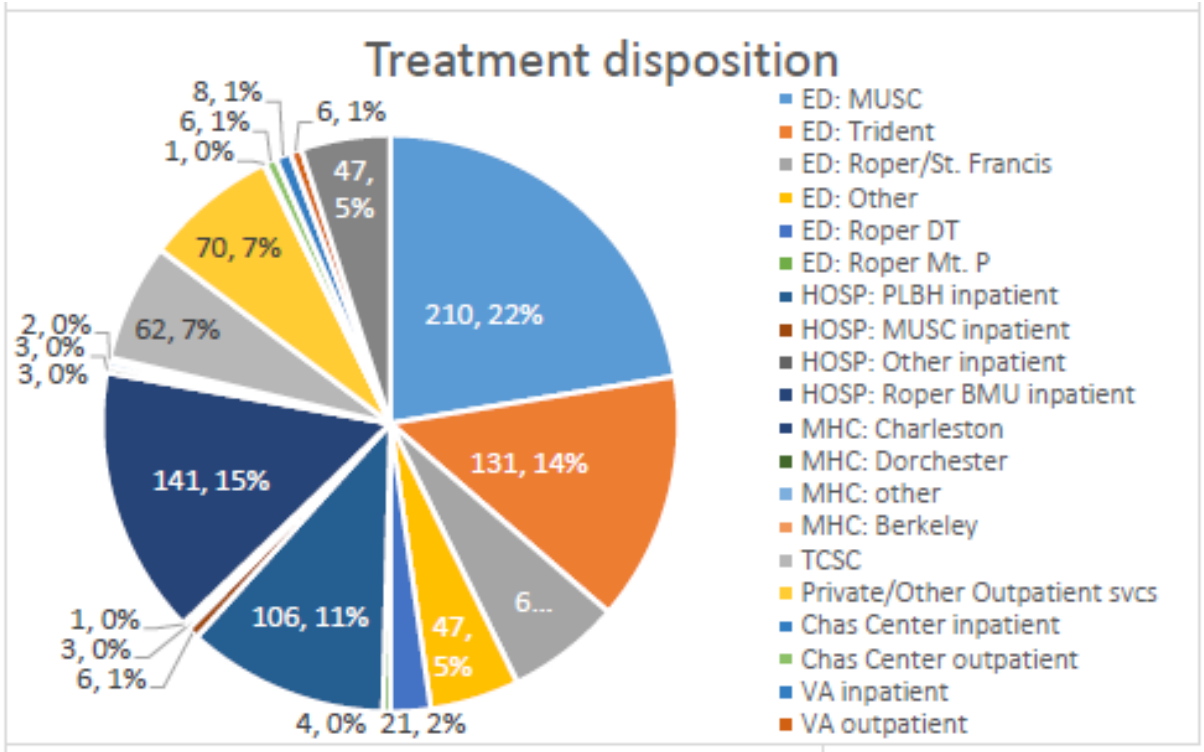


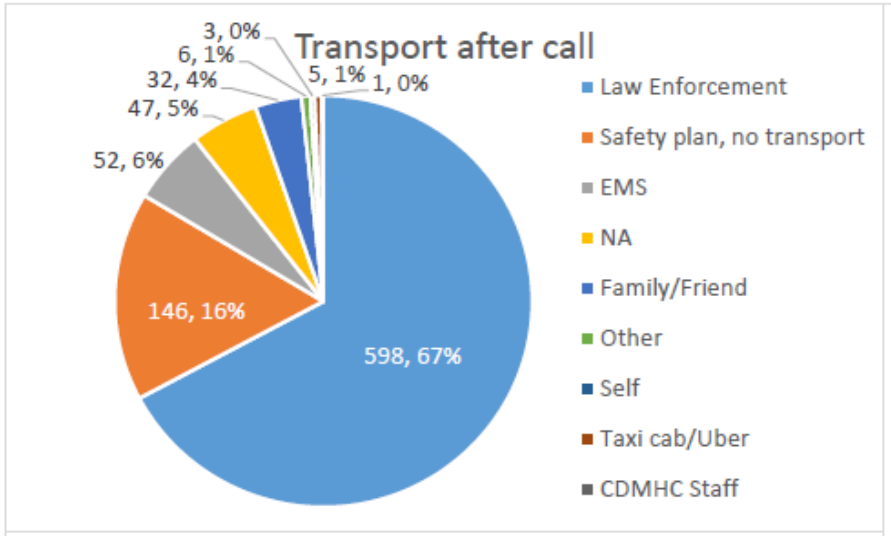


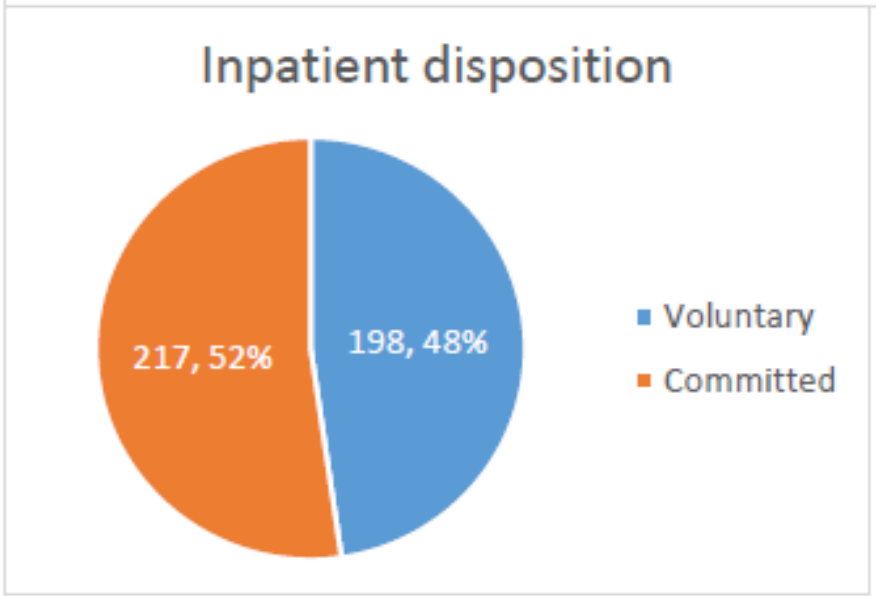


EMS/MOBILE CRISIS TELE-PSYCHIATRY ED/JAIL DIVERSION PROJECT

Charleston-Dorchester Mental Health Center







Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Block grant funding of recovery support services. (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

SCDMH partners with the local advocacy group SC SHARE to certify Peer Support Specialists for the state.

It is the mission of SCDMH to support Recovery Initiatives through the development of empowered patient leadership for persons served through the agency. SCDMH empowers patients by hiring them to be:
- planners
- policy makers
- program evaluators
- service providers

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Recovery is the process by which an individual overcomes the challenges of a mental illness to lead a life of meaning and purpose.

The South Carolina Department of Alcohol and Other Drug Abuse Services is the lead agency for recovery and recovery support services for individuals with substance use disorders in the state.

5. Does the state have any activities that it would like to highlight?

The SCDMH Art of Recovery project recognizes the talent of people who live with mental illnesses and the role that creative outlets like art can play in the recovery process. The project features artwork submitted by people who receive care through SCDMH programs and have been exhibited around the state.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

The Art of Recovery



The Art of Recovery showcases the talents of those receiving services from DMH and the role that art can play in the recovery process, and gives individuals living with mental illnesses the opportunity to exhibit and sell their works of art.

Pieces are submitted from across South Carolina by participants who use a variety of artistic media, not only as a means of empowerment, but also as a tool to educate the public about, and dispel the stigma associated with, mental illness.

DMH staff volunteers mat, frame, hang, transport, and display pieces in venues throughout the state. Works rotate on a frequent basis.

Pieces from The Art of Recovery have traveled across South Carolina, featured in public galleries, community centers, and conferences across the state. The program has been an official exhibitor at the Internationally known Piccolo-Spoleto Festival since 2013.

A widely acclaimed program, The Art of Recovery received the 2006 Elizabeth O'Neill Verner Governor's Award for the Arts, the highest Arts honor in South Carolina. It has received grant funding from Blue Cross Blue Shield of South Carolina and serves as a model for other mental health groups in the U.S.



Top: *Distance Sails*, Jeffrey Miller; Bottom: *Bluebird*, Allen Purvis

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	(•) Yes ( ) No
Home and community based services.	(•) Yes ( ) No
Peer support services.	(•) Yes ( ) No
Employment services.	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

The South Carolina Department of Mental Health is currently updating and revising its “Toward Local Care (Olmstead) Plan” with Protection and Advocacy for People with Disabilities of South Carolina. The Plan is to be finalized in September 2019.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

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Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? ( ) Yes (●) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

Through combined SAMHSA initiatives, the Joint Council on Children and Adolescents (JCCA) was formed to develop a coordinated system of care that promotes the provision of effective services and supports to children, adolescents and their families. The Council is made up of representatives of all child serving agencies and organizations with a major goal to integrate, thus avoid duplicative efforts and pool resources to improve the delivery system to children adolescents and their families. The Council works closely with the Legislative Committee on Children and the Behavioral Health Alliance of S.C.

7. Does the state have any activities related to this section that you would like to highlight?

State wide plan to integrate mental health professional into all schools by 2022.

The pooling of agency resource to improve the workforce to include state wide trauma informed training targeting school districts as well as community members.

The pooling of resources to provide trainings and an annual Cultural and Linguistic Summit targeting child serving agencies, providers and families.

The implementation of an integrated care model in an impoverished county lacking timely medical resources and high numbers of school disciplinary referrals. The model utilizes tele-health as well as tele-psychiatry resources to meet the needs using an integrated approach to care.

Building on a current SOC initiative involving three rural counties in S.C., a focus now exists to work collaboratively to meet the needs of transition age young adults.

Medicaid agency scheduled meetings to discuss data to target additional counties for system of care development.

Please indicate areas of technical assistance needed related to this section.

Engagement of Local Community Stakeholders

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

Our hope is with this multi-level approach, we are more likely to sustain our prevention efforts over time than any single-level intervention.

Our approach includes:
1.Working on building a suicide care pathway through the SCYSPI Zero Suicide Initiative at a systems-level with private partners (i.e., hospitals and private behavioral health providers), FQHC, and state agencies such as DMH and DAODAS, etc. on policy and procedure, trainings, coordinating the Statewide Suicide Prevention Coalition, and raising awareness and lowering stigma. (Socioecological model levels: structures/systems and organizational)

2.Working at regional levels within S.C. to help develop protocol and policies, provide trainings, develop resources guides, links and partnerships, and raising awareness through events and meetings. (Socioecological model levels: organizational, community, and structures/system levels)

3.Working with high-risk counties to implement a comprehensive community suicide prevention plan, including protocol and policy review and development; developing resources guides, links, and partnerships; coalition and capacity building; assisting with funding and resource applications; and raising awareness through events and meetings. (Socioecological model levels: organizational and community levels)

4.Using social marketing campaigns to raise awareness and lower stigma associated with mental illness and suicide prevention (Socioecological model levels: individual, interpersonal, and community levels)

For example: We have a comprehensive school suicide prevention program that collaborates with the local school district, Dep. of Education, and the local SCDMH school mental health program. We are working with the hospital association and local PCPs to incorporate a suicide care path and better referral system within our community to provide transition of care. We also provide comprehensive, evidence based practice trainings for prevention, intervention, and postvention of suicide. We provide support in building policy and procedure through systems of care and state agencies. We collaborate with the SC Child Fatalities review board. We are embedding Zero Suicide in all 16 Community Centers. We training law enforcement through the state.

These items were not part of the original work plan, but were part of Year 3 activities and will be included in the Year 4 work plan:
• We worked with SCDMH on the statewide suicide prevention policy and protocol with leadership buy-in. We were able to embed the Columbia-Suicide Severity Rating Scale (C-SSRS) in the initial clinical assessment as well as in all clinical notes. We have also included a child and an adult Collaborative Safety Plan within the Electronic Medical Records. We reviewed doctors' and nurses' documentation to include the C-SSRS at higher frequency, prompt safety plan, and crisis support plan. In 2018, the SCDMH clinical workforce began receiving Applied Suicide Intervention Skills Training (ASIST), Assessing and Managing Suicide Risk (AMSR), and Suicide 2 Hope training — which will be become mandatory training, replacing the current suicide prevention and intervention training for DMH statewide.
• Our ZERO Suicide Taskforce continues to meet monthly with various members of DMH, including a center director, a psychiatrist, various managers, therapists, and individuals with personal lived experiences with suicide.
• The ZERO Suicide initiative was presented to all 16 DMH Centers — including local leadership — across the state. We also begun providing technical assistance for behavioral and medical settings to initiate their own ZERO Suicide Taskforce.
• We are currently piloting a ZERO Suicide Initiative in the DMH Telepsychiatry program, the inpatient hospitals, and six community mental health centers (Spartanburg, Beckman, Berkley, Anderson-Oconee-Pickens, Lexington, and Santee-Wateree). The six

community centers are located in our high-risk priority areas.
• We developed a comprehensive school suicide prevention program that includes policy, procedure, and training. SCYSPI Team has been meeting with school districts across or throughout the state to review protocol, procedure, and potential training dates for administrators, teachers, nurses/clinical staff, parents, and student bodies. We are currently working in over 40 school districts.
• SCYSPI continues to collaborate with and provide regional trainings for the South Carolina Foster Care Parents Association. Currently, the partnership is looking to sustain and make the training mandatory for the duration of and after the grant life.
• SCYSPI collaborated with the Department of Juvenile Justice to create protocol and procedure and conducted an LGBT Youth and Suicide Prevention training for staff.
• The SCYSPI program director conducted a meeting with DSS to introduce incorporating LGBT suicide prevention training for foster parents.
• SCYSPI received carryover funds for Year 2 and was able to provide a ZERO Suicide Academy, LivingWorks Applied Suicide Intervention Skills Training (ASIST) training for Trainers (T4T) course for the Criminal Justice Academy and Connect Suicide Postvention training for Trainers (T4T) course.
• SCYSPI is collaborating with the National Guard to provide the Applied Suicide Intervention Skills Training (ASIST), a two-day interactive workshop in suicide First Aid. ASIST teaches participants to recognize when someone might have thoughts of suicide and work with them to create a plan that will help ensure their immediate safety. Although ASIST is widely used by healthcare providers, participants don't need any formal training to attend the workshop — anyone 16 or older can learn and use the ASIST model.
• Collaborated with the Criminal Justice Academy to have law enforcement trained as trainers in suicide prevention.
• A significant accomplishment in Year III the State Suicide Prevention Coalition. This accomplishment is largely attributed to the partnership between SC YSPI/SC DMH and AFSP SC. We committed ourselves to not only relaunch the Coalition but significantly improve it by recruiting/existing representatives who possessed the ability to make decisions and influence change. These change agents will expand the reach of the Coalition, the grant, and the capacity to save lives in South Carolina. The State Director of the SC Department of Mental Health is to be commended for stepping forward as the chair to establish credence and commitment. The Director of the SC YSPI and the AFSP SC Area Director presented at each quarterly meeting to keep members focused and building their respective knowledge bases. Sustainability is key, and this Coalition will be charged with looking forward so that our efforts are not in vain and continue to bear fruit for years to come.
• SCYSPI Youth Advisory Board. This year, our youth advisory board has given us solid feedback for how to improve our suicide prevention messaging they have impacted in the community and have developed a sustainable, youth-led structure that provides freedom for change and growth. The board meets once a month, with the date and time chosen by board members. As the liaison, Brandon Parker's role is to guide them in making decisions, not to be a teacher or group leader. He acted as a facilitator for a while, until they developed a solid leadership structure during the summer. The chair that they chose is now the facilitator, and she determines the content of the meetings, with minor input from Brandon. Who allows youth on the board to make as many decisions as possible about group leadership and responsibilities, meeting topics, and future plans.

One of the main goals of the board is to empower youth; we want them to feel like their voice matters. A couple of meetings this year were dedicated to developing a solid leadership structure, what the leadership will consist of, elect which youth will hold positions, and their responsibilities. We wish for input from the group about what they are going through and how we can help, so empowering them to choose their own leadership gives them the courage to not only tell us what we can be doing, but to give them the skills and confidence that they can use to make changes in their communities. All of our social media strategies and campaigns have been developed with input from the board. Youth understand social media very well, and we used that input to great success in increasing the reach of our suicide prevention messaging. One reason for why social media suicide prevention messaging is difficult when trying to reach youth is older generations we did not grow up with social media. Social media has been around for about 15 years now, which means that many youth have had it for some of, if not most of, and their lives. We cannot relate to that experience, which is why we need youth to give us input about how they use social media. One of the reasons our social media messaging has been successful is because of this input. Having this input is also valuable for answering questions we have about other ways to reach youth.

3. Have you incorporated any strategies supportive of Zero Suicide? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? (●) Yes ( ) No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted? (●) Yes ( ) No

If so, please describe the population targeted.

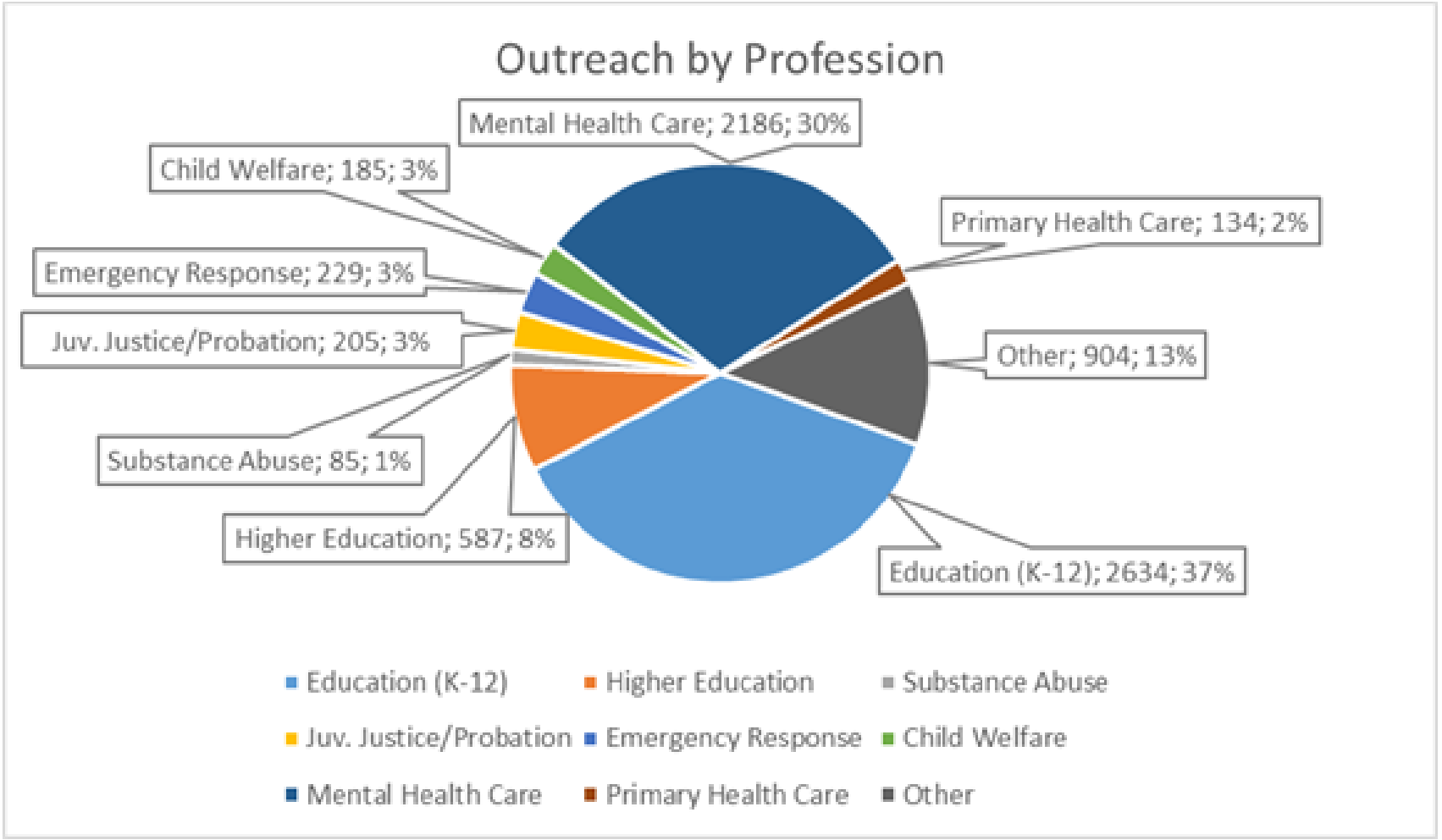
People living with SMI, incarcerated populations, and youth and young adults, and gender and sexual minority groups.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

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Footnotes:


Outreach by Profession
Mental Health Care; 2186; 30%
Child Welfare; 185; 3%
Primary Health Care; 134; 2%
Emergency Response; 229; 3%
Juv. Justice/Probation; 205; 3%
Other; 904; 13%
Substance Abuse; 85; 1%
Higher Education; 587; 8%
Education (K-12); 2634; 37%
Education (K-12)
Higher Education
Substance Abuse
Juv. Justice/Probation
Emergency Response
Child Welfare
Mental Health Care
Primary Health Care
Other



South Carolina Strategy for Suicide Prevention

2018-2025

Data, strategies, resources, and language contained in this document were aggregated from materials produced by numerous accredited suicide prevention authorities, including but not limited to:

The Substance Abuse and Mental Health Services Administration (SAMHSA)

The Centers for Disease Control and Prevention (CDC) The Suicide Prevention Resource Center (SPRC)

The American Association of Suicidology (AAS) The American Foundation for Suicide Prevention (AFSP)

Other Garrett Lee Smith Memorial Grant Program (GLS) suicide prevention plans

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Layout designed by Rob Cottingham, Suicide Prevention Coordinator

Photos donated by numerous photographers, whose names are listed at the end of this document.

Graphic charts courtesy of the Centers for Disease Control and Prevention's Web-based Injury Statistics Query and Reporting System; Centers for Disease Control and Prevention's *Vital Signs* publication

Special thanks go to Helen Pridgen, Director of the American Foundation for Suicide Prevention-SC Chapter; John Magill, Director of the South Carolina Department of Mental Health; Tinotenda Martin, SCYSPI Administrator; Taylor Davis, Ed. S, NBCC, LPC-A – SCYSPI Suicide Prevention Program Coordinator; Brandon Parker, SCYSPI Marketing Coordinator; and the entire S.C. Suicide Prevention Coalition.

This document is dedicated
to the people of South Carolina.

Every image contained within was either
a free-use photo or donated, and selected
to represent each county of our beautiful state.

Brookgreen Gardens
Georgetown County



While I breathe, I hope

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Abbeville Court Square
Abbeville County





A letter from the S.C. Suicide Prevention Coalition Chair

John H. Magill

Director of the S.C. Department of Mental Health

Dear Citizens of South Carolina,

During the last two years, leaders from across the state have come together to develop a better understanding of suicide and its impact on South Carolinians.

This group, known as the South Carolina Suicide Prevention Coalition, has been invested in creating hope and decreasing suicide rates. These individuals have been working diligently to present information and guidance about suicide in the Palmetto State.

Suicide is currently the second-leading cause of death for South Carolinians aged 10 to 35, and it affects every county within our state's borders.

The Coalition's goal is to develop broad-based support for suicide prevention, reduce stigma, advocate for change in policies and practices, and raise awareness about suicide — a preventable death.

This is a living document, preliminary in nature, that will continue to be updated with resources, research, and strategies, on an annual basis.

We want citizens, professionals and organizations to share this mission and effort in promoting health and improving safety in South Carolina.

It has been an honor and a privilege to serve as Chair of the South Carolina Suicide Prevention Coalition, a group of determined and compassionate individuals whose efforts I know will save lives.

Sincerely,

John. H. Magill
State Director
South Carolina Department of Mental Health

Members of the South Carolina Suicide Prevention Coalition

"Committed to reducing suicide rates in our state by 20% by 2025."

John H. Magill
South Carolina Department of Mental Health
State Director and South Carolina Suicide Prevention Coalition Chair

Helen Pridgen
American Foundation for Suicide Prevention
SC Chapter Director

Dr. Alexandra Karydi
South Carolina Department of Mental Health
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Dr. Meera Narasimhan
University of South Carolina School of Medicine
Associate Provost for Health Sciences
in the Department of Neuropsychiatry and Behavioral Sciences

Rep. Shannon Erickson
South Carolina State House District 124

Sen. Katrina Shealy
South Carolina State Senate District 23

Thornton Kirby
South Carolina Hospital Association
President and CEO

Judge Amy McCulloch
Richland County Probate Court Justice

Dr. Kevin Gray
Medical University of South Carolina
Associate Professor of Psychiatry and Behavioral Services
and Director of Child and Adolescent Psychiatry

COL. Ronald Taylor
South Carolina National Guard
Chief of Staff

SFC Christopher Allen
South Carolina National Guard
Suicide Prevention Program Manager

Molly Spearman
South Carolina Department of Education
State Superintendent of Education

Dr. Sabrina Moore
South Carolina Department of Education
Director of the Office of Student Intervention Services

Dr. Jim Hayes
National Alliance on Mental Illness - South Carolina
Board President

Michael Cunningham
AnMed Health
Vice President of Advancement



Aiken Horse Track
Aiken County

Members of the South Carolina Suicide Prevention Coalition

"Committed to reducing suicide rates in our state by 20% by 2025."

Dr. Shawn Stinson
Blue Cross Blue Shield of South Carolina
Senior Vice President of Healthcare Innovation and Improvement

Stacy Warren
The Duke Endowment
Program Officer

Dr. Pete Liggett
South Carolina Department of Health and Human Services
Deputy Director of Long Term Care and Behavioral Health

Alisa Liggett
University of South Carolina
Executive Director of Academic Integrity & Behavioral Intervention in the Office of Student Conduct

Jeff Schilz
South Carolina Commission for Higher Education
President and Executive Director

Dr. Robert Breen
South Carolina Department of Mental Health
Medical Director of Acute Services at Bryan Psychiatric Hospital

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

Amanda Adler
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Senior Resource Attorney at the Children's Law Center

Dr. Peter Warren
William Jennings Bryan Dorn Veterans Affairs Medical Center
Suicide Prevention Coordinator

Jane B. Simpson
Chair of the South Carolina Mental Health State Planning Council

Dr. Kathryn Cristaldi
Medical University of South Carolina Children's Hospital
Medical Director for School Based Health
and Assistant Professor in the Division of General Pediatrics

Susan Jackson
South Carolina Department of Environmental Health and Control
Division of Injury & Violence Prevention
SC Violent Death Reporting System

Kacey Schmitt
South Carolina Department of Environmental Health and Control
Director of Social Work
Community Health Services



There are people in this state who possess hearts with immeasurable compassion; heroes who take it upon themselves to ease the minds and shoulder the burdens of their fellow South Carolinians. The men, women, and children of our state need these champions, now.

Shall we count you among them?

Join the fight against suicide in the Palmetto State.

Suicide is a public health issue in South Carolina, but research indicates these deaths are preventable so long as members within a wide range of communities embrace their roles in a unified effort. We can fight suicide by creating suicide care pathways throughout our communities, state agencies, and organizations serving youth and adults that are evidence-based, data-driven, and collaborative in nature.

The details of this plan address what we can do on individual, interpersonal, community and societal levels to ensure that those among us struggling with suicidal thoughts feel safe to discuss their worries and illnesses openly, are encouraged to seek the help they need, have access to quality mental and physical health care, and are protected by their friends, families and peers as they valiantly pursue recovery.



Hartwell Dam
Anderson County

Continuity of Care

Following through on promises to our state

Suicide has been a topic of great concern to the State of South Carolina for quite some time, and the developments in recent years have only strengthened leadership's resolve to find solutions for a growing problem in our state.

In 2004, South Carolina's first Suicide Prevention Plan was released through the S.C. Department of Health and Environmental Control.

Using data from the South Carolina Violent Death Reporting System, the Plan was updated in 2010 under the guidance of the State Suicide Prevention Coalition to reflect current statistics and goals. (You may view the 2010 plan at *www.sprc.org/states/south-carolina*).

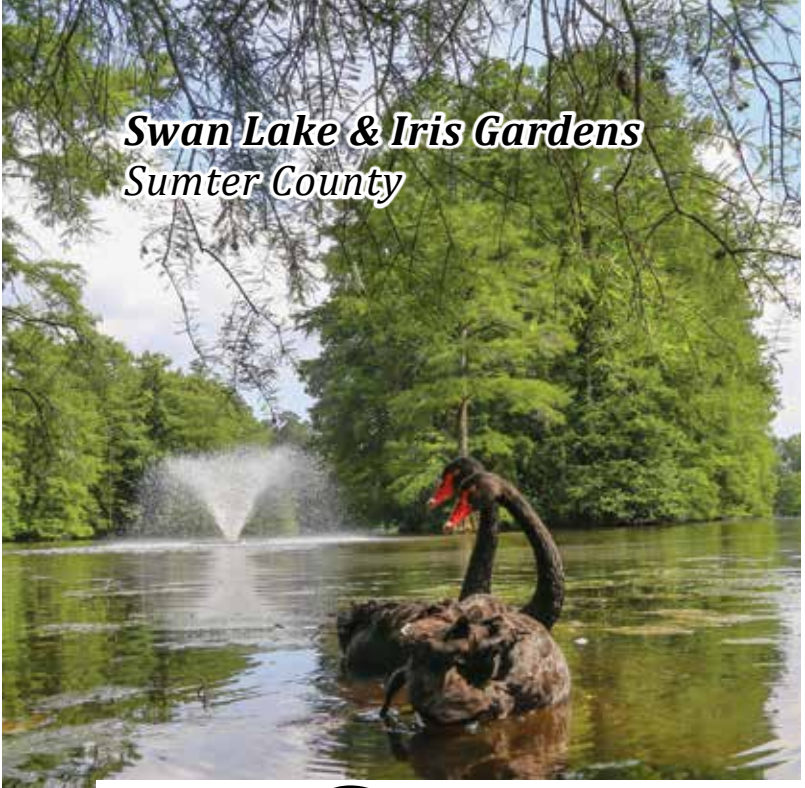
The Coalition was effectively relaunched in December 2016 to identify the Palmetto State's strengths and needs in suicide prevention, intervention, and postvention across the lifespan. The relaunch of the Coalition includes leadership and experts from state agencies (such as the Department of Mental Health and the Department of Health and Environmental Control), concerned members of the S.C. Legislature, and key community stakeholders, such as American Foundation for Suicide Prevention – SC Chapter (AFSP SC), Mental Health America of S.C. (MHA SC), and National Alliance on Mental Illness S.C. (NAMI SC), who also lead and collaborate on other suicide prevention efforts across the state.

In September 2015, the S.C. Department of Mental Health was awarded a federal Garrett Lee Smith Memorial grant to fund the S.C. Youth Suicide Prevention Initiative (SCYSPI). This initiative is an intensive, community-based effort with a goal of reducing suicide among South Carolina's youth and young adults aged 10-24 by 20% by 2025, a goal adopted from AFSP's Project 2025 (*afsp.org/project2025*). An additional goal for SCYSPI is to screen at least 30,000 youth and young adults for suicide risk and mental health needs during the next five years. For more information, visit *scyspi.org*.

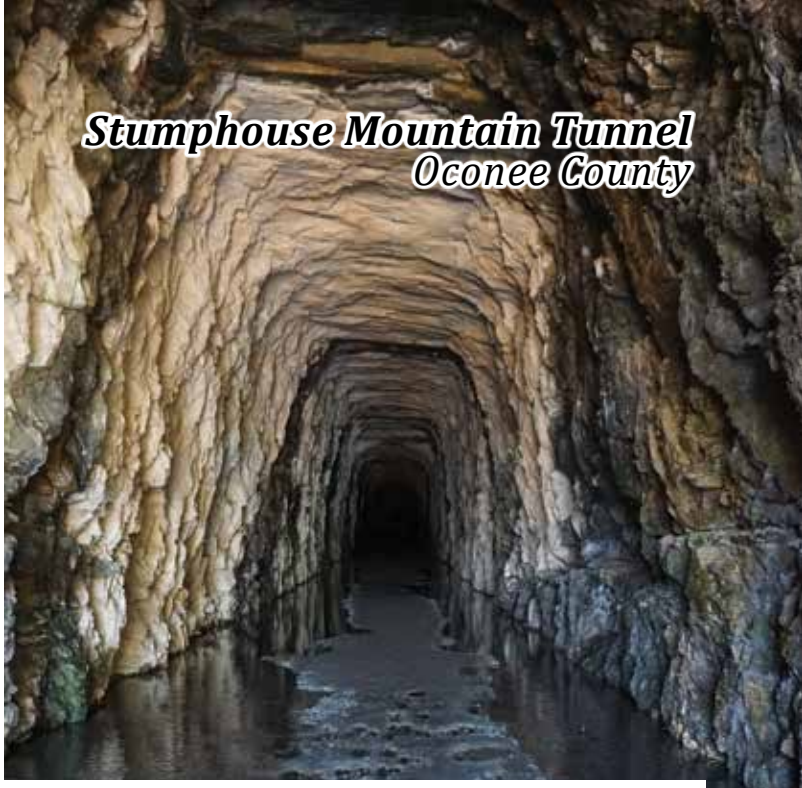
Currently, South Carolina law (§ 59-26-110) requires at least two (2) hours of training in youth suicide awareness and prevention for the renewal of certification every five (5) years for certified middle and high school educators. This was achieved through the adoption of the Jason Flatt Act



Denmark Depot
Bamberg County



Swan Lake & Iris Gardens
Sumter County

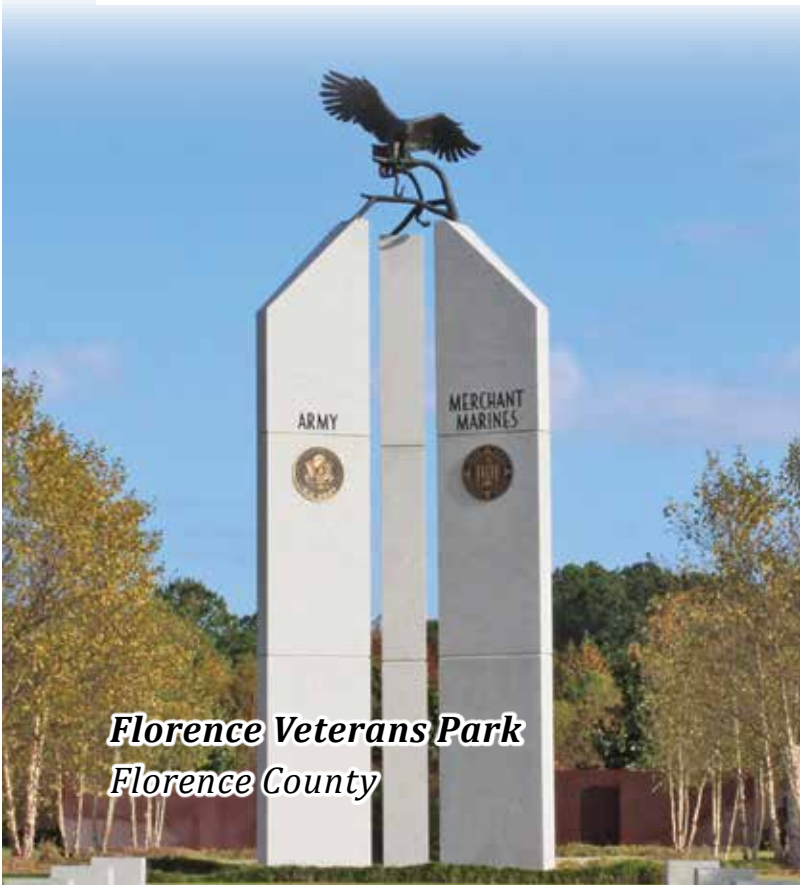


Stumphouse Mountain Tunnel
Oconee County

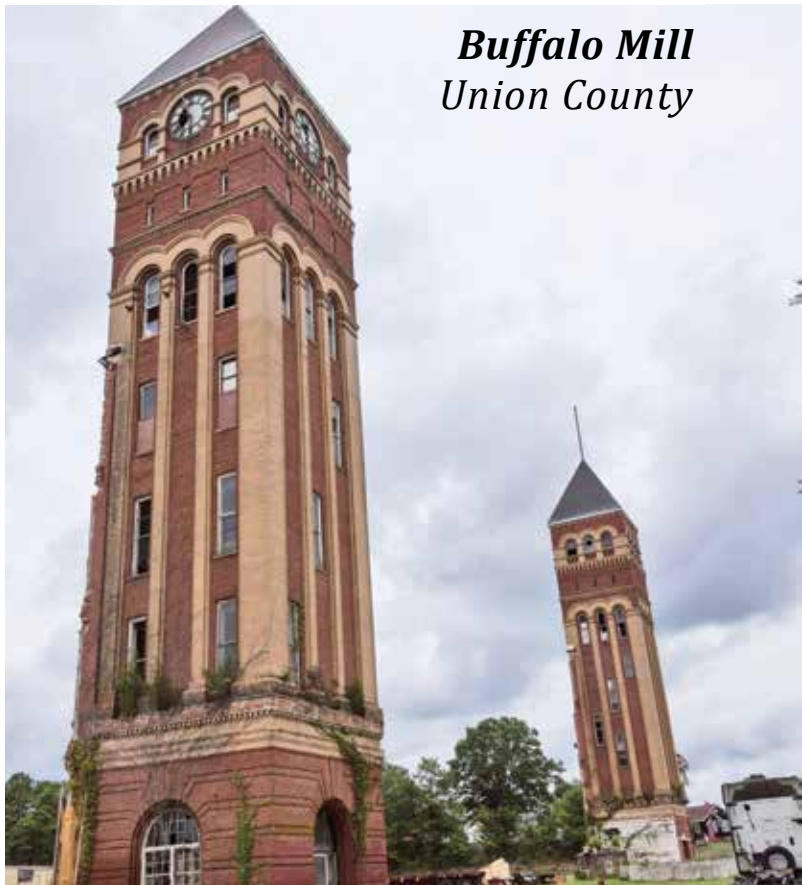
Considering the language

When discussing subjects of public concern, it is imperative we use the language and terminology constructed by the professionals who conduct and publish the research associated with that subject to maintain continuity, accuracy, and objectivity.

Suicidologists and others who have devoted their time to understanding and fighting suicide have created terms and crafted language pertaining to the subject for a reason, and when we fully adopt those definitions and practices, we increase our chances of effectively fighting suicide in the Palmetto State.



Florence Veterans Park
Florence County



Buffalo Mill
Union County

Considering the language | *A focus on accuracy*

In the Palmetto State, there are very few topics as steeped in stigmas as suicide — a simple utterance of the word can dramatically shift moods.

There was once a time when people did not discuss HIV/AIDS, cancer or teen pregnancy, but as people developed a better understanding about the subjects over time, they began having open conversations about these problems and embraced them as public health issues.

Suicide should be viewed no differently.

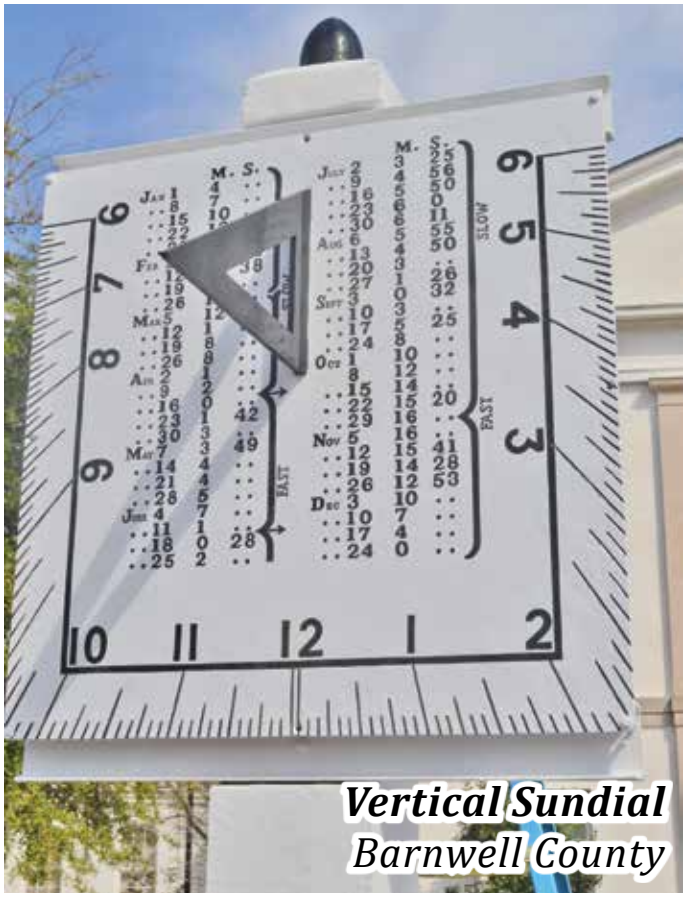
The brain is an organ, and like the heart or lungs, it is susceptible to disease and trauma that affect its ability to function properly.

When someone's heart is in crisis, a heart attack occurs. When the brain is in crisis, it often seeks death as a means to end the pain.

Suicide is not about dying; it's about ending the pain.

Considering the bio-chemistry, physiology and other factors that influence thoughts and behaviors, suicide should be discussed from a medical perspective. In doing so, we should strive to use appropriate and clinically correct terminology.

Changing the language will also reduce the stigmas surrounding subject, so that we address suicide as the public health concern it truly is.



Vertical Sundial
Barnwell County

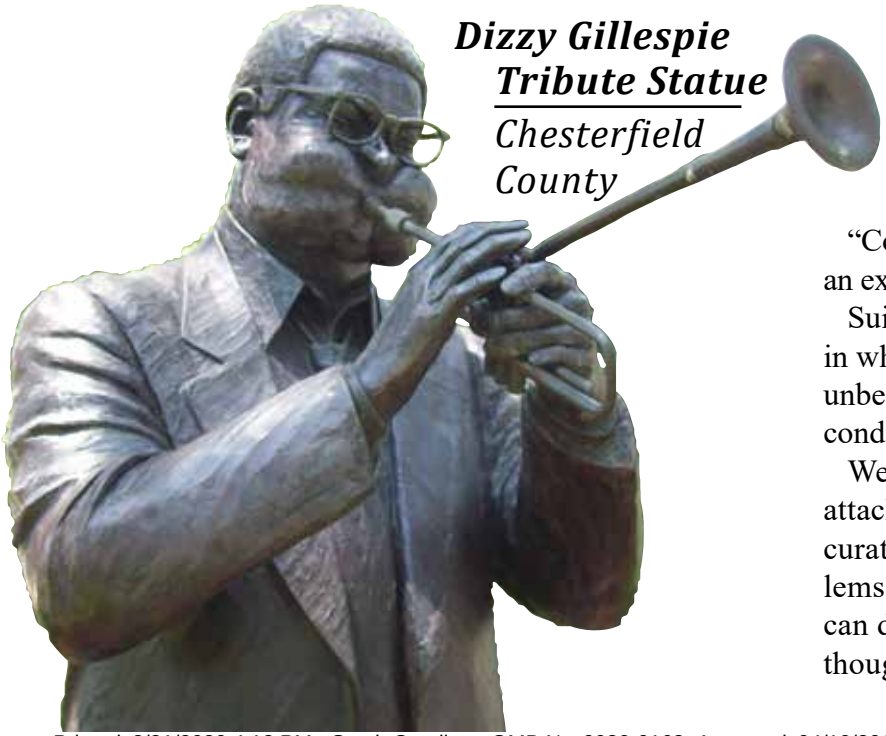
When referring to an intentionally self-inflicted death, the clinically correct language is "died by suicide"

The verb historically associated with suicide is "commit," a word professionals in the suicide prevention community do not use because it is inaccurate and stigmatizing.

"Commit" is connected to a criminal act, which is an extension of a character defect.

Suicide is not a defect, but a mental health crisis in which the brain is simply reacting to trauma or unbearable stress, often impaired by mental health condition(s).

We do not say that someone "committed a heart attack" or "committed cancer," which is a more accurate parallel to draw between mental health problems or symptoms and suicide. Using "commit" can deter those who are struggling with suicidal thoughts from seeking the help they need.



Dizzy Gillespie Tribute Statue
Chesterfield County

Considering the language | *A focus on accuracy*

This shift also grants freedom for those lost someone to suicide to have open conversations about their grief and coping progress, as the hurtful stigma is removed from the loss.

Another shift in language is the elimination of the word "successful" when discussing suicide, as there is nothing successful about a suicide. Instead, clinicians use "**completed**" when referring to someone who dies from a suicide attempt.

Those who attempt suicide but do not die are called "**survivors** of suicide" or "suicide **survivors**."

Family, friends, coworkers, and others who are affected by an individual's suicide are referred to as "**survivors of suicide loss**."

The importance of clear and consistent language for characterizing suicide-related behaviors is not only needed to decrease stigma but to also provide accuracy of the medical urgency. Problematic language has been around for a while, such as the commonly used label "suicide gesture."

Medical and behavioral health professionals have been strongly encouraged by the National Institute of Mental Health, the Center for Mental Health Services, and the American Association of Suicidology to consider discontinuing the use of the term "suicide gesture" in light of its associated dismissive connotation and inconsistent application in clinical practice and research.

Instead of "suicide gesture," recommendations have been made to provide more precise descriptions of suicidal behaviors and the functional assessment of suicide-related behaviors.

First and foremost, the seemingly inconsistent distinction drawn between a "genuine" suicide attempt and a suicide gesture ignores the fact that suicidal behavior is often characterized by mixed motives and considerable ambivalence about life and death.



Considering the language | *Terms to know*

On a societal level, general knowledge and use of appropriate terminology when dealing with issues related to suicide helps reduce stigma associated with seeking help.

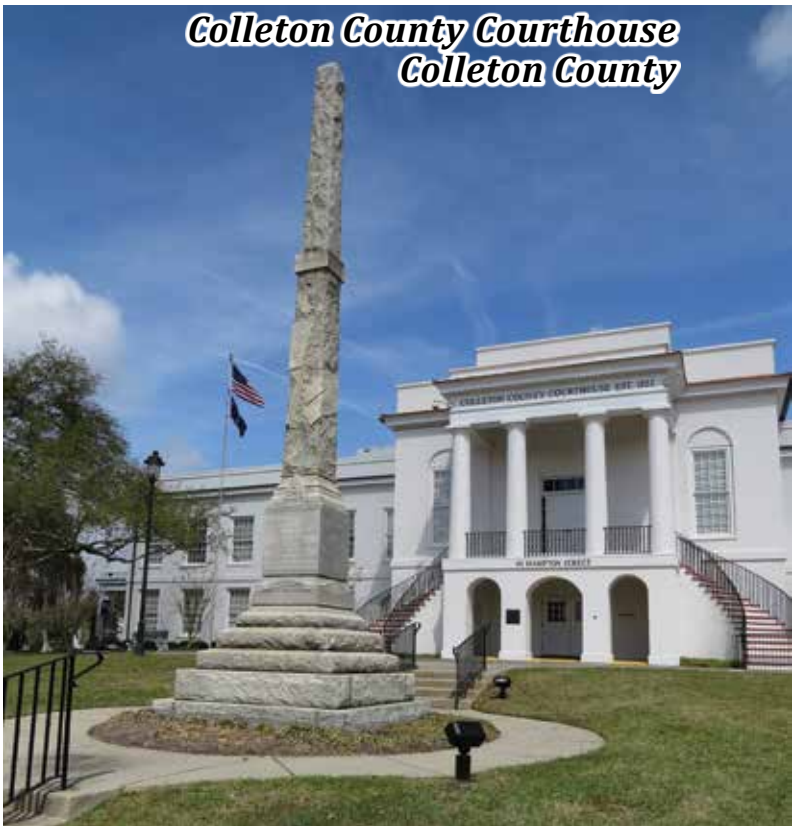
In medical settings, using accurate and appropriate nomenclature concerning suicide promotes and facilitates proper and concise care of at-risk individuals and those affected by suicide, as does referring those individuals to care.

The following terms are defined in reports from the Centers for Disease Control and Prevention (CDC) and the U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention:

Affected by suicide: All those who may feel the impact of suicidal behaviors, including those bereaved by suicide, as well as community members and others

Bereaved by suicide: Family members, friends, and others affected by the suicide of a loved one (also referred to as "survivors of suicide loss")

Means: The instrument or object used to carry out a self-destructive act, such as chemicals, medications, or illicit drugs



Colleton County Courthouse
Colleton County

Methods: Actions or techniques that result in an individual inflicting self-directed injurious behavior, such as overdose, suffocation, etc.



Cypress Gardens
Berkeley County

Considering the language | *Terms to know*

Other suicide behavior including preparatory acts: Acts or preparation toward making a suicide attempt, but before potential for harm has begun. This can include anything beyond a verbalization or a thought, such as assembling a method (such as collecting pills) or preparing for one's death by suicide (writing a suicide note, giving things away)

Postvention: Response to and care for individuals affected in the aftermath of a suicide attempt or suicide death

Protective factors: Positive conditions and personal and social resources that reduce the likelihood of an individual developing a disorder. For those already struggling with a disorder, these elements promote resiliency and reduce the potential for suicide and other high-risk behaviors. Protective factors may encompass biological, psychological, or social aspects in the individual, their family, or their environment

Resilience: Capacities within a person or organization that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes

Risk factors: Elements within a person's life that make it more likely that individual will develop a disorder. Risk factors may encompass biological, psychological, or social aspects in the individual, their family or their environment

Suicidal behaviors: Conduct related to suicide, including preparatory acts, suicide attempts and deaths

Suicidal ideation: Thinking about, considering, or planning suicide

Suicidal plan: A thought regarding a self-initiated action that facilitates self-harm behavior or a suicide attempt; often including an organized manner of engaging in suicidal behavior, such as a description of a time frame and method

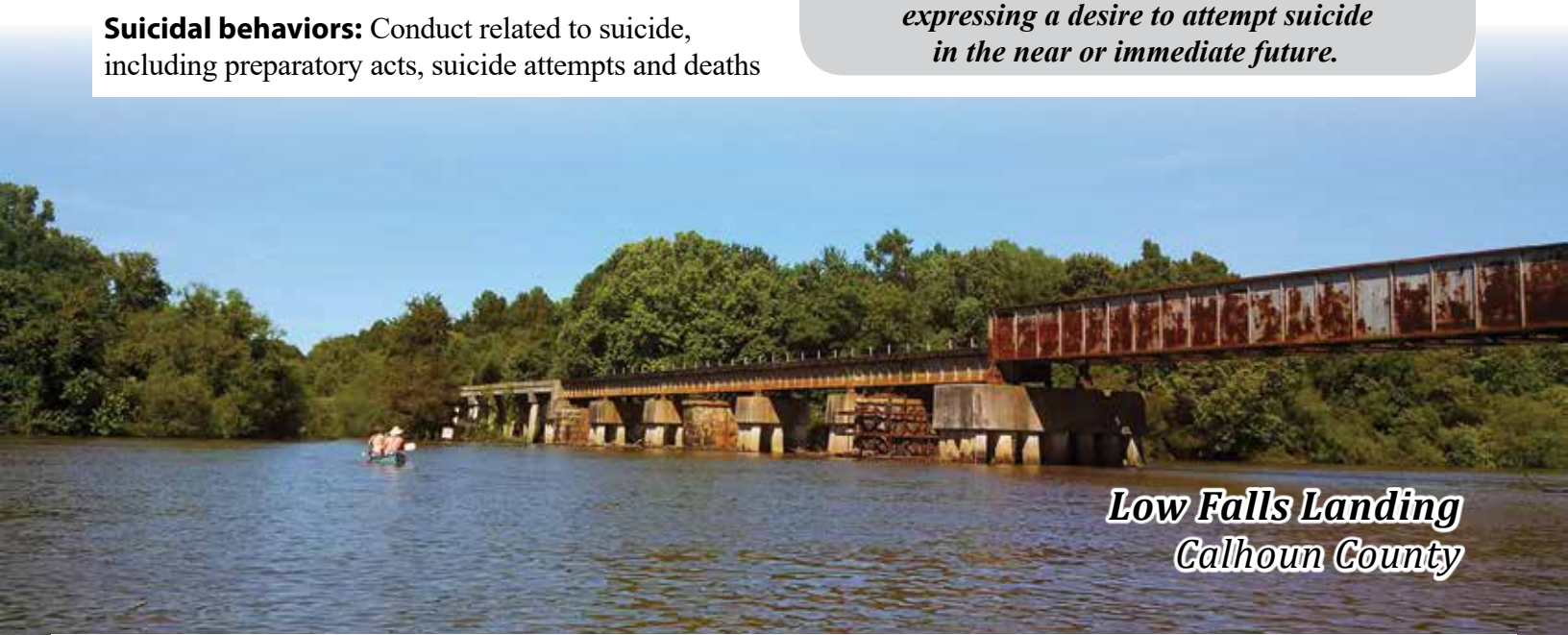
Suicide experiences: Suicidal ideations, suicide plans, and suicide attempts. People who experience suicidal ideation and make suicide plans are at increased risk of suicide attempts, and people who experience all forms of suicidal thoughts and behaviors are at greater risk of dying by suicide

Suicide (die by suicide, death by suicide, suicide death): Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

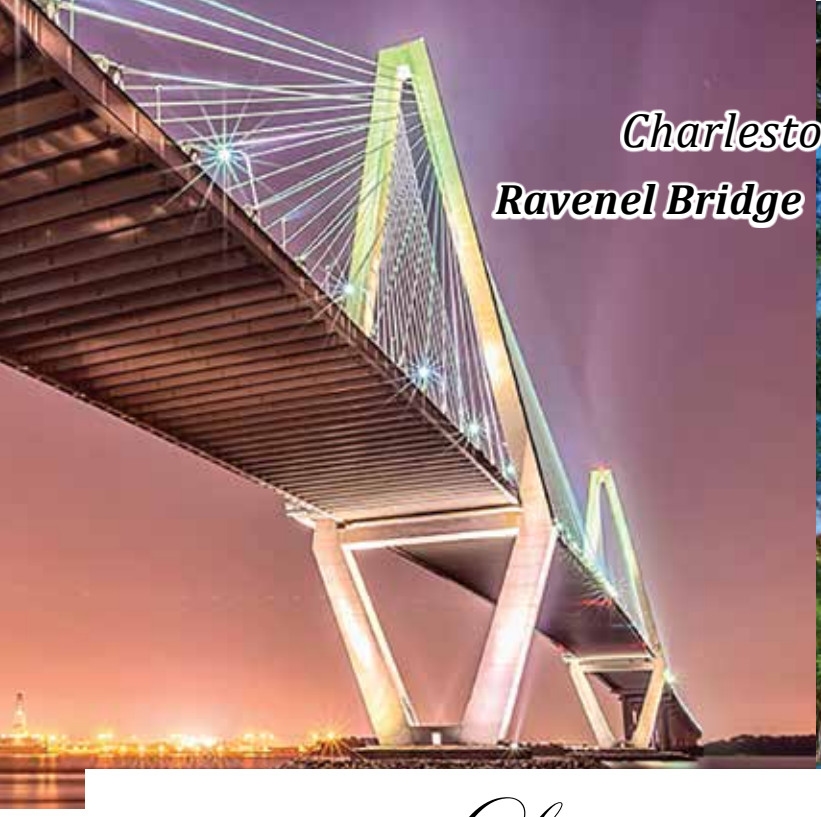
Suicide attempt: A non-fatal, self-directed, potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury

Suicide crisis (suicidal crisis or potential suicide): A situation in which a person is attempting to kill themself or is seriously contemplating or planning to do so. It is considered a medical emergency, requiring immediate suicide intervention and emergency medical treatment.

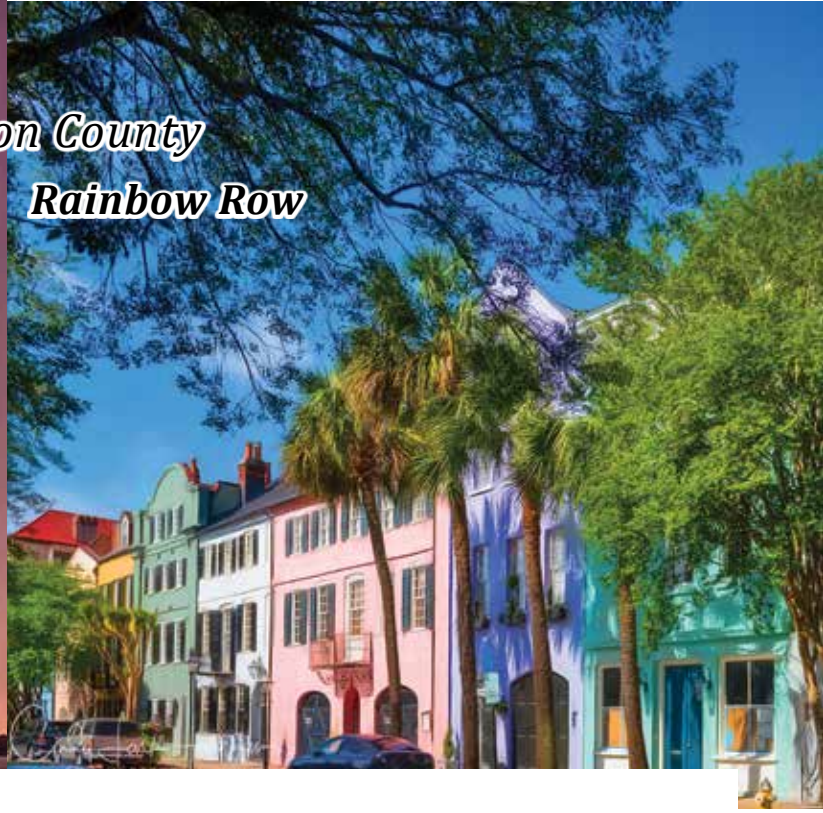
Note: HIPAA and FERPA policies do not apply to individuals attempting suicide or expressing a desire to attempt suicide in the near or immediate future.



Low Falls Landing
Calhoun County



Charleston County
Ravenel Bridge



Rainbow Row

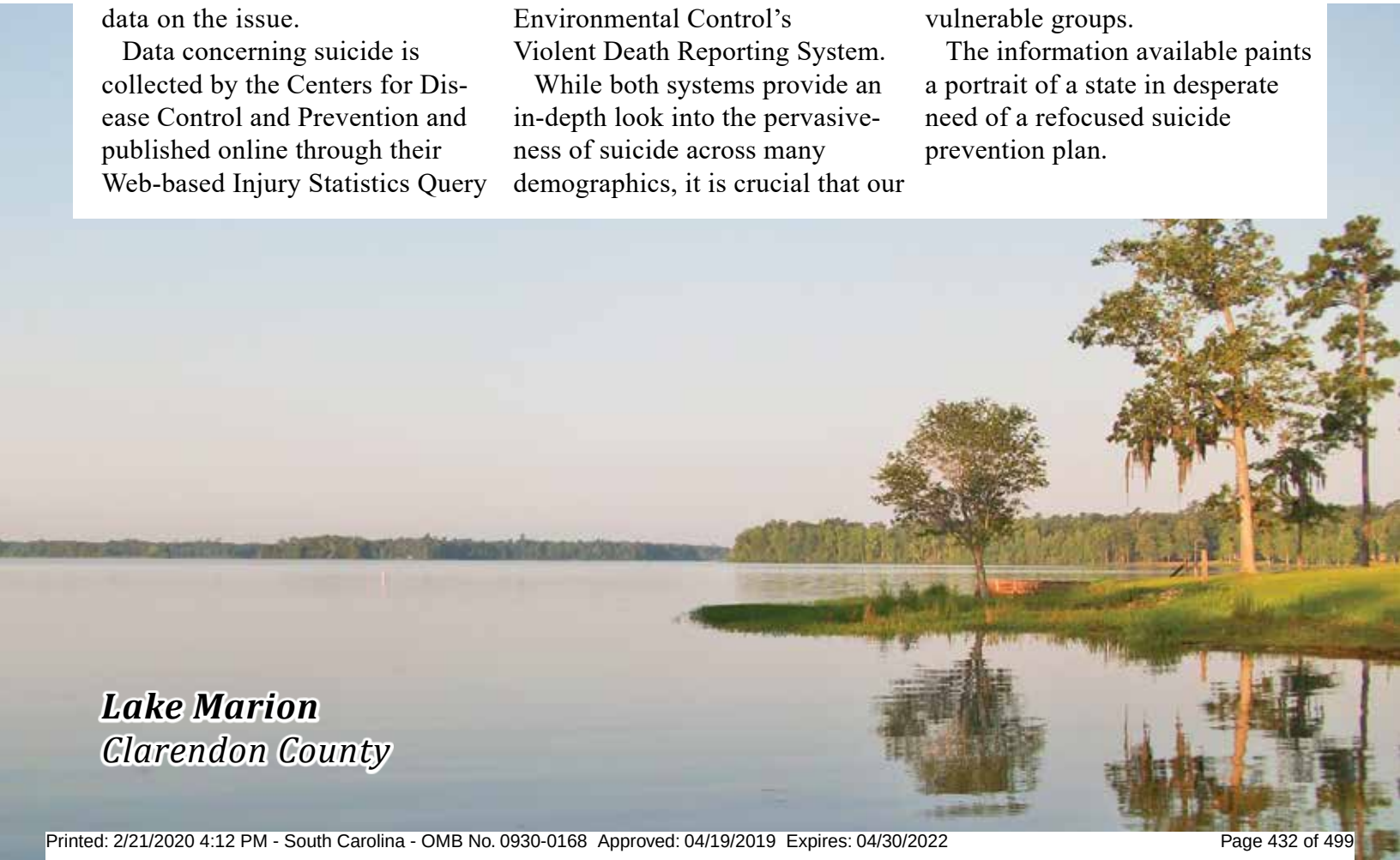
Looking at the data

To understand how far-reaching suicide is in South Carolina, it is necessary to observe quantitative data on the issue.

Data concerning suicide is collected by the Centers for Disease Control and Prevention and published online through their Web-based Injury Statistics Query and Reporting System. Other data specific to the Palmetto State is gathered and made available by the S.C. Department of Health and Environmental Control's Violent Death Reporting System.

While both systems provide an in-depth look into the pervasiveness of suicide across many demographics, it is crucial that our state collects more specific and diverse information to help develop unique strategies for preventing suicide among especially vulnerable groups.

The information available paints a portrait of a state in desperate need of a refocused suicide prevention plan.



Lake Marion
Clarendon County

Looking at the data | South Carolina at a glance

SUICIDE is now the 10th-leading cause of death in SC

Dum spiro, spero

- **#2** cause of death for ages **10-35**
- **#4** cause of death for ages **36-54**
- **#8** cause of death for ages **55-64**
- **#16** cause of death for ages **65 & older**

On average, **1** South Carolinian **dies by suicide** every **11 hours**.

There are nearly **twice** as many **suicides** each year in South Carolina as there are **homicides**.

	Suicides	Homicides
2015	742	448
2016	815	426

Suicide Death Rates

	Deaths by Suicide	Rate per 100,000	State Rank
South Carolina	**815**	**15.65**	**23**
Nationally	44,965	13.42	

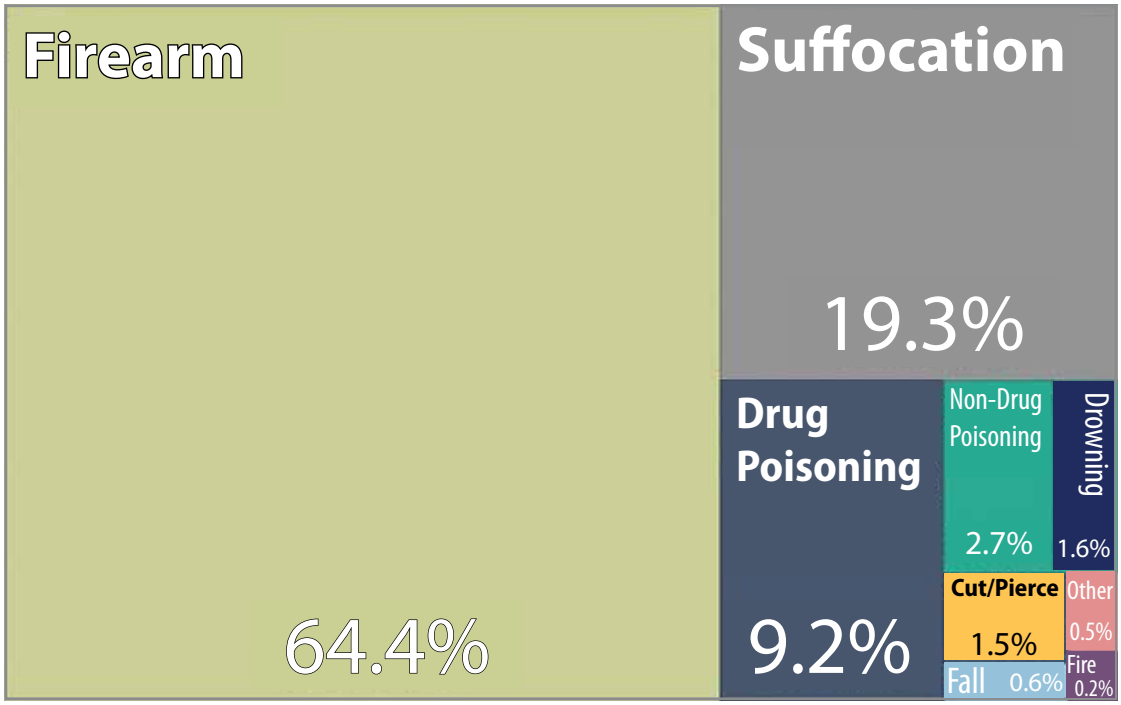
All tables, facts, and figures presented on this page is based on CDC data and research

Suicide cost South Carolina more than **$748 million** of combined lifetime medical and work loss in 2010, an average of **$1.18 million** per suicide death



The Peachoid
Cherokee County

Looking at the data | *Suicide by the numbers*



This chart depicts the most common methods of suicide across the lifespan. **Firearms** are used in **64.4%** of suicides. A distant second-most common method is **suffocation** (i.e. hanging), claiming **19.3%** of suicides. **Drug poisonings** accounterd for **9%** of suicides. The remaining 7.1% of suicides involved non-drug poisoning, drowning, cutting/piercing, falling, fire and others.

In studying suicide, understanding *how* it is happening is just as important as learning *why* it is happening.

By analyzing data regarding lethal means, we gain insight in devising more thorough strategies that help limit access to those means. This information also helps craft awareness, leading to the recruitent of stakeholders with mutual interests.

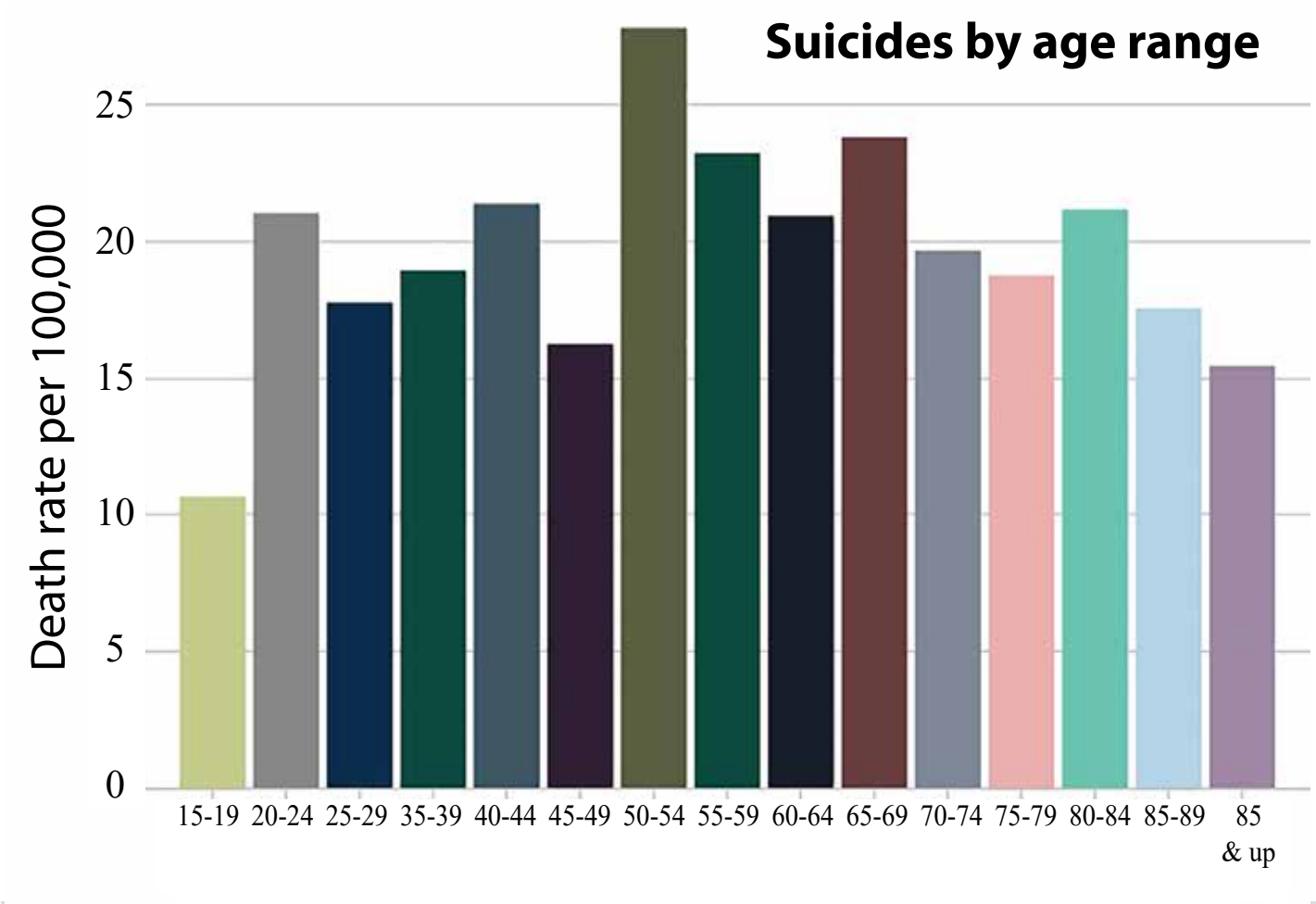
For example, knowing that **firearms** account for nearly **two-thirds of suicide deaths** might persuade firearms dealers to disseminate suicide prevention materials with their products.

Some states encourage or require gun dealers to emphasize **gun safety** at the point of sale.



Downtown Chester
Chester County

Looking at the data | *Suicide by the numbers*



Nearly everyone has a preconception about who is mostly likely to die by suicide.

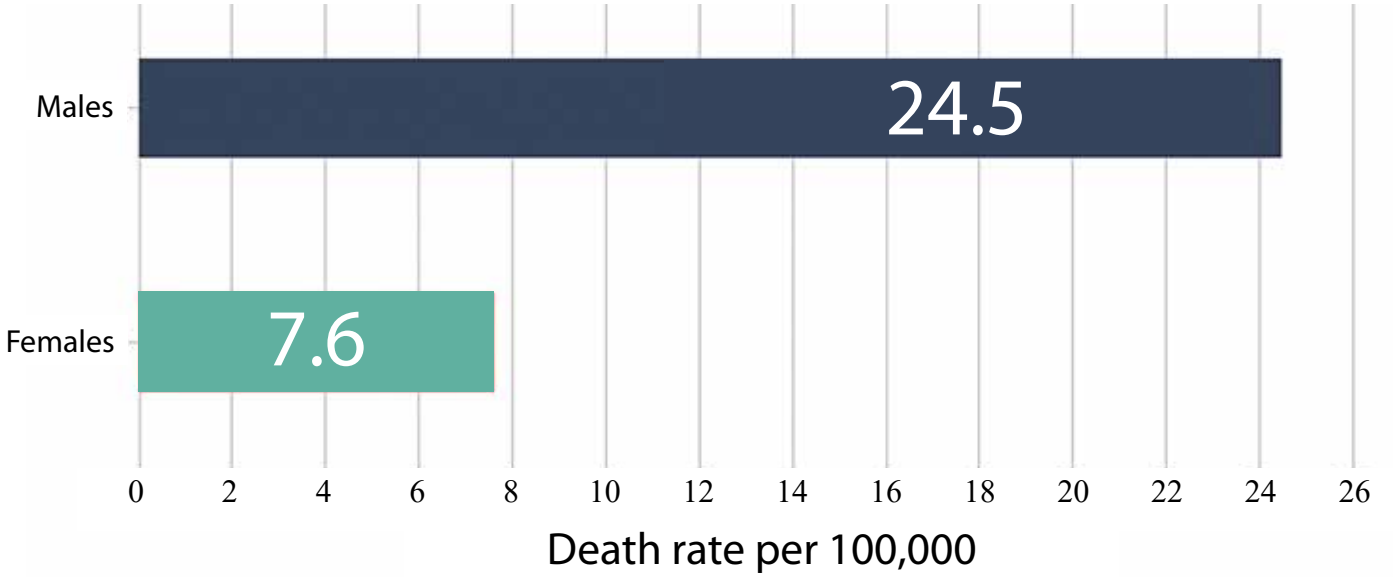
However, as this graph illustrates, any notion that suicide overwhelmingly affects one age group more than other is unfounded. Every age group is at risk of suicide, so plans to reduce suicide across an entire state must include strategies that address individuals of all ages.



Little Pee Dee State Park
Dillon County

Looking at the data | Suicide by the numbers

Suicides by gender identity



When observing the information presented in this graph, it might be easy to develop simple assumptions about suicide as it relates to gender in South Carolina.

While males are nearly **3 times** more likely to **die** by suicide than females, females **attempt** suicide at **3.5 times** the rate of males.

Part of this discrepancy is attributed to methodology: Males use more lethal means. According to the 2016 CDC data, **70% of males** who died by suicide used **firearms** and **19.3%** used **suffocation**. In general, males are more likely to own or have access to firearms.

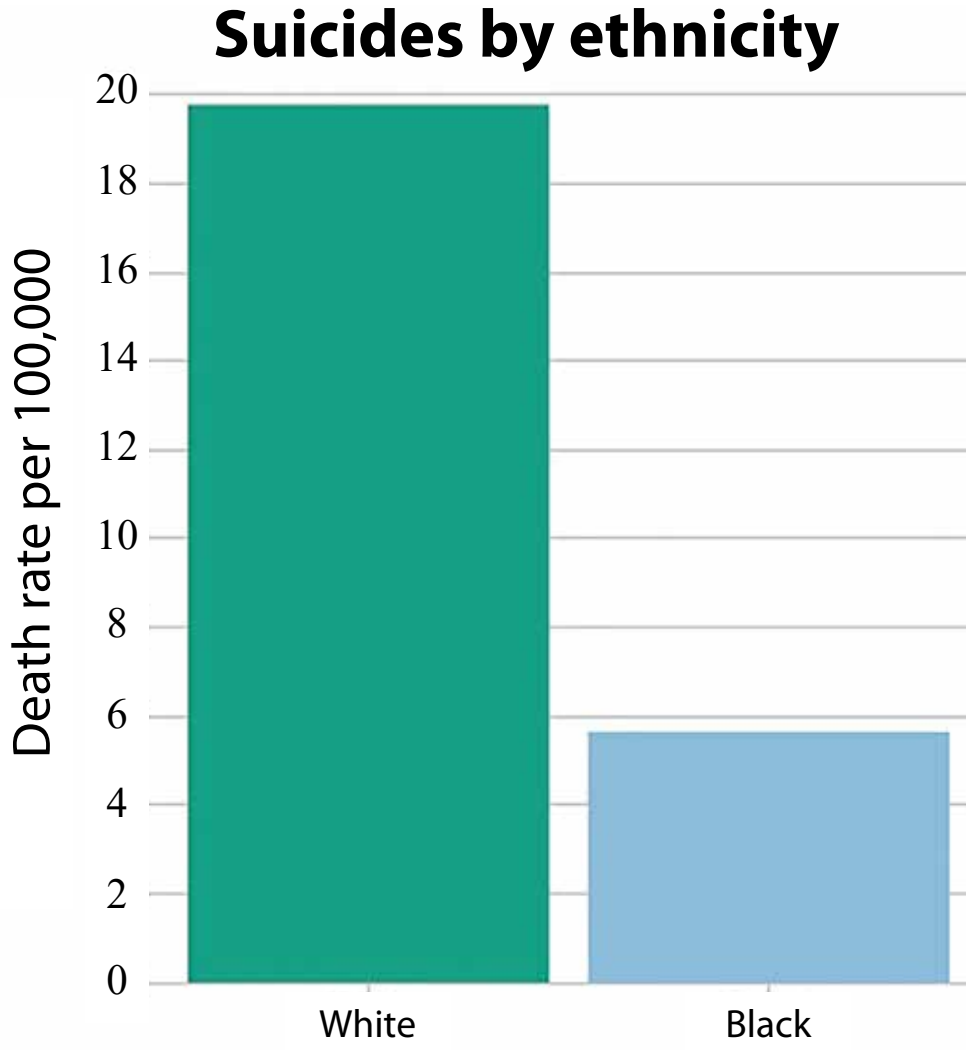
Only **47.5%** of females used **firearms** (though research indicates female use of firearms in suicide is increasing), while **26.5%** used **drug poisoning** and **19%** used **suffocation**.

The difference in method, however, is not an indication that females are "less serious" than males about taking their own lives. Every attempt is a true effort to that individual, regardless of method.



Bettis Academy & Junior College
Edgefield County

Looking at the data | *Suicide by the numbers*

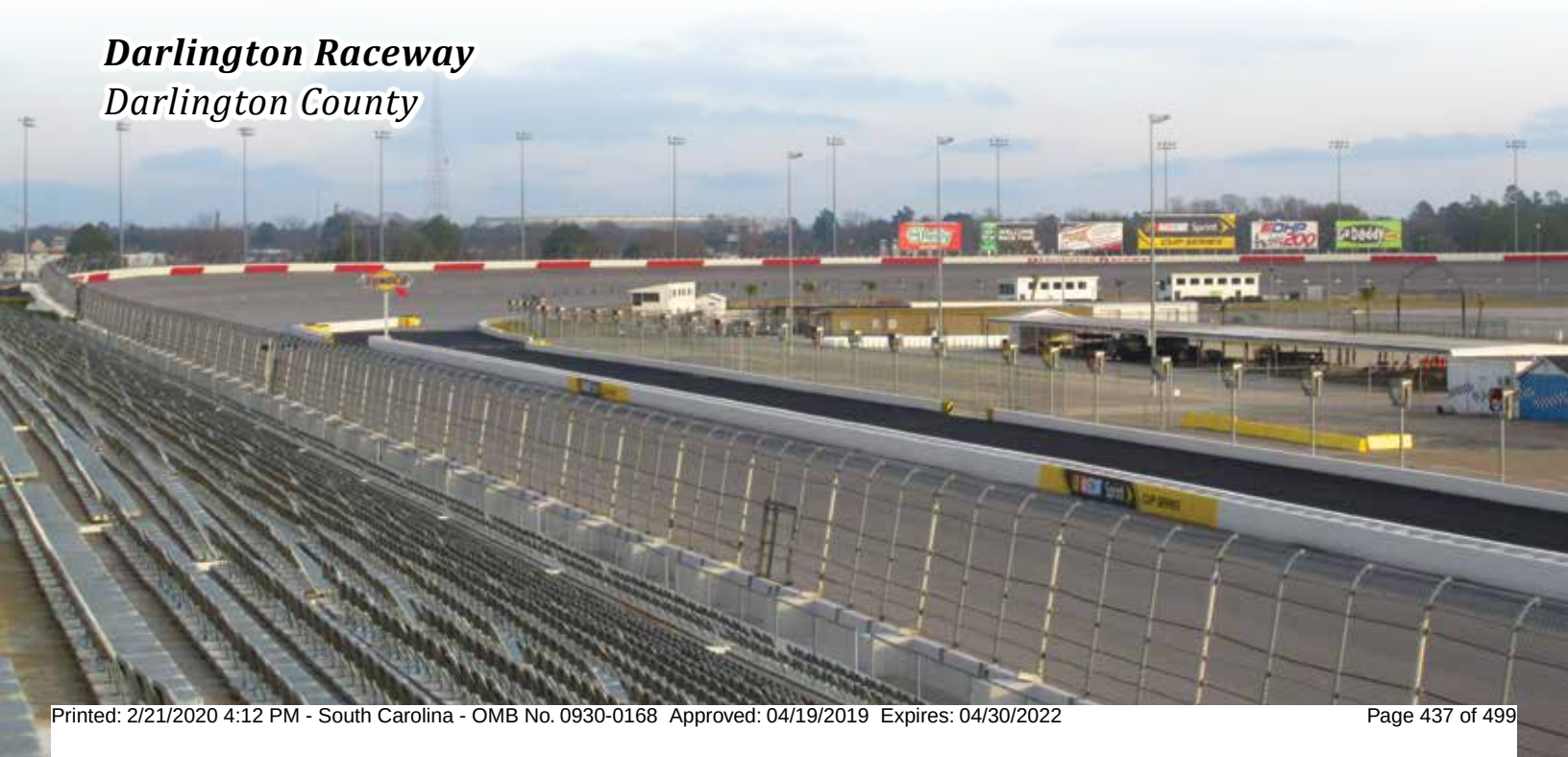


While suicide affects many ethnicities, CDC data about many demographic groups in South Carolina is limited.

According to the data that is available, whites across the lifespan are at more than three times the risk of dying by suicide than their black counterparts.

Among whites, the death rate for males is 30.1 per 100,000 and 9.6 per 100,000 for females. The overall crude death rate is 20.75.

As far as methods, 65.6% used firearms, 17.8% used suffocation, 10.2% used drug poisoning, and most of the remaining suicides involved non-drug poisoning, cutting, and drowning.



Darlington Raceway
Darlington County

A need for expanded data collection

To best combat suicide, it's important we gather as much information as possible about specific populations within South Carolina.

In collecting data about these groups, we learn their unique risk factors and how we might best assist at-risk individuals while respecting the elements of their cultures and situations.

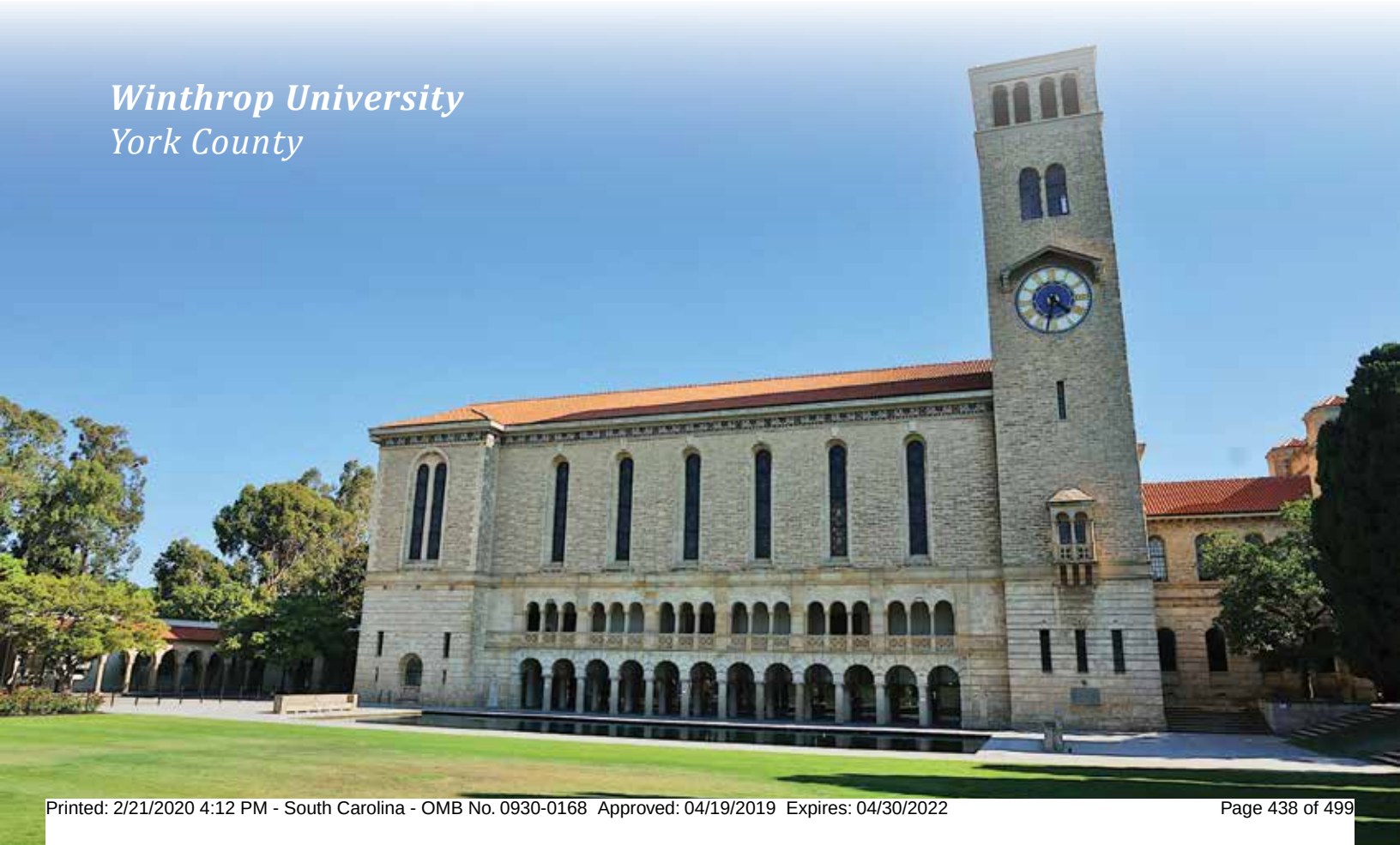
Even when filtering information by some of the most general denominators, such as race or ethnicity, very little information is available in our state.

On a national level, new research is restructuring our understanding of suicide among black populations. In an article published by the National Institute of Health in May 2018, researchers said they found **black children aged 5-12** were **twice as likely** to attempt suicide as their white counterparts.

Other research, such as articles published by the Suicide Prevention Resource Center, indicates that **immigrant youth** are at an **elevated risk of suicide**.

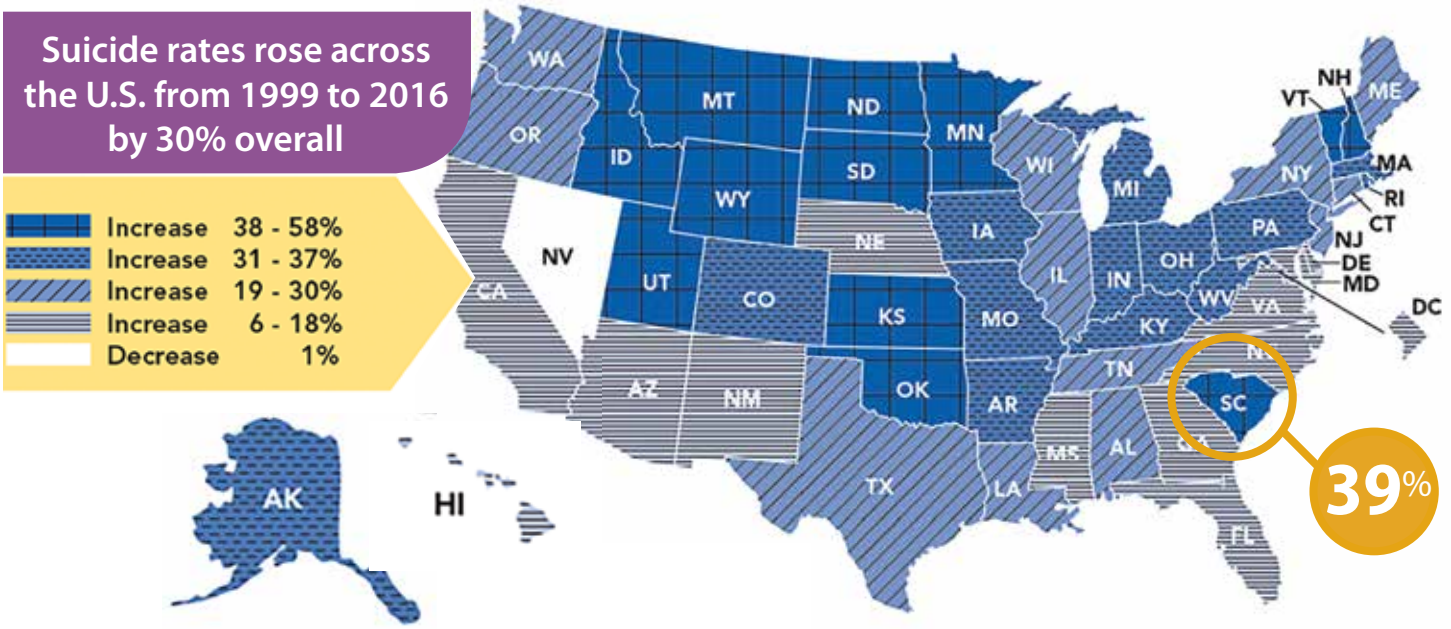
There is also very little data available about other populations in South Carolina, such as Lesbian, Gay, Bisexual, Transgender, and Queer (LGBT) individuals. National research and efforts within other states indicate the LGBTQ+ population is at higher risk than most other demographic groups, with some studies concluding these individuals are 1.5-3 times more likely to contemplate suicide than their heterosexual counterparts. Even within the LGBTQ+ population, transgender individuals are especially at risk, as nearly half report having attempted suicide — 92% attempt before the age of 25.

All lives within the Palmetto State are important and should be cherished. It is imperative we seek more data in all areas of suicide prevention research if we are to effectively serve these populations.

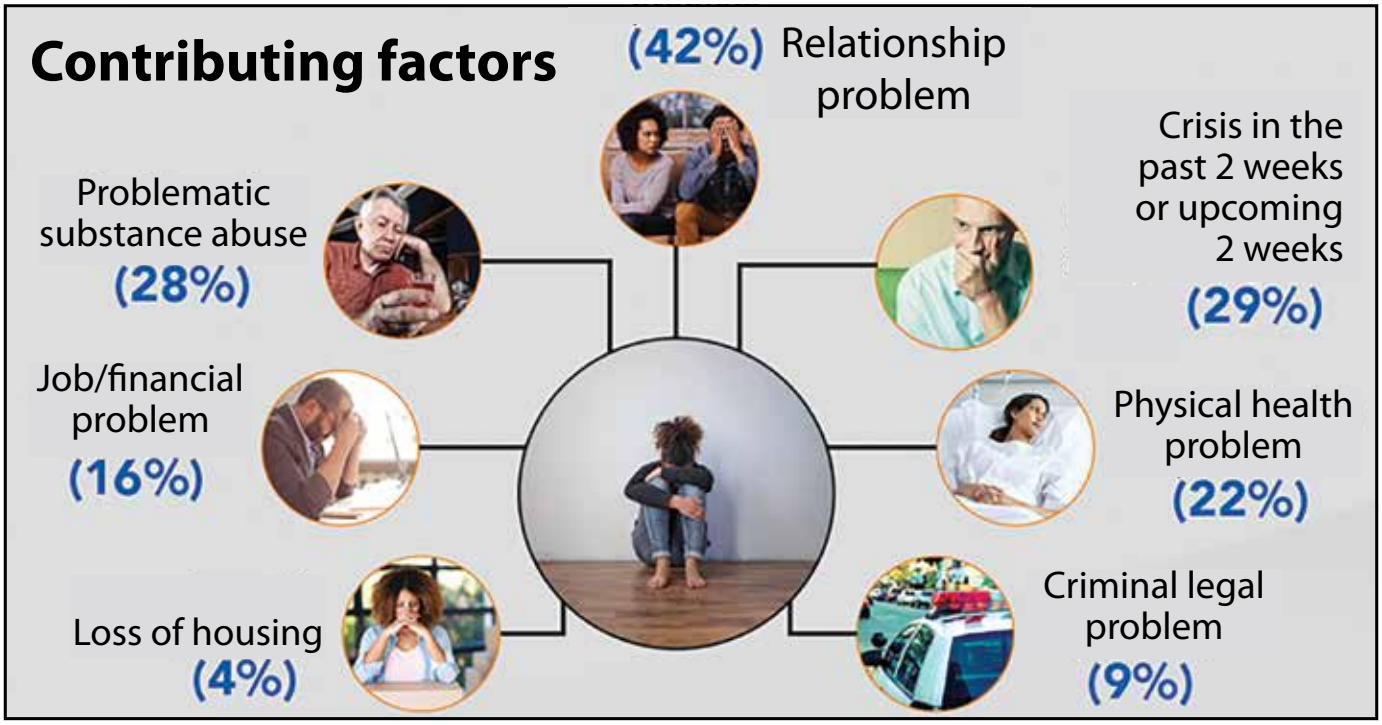


Winthrop University
York County

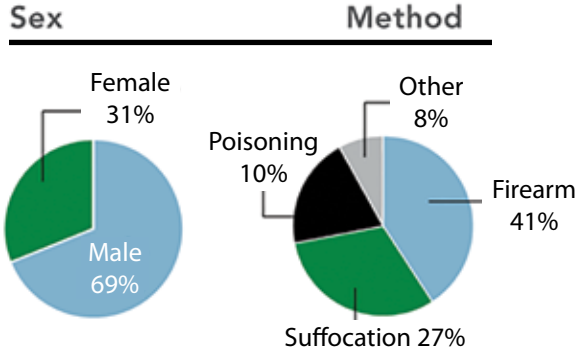
Suicide rates rose across the U.S. from 1999 to 2016 by 30% overall



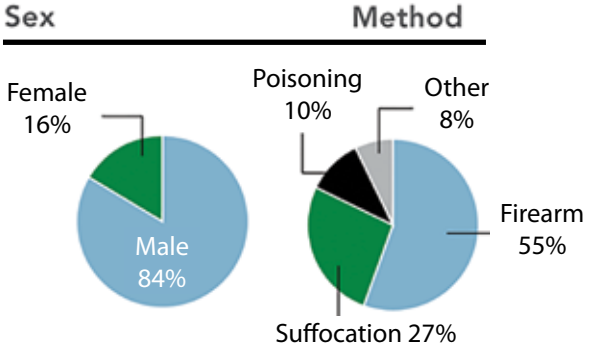
Contributing factors

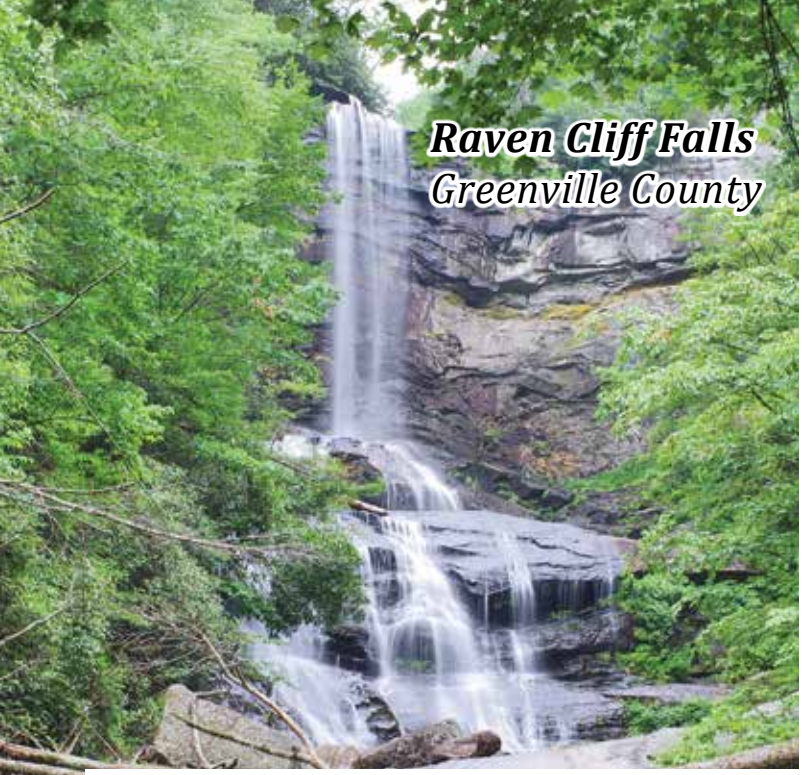


Known mental health conditions

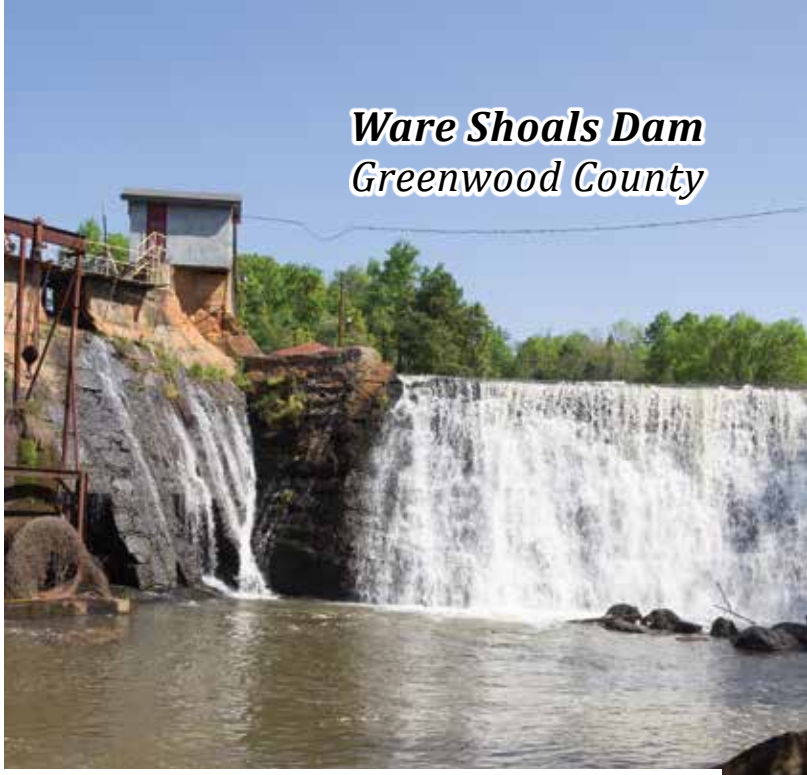


No known mental health conditions





Raven Cliff Falls
Greenville County



Ware Shoals Dam
Greenwood County

Understanding suicide

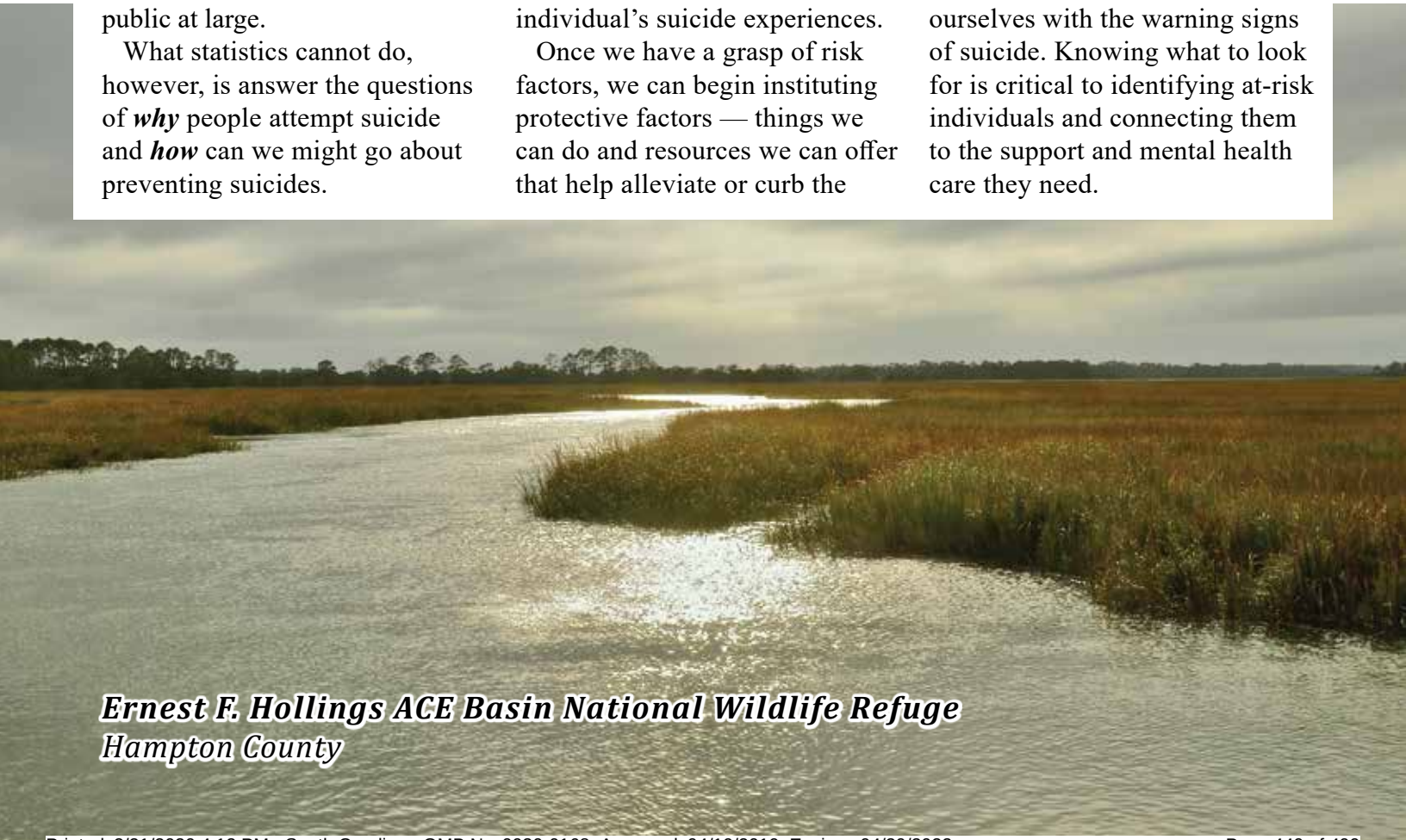
Statistics present information in an impactful, objective format that makes the scope of suicide deaths digestable for the public at large.

What statistics cannot do, however, is answer the questions of ***why*** people attempt suicide and ***how*** can we might go about preventing suicides.

To properly design suicide prevention efforts and protocols, we have to understand risk factors and how they contribute to an individual's suicide experiences.

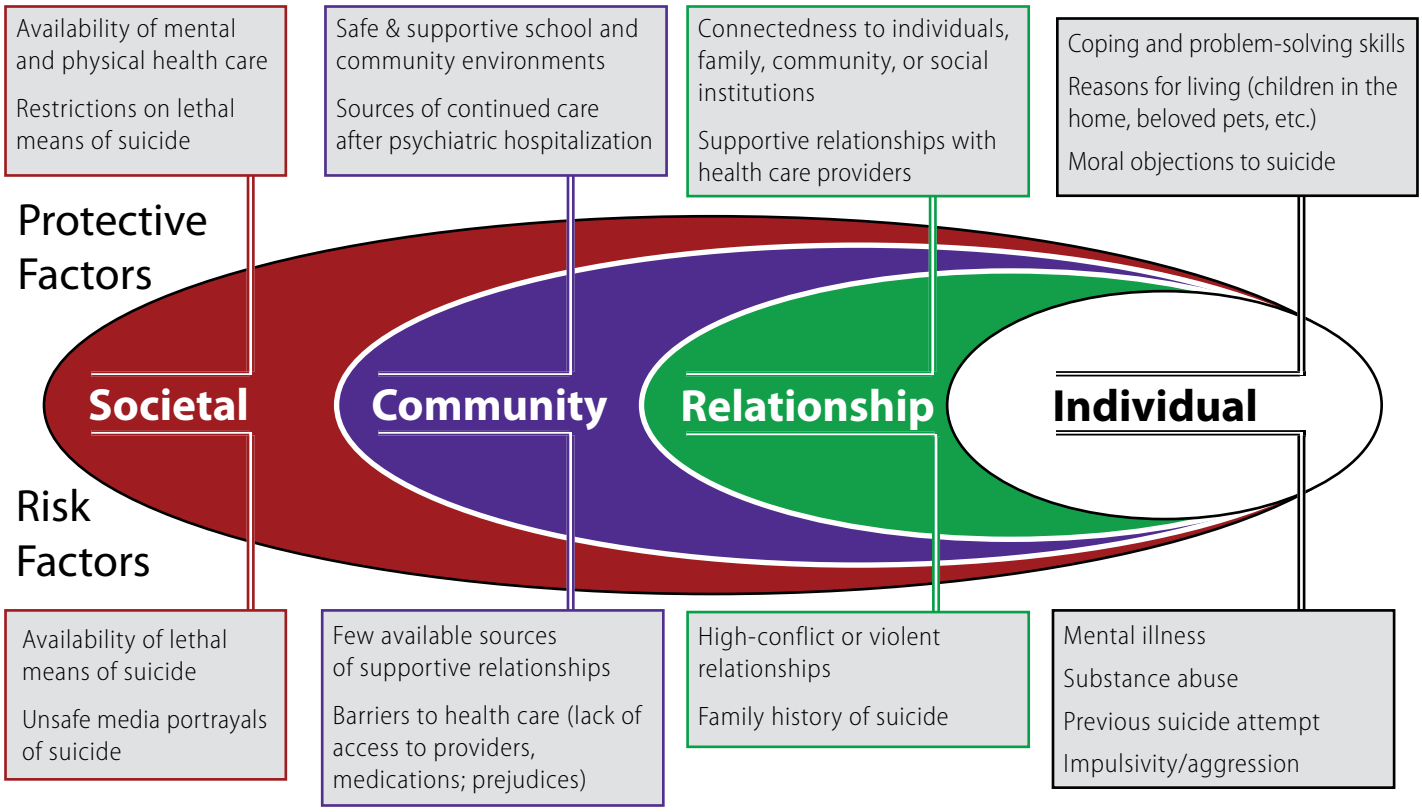
Once we have a grasp of risk factors, we can begin instituting protective factors — things we can do and resources we can offer that help alleviate or curb the impact of risk factors and reduce the likelihood of suicide attempts and deaths.

Finally, we must familiarize ourselves with the warning signs of suicide. Knowing what to look for is critical to identifying at-risk individuals and connecting them to the support and mental health care they need.



Ernest F. Hollings ACE Basin National Wildlife Refuge
Hampton County

Understanding suicide | The Social Ecological Model



One of the best tools for helping us understand risk and protective factors is the social ecological model, that categorizes the various factors that impact our lives.

In terms of the model, **Societal** refers to how the individual is affected by the perceptions and stigmas held by the culture of where they live on a larger scale, be it a country, a region, or a state.

Community refers more to the individual's geographical position on a smaller scale, such as a town or district. A person's location greatly affects the availability of resources and means of accessing health care.

Relationship refers to the health of the individual's connections to other people, such as romantic interests, friends, peers, and family members, and how those connections affect their mental health.

Individual means the factors that are almost entirely contained within that person, such as an existing mental illness, a substance abuse problem, or pain from past or currently ongoing trauma.

Camden Revolutionary War Site
Kershaw County



Understanding suicide | *Risk factors*

Risk factors are elements within a person's life that make it more likely an individual will be at risk of a mental health crisis. Risk factors include biological, psychological, or social aspects of the individual, their family or their environment.

Stress comes in many forms, from a combination of life events and an individual's interpretations of those events.

We all manage stress differently. Some may feel overwhelmed by the compounded pain and trauma they have experienced. This latter group are referred to as at-risk individuals, or those who might turn to suicide as a means to end their suffering.

For example, the 2017 CDC Suicide Technical Package reported that suicide rates increase during economic recessions marked by high unemployment rates, job loss, and economic instability and decrease during economic expansions and periods marked by low unemployment rates, particularly for working-age individuals 25 to 64 years old.

Identifying risk factors can potentially protect against suicide. For example, strengthening economic support systems.

Common Risk Factors include:

- Rejection
- Moving to a new place or attending a new school
- Death of a loved one
- Academic failure
- Divorce or separation
- Disciplinary crisis
- Breakups
- Arrest or incarceration
- Presence of a gun within the home
- Lack of meaningful attachments
- Witnessing a violent event
- Feeling unwanted by others, or a sense of being a burden
- History of suicidal behavior
- Suicide of a loved one
- Emotional or physical abuse
- Sexual or gender identity conflict
- Domestic violence
- Alienation
- Sexual abuse/ assault or rape
- Low self•esteem
- Serious illness in the family
- Becoming disabled
- Feelings of powerlessness
- Psychiatric illness
- Perfectionism
- Learning disability
- Loss of identity/ status
- Substance abuse
- Financial setbacks
- Loss of employment
- Retirement issues



Sergeant Jasper Park
Jasper County

Understanding suicide | Protective factors

Protective factors are positive conditions and personal and social resources that reduce the likelihood of an individual developing a disorder.

For those already struggling with a disorder, these elements promote resiliency and reduce the potential for suicide and other high-risk behaviors.

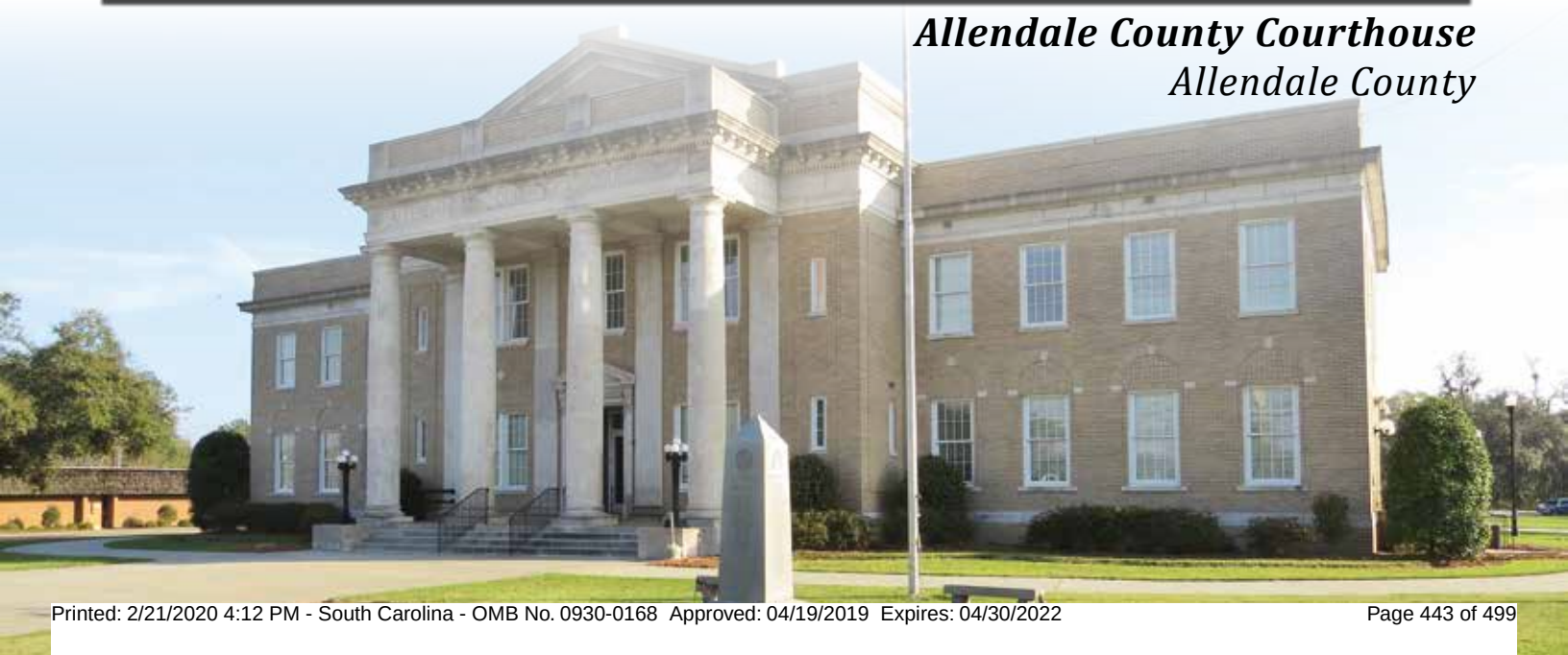
Research shows that a single protective factor is known to counteract up to four risk factors.

Protective factors may encompass biological, psychological, or social aspects in the individual, their family, or their environment.

Metaphorically, risk factors are "chronic diseases," and protective factors are "medications" or "treatments" that help an individual survive the crises caused by their trauma and pain.

Common Protective Factors include:

- Attitudes, values & norms that enforce strong belief in the value of life
- Problem-solving & coping skills
- Access to proper mental & physical health care
- Strong connections to friends, family, & supportive significant others
- Hope for the future
- Sobriety
- Impulse control
- Resiliency
- Strong sense of self-worth or self-esteem
- Reasons for living
- Having a pet
- Financial assistance
- Restricted access to lethal means
- General optimism
- Employment opportunities
- Support for victims of bullying, harassment, abuse, and physical or sexual assault
- Opportunities to participate in and contribute to school or community activities
- Ability to regulate emotions & tolerate frustrations



Allendale County Courthouse
Allendale County

Understanding suicide | Protective factors

Warning signs are observable indications that someone might be at risk of suicide — perhaps immediately or in the future.

If risk factors are methaphorically understood to be illnesses, then warning signs are the symptoms.

Much like an infection, when risk factors have resulted in tangible symptoms (warning signs), connecting the at-risk individual with care is of the utmost importance.

Fortunately, these indicators are easily seen, heard, and felt, so long as we acknowledge them as warning signs for suicide.

Common Warning signs include:

Verbal signs

If a person talks about:

- **Being a burden to others**
- **Feeling trapped**
- **Experiencing trauma**
- **Struggling to cope with the loss of a loved one**
- **Having no reason to live**
- **Killing themselves**
- **Death**

Behaviors

Specific things to look for:

- **Threats to attempt suicide**
- **Increased use of alcohol or drugs**
- **Misuse of prescription drugs**
- **Looking for a way to kill themselves, such as through online searches for materials or means**
- **Acting recklessly**
- **Withdrawing from activities**
- **Isolating themselves from friends and family**
- **Sleeping too much or too little**
- **Visiting or calling people to say goodbye**
- **Giving away prized possessions**
- **Aggression**
- **Self harm, such as cutting**
- **Making funeral arrangements**
- **Drastic mood changes**

Moods

Individuals who are thinking about suicide often display one or more of the following:

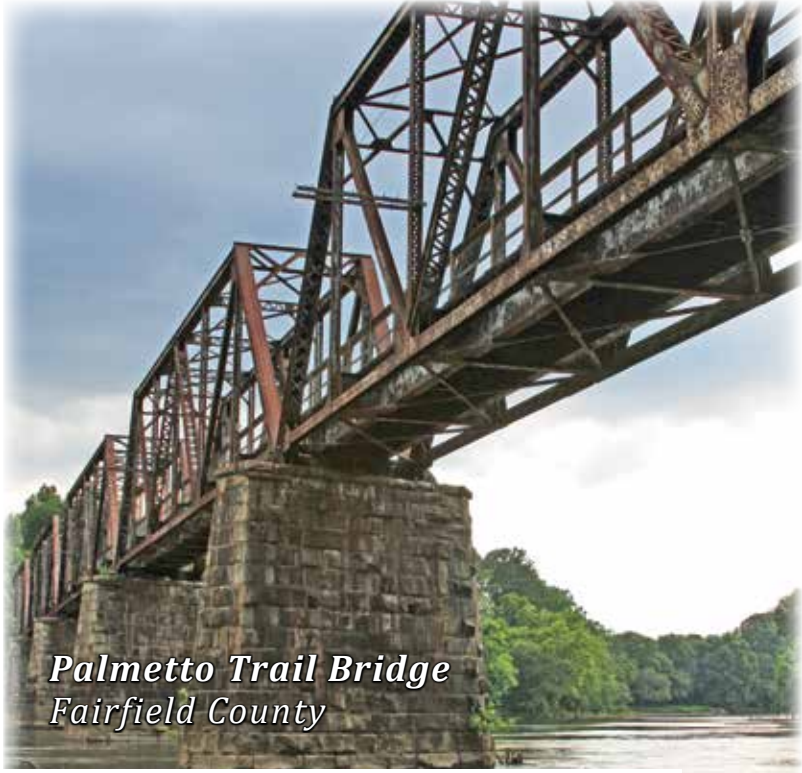
- **Depression**
- **Loss of interest**
- **Rage**
- **Irritability**
- **Humiliation**
- **Anxiety**



Clemson Memorial Stadium
Pickens County



Waxhaw Presbyterian Cemetery
Lancaster County



Palmetto Trail Bridge
Fairfield County

Activating protective factors

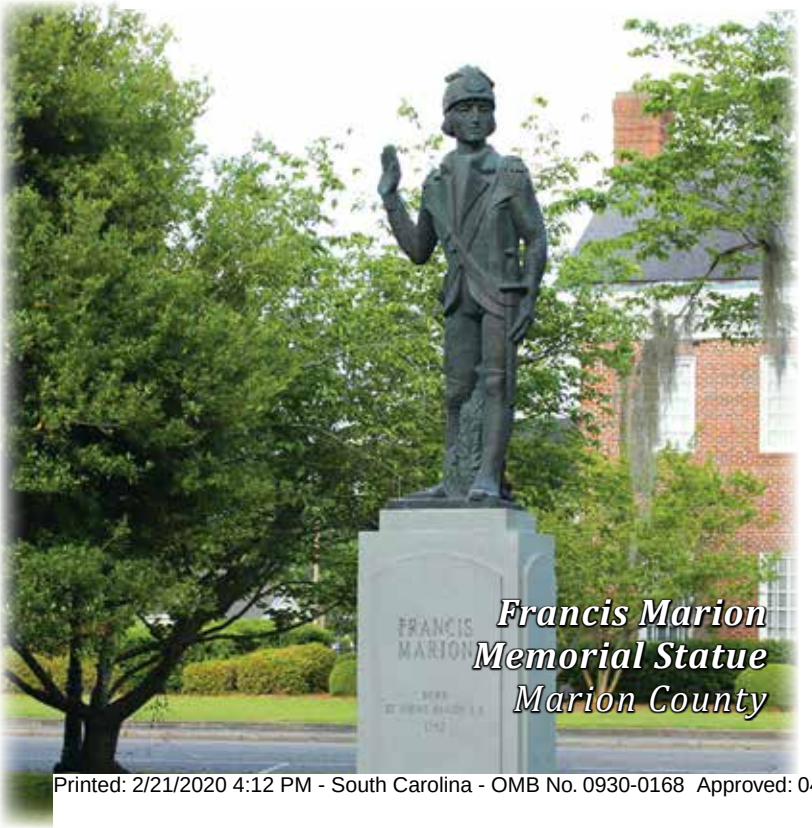
Goals, strategies and recommendations

Though educating residents of our state will improve their perspectives about suicide, having objectives and methods for fulfilling them is the only way to create effective, longterm suicide care pathways.

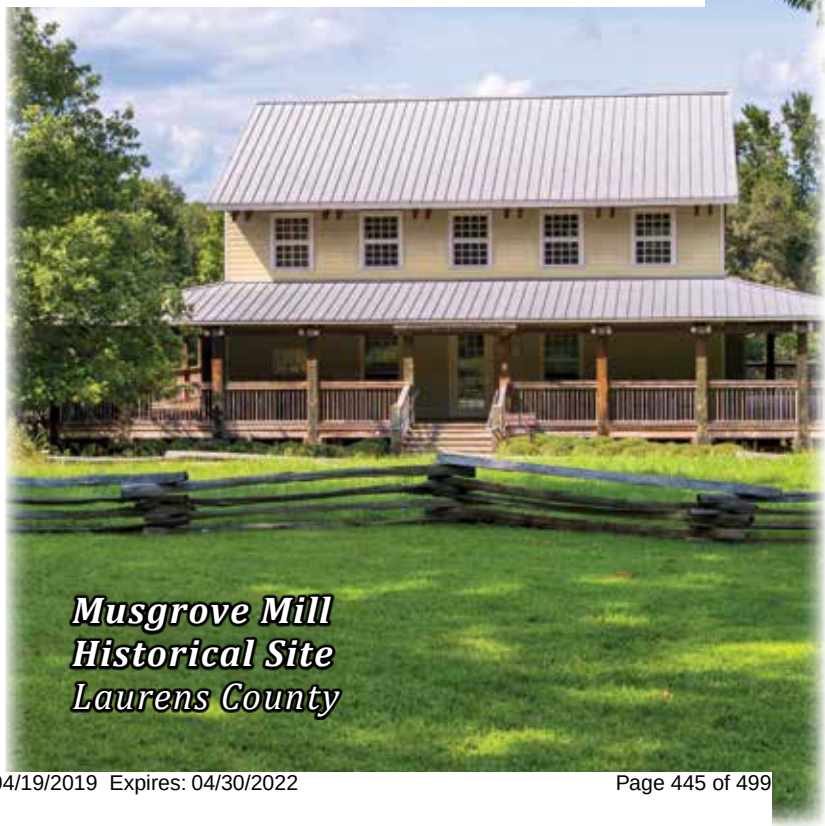
The goals, strategies, and recommendations in this plan address different areas of focus in suicide prevention, intervention, and longterm care, as well as how South Carolinians can help on individual, relationship, communal, and societal levels.

Each of these items is based on best-practice standards developed through extensive research, not simple opinions and conjecture.

If we work together, embracing the language and philosophies within this plan, these items will be of little difficulty to implement and accomplish.



Francis Marion Memorial Statue
Marion County



Musgrove Mill Historical Site
Laurens County

Activating protective factors | Overview

From the social ecological model, we established that risk factors must be addressed on four levels: Individual, interpersonal, community and societal.

Additional research has determined that there are nine essential protective factors that can be instituted by one or more of the levels identified in the social ecological model.

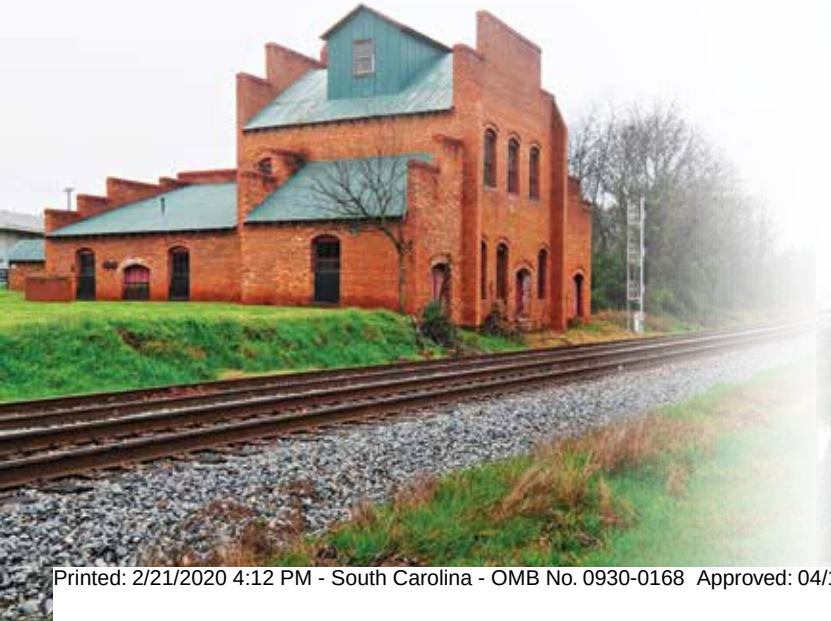
Social Ecological Model Levels



Identified Essential Protective Factors

- Increase coping & problem-solving skills
- Increase social norms that support recovery and help-seeking
- Improved access to quality physical & mental health care
- Increase connectedness to individuals, family, community & social institutions by creating safe & supportive school & community environments
- Increase safe media portrayals of suicide & adoption of safe messaging practices
- Increase support to suvivors of suicide loss
- Reduce access to lethal means
- Increase prevention & early intervention for mental health problems, suicidal ideation & behaviors, & substance abuse
- Increase collection & analysis of data regarding risk & protective factors to help guide prevention efforts

Dorn's Flour and Grist Mill
McCormick County



Marlboro County Courthouse
Marlboro County



On an individual level

Increase Coping and Problem-Solving Skills

STRATEGY: Make universal evidence-based health education and social/emotional health programs approachable and available.

EXAMPLES:

- Seeking mental and behavioral health services, i.e. Dialectical Behavioral Therapy
- Positive behavioral interventions and supports in schools, i.e. The Good Behavior Game, School-based mental health care services
- Life skills
- Financial planning & budgeting skills

THINGS YOU CAN DO FOR YOURSELF:

- Find a therapist or support group
- Build a support network (and use it) i.e. your social network, coworkers, friends, family, or spiritual connections
- Make a safety plan
- Call the **National Suicide Prevention Lifeline** or more resources and help: **1-800-273-8255 (TALK).**



Claflin University
Orangeburg County



On an interpersonal level



Increase connectedness to individuals, family, community & social institutions by creating safe & supportive school & community environments

STRATEGY: Promotion of child abuse prevention services to reduce risk factors that correlate to suicide

STRATEGY: Utilize the existing peer support infrastructure to embed suicide prevention strategies in supporting individuals in recovery

Things you can do for others anytime:

- Ask someone you are worried about if they're thinking about suicide
- Keep them safe. Reduce access to lethal means for those at risk
- Be there with them. Listen to what they need
- Help them connect with ongoing support. You can start with the **National Suicide Prevention Lifeline**:

1-800-273-8255

- Follow up to see how they're doing



Increase Coping and Problem-Solving Skills

STRATEGY: Implement and promote evidence-based parenting programs.

EXAMPLES:

- Guiding Good Choices
- Strengthening Families



Increase Support to Survivors of Suicide Loss

STRATEGY: Increase outreach to survivors of suicide loss through key partnerships to promote awareness of and access to suicide-specific grief supports.

STRATEGY: Provide support and resources to health and behavioral healthcare providers for when a client under their care dies by suicide.



On a community level



Increase Availability and Access to Quality Physical and Mental Health Care

Things communities can do to help:

- Identify and support people at risk of suicide
- Teach problem-solving and coping skills to help people manage challenges with relationships, jobs, health, or other concerns
- Promote safe and supportive environments
- Offer activities that bring people together so they feel connected and not alone
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary assistance for those struggling to make ends meet
- Prevent future risk of suicide among those who have lost a friend or loved one to suicide.
- Improve awareness of emergency resources like the National Suicide Prevention Lifeline (**1-800-273-8255**) and the Crisis Text Line (**741741**)

STRATEGY: Promote the adoption of the 'ZeroSuicide' framework by health and behavioral health care providers statewide.

Components of ZeroSuicide:

1. Engage leadership in a commitment to reduce suicide deaths
2. Develop a confident, competent, and caring workforce (quality training CMEs and CEUs for healthcare professionals)
3. Identify every person at risk for suicide using quality assessments (increase use of the Columbia-Suicide Severity Rating Scale)
4. Suicide Care Management Plan (policies and procedures)
5. Use evidence-based treatment to treat suicidal thoughts and behaviors directly

   EXAMPLES:
   - Use of the Stanley Brown Safety Plan
   - Counseling on Access to Lethal Means
   - Collaborative Assessment and Management of Suicidality
   - Dialectical Behavioral Therapy
   - Cognitive Behavioral Therapy for Suicide Prevention)
6. Support patients through every transition in care (sources of continued care after psychiatric hospitalization, warm handoffs and caring contacts and follow up procedures during care transitions)
7. Apply data-driven quality improvement

On a community level

Increase Availability and Access to Quality Physical and Mental Health Care

STRATEGY: Expand and strengthen South Carolina's existing crisis services and follow-up after a crisis

OBJECTIVES:

1. Promote existing services to increase awareness and utilization
2. Increase use of areas offering Mobile Crisis (CCRI), receiving centers and other stepped interventions and services

STRATEGY: Increase access to physical and behavioral healthcare services

OBJECTIVES:

1. Increase telehealth availability, particularly in rural communities
2. Increase access to psychotropic medication

Williams-Brice Stadium
Richland County



On a community level

Increase social norms that support recovery and help-seeking

STRATEGY: Increase awareness of suicide as a preventable public health problem utilizing research-informed communication that is designed to prevent suicide by changing knowledge, attitudes and behaviors.

OBJECTIVES:

1. Annually distribute data and resource flyers to professionals and individuals in SC which includes suicide data, prevention resources and crisis line numbers
2. Continue to increase SC capacity for evidence-based gatekeeper trainings (such as ASIST, Mental Health First Aid, Question, Persuade, Refer [QPR], etc.)
3. Develop, implement and evaluate communication initiatives that reach the whole or segments of the population to increase help seeking and promote recovery (e.g., Man Therapy, social media, etc.)



Dixie Belle Peach Orchard
Saluda County

On a community level

Limit access to lethal means

Firearms are the most lethal and most common method of suicide, accounting for 64.4% of all suicide deaths in the Palmetto State.

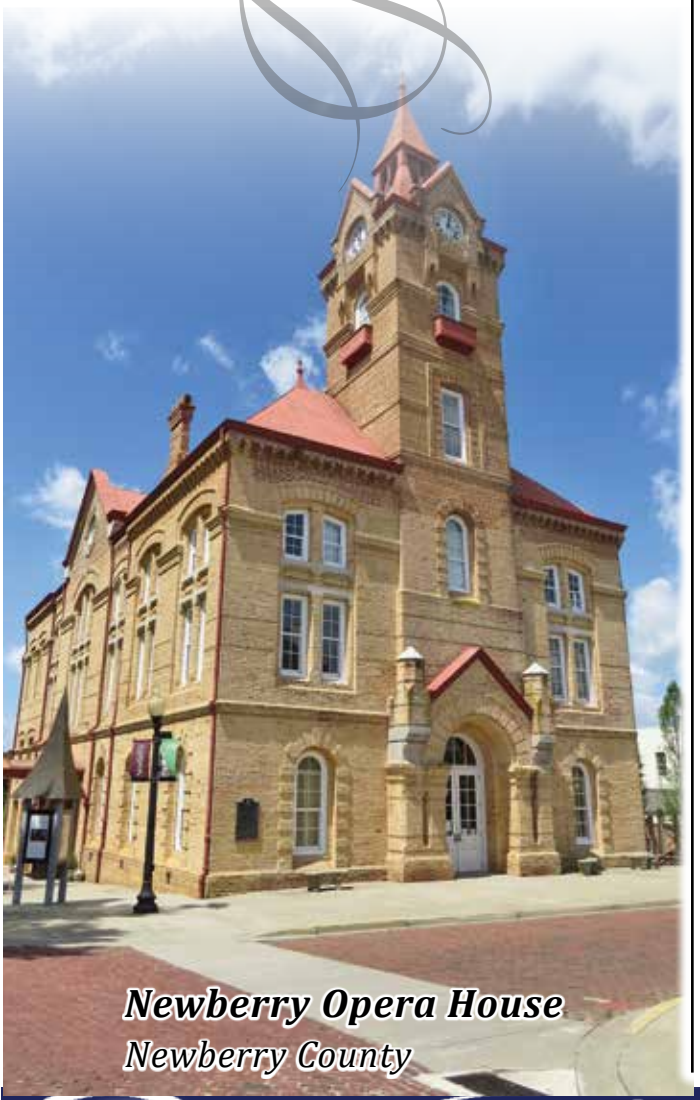
More people who die by suicide use a gun than all other methods combined. Suicide attempts with a firearm are almost always fatal. Those who use other methods are less likely to die; nine out of ten people who survive a suicide attempt do not go on to die by suicide, later.

Every U.S. study that has examined the relationship has found that access to firearms is a risk factor for suicides.

Firearm owners are not more suicidal than non-firearm owners; rather, their suicide attempts are more likely to be fatal. Many suicide attempts are made with little planning during a short-term crisis period. If highly lethal means are less available and temporarily postpone their attempt, the odds are increased that they will survive.

Studies in a variety of countries have indicated that when access to highly lethal and leading suicide methods is reduced, the overall suicide rate drops.

At a state and local level, we can work to ensure that every suicidal person and their loved ones hear the message that keeping firearms out of reach during a suicidal crisis can save lives.



Newberry Opera House
Newberry County

On a community level





Limit access to lethal means

Four practical steps:

1. Change policies by adding "Lethal means counseling" protocols to providers' and gatekeepers' existing suicide prevention protocols.
2. Train providers and gatekeepers how to conduct lethal means counseling.
3. Change information systems to cue providers to educate families.
4. Expand options in the community for temporary storage or disposal of firearms for families requesting these services.

1. Change policy

Encourage statewide and local professional groups and institutions to add a "lethal means counseling" policy to their current suicide prevention protocols to ensure that all suicidal or at-risk patients and their families are counseled about reducing access to guns at home.

Examples of state associations to target: state hospital association, social workers' association, school psychologist association, truancy officer association, etc.

Examples of local agencies to target: mental health agencies, emergency departments, schools, employee assistance groups, etc.

In most cases, your goal will be to add lethal means counseling policies to existing suicide prevention policies.

If a group doesn't have basic suicide prevention policies, try to work with them (or ask The S.C. Suicide Prevention Coalition) to work with them to adopt basic suicide prevention policies, as well as lethal means counseling policies.



On a community level



Limit access to lethal means

2. Train providers

Train providers who come into contact with people at risk for suicide and their families on how to talk about reducing access to firearms at home.

Most currently do not. A good training model is the CALM Training (Counseling on Access to Lethal Means), which trains mental health providers, emergency department personnel, and primary care providers.

The training covers three general areas (the public health approach to suicide prevention, firearm safety basics, and clinical skills in speaking with families about reducing access to firearms and lethal medications at home).

Suicidal people — particularly those who use a firearm — often don't seek out care by a mental health provider.

Think about other types of providers with whom they may come into contact, such as police, counselors providing services to domestic abusers, defense attorneys, substance abuse counselors, school truancy officers, primary care providers, etc. See other examples of means reduction programs.

3. Change Information Systems

One way to ensure that at-risk patients and their families receive lethal means counseling is to build reminders into an agency's information system.

For example, a health care institution with electronic patient charting software can add a flag to indicate whether the patient is considered at risk for suicide.

Checking off the patient as "at risk" would trigger the software to remind the provider to talk with the patient and his/her family about firearms and lethal medications at home, in addition to following the agency's existing protocols for responding to suicidal risk.

Standard paper forms (for example, intake forms for new psychiatric patients, suicide assessment forms used by school psychologists, etc.) could also include check-off boxes cueing the provider to ask about firearms at home.

On a community level

Limit access to lethal means

4. Expand options

Work with local police and other public safety groups to expand options for families who want to permanently or temporarily remove their guns.

Many police departments currently have no policy or protocols in place to dispose of or store firearms and are not able to help families. Work with them to explore some feasible options.

If you come up with good options (such as getting a local shooting range to offer storage lockers), please contact your local suicide prevention organizations and let us know so that we can spread the word.

STRATEGY: Provide training to providers (pharmacists, counselors, and physicians) who interact with individuals who may be at risk for suicide on counseling on access to lethal means.

STRATEGY: Partner with firearm retailers and gun owners to incorporate suicide awareness and prevention as a basic tenet of firearm safety and responsible firearm ownership.

STRATEGY: Promote and distribute tools/strategies to reduce access to lethal means such as gun locks, safes, and medication lock boxes/bags, etc. Promote existing resources such as drug takeback events, prescription drug drop-offs, and Use Only As Directed campaign.



School for the Deaf and Blind
Walker Hall
Spartanburg County

On a community level





Increase Connectedness to Individuals, Family, Community & Social Institutions by Creating Safe & Supportive School & Community Environments

STRATEGY: Support primary prevention and early identification of Adverse Childhood Experiences using partnerships with government, healthcare and behavioral health providers, schools and non-profits.

STRATEGY: Create safe environments for Lesbian, Gay Bisexual, Transgender, and Queer/ Questioning (LGBTQ+) youth and young adults including the promotion of research-supported initiatives such as Gay-Straight Alliances, the Family Acceptance Project, and the Trevor Project.

STRATEGY: Utilize community coalitions to increase opportunities for prosocial involvement by all community members.

STRATEGY: Partner with businesses to implement workplace wellness and suicide prevention/ postvention strategies.

STRATEGY: Support the local school district in the adoption of evidence-based suicide prevention, intervention, and postvention strategies and policies.



Increase Support to Survivors of Suicide Loss

STRATEGY:
Improve the quality and quantity of resources available to survivors of suicide loss by providing research-supported training opportunities.

On a community level



Increase safe media portrayals of suicide & adoption of safe messaging practices

STRATEGY: Increase positive hopeful communications efforts and support safe communication strategies in all media channels.

STRATEGY: Educate stakeholders and media representatives about safe messaging principles through resources like the National Action Alliance for Suicide Prevention.

STRATEGY: Use multiple media channels to increase sharing of lived experience stories of recovery from suicide and mental health conditions.

Increase Comprehensive Data Collection & Analysis Regarding Risk & Protective Factors to Guide Prevention Efforts

STRATEGY: Partner with the coroners' offices to increase access to data regarding suicides.

STRATEGY: Increase timely availability of suicide data to key stakeholders involved in prevention efforts.

STRATEGY: Implement the state level suicide fatality review committee to reduce gaps in services, improve inter-agency collaboration, and reduce barriers to accessing care.

STRATEGY: Strategize and prioritize methods to collect more comprehensive data regarding LGBTQ persons' risk of suicide ideation and suicide fatality.

On a community level

Increase Prevention & Early Intervention for Mental Health Problems, Suicide Ideation and Behavior and Substance Misuse

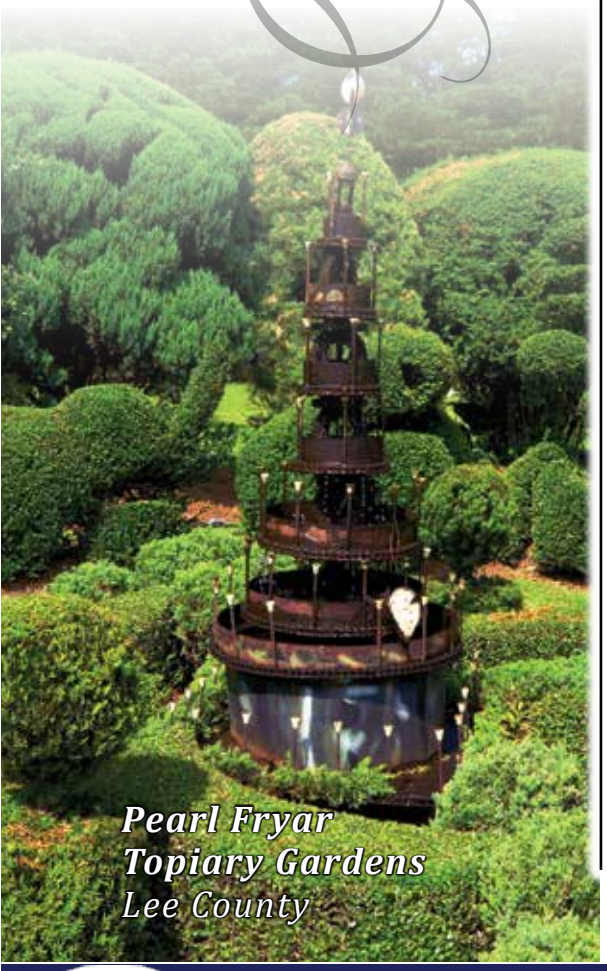
STRATEGY: Increase awareness of suicide as a preventable public health problem using research-informed communication that is designed to prevent suicide by changing knowledge, attitudes and behaviors.

STRATEGY: Develop and sustain public-private partnerships to advance suicide prevention.

OBJECTIVES:

1. SC Suicide Prevention Coalition including workgroups as currently constituted: Youth, LGBTQ, First Responders, Community Awareness, Firearm Safety, Workplace, Zero Suicide, Executive Committee.
2. The SC Suicide Prevention Coalition will provide support and technical assistance to community coalitions statewide to improve infrastructure and ability to address suicide prevention in their local communities.

STRATEGY: Promote and support the expansion of school-based mental health services, Mobile Crisis, and Family Resources Programs in all communities throughout SC.



Pearl Fryar
Topiary Gardens
Lee County



On a community level

Instill a sense of worth, belonging, and purpose in faith-based settings

Faith communities are a natural setting for suicide prevention, as spiritual beliefs and practices tend to help people experience greater hope and meaning in their lives.

Faith communities can also provide opportunities for developing positive relationships with others and can be an important source of support during difficult times.

There are nationwide initiatives and resources specifically aimed at recruiting and guiding faith-based communities in suicide prevention efforts.

Things faith-based communities can do:

- Reach out to individuals who you think might be at risk of suicide, then be supportive by listening to them and connecting them to resources
- If someone admits to suicidal thoughts or makes threats of suicide, emphasize the value of their lives; help them celebrate reasons for living
- Help individuals thinking about suicide build healthy social connections
- Create support groups and in-house services for individuals who are considering or have attempted suicide, as well as those who have lost someone to suicide.

General spiritual and faith-specific strategies for suicide prevention efforts can be found:

Faith.Hope.Life

http://actionallianceforsuicideprevention.org/faith-communities-task-force

Suicide Prevention Resource Center: The Role of Faith Communities in Preventing Suicide

http://www.sprc.org/sites/default/files/migrate/library/faith_dialogue.pdf



On a community level



Increase access to resources and normalize conversations about suicide in the workplace

The majority of people who die by suicide are of working age, and the workplace offers crucial opportunities to help employees who are struggling with suicidal thoughts, suicide attempts, or the aftermath of a suicide death.

The participation of business leaders, employers, managers, and coworkers is critical to the success of suicide prevention among working-age adults.

Every place of employment, regardless of size, can offer assistance.

For more information, visit:

www.theactionalliance.org/communities/workplace

Things managers and human resource personnel can do

- Post or disseminate suicide prevention resources to employees on a regular basis
- Include basic suicide prevention training for new hires, as well as refresher courses for existing employees
- Create a protocol for when an employee dies by suicide, including resources for those grieving the loss of their coworker
- Designate certain staff to act as a response team during the event of an employee's death by suicide
- Offer appropriate resources for employees who experience a loss to suicide outside the workplace
- Promote worker use of mental health resources and services
- Shift the cultural perspective on mental health by making it a priority. Leadership must model this shift, especially, and clearly communicate employee benefits and answer questions for concern.

On a societal level

Increase Connectedness to Individuals, Family, Community & Social Institutions by Creating Safe & Supportive School & Community Environments

STRATEGY: Promote evidence-based training, policies and protocols for first responders to support them in responding to mental health, substance use and suicide related incidents in the community



Colonial Dorchester Ruins
Dorchester County

THINGS OUR SOCIETY CAN DO EVERY DAY:

- Work to eliminate stigmas to help normalize conversations about mental health and suicide
- Support and promote suicide prevention efforts
- Encourage media outlets to adopt safe messaging practices about suicide
- Make learning about risk factors, protective factors and warning signs a common practice
- Familarize ourselves with resources for those at risk of suicide
- Improve willingness to identify and support individuals at risk of suicide
- Expand and improve assistance for housing and unemployment stresses

On a societal level





Increase Support to Survivors of Suicide Loss

STRATEGY: Promote and disseminate postvention protocols — including, but not limited to, Connect Suicide Postvention Training — in a variety of settings: workplace, schools, clinical settings, community, and media to promote healing and reduce risk of contagion.



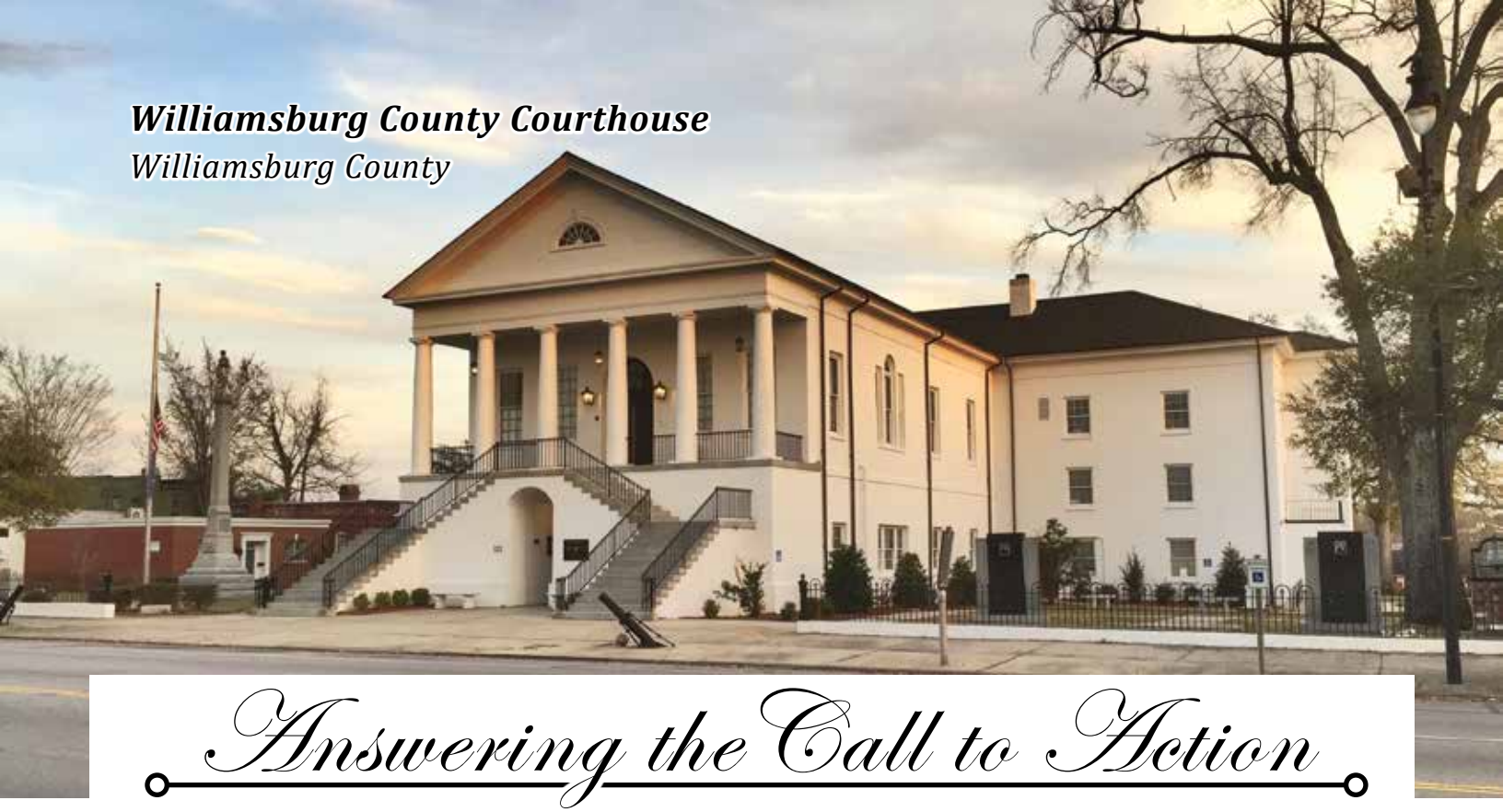
Increase Prevention & Early Intervention for Mental Health Problems, Suicide Ideation and Behavior and Substance Misuse

STRATEGY: Continue to increase South Carolina's capacity for evidence-based gatekeeper trainings

STRATEGY: Promote the implementation of mental health screening and referrals in work sites, schools, senior centers, and community settings.

EXAMPLES:

- ASIST
- Mental Health First Aid
- Question, Persuade, Refer (QPR)



Williamsburg County Courthouse
Williamsburg County

Answering the Call to Action

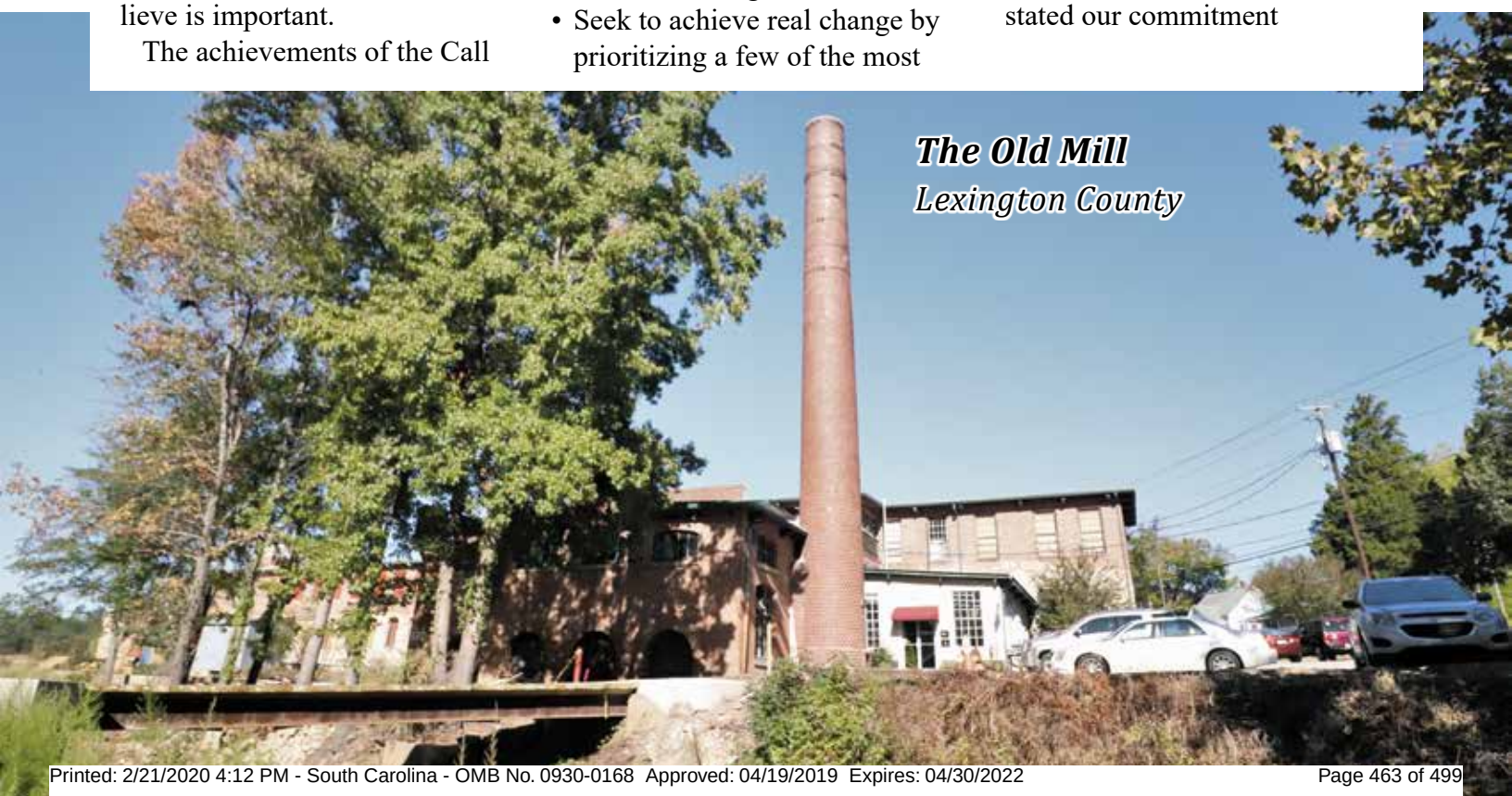
In South Carolina, a person dies every eleven hours by suicide. There are more than 44,000 deaths by suicide each year. More lives are lost to suicide than to road traffic accidents or homicide.

The Call to Action has been shaped by what stakeholders believe is important.

The achievements of the Call to Action are strongly dependent on the will and commitment of stakeholders to take action and to work together.

Help us fight suicide

- Engage organizations and communities so that together each of us plays their individual role in reducing suicide
- Seek to achieve real change by prioritizing a few of the most important issues to focus our joint energies on
- Recognize the good work already underway and help stakeholders share and coordinate activity
- Make us all more accountable for what we have promised to do because we have publicly stated our commitment



The Old Mill
Lexington County

FOR EMERGENCIES

If an individual is in immediate danger or poses a threat to someone else, please call **911**

National Suicide Prevention Lifeline
1-800-273-8255

Crisis Text Line
Text "HOME" to **741741**

State and Community Organizations

South Carolina Department of Mental Health

What we do: We aim to prevent suicides in South Carolina by de-stigmatizing suicide and increasing awareness through preventative services and training, campaigning for social policy change and contributing locally, regionally and nationally to implement an achievable cross-sector strategy.

What we aim to do:

- Work with schools to improve outcomes for children and young people with social, emotional or behavioural difficulties
- Strengthen regional SCYSPI partnerships
- Train in young suicide prevention
- Campaign for change in problem areas
- Hold strategic meetings with local & regional leads

How we would like to work with others:

Promote mental health and emotional wellbeing of all children and young people by:

- Reducing stigma
- Provide effective, easily accessible and acceptable mental health services for children and young people.
- Institute a common, unbranded, online portal where people can find help
- A universally accepted standard against which every health or public service provider can be assessed and which assures everyone can get appropriate support when trying to prevent a suicide
- A clear, simple, publicly accessible, universal, accurate data collection method, which produces more timely and accurate statistics of suicides, serious self-harm events, etc.

South Carolina Youth Suicide Prevention Initiative (SCYSPI)

What we do: The South Carolina Youth Suicide Prevention Initiative is a grant program of the Department of Mental Health (DMH). We are federally funded and evaluated by the Substance Abuse and Mental Health Administration (SAMHSA) division of the U.S. Department of Health and Human Services.

We have been tasked with reducing the instance of suicide among youth and young adults ages 10 to 24 in South Carolina. However, our systemic efforts positively impact the health and wellness of diverse populations across the lifespan.

We promote strength, resiliency, and hope for young people and their families by developing collaborative partnerships with statewide community-based organizations, state and local agencies, hospitals, inpatient facilities, academic institutions and many others who work together to reduce the incidents of suicide in youth and young adults throughout our state.

What we aim to do: To achieve our mission, we seek out and involve community partners and have built a coalition focused on preventing suicide in youth and young adults. We believe our role within the suicide prevention process works best when youth, young adults, survivors, those left behind by suicide, and professional and community stakeholders work together to:

- Understand cultural barriers associated with the topic of suicide prevention and grief support
- Be open, respectful and inclusive to the diversity in all lived experiences
- Provide access to information and resources

- Instill hope and advocate for programs and services that enhance community awareness
- Intervene and provide a space for those who are lonely, depressed, and suicidal or grieving the loss of someone by suicide to be heard
- Embrace recovery and nonjudgmental listening as the means for communicating and connecting with those affected by suicide

How we would like to work with others:

- Implore South Carolina schools to adopt our Suicide Prevention School-Based Program
- ZeroSuicide Program Implementation in health and behavioral health care settings
- Provide access to information and resources
- Best-Practice Suicide Safe Policy and Protocol development
- Follow-up / Aftercare planning and development
- Destigmatization and awareness strategies
- Tiered comprehensive best practice for community members and multi-disciplinary audiences
- Cultural competency trainings focused on high-risk populations (i.e. LGBTQ+ populations, individuals living with serious mental mental illnesses, etc.)
- Coalition and task force development
- Postvention consultation

Contact information:

South Carolina Youth Suicide Prevention Initiative
2205 Main Street
Columbia, SC 29201
Phone: (803) 896-4740
Email: *scyspi@gmail.com*
Website: *scyspi.org*

American Foundation for Suicide Prevention (AFSP) – South Carolina Chapter

What we do: Our grassroots work focuses on eliminating the loss of life from suicide in South Carolina by delivering innovative prevention programs, educating the public about risk factors and warning signs, raising funds for suicide research and programs, and reaching out to those individuals who have lost someone to suicide.

We bring together people from all backgrounds who want to prevent suicide in our communities. Families and friends who have lost someone to suicide, vulnerable individuals, mental health professionals, clergy, educators, students, community/business leaders, and many others energize our chapter.

What we aim to do: As an organization that is dedicated to saving lives and bringing hope to those affected by suicide, AFSP creates a culture that's smart about mental health by engaging in the following core strategies:

- Funding of scientific research
- Educating the public about mental health and suicide prevention
- Advocating for public policies in mental health and suicide prevention
- Supporting survivors of suicide loss and those affected by suicide.

How we would like to work with others:

Research

AFSP began as a research organization dedicated to finding the best ways to prevent suicide. Much of what is known about suicide comes from studies that AFSP has funded. Our studies open up new areas of inquiry, and our council of scientific advisers helps set the national research agenda.

- Encourage research and promote AFSP research opportunities.

Education

Talk Saves Lives™ Training: A community-based presentation that covers the general scope of suicide, the research on prevention, and what people can do to fight suicide.

- Conduct Talk Saves Lives™ presentations throughout the state to educate South Carolinians on the risk and warning signs of suicide, and how together, we can help prevent it. Talk Saves Lives is also available in Spanish and in the following additional modules: Firearm Owners, Seniors, and LGBT.

Mental Health First Aid Training: In a partnership with the National Council for Behavioral Health, AFSP chapters host Mental Health First Aid (MHFA) train-

ings. MHFA is an eight-hour training that teaches participants a five-step action plan to help someone who is suffering from a mental health crisis.

- Provide MHFA training to teach participants an action plan to help someone in distress.

SafeTALK: A Living Works program, SafeTALK is a half-day alertness workshop that prepares anyone over the age of 15, regardless of prior experience or training, to become a suicide alert helper.

Seniors and Suicide brochure and literature: distribution of our Seniors and Suicide brochure and literature with the Governor's Office on Aging and locations affiliated with senior programs and outreach.

College Campuses

- Implement AFSP's signature intervention program, the **Interactive Screening Program** (ISP) at additional SC colleges
- Grow **Out of the Darkness Campus Walks** on SC college campuses
- Provide the AFSP-produced film **It's Real: College Students and Mental Health** that is designed to raise awareness about mental health issues commonly experienced by students, and is intended to be used as part of a school's educational program to encourage help-seeking. The film and guide encourage students to be mindful of the state of their mental health, to acknowledge and recognize when they are struggling, and to take steps to seek help.

Middle Schools and High Schools

- Continue to train school counselors and educators to deliver **More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel** and **More Than Sad: Teen Depression**
- Implement training programs for parents with **More Than Sad: Parent Training**
- Promote **Signs Matter** online program for K-12 Educators

Advocacy

- Sponsor Advocacy Events for legislators to bring attention to policies that can make a difference in saving lives
- Recruit new volunteers for Field Advocate Program
- Continue partnerships and/or task groups with SC Department of Education, Department of Mental Health, and DHEC - SC Violent Death Reporting System.
- Continue to build relationships with the military and veterans through summits, workshops and other program activities with Fort Jackson, South Carolina National Guard, Veterans Administrations, and the Veterans Policy Academy.

Support survivors of suicide loss

- Provide programs and resources for healing as well as volunteer opportunities for survivors who find meaning in supporting their peers.
- Promote **Survivors Outreach Program**. In the aftermath of a suicide, trained AFSP suicide loss survivor volunteers meet in person, by phone, or video chat with the newly bereaved to provide support and resources.
- Provide host sites for **International Survivors of Suicide Loss Day** held yearly the Saturday before Thanksgiving. On Survivor Day, people affected by suicide loss gather in local communities to find comfort and gain understanding as stories of healing and hope are shared.
- **Administer AFSP's signature Out of the Darkness Community Walks** to increase suicide prevention awareness and provide support to those affected by suicide.
- (803) 552-9318

NAMI South Carolina
National Alliance on Mental Illness

National Alliance on Mental Illness (NAMI) South Carolina

What we do: NAMI is the nation's largest grassroots mental health nonprofit organization dedicated to building better lives for the millions of Americans affected by mental illness. One in four adults and one in five youth are affected by mental health conditions. We are working to dispel the myths and reduce the stigma associated with mental illness through support, education and advocacy in South Carolina.

What we aim to do:

- Support individuals living with a mental health condition and their families through free area sup-

port groups
- Offer free education presentation programs for students, school staff and families which includes warning signs and symptoms for mental health conditions, facts and statistics. There is a portion of each of the three Ending the Silence programs that focuses on suicide awareness and prevention.
- Offer free presentations (Ending the Silence, In Our Own Voice) and course presentations (Family-to-Family, NAMI Basics, Homefront, Peer-to-Peer, Provider Education, Crisis Intervention Training) in the community and to individuals living with mental health conditions and their families.
- Collaborate with partners and advocate to raise awareness and bring more services to South Carolina.

How we would like to work with others:
- A common, unbranded, online portal where people can find help.
- A universally accepted standard against where all service providers can be assessed to assure everyone can get appropriate support when trying to prevent a suicide.
- A clear, simple, publicly accessible, universal, accurate data collection method, which produces more timely and accurate statistics of suicides, and serious self-harm events.

Contact information:
NAMI South Carolina
P.O. Box 1267
Columbia, SC 29202
(803) 733-9591

Mental Health America of South Carolina
(803) 779-5363

South Carolina Coalition Against Domestic Violence and Sexual Assault (SCCADVASA)

What we do: SCCADVASA is the statewide coalition of organizations providing intervention services to victims and survivors of domestic violence and sexual assault and Primary Prevention programs to students and communities across the state.

What we aim to do: We work towards ending domestic and sexual violence in South Carolina and beyond through engaging individuals and communities in advocacy, collaboration and education. We advocate for the transformative social change that will result in a society free of violence, push for policy changes that support survivors, and provide education and technical assistance to build the capacity of our members, allied organizations and communities to provide trauma-informed and survivor-centered services.

How we would like to work with others:
- Collaborate in preventing all forms of violence and trauma and understanding how our work can contribute to the overall goal of greater safety for everyone in the state.
- Support allied organizations in understanding the dynamics of sexual and domestic violence and the diverse needs of survivors when they access services.
- Incorporate suicide prevention strategies into services for survivors of domestic and sexual violence.

Contact Information:
Phone: 803-256-2900
Mail: P.O. Box 7776
Columbia, SC 29202
Email: *info@sccadvasa.org*

SOUTH CAROLINA NATIONAL GUARD

South Carolina National Guard (SCNG) Suicide Prevention Program

What we do: *"One suicide is one too many."*
Our goal is to improve awareness through the development and enhancement of the Suicide Prevention Program policies designed to minimize suicide behavior and reduce the stigma to facilitate the willingness to seek Behavioral Health treatment, thereby preserving life through individual readiness for service members, their families, and the citizens of South Carolina. The end state of this goal is to have Zero Suicides in South Carolina, and to build a Suicide-Safer Community.

What we aim to do:

- Educate our population about the resources both military and civilian around South Carolina
- Use Applied Suicide Intervention Skills Training (ASIST) and Ask, Care, Escort (ACE) to prepare our Military and Community Leaders to Engage with someone who is having Suicidal Thoughts and Empower them with the ability listen, show compassion, and encourage self-motivation to seek and receive Behavioral Health treatment.

  Applied Suicide Intervention Training (ASIST)
  ASIST is a two day course developed by living works education. The Key learning objective is awareness of person at risk concerns, caregiver tasks, and development of intervention skills using an internationally known suicide intervention model. ASIST two day workshops are coordinated one a month throughout the year by the Suicide Prevention Program Manager (SPPM) of SCNG.

  Ask, Care, Escort (ACE)
  ACE training equips personnel with the skills necessary to recognize suicidal signs and symptoms and basic intervention techniques.
- Consistently be a Voice to all levels of leadership in the importance of providing Suicide Prevention Training and Awareness activities and events throughout our units and in our local community.
- Attend State, Regional, and Local Coalition and other policy meetings to coordinate our efforts with other Leaders in the Suicide Prevention Community.

How we would like to work with others:

- We coordinate with the ASIST Trainers from all community partners to provide ASIST training anywhere in SC.
- We have a page where everyone can find out what our resources are www.facebook.com/SCNGSP-PM.
- SCNG provides 8 Centers around SC that have a Behavioral Health Specialist that is licensed and ASIST trained.
- We provide Speaking Presentations for one hour or up to an all-day workshop.
- Our Volunteers from the SCNG provide over 500 hours of service to assist various Suicide Prevention Organizations around SC.

Contact information:

SFC Christopher Allen
R2 Suicide Prevention Program Manager
Office: 803.299.2736
Cell: 803.727.2092
Email: christopher.j.allen2.mil@mail.mil

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The South Carolina Suicide Prevention Coalition would like to thank the numerous photography talents who donated their artwork to this document.

Your contributions capture the beauty and history of our beloved state from perspectives and through artistic lenses as diverse and unique as the residents who call The Palmetto State home.

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Abbeville Court Square — Page 4
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References

- *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*. Deb Stone, ScD, MSW, MPH; Kristin Holland, PhD, MPH; Brad Bartholow, PhD; Alex Crosby, MD, MPH; Shane Davis, PhD; Natalie Wilkins, PhD. National Center for Injury Prevention and Control – Division of Violence Prevention, Centers for Disease Control and Prevention. 2017. URL: *https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf*

- *Vital signs: June 2018*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. 2018. URL: *www.cdc.gov/vitalsigns/pdf/vs-0618-suicide-H.pdf*

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

While SCDMH has historically worked with the South Carolina Department of Education, the South Carolina Law Enforcement Assistance Program, and the South Carolina Vocational Rehabilitation Department, respectively, SCDMH has in the past 12 months begun new initiatives with each organization, demonstrating the long-term commitment all four organizations have to the shared populations they serve.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

The South Carolina Department of Mental Health (SCDMH) has a diverse portfolio of strategic partnerships that contribute to the achievement of its mission: to support the recovery of people with mental illnesses. Included in the portfolio are other departments of South Carolina State Government; entities representing service providers, advocates, associations, and other stakeholders; and educational institutions in South Carolina and other states. The number of such partnerships, however, is likely to increase as the Department constantly scans its environment to capitalize on its collective wisdom to describe the future as clearly and comprehensively as possible, and to identify partners who will affect positive outcomes for the citizens of the State of South Carolina, especially those impacted by mental illnesses.

Evidence of the support of state partners is best represented by the active role of certain agencies (listed below) in serving on the South Carolina Mental Health State Planning Council (Planning Council).

South Carolina Department of Education
South Carolina Department of Health and Human Services
South Carolina Department of Juvenile Justice
South Carolina Department of Social Services
South Carolina Department of Vocational Rehabilitation
South Carolina State Housing Finance and Development Authority
South Carolina Department of Alcohol and Other Drug Abuse Services

The Planning Council also includes a representative from one of the major public educational institutions in the state: Clemson University.

SCDMH also maintains contracts, memorandums of agreement, and other working-level documents with agencies that demonstrate specific efforts and endeavors on which SCDMH and these agencies are partnered. Such relationships include the South Carolina Emergency Management Division, South Carolina Department of Environmental Control, and the South Carolina Department on Aging.

Additional partnerships are evidenced by the 700+ schools in which SCDMH has placed a Mental Health Professional, relationships which require a contractual basis and philosophical agreement.

It should be noted that the information provided above serves only as a sample of the diverse portfolio of strategic partnerships that is maintained by the South Carolina Department of Mental Health. These relationships demonstrate recognition by each agency that solutions to the issues facing individuals with mental illnesses are not constructed in isolation, but require overlapping layers to address what are often times overlapping conditions and situations.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The South Carolina Department of Alcohol and Other Drug Abuse Services is responsible for the mechanisms to plan and implement substance misuse prevention, SUD Treatment, and recovery services related thereto.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Please see the attached South Carolina Mental Health State Planning Council Bylaws; specifically, Article II.

As a function of the South Carolina Mental Health State Planning Council's classification as a body politic, it publishes each year and places on the SCDMH website (https://scdmh.net/public-information/) Events Calendar. a Notification of Meeting Schedule (see attached) which provides an opportunity for the public to interface with the Planning Council and SCDMH.

Please also see Letter from South Carolina Mental Health State Planning Council Chairperson.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[70]

[70] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

SOUTH CAROLINA MENTAL HEALTH STATE PLANNING COUNCIL BYLAWS

ARTICLE I. NAME

The name of this organization shall be the South Carolina Mental Health State Planning Council. The South Carolina Mental Health State Planning Council may also be informally referred to as the "Council," the "Planning Council" or the "State Planning Council."

ARTICLE II. PURPOSE

As required under the Public Health Services Act, 42 U.S.C. 300x-3, the purpose of the Council is to:

a. Review the Community Mental Health Services Block Grant Uniform Application and Behavioral Health Report and make recommendations.
b. Serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses.
c. Monitor, review, and evaluate – not less than once a year – the allocation and adequacy of mental health services within the state.

ARTICLE III. MEMBERSHIP

Section 1. Qualifications

a. Council membership composition shall reflect the mental health stakeholder community.
b. Council members shall include adults with serious mental illness who are receiving or have received mental health services, family members of such adults or families of children with emotional disturbance, public and private community-based providers, advocacy organizations, and state agency representatives from mental health, education, vocational rehabilitation, criminal justice, housing, social services, alcohol and drug, and health and human services Medicaid division.
c. The ratio of parents of children with a serious emotional disturbance to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council.
d. At least fifty-one percent (51%) of the Council shall be comprised of adults with serious mental illness who are receiving or have received mental health services or who are family members of such adults or families of children with emotional disturbance.

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e. The Council, upon recommendation of the Nominating/Membership Committee, shall determine status as a "provider" of mental health services. Such determination shall be made upon recommendation of election by the Council and may be changed upon receipt of new or changed information. In order to facilitate such determination, applicants for and members of the Council shall be required to disclose to the Nominating/Membership Committee any work regularly performed for pay as, or for, a provider of mental health services.
f. Volunteers, advisory, and governing board members shall not be considered as providers solely based on such status.
g. Under general ethical principles, members of the Council shall recuse themselves when they have a direct financial stake in the outcome of a Council decision, independent of their status as a provider.

Section 2. Election

a. Prospective members and returning members shall be elected by a majority vote of current members present and voting.
b. Elections should be held at the last regular meeting of the fiscal year, no later than June 30. However, upon approval by a majority vote of current members present and voting, elections may be held out-of-cycle.
c. Current members may recommend prospective members to the Nominating/Membership Committee.
d. Prospective members must complete the Application for Election to the South Carolina Mental Health State Planning Council and submit said application, and any other supplemental information requested and related thereto, within reason, to the Nominating/Membership Committee.
e. Upon review and proper vetting of the application of a prospective member by the Nominating/Membership Committee, the names of those prospective members deemed qualified to serve on the Council, along with the respective applications, will be submitted to the State Director of the South Carolina Department of Mental Health for review and recommendation(s). Said recommendation(s) will then be submitted to the Chair of the Nominating/Membership Committee for presentation to the Council on which the Council will then vote according to Article III, Section 2, Items a and b,

Section 3. Terms

a. The terms of the Council members shall be three (3) years and staggered.
b. A member may serve multiple terms subject to Article III, Section 5.
c. A term is established by and follows the state fiscal year – July 1 to June 30.

Section 4. Vacancies

a. Any member appointed to fill a vacancy for an unexpired term, subject to Article III, Section 2, Items d and e, shall serve for the remainder of such term. Upon

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completion of said unexpired term, said member may be re-elected to the Council for a full-term.

Section 5. Resignation and Removal

a. A Council member may resign at any time by giving written notice to the Chair, which will take effect upon receipt of the notice.
b. A Council member may be removed at any time upon a majority vote of those members of the Council present at the meeting during which the vote is scheduled to be taken.
    a. Causes for removal include one or more of the following:
        i. Absence from three (3) consecutive Council meetings without a justifiable medical, business, or personal excuse;
        ii. When the member is no longer a resident of the state; or
        iii. When a conflict of interest renders an individual unqualified to serve on the Council pursuant to Article III. Section 1.

ARTICLE IV. FISCAL YEAR

The fiscal year of the Council shall be July 1 through the following June 30.

ARTICLE V. MEETINGS

Section 1. Schedule

a. The Council shall meet at least four (4) times per fiscal year.
b. The purpose of these meetings shall comport with the duties of the Council as defined by PL 102-321 and Article II above.

Section 2. Quorum

a. For the purpose of conducting the business of the Council, the members present shall constitute a quorum.
b. Any member of the Council who has been absent from two consecutive meetings will forfeit their voting privileges. Voting privileges will be reinstated at the next attended meeting.

Section 3. Compensation

a. The members of the Council shall serve without pay.
b. The Council may authorize or recommend the timely payment of reasonable and necessary expenses incurred by members in the performance of their duties. Such payment is subject to the availability of Community Mental Health Services

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Block Grant Funds appropriated for said purposes and the approval of the South Carolina Department of Mental Health.

a. Members of the Council whose participation is not being rendered in the course of a job function, or as the result of an affiliation with any organization, are eligible for mileage reimbursement at the maximum mileage reimbursement rate for state employees when a state vehicle is not available as set forth in the Appropriations Act of the General Assembly of the State of South Carolina under the proviso entitled "Travel – Subsistence Expenses & Mileage."
    i. Members whose participation in Council activities are rendered on a volunteer basis, generally those whose Type of Membership as described in Article III, Section 1 is designated as either "Individuals in Recovery (from Mental Illness and Addictions)" and "Family Members of Individuals in Recovery (from Mental Illness and Addictions" according to the prevailing definitions by the Substance Abuse and Mental Health Services Administration (SAMHSA) at the time of request for reimbursement qualify for mileage reimbursement.
    ii. The value per mile for mileage reimbursement shall be calculated according to the prevailing rate utilized by the South Carolina Department of Mental Health at the time at which the request for reimbursement is initially received.

Section 4. Open Meetings

a. All meetings of the Council shall be open to the public.
b. A reasonable period of time shall be set aside at all meetings of the Council for members of the public to address the Council.
c. Members of the public shall be permitted to propose "new business" for the next meeting of the Council. Subject to veto by the Council, such new business shall be placed on the next Council meeting agenda.

ARTICLE VI. ELECTION OF OFFICERS

The officers of the Council shall be Chair, Vice Chair, and Secretary.

Section 1. Election and Terms

a. Officers should be elected for a two (2) year term by a majority vote of Council during the last regular meeting of the fiscal year. However, upon approval by a majority vote of current members present and voting, elections may be held out-of-cycle.
b. Officers shall be elected either upon the expiration of the term of the respective office as defined by Article VI, Section 1, Item a, or upon the resignation of the member of the Council holding said office. A member of the Council filling a

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vacancy shall serve for the remainder of such term. Upon completion of said unexpired term, said member may be re-elected to the office for a full-term, but not to exceed two (2) full terms as described in Article VI, Section 1, Item d.

c. Officers shall assume their official duties beginning July 1.
d. A member of the Council shall not be eligible to serve more than two (2) full consecutive terms in the same office.
e. Only a member of the Council who has served for at least one (1) year shall be eligible to hold office.
f. Only those persons who have signified their consent to serve, if elected, shall be nominated for, or elected to, such office.

Section 2. Role of the Nominating/Membership Committee and Council in the Election of Officers for the South Carolina Mental Health State Planning Council

a. The Nominating/Membership Committee shall solicit from the Council names of eligible members of the Council for specific officer positions.
    1. No member serving on the Nominating/Membership Committee, nor any member of the Council who has served on the Nominating/Membership Committee within one (1) year of the current election of officers, may be nominated for an officer position until such time as one (1) year has elapsed between said service and the election of officers.
b. The Nominating/Membership Committee shall report the slate of prospective officers to the Council fourteen (14) days prior to the last regular Council meeting of the fiscal year. Nominations for said officer positions may also be accepted from the floor.
    1. If more than one candidate is presented for a specific officer position, then a separate vote must be held for said position. The candidate receiving the majority of the votes of quorum will be awarded the office.
c. Upon acceptance of the slate of prospective officers by the Council, the slate shall be elected by a majority vote of the quorum, or, if no alternate candidates are proposed, by acclamation.

Section 3. Vacancies

a. Upon vacancy of an office, the Nominating/Membership Committee shall recommend an eligible member to the Council with a fourteen (14) day notice before the next regular Council meeting.
b. A vacancy occurring in any office shall be filled for the unexpired term by a qualified member elected by a majority vote of the remaining members of the Council.

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ARTICLE VII. DUTIES OF OFFICERS

Section 1. The Chair shall:

a. Oversee all regular and called meetings of the Council;
b. Serve as ex-officio member of all committees;
c. Work in partnership with the state planner to ensure Council resolutions are carried out;
d. Call special meetings of the Council, or its respective standing, or ad hoc committees, if necessary;
e. Appoint, with approval by the Council, all committee members and committee chairs, excluding the Nominating/Membership Committee, in consult with the planner;
f. Assist in preparing the agenda for Council meetings;
g. Assist in conducting new member orientation;
h. Work with the Nominating/Membership Committee to recruit new Council members;
i. Act as a spokesperson for the Council;
j. Periodically consult with members on their roles and help them assess their performance.

Section 2. The Vice Chair shall:

a. Attend all Council meetings;
b. Understand the responsibilities of the Chair and be able to perform these duties in the absence of the Chair;
c. Participate in Council leadership.

Section 3. The Secretary shall:

a. Attend all Council meetings;
b. Review meeting minutes;
c. Assist the Chair with attendance, quorum and action of the Council;
d. Assume responsibilities of the Chair in the absence, or inability, of both the Chair and Vice Chair.

ARTICLE VIII. COMMITTEES

Section 1. The following committee(s) of the Council is provided for by reference in these Bylaws in Article VI, Section 2.

a. The Nominating/Membership Committee

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Section 2. Nominating/Membership Committee

a. At a regular meeting of the Council in the month of January a Nominating/Membership Committee and Chair consisting of an uneven number - not less than three (3) – of members of the Council shall be elected by the Council to serve a one (1) year term.
b. The role of the Nominating/Membership Committee is designated within the respective Articles of these Bylaws.

Section 3. Ad Hoc Committees

The Chairperson may appoint special or standing committees as may be deemed advisable. Each such committee shall have such powers and authority as shall be specified by the Council. The Chairperson shall appoint members of committees and shall designate the chairperson of each committee.

Section 4. Removal

The chair or any member of any committee may be removed for willful misconduct by a majority of a quorum of the Council at any time at a properly called meeting of the Council.

ARTICLE IX. ANTI-DISCRIMINATION

The Council shall not discriminate in any regard with respect to race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy, parenthood, custody of a minor child or physical or mental disability.

ARTICLE X. PARLIAMENTARY AUTHORITY

The rules contained in the current edition of Robert's Rules of Order. Newly Revised shall govern the Council in all cases to which they are applicable and in which they are not in conflict with these bylaws and any special rules of order that the Council may adopt.

ARTICLE XI. PROCEDURES

Section 1. Quorum

See Article V, Section 2.

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Section 2. Voting

a. Council decisions should be made by consensus.
b. If voting becomes necessary, a simple majority of the members present at the meeting will be sufficient for a vote on any issue.
    1. Types of Voting
        i. By Voice – The Chairperson may ask the members of the Council to indicate in the affirmative those members in favor of a motion, and to indicate an objection those members not in favor of a motion. Any member may move for an exact count.
        ii. By General Consent – The Chairperson may present all members with the opportunity to object, which by their silence will indicate agreement with the motion. If a member indicates an objection, the motion must be put to a vote.
        iii. By Ballot – Any member may request that a ballot vote be conducted regardless of the subject matter.

ARTICLE XII. AMENDMENT OF BYLAWS

The bylaws may be amended at any regular meeting of the Council by a two-thirds vote of all members listed on the Membership Roster of the Council provided that the proposed amendment has been submitted in writing to all members fourteen (14) days in advance of the meeting. The bylaws may be reviewed every two (2) years and any amendments and revisions shall be in accordance with PL 102-321.

Adopted the 21st day of March 20 18.

Chair Jane B Simpson
Signature

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Notification of 2019 Meeting Schedule
South Carolina Mental Health State Planning Council

Notice is hereby given that at the November 21, 2018 meeting of the South Carolina Mental Health State Planning Council (Council), the Council approved the dates and times upon which it will convene its meetings in 2019.

The meetings will be held from 10:00AM to 11:45AM on the following dates in Room 323 of the South Carolina Department of Mental Health Administration Building, located at 2414 Bull Street, Columbia, SC.

January 16, 2019	July 17, 2019
March 20, 2019	September 18, 2019
May 15, 2019	November 20, 2019

Please note that the Council may also convene subcommittee meetings on the same dates. Additional information will follow. Please refer to the published agenda for each respective date to determine if subcommittee meetings are intended.

For additional information, please contact Stewart Cooner, Director of Special Programs, at 803-898-8632, or via email at stewart.cooner@scdmh.org, or via postal mail at 2414 Bull Street, Suite 201, Room 1, Columbia, SC 29201.

August 29, 2019

Ms. Odessa Crocker
Grants Management Officer
Division of Grants Management, Office of Financial Resources
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, Maryland 20857

To Whom It May Concern:

I am writing on behalf of the South Carolina Mental Health State Planning Council.

The Council has been reviewing the indicators, and other block grant information. Comments from members are included in this Application. The Council has also been asked to share its goals for Department of Mental Health (DMH) services for the coming year.

We have been expanding Council membership to include a wide variety of members in our combined voice. For example, the Council has broadened the "other" category. We have added a Charleston Law Enforcement officer as well as a Suicide Prevention Officer for the South Carolina National Guard.

The Council has instituted a "name tag" policy for all members. Each Council member wears, during the meeting, a lanyard identification showing only their first name. This is to reaffirm how everyone's voice on the Council is equal - from an individual to a deputy director of any state agency. The Chair of the South Carolina Mental Health Commission, who oversees the governing body of SCDMH, attends and has requested we all refer to him only as "Greg" so as to reiterate that all our voices are equal.

The Council holds special presentations at every meeting so we can evaluate the effectiveness of certain mental health services throughout the state. So far this year, we've had presentations by the SCDMH director of the auditing department, the program manager for Telepsychiatry, the Director and a peer support specialist from G. Werber Bryan Psychiatric Hospital, and the lead psychologist from South Carolina Department of Juvenile Justice. At the upcoming September meeting, we will be learning about all the transition services for people moving from DMH psychiatric hospitals into the community. DMH has taken several steps to ensure a smooth transition for mental health patients. At our final meeting of the year, in November, a center director is bringing in some of her therapists to share about their Dialectical Behavioral Therapy services.

The Council monitors mental health services by inquiring about and discussing the topics the Director of SCDMH and all his Deputy Directors report on each meeting. The reports include updates from various divisions at SCDMH which allows members to review specific information.

As Chair, I've advocated at the SC Legislature regarding mental health issues. As a Council, we take a strong interest in mental health legislation moving through the Assembly.

I gave sworn testimony to a House Legislative Oversight Subcommittee on August 12, 2019 at the SC State House. Below is the testimony I shared with the subcommittee.

Dear Chair and Members of the Legislative Oversite Subcommittee:

Thank you for allowing me to speak today.

I'm Janie Simpson and I'm a mental health advocate.

I'm also a person living with mental illness. So, I want to truly thank you for respecting the privacy of someone like me.

I'm open about my struggles and speak out to fight stigma - but still, it is my choice what I share or do not share.

Today I want to talk to you about my interactions with staff and senior leadership at the Department of Mental Health. There's a pattern and I'd like to share with you what I've experienced.

Years ago, there were no cameras in Bryan Psychiatric Hospital and I really wanted to see them added!

I've had experiences in private psychiatric hospitals where I was not protected and had there been cameras, there would have been proof of my concerns.

So I went to then State Director, John Magill - asking him to please install cameras at Bryan to protect patient rights.

A few years later after cameras were installed, I was given a tour of the hospital so I could see all the cameras. They were all throughout the lodges, small black orbs that picked up everything that was happening.

Now, I want to tell you about the Director of Bryan psychiatric hospital, Stuart Shields. Stuart gave me the tour of the hospital. What really struck me was how comfortable the patients were approaching Stuart, telling him about any concerns they may have. He listened and it was obvious how much he cared; you could see they knew he was truly listening. Stuart told me at one point, if he was having a difficult day, he'd go out to the floors of Bryan. He said talking to the patients reminded him of why he was really there.

Finally, I want to share an example of the general attitude of senior leadership at DMH. I'll be reading you an email REPLY I received from Interim State Director, Mark Binkley

after I sent him a message thanking him for some measures he took after a beloved member of our mental health community died by suicide.

Here is what interim state director Mark Binkley said to me:

"Thanks, Janie—

Caring hurts at times when, despite all your efforts and the efforts of other people who care, bad things still happen. It's understandable to feel discouraged or frustrated, but you know and I know that we won't stop caring. And despite the tragedies, everyone who cares and does their best is making a positive difference, including you. We are helping a lot of people, and saving a lot of lives. But it's still discouraging when something bad happens.

--Mark"

So, this is typical of my experiences with the Department of Mental Health. I've seen them add cameras to protect the patients, walked the hospital floors with the Director, observing all the positive interactions between him and the patients. And overall, I've seen how much compassion and understanding the senior leadership has for people like me.

I still struggle with psychiatric symptoms from time to time. But I haven't felt I had to hide my symptoms for fear of losing respect as a mental health advocate. I've received nothing but understanding and support within all the levels of leadership - from the State Director to members of the DMH staff and even so far as the Commission, the governing body of the Department of Mental Health.

These people truly care about individuals with mental illness and are dedicated to doing everything they can to help people like me, people living with mental illness, in this state.

On a personal note, I've been experiencing some psychiatric symptoms this past year and have been able to share this information with the Council. I have received strong support from all members as well. We, as a Council, encourage being open and honest about our mental health struggles and journeys. We are all bound by a common goal to ensure recovery options and support for individuals with mental illness being served by DMH.

"Council Comments" are an important portion of our meetings. Every member is encouraged, during this time, to share their thoughts about mental health matters. We believe it is very important each member is offered a specific time to speak so as to ensure we hear from all members in attendance.

With all these formal presentations, it could be assumed Council meetings are dry and dull, but that couldn't be further from the truth. We set an informal tone that can inspire some humor but even more importantly, encourage all present to be their authentic selves in a safe environment where all are accepted just as they are.

In closing, we have monitored, reviewed, and evaluated the mental health services in this state and we recommend that this block grant be approved.

Sincerely,



Jane B Simpson
Chairperson
South Carolina Mental Health State Planning Council

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Chris Allen	Others (Advocates who are not State employees or providers)	South Carolina National Guard Suicide Prevention		
Brian Ambrose	Others (Advocates who are not State employees or providers)	Charleston Police Department		
Jack Balling	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Versie Bellamy	State Employees	SC Department of Mental Health		
Mark Binkley	State Employees	SC Department of Mental Health		
Deborah Blalock	State Employees	SC Department of Mental Health		
Hannah Bonsu	State Employees	SC Department of Alcohol and Other Drug Abuse Services		
Zee Brown	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Debbie Calcote	State Employees	SC Department of Mental Health		
Jenah Cason	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Marilla Copeland	Parents of children with SED/SUD			
Becky Davis	State Employees	SC Department of Education		
Lee Fletcher	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Raj Gavurla	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Marcy Hayden	State Employees	SC Commission for Minority Affairs		
Joan Herbert	Others (Advocates who are not State employees or providers)			
Joy Jay	Others (Advocates who are not State employees or providers)	Mental Health America of South Carolina		

Louise Johnson	State Employees	SC Department of Mental Health		
Amy Jolly	Providers	Work-In-Progress		
Ed Knight	State Employees	SC State Housing Finance and Development Authority		
Pete Liggett	State Employees	SC Dept of Health and Human Services		
Bill Lindsey	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Brett Macgargle	State Employees	SC Department of Juvenile Justice		
Pheobe Malloy	Parents of children with SED/SUD			
Mandy Medlock	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Elizabeth Morris	State Employees	Clemson University		
Timothy Nix	State Employees	SC Department of Social Services		
Bonnie Pate	Others (Advocates who are not State employees or providers)	SC SHARE		
Melissa Reitmeier	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Carol Rudder	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Janie Simpson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Maria Beth Smith	Parents of children with SED/SUD			
Tray Stone	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Janet Upthegrove	Others (Advocates who are not State employees or providers)			
Steven Von Hollen	State Employees	SC Department of Disabilities and Special Needs		
Sissy Weaver	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Ramona Williams Carr	State Employees	SC Department of Vocational Rehabilitation		

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**45**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	4	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	8	
Parents of children with SED/SUD*	3	
Vacancies (Individuals and Family Members)	4	
Others (Advocates who are not State employees or providers)	6	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**25**	**55.56%**
State Employees	15	
Providers	1	
Vacancies	4	
Total State Employees & Providers	**20**	**44.44%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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Footnotes:

The South Carolina Mental Health State Planning Council is actively recruiting potential candidates for membership. In an effort to fill its 4 vacancies in the category of "Total Individuals in Recovery, Family Members & Others" and its 4 vacancies in the category of "Total State Employees & Providers," the Nominating Committee of the South Carolina Mental Health State Planning Council (Council) has met to review the Council's membership roster.

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ◉ No

b) Posting of the plan on the web for public comment? ◉ Yes ○ No

If yes, provide URL:

Please see the following pages for a summary of the steps the State took to make the public aware of the plan and allow for public comment.

The MHBG Application and MHBG Report are available at: https://scdmh.net/public-information/reports/

c) Other (e.g. public service announcements, print media) ◉ Yes ○ No

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Footnotes:

Public Comment on the State Plan

Illustration 1. Notification on SCDMH Internet Site (Homepage)

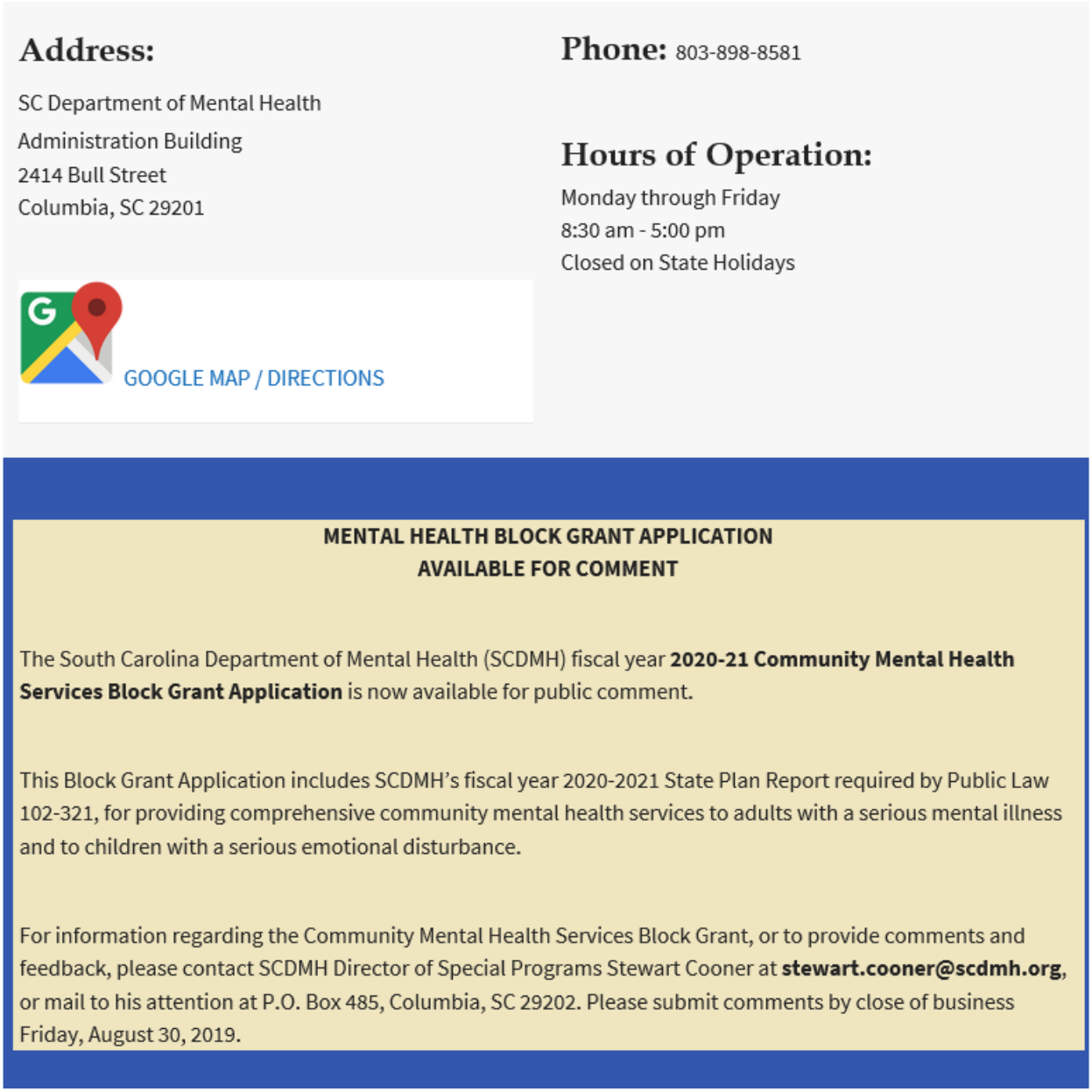


Illustration 2. Notification on SCDMH Intranet Site (Homepage)



News

- **Memo:** Appointment of SCDMH General Counsel
- **Notice of Availability** of application and opportunity for comment for State Path Formula Grant
- **New:** Beckman Center for Mental Health Profile
- **News Release:** VA Grants Funding for New State Veterans Nursing Homes
- **News Release:** Together, We're Greater: Greenville-area Mental Health Centers to Merge
- **Memo:** Appointment of Executive Director, Lexington County Community Mental Health Center
- **Memo:** Appointment of Executive Director, Waccamaw Center for Mental Health
- **News Release:** L. Gregory Pearce, Jr. Appointed to SC Mental Health Commission

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MENTAL HEALTH BLOCK GRANT APPLICATION AVAILABLE FOR COMMENT

The SCDMH fiscal year **2020-21 Community Mental Health Services Block Grant Application** is now available for public comment.

This Block Grant Application includes SCDMH's fiscal year 2020-2021 State Plan Report required by Public Law 102-321, for providing comprehensive community mental health services to adults with a serious mental illness and to children with a serious emotional disturbance.

For information regarding the Community Mental Health Services Block Grant, or to provide comments and feedback, please contact SCDMH Director of Special Programs Stewart Cooner at **stewart.cooner@scdmh.org**, or mail to his attention at P.O. Box 485, Columbia, SC 29202. Please submit comments by close of business Friday, August 30, 2019.

Illustration 3. Notification on SCDMH Facebook Pages

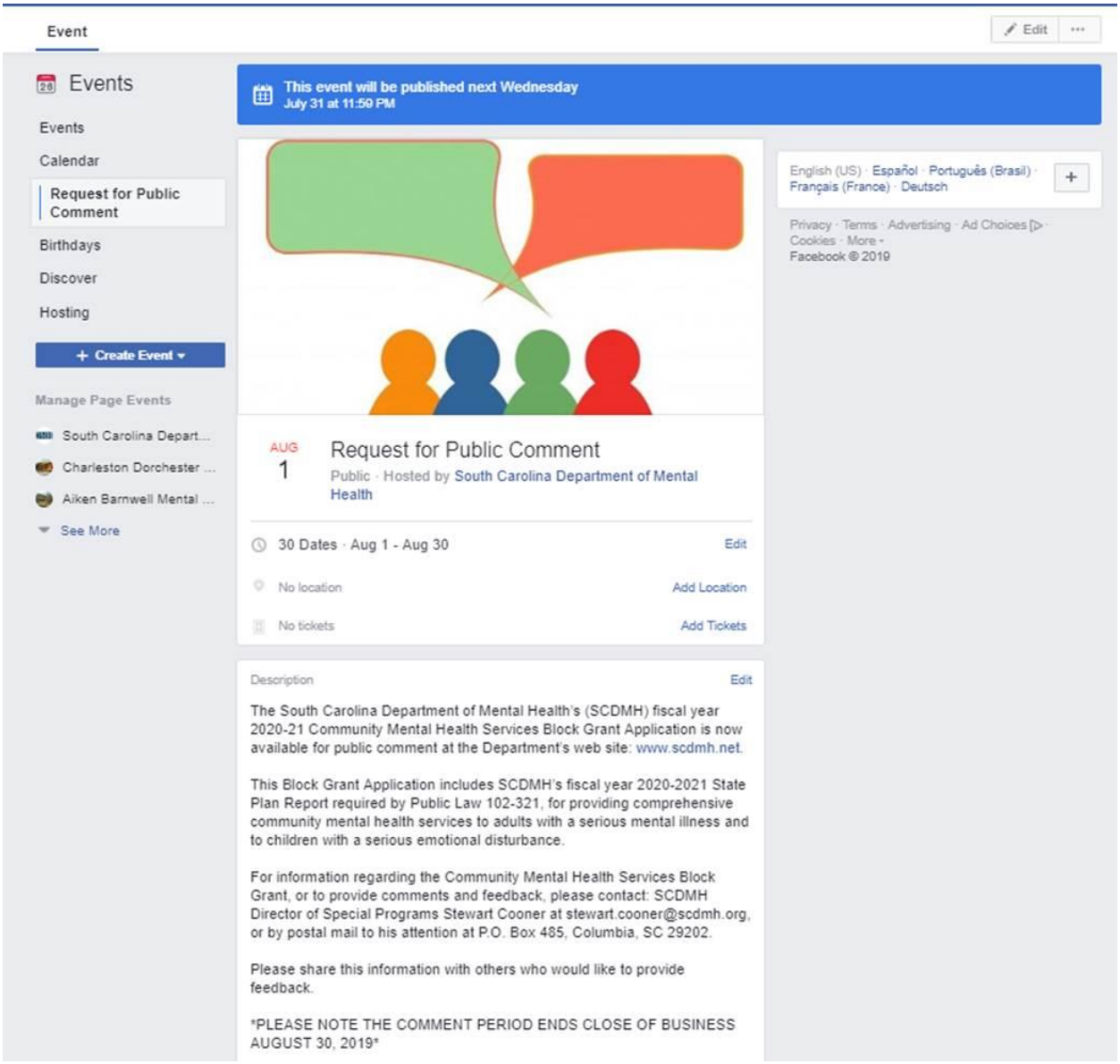


Illustration 4. Public Notice

MENTAL HEALTH BLOCK GRANT APPLICATION AVAILABLE FOR COMMENT

The South Carolina Department of Mental Health's (SCDMH) fiscal year 2020-21 Community Mental Health Services Block Grant Application is now available for public comment at the Department's web site: www.scdmh.net.

This Block Grant Application includes SCDMH's fiscal year 2020-2021 State Plan Report required by Public Law 102-321, for providing comprehensive community mental health services to adults with a serious mental illness and to children with a serious emotional disturbance.

For information regarding the Community Mental Health Services Block Grant, or to provide comments and feedback, please contact SCDMH Director of Special Programs Stewart Cooner at stewart.cooner@scdmh.org, or mail to his attention at P.O. Box 485, Columbia, SC 29202.

Comments on this draft plan should be submitted by close of business Friday, August 30, 2019.

Example 1. Public Notice – The Laurens County Advertiser (August 7, 2019, Circulation: 7,825)

SCDMH seeks public input

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Steps to Request Public Comment on the FY2020-2021 Mental Health Block Grant Application

Regarding steps the State took to make the public aware of the plan and allow for public comment:

- On August 1, 2019, members of the South Carolina Mental Health Commission were notified via email of the availability of the draft FY2020-2021 Mental Health Block Grant Application.
- On August 1, 2019, members of the South Carolina Mental Health State Planning Council were notified via email of the availability of the draft FY2020-2021 Mental Health Block Grant Application.
- On August 1, 2019, specific South Carolina mental health advocate organizations were notified via email of the availability of the draft FY2020-2021 Mental Health Block Grant Application.
- On August 1, 2019, members of the general public were notified of the availability of the draft FY2020-2021 Mental Health Block Grant Application via SCDMH's standard procedure to provide statewide public notice by sending a 'media alert' notification to all daily and non-daily newspapers in the state.
    - 17 daily newspaper contacts were notified.
    - 41 non-daily newspaper contacts were notified.
- On August 1, 2019, members of the general public were notified of the availability of the draft FY2020-2021 Mental Health Block Grant Application via creation of an event on SCDMH's 22 Facebook pages.
- On August 1, 2019, members of the general public were notified of the availability of the draft FY2020-2021 Mental Health Block Grant Application via SCDMH's internet and intranet home pages on which were placed banners of announcement.
- A paid Notice of Availability of Mental Health Block Grant Application and Report was placed in the three largest newspapers in South Carolina, representing the Upstate, Midlands, and Lowcountry regions: The Greenville News (July 2018, December 2018, July 2019); The State Newspaper (July 2018, March 2019, July 2019); and, The Post and Courier (July 2018, December 2018, July 2019), respectively. Public comment was requested via letter, email, and telephone.
    - Please note that while the notices prior to July 2019 specifically cited the previous Uniform Application – State Behavioral Health Assessment and Plan and the then current Behavioral Health Report, each also stated: "Both documents are posted at this URL at all times; information is available and there is no deadline for feedback."
- As of August 30, 2019, no recommendations for modifications to the FY2020-2021 Mental Health Block Grant Application were offered during the public comment period by the South Carolina Mental Health State Planning Council.

[End]