

South Carolina

UNIFORM APPLICATION

FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND
PLAN

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 11/30/2017 1.59.46 PM)

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

State Information

State Information

Plan Year

Start Year 2017

End Year 2019

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 John H.

Last Name Magill

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 803-898-8590

Email Address john.magill@scdmh.org

III. Third Party Administrator of Mental Health Services

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 9/1/2017 10:54:20 AM

Revision Date 11/30/2017 1:58:45 PM

VI. Contact Person Responsible for Application Submission

First Name Stewart

Last Name Cooner

Telephone 803-898-8632

Fax 803-898-2206

Email Address stewart.cooner@scdmh.org

Footnotes:

State Information

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

Fiscal Year 2018

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 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
 Title 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 |
| Section 1911 | Formula Grants to States | 42 USC § 300x |
| Section 1912 | State Plan for Comprehensive Community Mental Health Services for Certain Individuals | 42 USC § 300x-1 |
| Section 1913 | Certain Agreements | 42 USC § 300x-2 |
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| Section 1916 | Restrictions on Use of Payments | 42 USC § 300x-5 |
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| Section 1953 | Continuation of Certain Programs | 42 USC § 300x-63 |
| Section 1955 | Services Provided by Nongovernmental Organizations | 42 USC § 300x-65 |
| Section 1956 | Services for Individuals with Co-Occurring Disorders | 42 USC § 300x-66 |

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: 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.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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 (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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, day care, 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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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: John H. Magill

Signature of CEO or Designee¹: _____

Title: State Director, SCDMH

Date Signed: _____

mm/dd/yyyy

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

Footnotes:



HENRY McMASTER
GOVERNOR

August 25, 2017

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

Dear Ms. Crocker,

I delegate authority to John H. Magill, 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,

A handwritten signature in blue ink, appearing to read "Henry McMaster".

Henry McMaster



State of South Carolina
Department of Mental Health

MENTAL HEALTH COMMISSION:

Alison Y. Evans, PsyD, Chair
Everard Rutledge, PhD, Vice Chair
Beverly Cardwell
Louise Haynes
Bob Hiott, MEd
J. Buxton Terry
Sharon L. Wilson

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

John H. Magill
State Director of Mental Health

September 1, 2017

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

Dear Ms. Crocker:

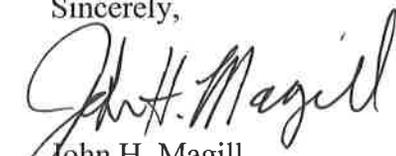
Please find attached with this letter the following documents as required by the FY2018-2019 Substance Abuse and Mental Health Services Administration, Community Mental Health Services, Mental Health Block Grant Application due September 1, 2017. The documents conform to the requirements set forth in the WebBGAS application system as of July 3, 2017.

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,


John H. Magill
State Director of Mental Health

MISSION STATEMENT

To support the recovery of people with mental illnesses.



State Information

State Information

Plan Year

Start Year 2017

End Year 2019

State DUNS Number

Number 043980093

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First Name John H.

Last Name Magill

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

City Columbia

Zip Code 29202

Telephone 803-898-8319

Fax 803-898-8590

Email Address john.magill@scdmh.org

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name Stewart

Last Name Cooner

Telephone 803-898-8632

Fax 803-898-2206

Email Address stewart.cooner@scdmh.org

Footnotes:

NOT FINAL

State Information

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Fiscal Year 2018

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
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 Community Mental Health Services Block Grant Program
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| Title XIX, Part B, Subpart II of the Public Health Service Act | | |
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(Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955. as amended (42 U.S.C. §§7401 et seq.): (a)

- 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).
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 16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
 17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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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: _____

Signature of CEO or Designee¹: _____

Title: STATE DIRECTOR, SCDMH

Date Signed: _____

AUGUST 23, 2017

mm/dd/yyyy

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

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:

Footnotes:

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.

State Information

Disclosure of Lobbying Activities

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

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Name

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Organization

Signature:

Date:

Footnotes:

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.

Planning Steps

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

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health 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 SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health 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 gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

Section II – Step 1– Assess the Strengths and Needs of the Service System to Address the Specific Populations

Assessing Strengths and Needs

In order to assess the strengths and needs 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.

2017 Developments and Achievements

On May 12, 2017, SCDMH published its annual list of developments and achievements to a broad audience that included the Governor of the State of South Carolina and other elected state officers, the General Assembly of the State of South Carolina and legislative staff, the South Carolina Mental Health Commission, members of the Community Mental Health Centers Advisory Boards, advocates, academic partners, hospital leaders, and other community partners. An excerpt is provided below.

“The South Carolina Department of Mental Health (DMH) strives to improve and expand its services to the citizens of our state. With your support, we continue to make progress. This document is an update of select examples of Agency milestones, achievements, and services for the year 2017.

- Shortening the length of time that criminal defendants wait for admission to the Department’s secure forensic hospital is the Agency’s current number one priority. By law, criminal defendants found incompetent to stand trial due to a mental illness must go through a commitment process to a DMH 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, the Department made reducing the wait time for forensic admissions its first priority and developed a multi-faceted Action Plan. That Plan, which is ongoing, is showing promising results.
 - The number of defendants awaiting forensic admission has decreased 54% since April, 2016.
 - From January to April of 2017, 100 forensic patients were admitted, an increase of 20% compared to the same time period in 2016.
 - From January to April of 2017, DMH discharged 48% more forensic patients to secure or supervised community settings than during the same time period in 2016.
 - Furthermore, the average length of stay from January to April of 2017 has decreased by 40% compared to the same time period in 2016.
- Thanks to the support of the Governor and the General Assembly, DMH has increased access to community mental health services. DMH has increased productivity and access standards in its community mental health services: from FY14 to FY15, new cases (new/readmissions) increased 3.17%. From FY15 to FY16, new cases (new/readmissions) increased 3.29%. In a majority of mental health centers, patients in crisis can see a Mental Health Professional on the day they walk in, and wait times for appointments with counselors and psychiatrists have been reduced. In FY16, DMH community mental health centers provided more than 1.3 million clinical services.
- DMH’s telepsychiatry programs have provided more than 60,000 psychiatric services.
 - As of April 2017, DMH’s innovative and award winning Emergency Department Telepsychiatry Consultation Program has provided more than 33,000 psychiatric consultations 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.

- 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 28,000 psychiatric treatment services to DMH patients throughout South Carolina.
- In September 2015, DMH received a major 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 made great strides in meeting its outreach and awareness goal of 300,000 individuals by year five, having reached more than 100,000 individuals across the state in 2016-2017 alone.
 - SCYSPI offers trainings in suicide prevention to multi-disciplinary audiences and community members. To date, the Initiative has trained more than 4,167 individuals in suicide prevention, including more than 80 law enforcement personnel, more than 100 foster parents, and more than 515 youths.
 - Bamberg Job Corps, the only Job Corps in South Carolina, has adopted the SCYSPI Model Policy and Protocol at its Lowcountry center to enhance its capacity to effectively serve its participants. Moreover, the organization has begun the training portion of its prevention action plan by having the entire staff trained in "ASK about Suicide to Save a Life".
 - In collaboration with The Regional Medical Center: Orangeburg (tRMC) emergency department, Behavioral Health and Home Health, SCYSPI has developed a Model Protocol for Emergency Departments. The protocol is aimed at ensuring individuals who have survived a suicide attempt are effectively linked to needed community services. SCYSPI looks forward to piloting this protocol in both the Emergency Department at tRMC as well as its ambulatory care centers.
 - SCYSPI has begun implementation of 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 three DMH mental health centers: Anderson-Oconee-Pickens, Lexington, and Santee-Wateree, with the goal of eventual Agency-wide implementation.
- With funds appropriated by the SC General Assembly in FYs 15, FY16, and FY17, DMH has continued to expand school-based programs. DMH School-based Services are now available in 540 schools across South Carolina.
- Parcel sales of the Bull Street property have continued; additional parcel sales took place in August, September, and December, 2016. The Buyer has continued to exceed – remain ahead of – the minimum payment schedule required in the Agreement.
 - An accurate accounting of the funds received to date by the Department is maintained and the proceeds are deposited in a segregated account. The Commission has authorized the agency to use the initial sale proceeds to increase additional affordable housing for patients in the community. A funding solicitation will be issued later this year for affordable housing developers to partner with DMH to expand housing options for clients across the state.
- Following the September 28, 2016 School shooting in Townville, SC, the Anderson-Oconee-Pickens Community Mental Health Center (AOP), with additional personnel from other DMH Upstate community mental health centers, provided crisis counseling and support to the victims, families and school personnel. Following the initial response, AOP continues to provide support for the affected community and the school children and personnel in dealing with the longer term impact of this tragic event.

- DMH is actively engaged in year two 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, the United Way of the Midlands, and the South Carolina Interagency Council on Homelessness.
 - Palmetto Health is operating an Assertive Community Treatment (ACT) team in Columbia, which provides mental health services to homeless individuals wherever they are, and encourages them to accept available services.
 - CABHI-SC is funding five grant-supported positions at Greenville Mental Health Center to expand its existing ACT-Like team to a full fidelity ACT team that will serve an additional 34 chronically homeless patients by the end of the Grant.
 - As of April 2017, the two CABHI-SC treatment sites at Palmetto Health and Greenville Mental Health Center are serving a combined total of 40 clients and are committed to serving a total of 109 people by the end of the Grant.
 - In addition to funding ACT teams, CABHI-SC also funds four SSI/SSDI Outreach, Access, and Recovery (SOAR) benefits specialists throughout South Carolina. As of March 2017, these specialists have submitted a combined total of 39 applications to connect people with disabilities to SSI/SSDI income supports in order to support their recovery.
 - The South Carolina Interagency Council on Homelessness has expanded and includes 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 behavioral health issues.
- DMH has received a \$1 Million appropriation to develop crisis stabilization centers in communities.
 - The Charleston community, through a funding partnership comprising local hospitals, the Charleston-Dorchester Community Mental Health Center, law enforcement and others, will open a 10-12 bed center this year.
 - Discussions are ongoing in Spartanburg, Anderson, and Greenville with local community stakeholders, including hospitals, law enforcement, county councils and local alcohol and drug agencies to look at the future development of crisis stabilization centers.
- DMH has also entered into agreements with community hospitals to embed mental health professionals to assist EDs in meeting the needs of psychiatric patients. DMH currently has this type of partnership in multiple community hospitals, resulting in more than 5,700 dispositions from EDs in FY16.
- The Joint Bond Review Committee and the State Fiscal Accountability Authority gave Phase II approval for a new Santee-Wateree Mental Health Center in June, 2016. The bidding process is complete and the construction contract was awarded in April. Notice to proceed was issued on April 28, the preconstruction conference was held May 4, and the contract completion date is May 2018. The new building will allow the Center to provide comprehensive mental health services under one roof in a state-of-the-art facility.

DMH is dedicated to supporting and retaining excellent staff.

- Six of DMH's Nurses were recognized April 22 as Palmetto Gold Nurses. Lakeshia Cannon, RN; Tammy Cleveland, RN, MBA; Michele Dreher, MSN; Sherry S Hall, RN; Mary S Raaf, Nurse Practitioner; and Jonathan Worth, RN, were honored as Registered Nurses who exemplify excellence in nursing practice and commitment to the nursing profession in South Carolina.
- On April 12, Heather Smith received the Victims' Rights Week 2017 Distinguished Humanitarian Award from the SC Victim Assistance Network. Smith, who is a Chief Mental Health Counselor at DMH's Metropolitan Children's Advocacy Center (formerly known as the Assessment and Resource Center), was nominated by the 11th Circuit Solicitors Office for her "lifelong devotion to treating, supporting, and uplifting survivors of child abuse."
- DMH has partnered with multiple organizations to coordinate and sponsor training for professionals not only in its own organization, but also associated groups, to share information and best practice updates:

- In late March, more than 400 professionals participated in the second statewide Cultural and Linguistic Competency Summit, designed to increase professionals' and individuals' capacity to effectively address cultural differences among diverse children and families in South Carolina.
- On April 27 and 28, nearly 500 professionals attended the 2017 Southeastern School Behavioral Health Conference, the goal of which was *Moving Toward Exemplary and High Impact School Behavioral Health*.
- Like many healthcare providers, DMH 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. The Department is pursuing a number of new measures to reach prospective employees, including dedicating recruiting staff to attend job fairs, expanding the Department's presence on social media, and placing job announcements in professional publications. The Agency'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.

The South Carolina Department of Mental Health's mission is to support the recovery of people with mental illnesses, giving priority to adults with serious and persistent mental illness and to children and adolescents with serious emotional disturbances.

- Each of DMH's 17 community mental health centers is accredited by CARF International, an independent, nonprofit accreditor of human service providers. In addition, Morris Village Treatment Center, the Agency's inpatient drug and alcohol hospital, is also accredited by CARF International.
- DMH's psychiatric hospitals 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 DMH's four nursing homes is licensed by DHEC and certified by CMS. Three of the four nursing homes (516 beds) serve veterans exclusively and are certified by the Department of Veterans Affairs. The Tucker Nursing Care Facilities (Roddey-General Nursing Home and Stone-Veterans Nursing Home) are nationally accredited by The Joint Commission (TJC) and represent two of only 10 Nursing homes in South Carolina with this distinction. **There are 195 nursing homes in the State of South Carolina.*
- DMH has more than 800 portals by which citizens can access mental health services, including:
 - a network of 17 outpatient community mental health centers, 43 clinics, multiple psychiatric hospitals, one community nursing care center, and three veterans' nursing homes;
 - more than 30 specialized clinical service sites (DMH offices that provide some type of clinical care, but do not offer a full array of services found in a center or clinic);
 - more than 20 South Carolina hospitals with Telepsychiatry services;
 - more than 140 community sites (non-DMH entities or businesses where DMH staff regularly and routinely provide clinical services), and
 - 540 school-based service program sites.

We will continue to highlight select examples of DMH's system, programs, and achievements in future periodic updates."

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 Section IV. Environmental Factors and Plan, Item 10. Statutory Criterion for MHBG. It is substantiated by the attached *Public Mental Health in South Carolina*.

Criterion 1. Comprehensive Community-Based Mental Health Service System

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 *Public Mental Health in South Carolina*). 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 NRI, Inc. (NRI) provides to SCDMH an estimate of the prevalence in the state of SMI among adults and SED among children as outlined below per NRI.

“URS table 1 (Profile of the State Population by Diagnosis) specifies that prevalence estimates for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) will be completed for states by the Center for Behavioral Health Statistics and Quality (CBHSQ). As has been done in prior years, we have updated the state level estimates of the prevalence of adults with SMI and children with SED and are providing you with a copy of these estimates.

The attached Excel file includes state-by-state estimates of adults with SMI and children with SED using the official SAMHSA estimation methodology for the prevalence of SMI and SED. The SAMHSA estimation methodology was developed and tested by SAMHSA during the 1990s and was published in the *Federal Register* in 1998. The calculation of estimate of adults with SMI relies on state civilian population data for the 50 states and the District of Columbia and on resident population data for Puerto Rico, while the estimates for children with SED use a combination of state civilian population and poverty data.”

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 *Public Mental Health in South Carolina* provides a comprehensive overview of SCDMH's management systems.

Public Mental Health in South Carolina

As referenced herein, the attached PowerPoint presentation entitled “Public Mental Health in South Carolina” provides 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]



Public Mental Health in South Carolina

DMH South Carolina
Department of
Mental Health

John H. Magill

State Director of Mental Health

Updated 1/08/2016

Purpose:

This PowerPoint presentation is designed to serve as an overview of DMH; Agency staff may tailor it as needed to specific centers, facilities, regions, or audiences. It highlights DMH's history, mission, accomplishments, Blue Ribbon programs, and projects/programs/initiatives that many outside of our agency may not be aware of.

This document is a work in progress and will be updated periodically.

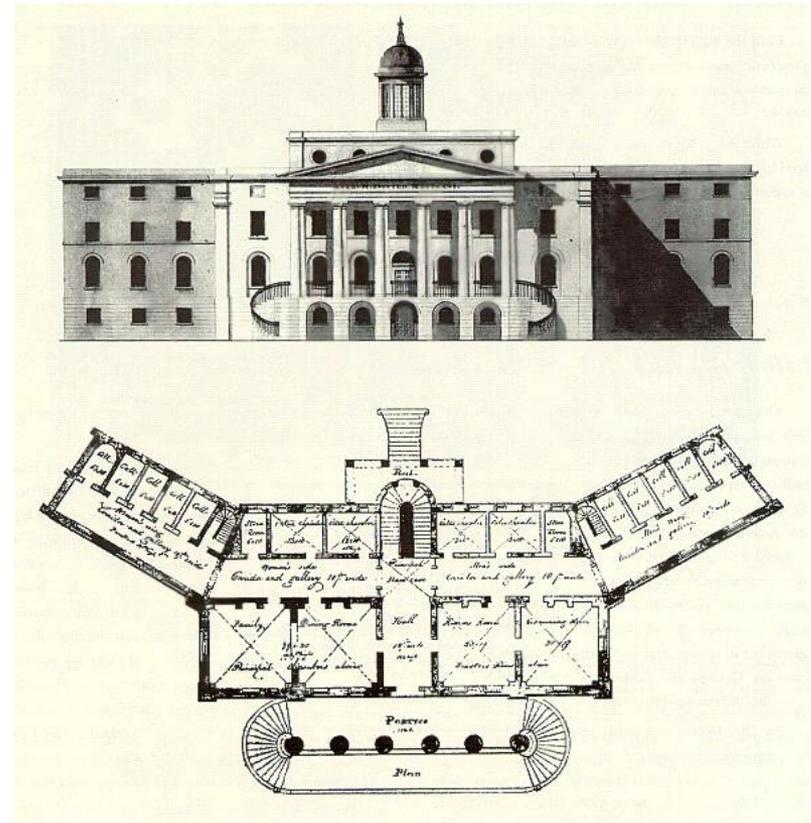
If you have questions or comments, contact Tracy LaPointe in the DMH Office of Public Affairs at (803) 898-8582 or tracy.lapointe@scdmh.org.

DMH: Beginnings

- In the 18th century, what to “do” with a mentally ill person depended upon the individual’s status, domestic situation, location, and medical condition.
- Insanity was viewed as a private matter and family responsibility, and it was expected that family would render care or pay someone else to do it.
- It was not uncommon for the mentally ill to live in workhouses or debtors’ prisons.

Beginnings

- Colonel Samuel Farrow, a member of the House of Representatives, and Major William Crafts, a member of the Senate, worked zealously to sensitize their fellow lawmakers to the needs of the mentally ill. On December 20, 1821, the South Carolina State Legislature passed a statute-at-large approving \$30,000 to build the *SC Lunatic Asylum*.
- This legislation made South Carolina the third state in the nation (after Virginia and Maryland) to provide *state funding* for the care and treatment of people with mental illnesses.
- Renowned architect Robert Mills was enlisted to design the new SC Lunatic Asylum, the cornerstone for which was laid in 1822. It featured such innovations as central heating and fireproof ceilings.



The South Carolina Lunatic Asylum

First patient admitted – Lunatic Asylum – Columbia, SC – Dec. 12, 1828

Removed – February 7, 1829 – uncured

Dec. 12th 1828. Eliza Fanning at 20 of Barnwell Dist. SC was brought by her parents and admitted into the Lunatic Asylum.

History of the case. She has enjoyed good health during life with the exception of some irregularity in her catamenial discharges: which for the last two months have not appeared at all. This irregularity, however, has never appeared to create any constitutional disturbance. She is of a fair complexion and yellow hair (a large suit of it) and inclined to pleasantness of form with a healthy appearance. For a year last past she has been religiously disposed. For several weeks last past she has attended religious meetings especially an association – and during the same time was watching an aunt who was ill every night, and thereby lost her sleep.

On Dec. 1st she first betrayed symptoms of insomnia. Her theme was of a religious character, interspersed with profane expressions. She alternately sung sacred tunes, prayed, muttered incoherent nonsense, and lay silent.

Beginnings

- South Carolina's asylum was one of the first in the nation built expressly for the mentally ill.
- South Carolina's mental health system was the third in the U.S., as well as the third *funded by a state government*.
- By the 1850s, a large number of people were being admitted, and land was needed for new buildings and patient recreation and gardens. Some asylum leaders believed the institution should be moved to the country. Largely because the Legislature was unwilling to fund a new complex, it remained at the original location. Land was purchased next to the complex, and more buildings were erected. This is the campus we know today as the "SC State Hospital," or "Bull Street," as it is known throughout the Southeast.
- The asylum did not reach its full capacity of 192 until 1860 – more than 30 years after opening its doors. Many families preferred to care for mentally ill relatives at home, while others wanted them closer to home even if it meant they lived in the county jail or the work house.

Beginnings: A city within a city...



With walls closing patients off from the noisy and harried growing city, the campus was almost its own *city*, housing at one time or another a dairy, ice cream factory, mattress factory, bakery, lock shop, welding shop, and greenhouses. Doctors and nurses lived in homes on the campus, and many citizens today recall growing up in the pastoral setting of the grounds.

Beginnings: Progress

In 1892, a nursing school was founded, which remained open until 1950;

In 1896, the SC Asylum was renamed the *SC State Hospital for the Insane*;

The cost for each patient in 1877 was \$202 per year (55¢ per day);

By 1900, the State Hospital had 1,040 patients;

A legislative study of the Asylum in 1909 found many problems, ranging from poor sanitation and dilapidated buildings to unclean quarters and lack of room for patients. Many of the problems the State Hospital faced were common to facilities nationwide.

By 1910, after a legislative committee reported the asylum was too small, land was purchased north of Columbia, and plans were submitted for a new complex, which became known as "State Park." When it opened in 1913, it was for black patients only. This hospital, named *Palmetto State Hospital* in 1963, was renamed the *Crafts-Farrow State Hospital* in 1965. Today, this campus is home to many parts of DMH's central operations.

Development

Following the legislative study and opening of State Park, Dr. Fred Williams, who served as SC State Hospital superintendent from 1915 to 1945, realized that South Carolina's mental health system needed community mental health clinics. As such, he encouraged a program to educate the public about mental illness, its causes, and methods of prevention.

The first clinic to provide services for the mentally ill who did not need hospitalization was opened at the SC State Hospital in 1920. The first permanent outpatient clinic opened in Columbia in 1923. The success of this clinic inspired the opening of traveling clinics in Greenville and Spartanburg in 1924.

By 1927, clinics were established in Florence, Orangeburg, and Anderson. In 1928, a clinic opened in Charleston, with plans for one in Rock Hill.

Reopening of the clinics, which had closed as staff served in WWII, was delayed until late 1947 due to a lack of adequately trained personnel. As clinics continued to grow throughout the state, the need for state and federal funding increased. Help came in 1946 with the passage of Federal Public Law 487.

The Mental Health Act



The first outpatient clinic in Columbia, S.C.

- The Mental Health Act provided for a Mental Health Commission to be in charge of all mental health facilities. Communities were required to contribute one third of the cost of clinic or center operation and the state would furnish the remaining two thirds. The Mental Health Commission is still in place to this day and meets monthly.
 - By 1957, clinics were in operation in six counties.
 - Major functions of these clinics included: cooperation and consultation with other agencies and professional people in the community; evaluation and treatment of emotional disturbances in adults and children; public education; and training psychiatric and pediatric resident doctors from the Medical College Hospital.
-
- In addition to self-referrals, patients were referred to the centers by physicians, ministers, lawyers, Vocational Rehabilitation, juvenile and domestic relations courts, and the Department of Public Welfare.
 - The 1960s ushered in the beginnings of the community mental health movement. The introduction of Medicaid and other improvements in the social welfare system underwrote the treatment of patients in their own communities, and the 1963 Federal Community Mental Health Centers Act provided matching federal funds for construction of community mental health centers.

Progress

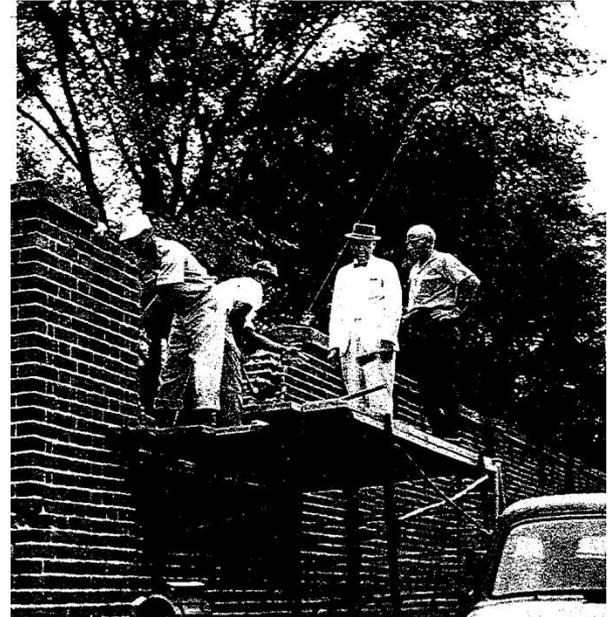
In 1967, the Columbia Area Mental Health Center became the first comprehensive community mental health center in the Southeast. In that same year, Dr. William S. Hall, the first “South Carolina State Commissioner of Mental Health,” participated in a ceremony in which part of the wall surrounding the State Hospital came down.

During Dr. Hall's 21 year tenure, DMH made strides in community-based care. A comprehensive, statewide mental health care delivery system emerged, and grew to encompass 10 major inpatient facilities and 17 community mental health centers, providing services in all of the state's 46 counties, with more than 6,000 employees.

During the 1970s, South Carolina experienced a number of firsts, including the establishment of a transitional living project to help patients return to the community after long hospital stays, a facility for psychiatric patients who needed long-term care, a program for autistic children, an alcohol and drug addiction treatment center, and a patient advocacy system to protect the rights of those DMH served.

In 1983, DMH adopted a plan calling for the development of community-based services, the decentralization of hospital services, and a significant decrease in the population of its psychiatric facilities in Columbia. This is what we often hear referred to as “deinstitutionalization.”

Joseph J. Bevilacqua, Ph.D., who became state commissioner of Mental Health in 1985, led with the view that patients treated in the community progress better clinically; people with mental illnesses need and require close family and community support. Patients recover faster and stay well longer when receiving services in their communities, if such programs are reasonably funded, well organized, and easily available.



Dr. Hall looks on as part of the wall is taken down.

Progress: Community-based Services

- In 1989, the SC Department of Mental Health, with support from the National Institute of Mental Health, hosted a national conference to explore how other states shifted to community-based services, how they defined priority populations, and how they planned and located services.
- It was determined that the services necessary for the successful transition of patients into communities did not exist and must be developed. It was also clear that some patients could not be safely discharged into the community and should continue to be cared for in DMH facilities until appropriate services could be created.
- Some communities struggled to develop community-care programs at first. Patients faced a shortage of appropriate housing options, a lack of crisis care for short-term acute situations, and a lack of employment opportunities.
- Still, the agency moved forward. In 1993, 127 patients, from the South Carolina and Crafts-Farrow State Hospitals, moved into seven customized programs in Aiken, Charleston, Columbia, Lexington, Orangeburg, and Sumter. They were provided with appropriate housing, medication monitoring, psychiatric and medical services, supportive community services, meaningful activity, and employment assistance.
- In two separate moves between 1992 and 1995, 265 patients were discharged from inpatient facilities to Toward Local Care projects in community mental health centers across the state.
- The State Hospital, or “Bull Street” campus, except for William S. Hall Psychiatric Institute for children and a few administrative offices, is closed. DMH now provides care via an outpatient, community-based system, comprising 17 community mental health centers (each with clinics and satellite offices), four psychiatric hospitals, three veterans’ nursing homes, and one community nursing home.

Governance



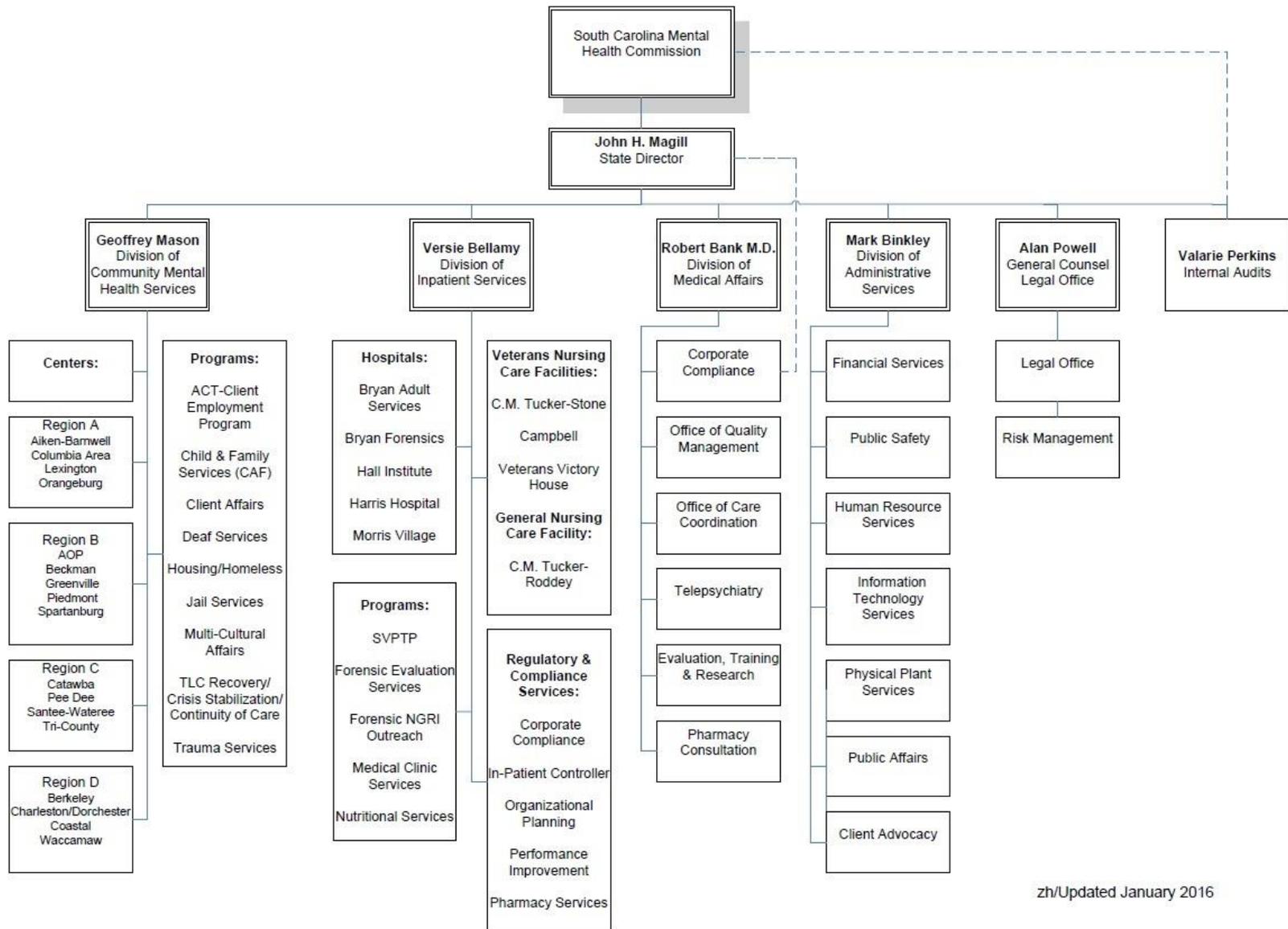
Governance

In 1827, the SC Legislature passed an act to bring the Asylum into *operation*. The act placed the organization and superintendence of the Asylum into the hands of nine Regents, or “Commissioners,” elected by the Legislature.

The Mental Health Commission still exists. It comprises 7 Commissioners, who are appointed by the Governor, with the consent of the SC Senate, and serve terms of 5 years.

The Commission convenes monthly, with meetings rotating among DMH’s centers and hospitals.

Governance



zh/Updated January 2016

Operations



The DMH Today

The DMH system:

- Comprises 17 community-based, outpatient mental health centers, each with clinics and satellite offices, which serve all 46 counties in our state;
- Provides services approximately 100,000 patients per year, approximately 30,000 of whom are children;
- Operates four licensed hospitals, including one for substance abuse treatment;
- Operates four nursing homes, including three for veterans;
- Is one of the largest hospital and community-based systems of care in South Carolina;
- Includes operation of a Forensics program; and
- Includes operation of a Sexually Violent Predator Treatment Program.

Community Mental Health Centers

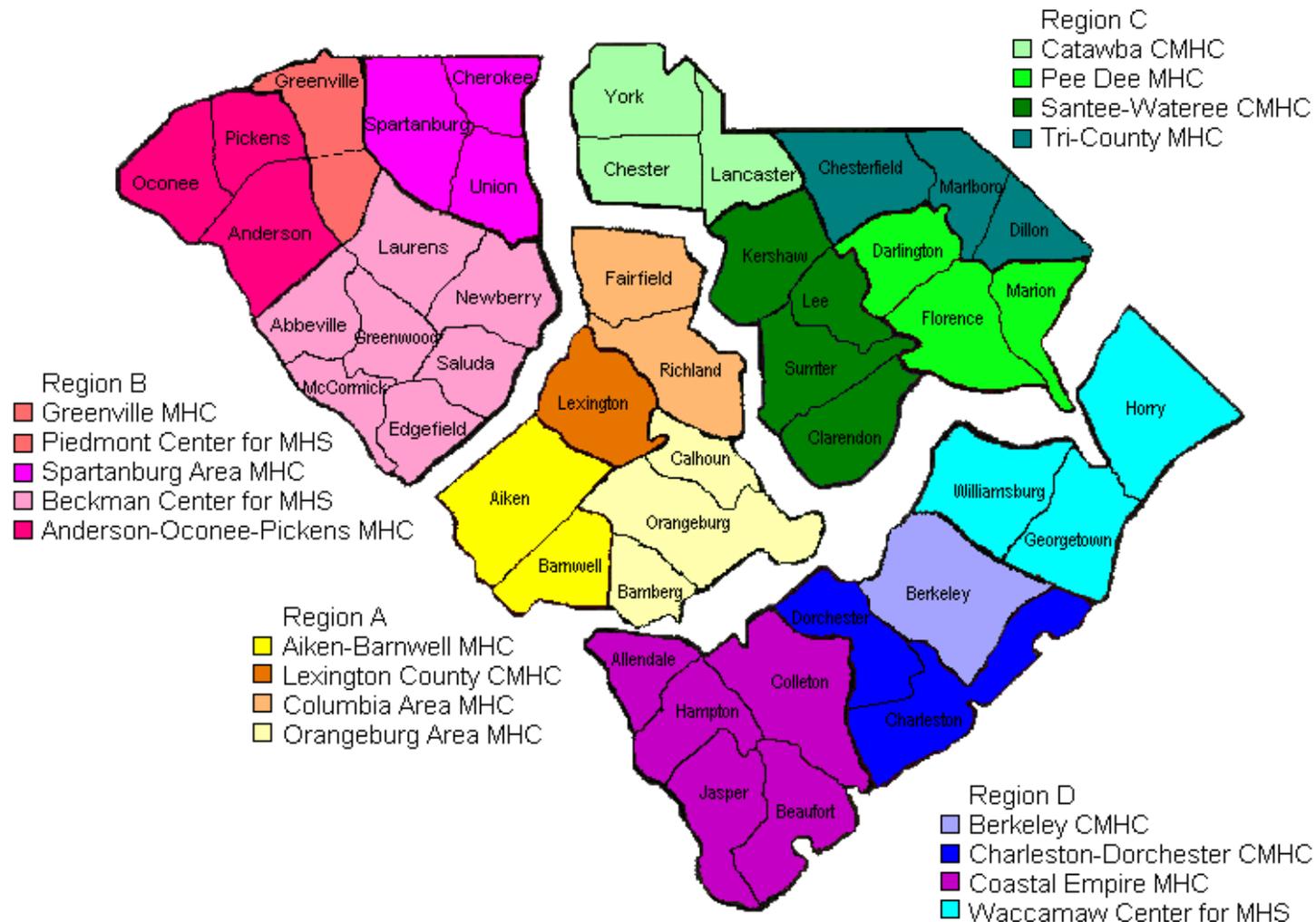
Community mental health centers (CMHCs) provide comprehensive mental health services, offering outpatient, home-based, school, and community-based programs to children, adults and families throughout South Carolina.

DMH Community Mental Health Centers

Aiken-Barnwell Community Mental Health Center
Anderson-Oconee-Pickens Mental Health Center
Beckman Center for Mental Health Services
Berkeley Community Mental Health Center
Catawba Community Mental Health Center
Charleston-Dorchester Mental Health Center
Coastal Empire Community Mental Health Center
Columbia Area Mental Health Center
Greenville Mental Health Center
Lexington County Community Mental Health Center
Orangeburg Area Mental Health Center
Pee Dee Mental Health Center
Piedmont Center for Mental Health
Santee-Wateree Community Mental Health Center
Spartanburg Area Mental Health Center
Tri-County Community Mental Health Center
Waccamaw Center for Mental Health

- All 17 DMH CMHCs are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), an independent, nonprofit accreditor of health and human services.
- Each DMH community mental health center has an advisory board, with nine to fifteen members, including at least one medical doctor. Center boards meet monthly.

Community Mental Health Centers



DMH Inpatient Hospitals & Facilities

DMH's Inpatient Services comprises four psychiatric hospitals, one community nursing care center, three veterans' nursing homes, and a Sexually Violent Predator Treatment Program.

- Each of DMH's three psychiatric hospitals is 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.
- Morris Village Treatment Center, the Agency's inpatient drug and alcohol treatment facility, is licensed by the South Carolina Department of Health and Environmental Control (DHEC) and accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), an independent, nonprofit accreditor of health and human services.
- Each of DMH's four nursing homes is licensed by the SC DHEC and certified by the Centers for Medicare & Medicaid Services.
- Three of the Agency's four nursing homes (comprising more than 500 beds) serve veterans exclusively and are certified by the Department of Veterans Affairs.
- The Tucker Nursing Care Facilities (Roddey, a general nursing home, and Stone, a veterans' nursing home) are nationally accredited by the Joint Commission and represent two of 10 Nursing homes in South Carolina with this distinction.

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.

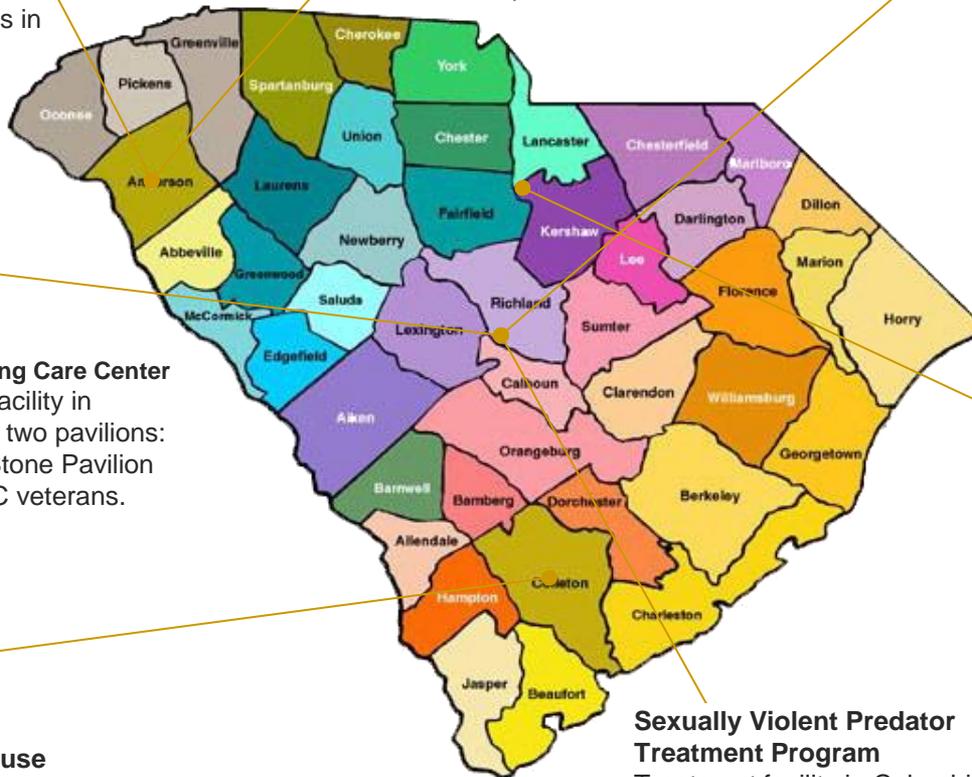
William S. Hall Psychiatric Institute
Child and Adolescent psychiatric hospital on the Bryan Campus with acute, residential and alcohol and drug addiction treatment.



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.



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



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

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

Updated November 2014

DMH Hospitals

G. Werber Bryan Psychiatric Hospital (Columbia)

G. Werber Bryan Psychiatric Hospital (Bryan) provides inpatient psychiatric treatment to adults. It is licensed by the State of South Carolina as a Specialized Hospital and is accredited by The Joint Commission.



Adult Services - Bryan's Adult Services patients are admitted primarily from the 33-county Midlands, Pee Dee, and Lowcountry regions of South Carolina. The majority of patients are civil involuntary admissions.

Forensics - The Forensics Division provides inpatient evaluation and treatment, rehabilitation, and outpatient services. Admissions are court-ordered from across the state through the judicial system.

William S. Hall Psychiatric Institute (Hall) -

Hall provides inpatient treatment for children and adolescents ages 4-17. Hall is licensed by the State of South Carolina as a Specialized Hospital, with a separately-licensed Residential Treatment Facility for adolescents ages 13-21. Hall Institute is accredited by The Joint Commission.

Hall has three inpatient programs: Adolescent Acute, Child Acute, and Alcohol and Drug. Hall also has a Residential Treatment program for boys.

Updated November 2014

DMH Hospitals, cont.

Patrick B. Harris Hospital (Anderson)

Harris Hospital provides inpatient treatment to adults. It is licensed by the State of South Carolina as a Specialized Hospital and is accredited by The Joint Commission. Patients are admitted from the 13 Upstate counties of South Carolina, and the majority are civil involuntary admissions.

In 2015, Harris was recognized as a 2014 Top Performer on Key Quality Measures by The Joint Commission. The award recognizes accredited hospitals and critical access hospitals that attain and sustain excellence in accountability measure performance. Recognition in the program is based on an aggregation of accountability measure data reported during the previous calendar year.



Updated November 2014

23

DMH Hospitals, cont.

Morris Village Alcohol & Drug Addiction Treatment Center (Columbia)

Morris Village provides inpatient treatment for adults with alcoholism and drug addictions, and, when indicated, addiction accompanied by psychiatric illness. It is licensed by the State of South Carolina and is accredited by the Commission on Accreditation of Rehabilitation Facilities.



Patients are admitted from throughout the state with referrals from community mental health centers, community alcohol and drug commissions, community hospitals, and the judicial system. The majority of patients are civil involuntary admissions.

Nursing Homes

C. M. Tucker, Jr. Nursing Care Center (Columbia)

Tucker Center is an intermediate and skilled long-term care facility. It is licensed by the state of South Carolina, dually-certified by the Centers for Medicare/Medicaid, and accredited by The Joint Commission. It comprises two nursing homes, Roddey Pavilion and E. Roy Stone, Jr. Veterans Pavilion.

Roddey Pavilion

- Provides care to residents from around the state. Referral sources include hospitals, family members, service agencies, and other nursing homes.

Stone Pavilion

- Provides long-term nursing care for South Carolina veterans and is additionally certified by the Veterans Administration (VA). Residents are admitted from across the state. Referral sources include the VA, hospitals, family members, service agencies, and other nursing homes.



In 2014, Stone Pavilion was ranked as one of the top nursing care facilities in South Carolina and the nation by both the Centers for Medicare and Medicaid Services and the US News and World Report, earning the facility a 5-star rating - the highest rating obtainable.

Updated November 2014

Nursing Homes, cont.

Richard M. Campbell Veterans Nursing Home (Anderson)

Campbell is a VA-certified nursing care facility in Anderson. It admits eligible veterans from across the state and is operated by an independent health care contractor. Referral sources include the VA, hospitals, family members, service agencies, and other nursing homes.



Updated November 2014

Nursing Homes, cont.

Veterans Victory House (Walterboro)



Veterans Victory House is a VA-certified nursing care facility in Walterboro. It admits eligible veterans from across the state and is operated by an independent health care contractor. Referral sources include the VA, hospitals, family members, service agencies, and other nursing homes.

Updated November 2014

Sexually Violent Predator Treatment Program

- The Sexually Violent Predator Treatment Program was established by legislation to provide treatment for persons adjudicated as sexually violent predators.
- The Sexually Violent Predator Act (SVPA) was passed in 1998 and created a new civil commitment process. Under the SVPA, persons previously convicted of a sexually violent offense are screened prior to release from prison. Those meeting the criteria in the SVPA are referred for possible civil commitment. If subsequently adjudicated as “sexually violent predators,” the SVPA requires that they be committed to the Department of Mental Health for treatment, and that they be kept segregated from DMH patients.
- Persons committed to DMH as sexually violent predators are treated in the Sexually Violent Predator Treatment Program, located within the confines of facilities maintained by the SC Department of Corrections.

DMH Portals to Mental Health Services

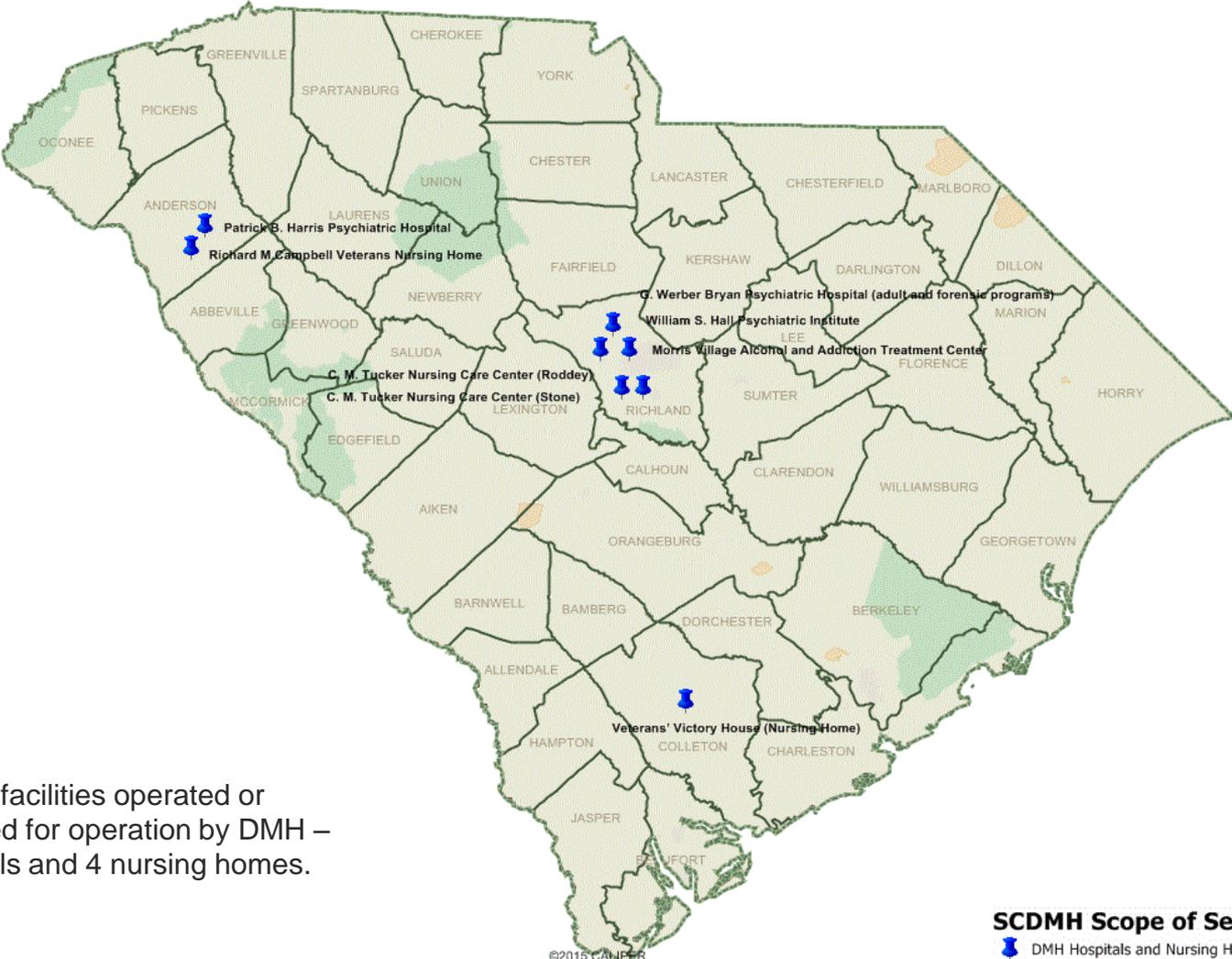
DMH provides more than 700 portals to access mental health services.



John H. Magill

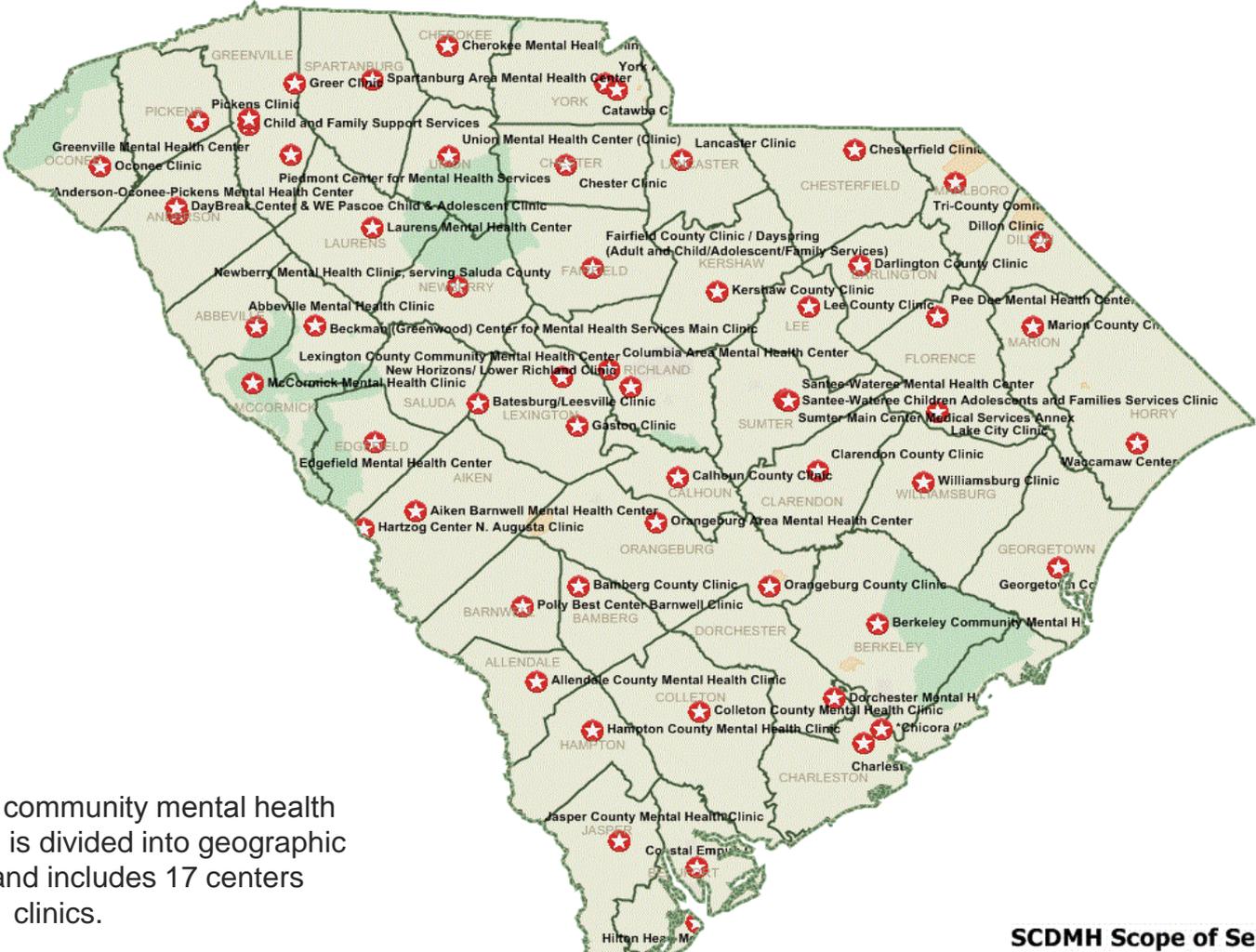
State Director of Mental Health

DMH Portals: Hospitals & Nursing Homes



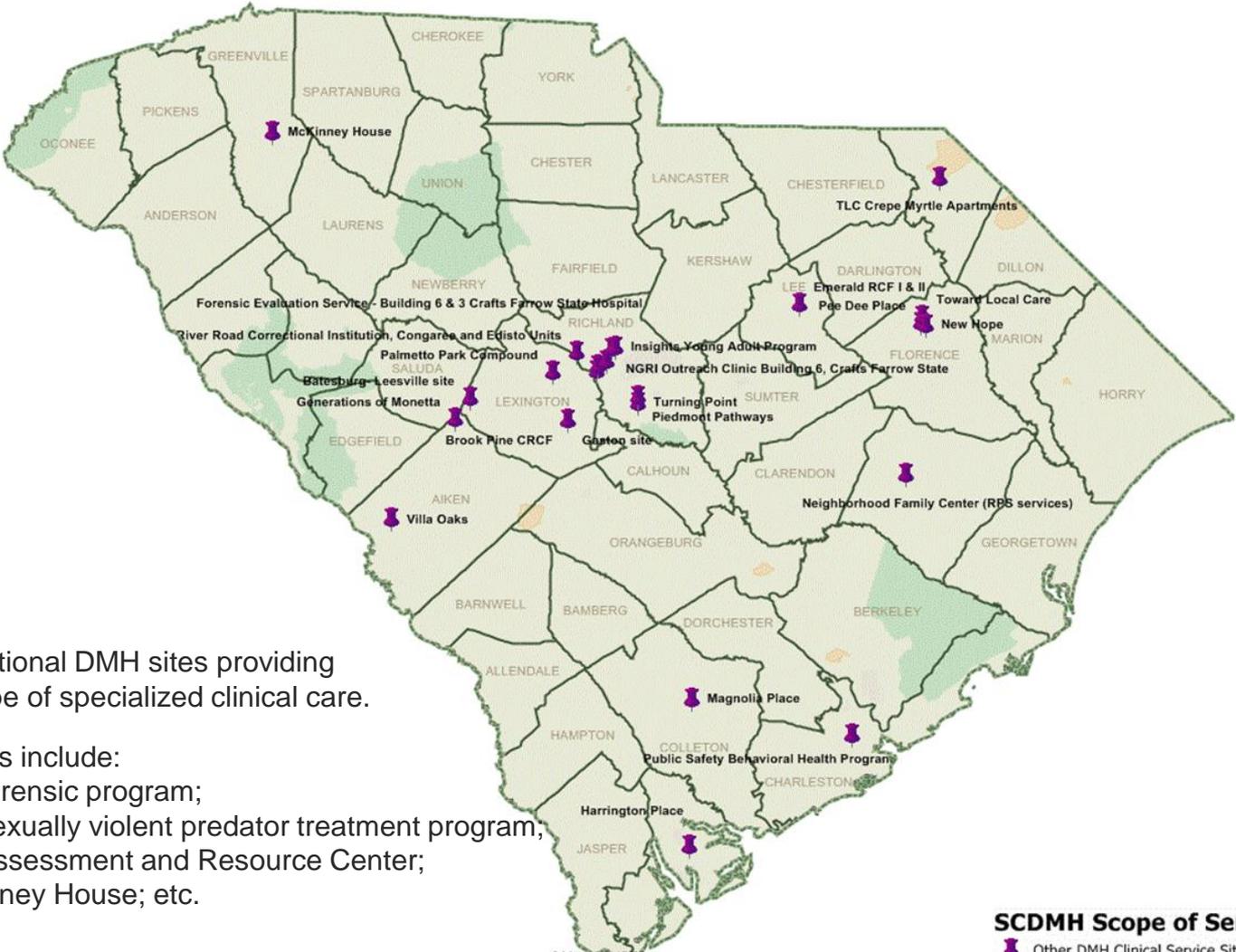
Inpatient facilities operated or contracted for operation by DMH – 4 hospitals and 4 nursing homes.

DMH Portals: Mental Health Centers & Clinics



DMH's community mental health system is divided into geographic areas and includes 17 centers and 43 clinics.

DMH Portals: Specialized Clinical Service Sites

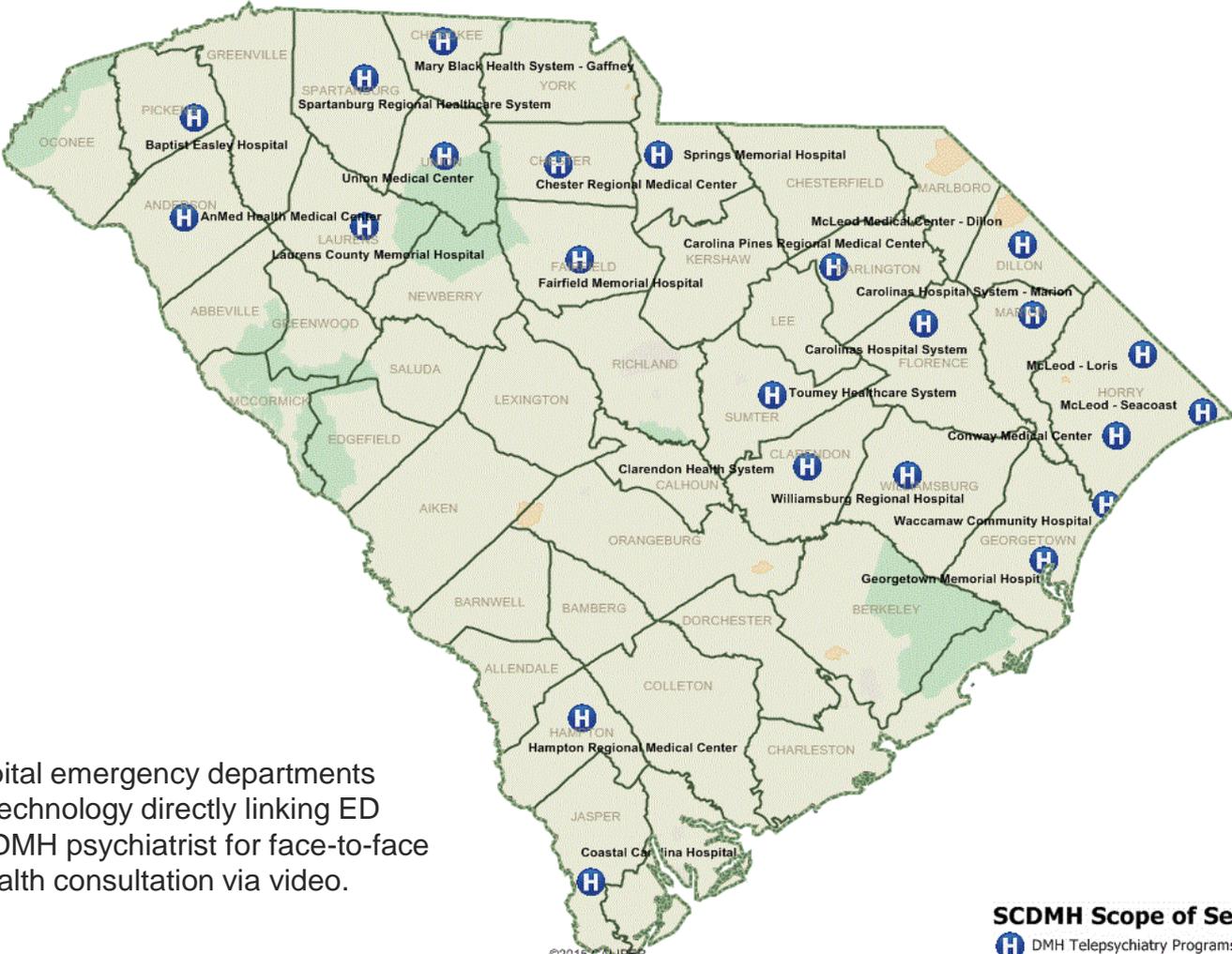


20+ additional DMH sites providing some type of specialized clinical care.

Examples include:

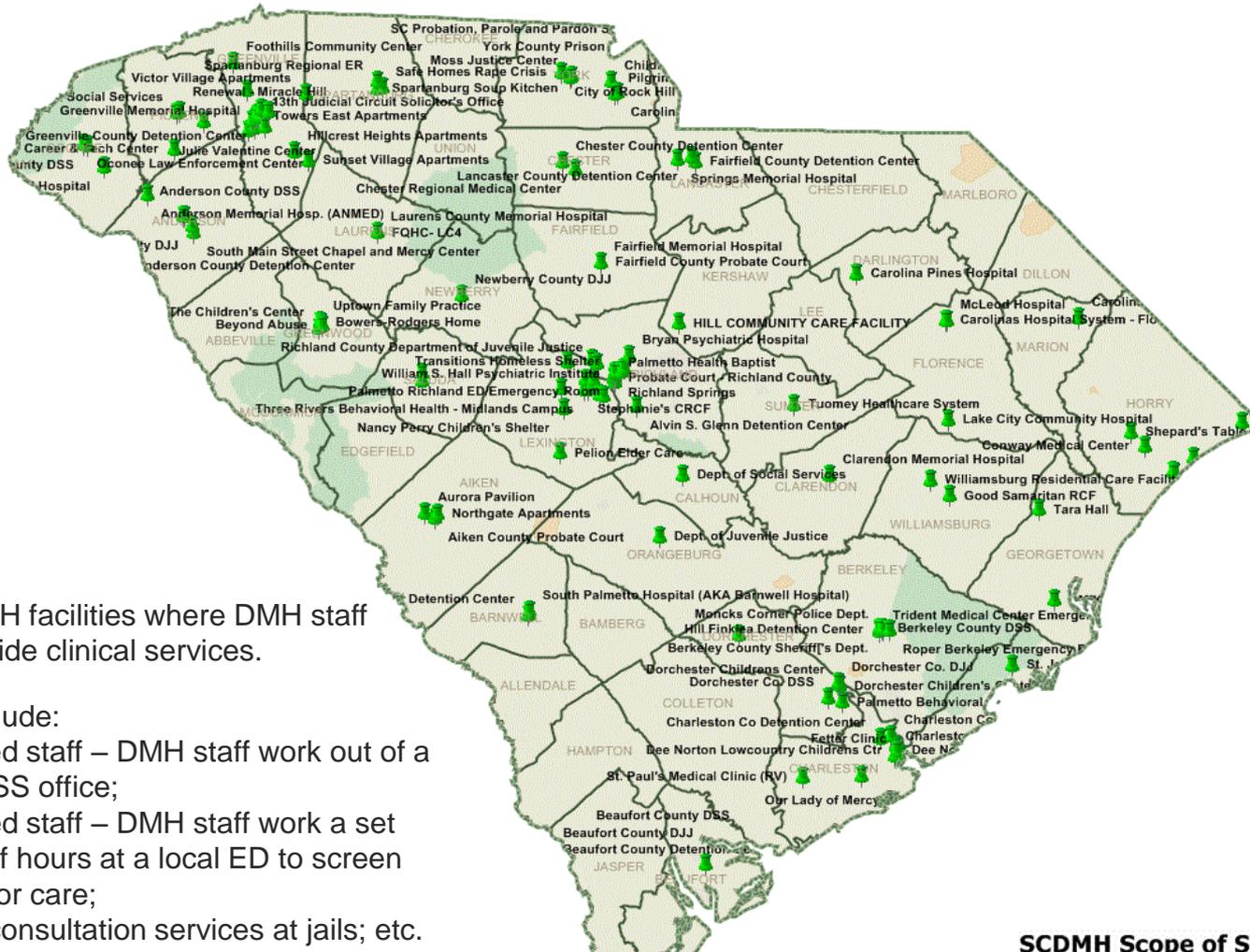
- The forensic program;
- The sexually violent predator treatment program;
- The Assessment and Resource Center;
- McKinney House; etc.

DMH Portals: Hospitals Utilizing DMH ED Telepsychiatry



23 Local hospital emergency departments (EDs) utilize technology directly linking ED patients to a DMH psychiatrist for face-to-face behavioral health consultation via video.

DMH Portals: Community Sites with Embedded DMH Staff



140+ non-DMH facilities where DMH staff regularly provide clinical services.

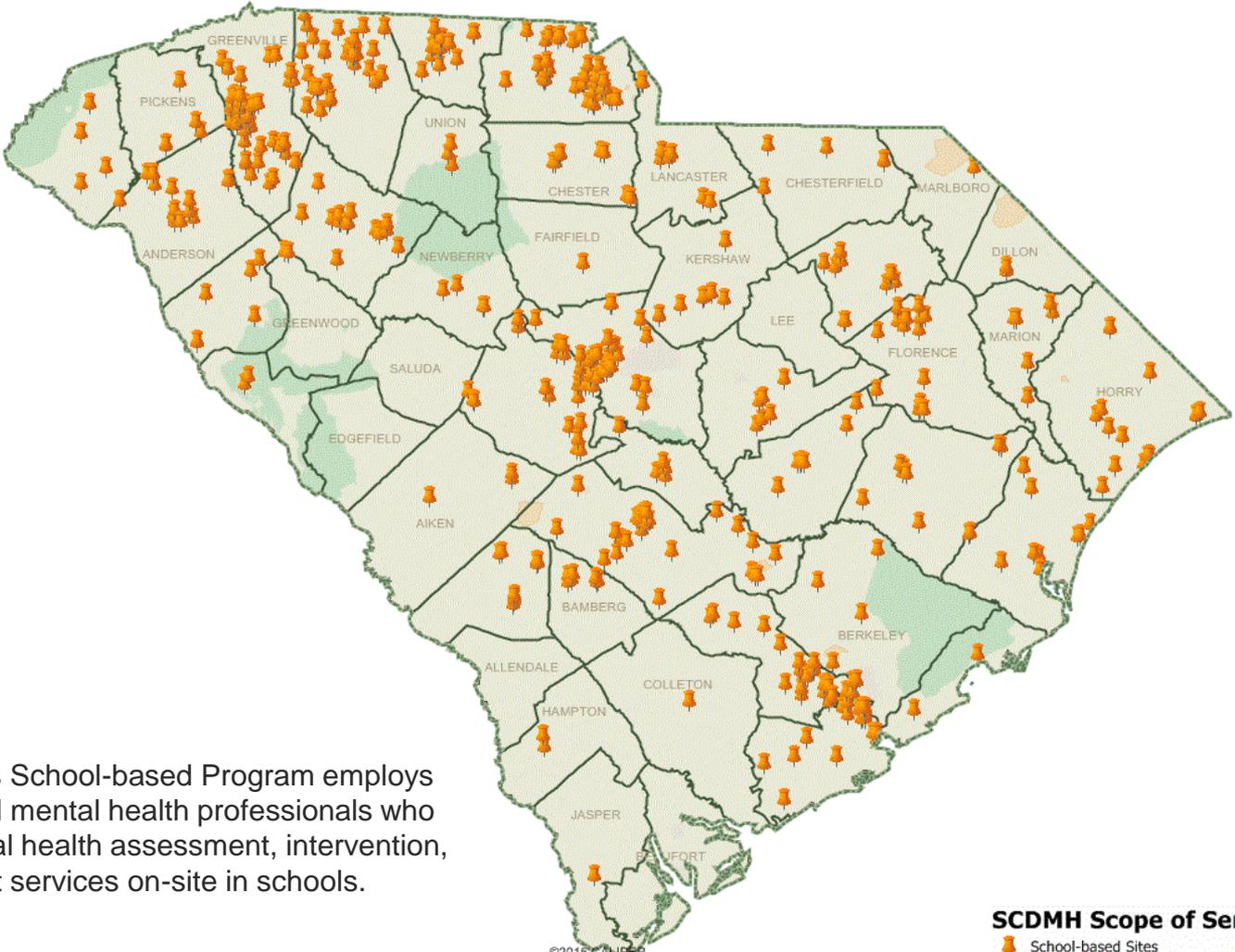
Examples include:

- Co-located staff – DMH staff work out of a DJJ or DSS office;
- Embedded staff – DMH staff work a set number of hours at a local ED to screen patients for care;
- Regular consultation services at jails; etc.

SCDMH Scope of Services

Staff Embedded in Community

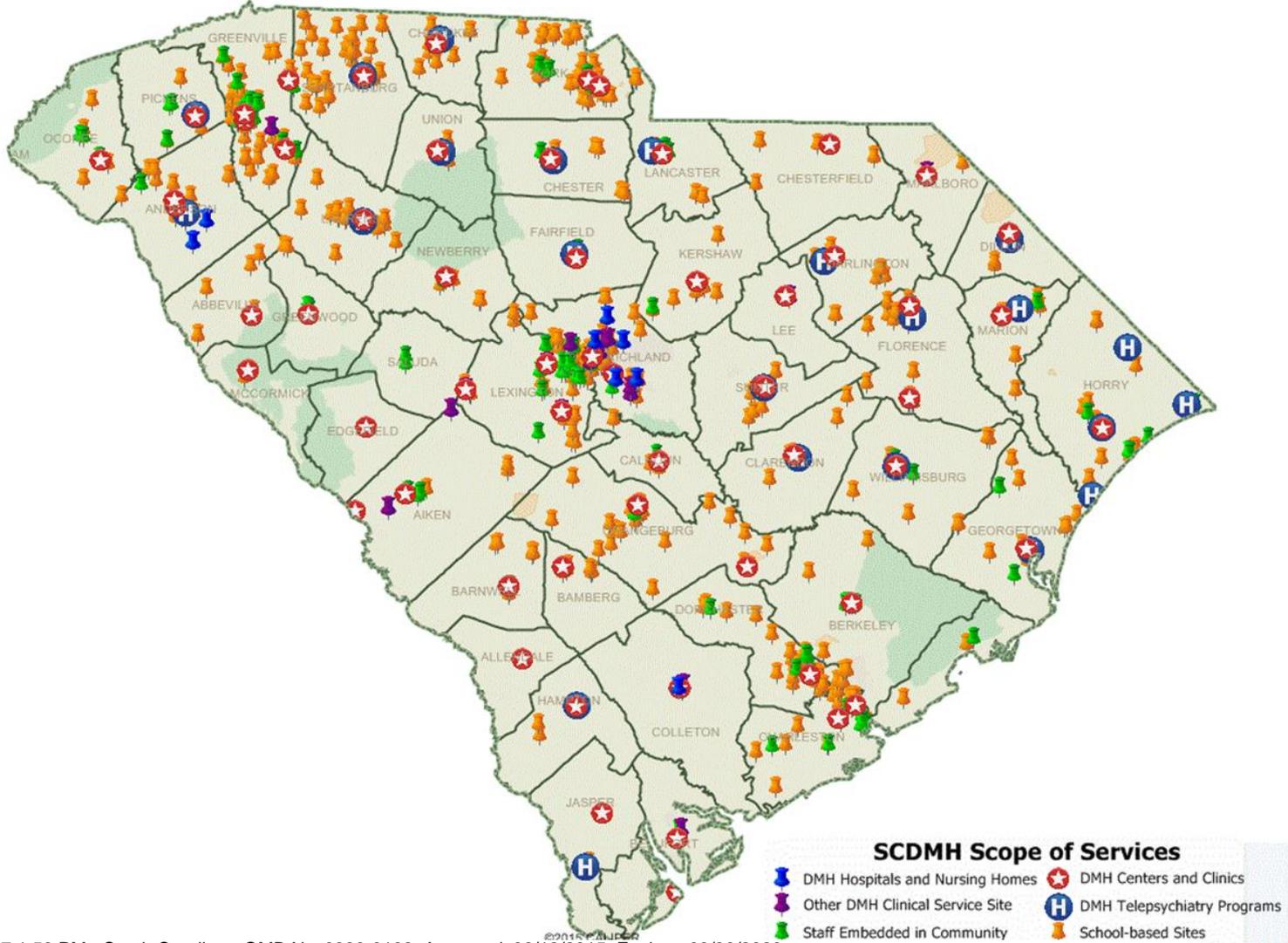
DMH Portals: DMH School-based Program Sites



(500+) DMH’s School-based Program employs Master’s-level mental health professionals who provide mental health assessment, intervention, and treatment services on-site in schools.

SCDMH Scope of Services
📌 School-based Sites

DMH Portals: 700+ Portals to DMH Services



Innovation

Using Technology to Improve & Expand Services



John H. Magill

State Director of Mental Health

Innovation: Telepsychiatry



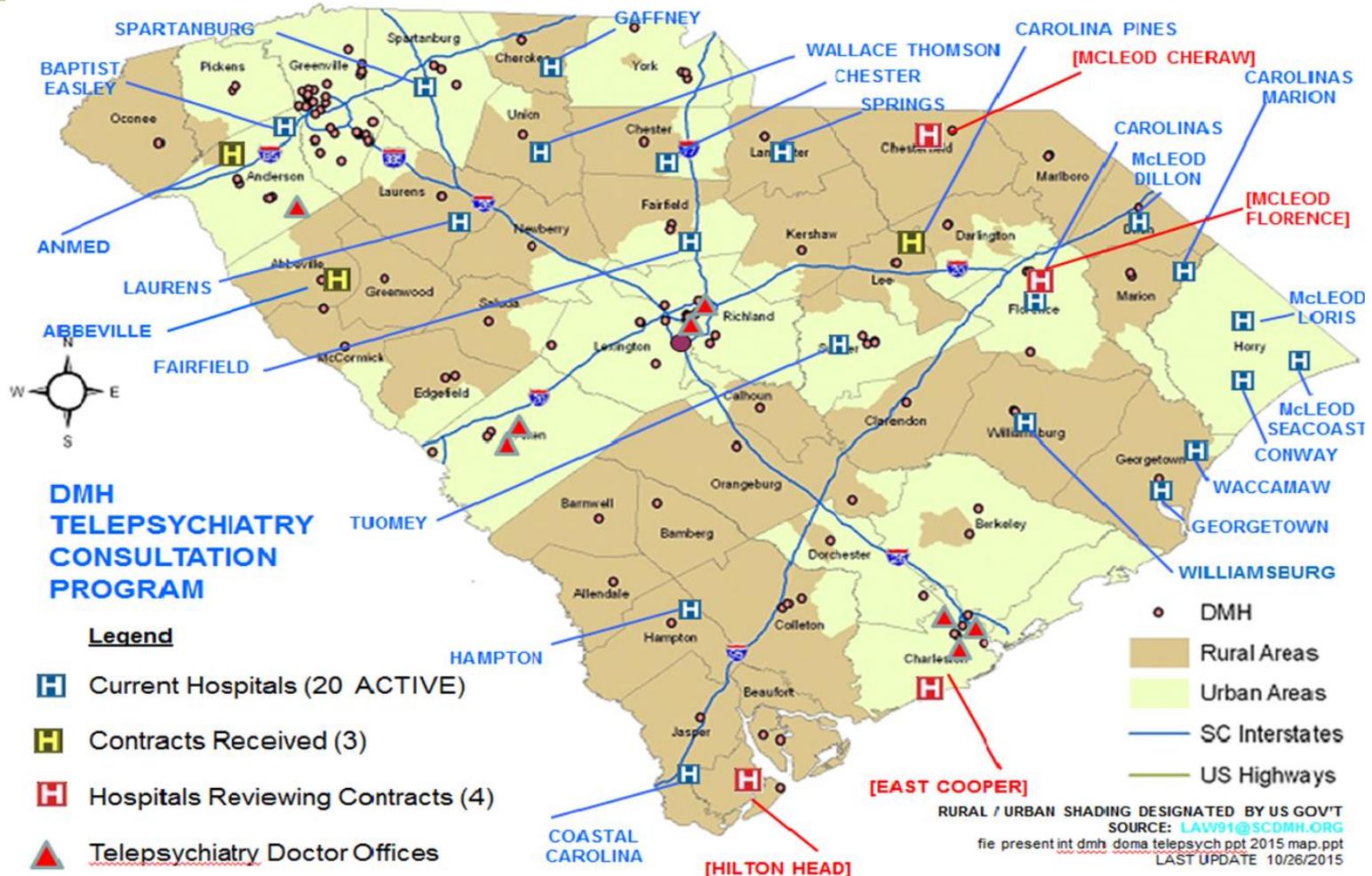
DMH, in partnership with The Duke Endowment (TDE), the University of South Carolina School of Medicine, the South Carolina Hospital Association, and the South Carolina Department of Health and Human Services (SC DHHS), received several grants to provide psychiatric consultations (via telemedicine) in emergency departments (EDs) across South Carolina beginning in March of 2009.

Since July 2012, the program is funded by TDE, state appropriations, SC DHHS, and via subscription fees from participating hospitals.

SC is the first state successfully connecting patients in EDs statewide with telepsychiatrists.

As of December 1, 2015, 23 hospitals are connected to the Telepsychiatry program. There have been nearly 26,000 consultations since the program's inception, with recommendations to divert 51% of these patients from inpatient admission.

Telepsychiatry: Deployment



Innovation: Electronic Medical Record

The outpatient Electronic Medical Record (EMR) is used in all 17 community mental health centers. Future goals include:

- Expansion of online clinical documentation beyond basic forms (e.g. Screening Form, Discharge Summary, etc.);
- Continuing to utilize Electronic Prescribing (ePrescribing) services;
- Researching the purchase of an Inpatient EMR as funds become available,
- Sharing (with patient consent ONLY) clinical data with the South Carolina Health Information Exchange (SCHIEEx) for continuity of care across providers.

Innovation: School-based Services

This Best Practice program seeks to identify and intervene at early points in behavioral and emotional disturbances and assist parents, teachers, and counselors in developing comprehensive strategies for resolving these disturbances.

Services include:

- Primary prevention - e.g., helping to increase parental involvement in school, helping to coordinate activities related to a violence prevention initiative, helping to intervene and increase positive choices that support positive behaviors.
- Early intervention and services to youth dealing with transitions and milestones - e.g., social skills training, school transition programs, and parental involvement in schools.
- Individual and family services - e.g., individual, family, and group counseling, crisis intervention, and application of Evidence-based Treatment (EBT) is used to provide these services.

Funding:

- In FY 14, DMH received \$1 Million in funding from the SC General Assembly for the expansion of school-based mental health services.
- Another \$1 Million was recently appropriated for the second phase of expansion of school-based mental health services.

FY 15 Program Data:

- In FY 15, with appropriated funds from the SC General Assembly, DMH school-based programs provided clinicians to more than 500 of the 1,231 public schools in South Carolina, or 41% of schools.
- DMH had staff in 502 schools statewide – 47% of SC schools.
- This expansion will allow school-based services to serve approximately 18,000 students.

Innovation: Assessment/Mobile Crisis

- Assessment/Mobile Crisis (AMC) is a psychiatric emergency services program of Charleston/Dorchester Mental Health Center (CDMHC), created in 1987.
- The AMC team comprises 7.5 Master's level clinicians and a Master's level team leader.
- 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 distress.
- CDMHC's AMC is the only 24/7 psychiatric emergency response team of its kind in South Carolina.

Assessment/Mobile Crisis, cont.

- In Fiscal Year 2015, Assessment/Mobile Crisis:
 - Provided 795 emergency department diversions
 - Provided 405 hospital diversions
 - Responded to 292 crisis calls
 - Handled 1,543 after-hours crisis phone calls
 - Completed 1,741 intakes
 - Provided services to 1,118 walk-in patients

- AMC partners with the Lowcountry Crisis Negotiators' team to assist at bridge jumping, barricade, and hostage scenes. The behavioral health expert sent to the scene can often get the person in crisis directed to treatment.

Innovation: Highway to Hope RV Project

- The Highway to Hope RV of the CDMHC (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
 - Medication management
- Staff include a counselor, a psychiatrist, a nurse, and other mental health professionals.
- Services are available Monday through Thursday from 8am to 5pm; 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.

Innovation: Research & IRB

DMH recognizes the need for safeguarding the rights and welfare of research subjects.

In accordance with Department of Health and Human Services regulations, DMH has an established Institutional Review Board (IRB), which is charged with these responsibilities.

DMH's IRB online manual provides researchers with tools and information necessary to ensure these obligations are met and facilitates the research process.

http://www.state.sc.us/dmh/irb_manual

The DMH IRB has approved research projects conducted in-house and/or with research partners, including faculty and staff from USC, MUSC, Clemson University, Emory University, Georgia Regents University, and the University of Florida.

Innovation: Research

Examples:

- *“A Multi-Center Validation Study of the Virtual Reality Functional Capacity Assessment Tool (VRFCAT)”*
- *“Development of the Sleep Research Data”*
- *“A Randomized Controlled Trial of Buspirone for Relapse-Prevention in Adults with Cocaine Dependence (BRAC2)”*
- *“Exploration of Craving Correlates Among Substance Users”*
- *“Exploration of Reasons for Substance Use with Addicts”*
- *“Latino/a Mental Health in South Carolina: An Assessment of Mental Health Needs, Existing Resources, and Current Challenges”*
- *“Bedside Evaluation of Sleep Apnea and Clinical Correlates in Hospitalized Psychiatric Patients by Using Portable Apnea Risk Evaluation System (ARES)”*
- *“Service Supports for Community Living: Exploring the Role of Case Management in Promoting Community Integration for Clients within a Community Mental Health Center”*
- *“Suicide Prevention Program”*
- *“Testing Integrative Models to Improve School Safety: Positive Behavior Interventions Support and the Olweus Bullying Prevention Program”*

Innovation: The Ensor Trust

- The Ensor Trust at DMH was established years ago through a donation.
- All monies used from the Ensor Trust must be used consistent with the wishes of the settler of the Trust, meaning that the money spent in the form of Ensor Grants must foster and support research initiatives in the area of mental health treatment.
- The program looks specifically for proposals in the area of Translational Research and Clinical Outcomes related to mental health. However, the focus of research may change each year based on the needs and/or mission of DMH and the discretionary authority for Directive Research.
- All requests for Ensor Funds are reviewed and approved by the DMH Research Committee and the State Director and are monitored by the DMH Grant Steering Committee.
- Grant recipients must submit periodic reports and a final product (presentation, publication and new research proposal submission for external funding) is anticipated as an outcome of the proposed research.

Collaboration

Building Partnerships to Meet Unique Local Needs



John H. Magill

State Director of Mental Health

Collaboration: Response to the Mother Emanuel AME Shooting

- On the evening of Wednesday, June 17, 2015, 10 people were shot in an attack during a prayer service at Emanuel AME Church in Charleston. Nine of the victims died.
- Due in part to excellent working relationships with local law enforcement and community groups, staff from Charleston-Dorchester MHC were able to respond immediately in the wake of the tragedy.
- The Center reached out to victims, their families, the Emanuel Community, the Office of the Mayor, first responders (EMS, law enforcement, the coroner's office), the Media, victims' advocates, and the community at large.
- The following is a brief summary of services provided by Charleston-Dorchester MHC and its partners following the shootings.

Collaboration: Response to the Mother Emanuel AME Shooting



- CDMHC quickly collaborated with multiple community partners, including:
 - Berkeley MHC
 - Orangeburg MHC
 - Waccamaw CMHS
 - DMH Central Administration
 - The National Crime Victims' Center (MUSC)
 - 211 hotline
 - Lowcountry Pastoral Counseling
 - SAVE, Inc. (County and City employee assistance program)

Collaboration: Response to the Mother Emanuel AME Shooting

- Together, these partners were able to provide immediate access to care, via:
 - A Family Assistance Center
 - A Church Assistance Center
 - Regular and timely debriefings
 - Funeral planning meetings
 - Phone banks and interviews
 - Community assistance at the Mental Health Centers
 - Support presence at prayer vigils
 - Support presence at every victim's wake and funeral
 - Highway to Hope RV presence at the memorial service at Emanuel AME

Collaboration: Response to the Mother Emanuel AME Shooting

- Partners continued to provide support in the following weeks and months, including:
 - Counselors at every worship service
 - Presence at all court hearings
 - Counselors at various ministry meetings
 - Church bulletin inserts
 - Grief support groups
 - Individual therapy
 - Applying for a Victims of Crime grant to provide ongoing support
 - Opening a Recovery Center for victims and the community at large
 - A case study, outlining actions taken, outcomes, and lessons learned
 - Ongoing grief groups - 2 per week
 - A retreat for families of the victims

Collaboration: Response to the Mother Emanuel AME Shooting

- The group who responded to this tragedy were careful to ensure that they “Cared for the Caregivers”; many staff at the nearby MHCs knew victims or their families. The entire community was affected.

- To ensure that those providing services to others were well, partners:
 - Held internal “town hall meetings”
 - Conducted debriefings
 - Provided ongoing training and consultation
 - Ensured constant communication
 - Received ongoing DMH Central Administration support

- The CDMHC and its partners have made sure the local community knows they are “in it for the long haul,” and will continue to provide support **as long as it is needed.**

Collaboration: Beckman CMHS with Greenville Hospital System/ Laurens County Memorial Hospital

- This unique partnership began with Telepsychiatry - the first consult in Laurens Hospital took place July 11, 2010.
- In 2011, the Upstate Hospital Consortium launched, to facilitate communication between Upstate hospitals and DMH community mental health centers with regard to psychiatric services in emergency departments.
- As a result of the Consortium, Beckman CMHS and Laurens Hospital developed a contract in August of 2012 to provide a full-time mental health professional (MHP) to provide services in the hospital's emergency department.
- The contract expanded in July of 2014 to include another full-time MHP to cover LC4, the urgent care area of the Federally Qualified Healthcare Center, located in the former Laurens Hospital emergency department.

Beckman CMHS, Greenville Hospital System/Laurens County Memorial Hospital, cont.

- The MHP provides consultative services to patients experiencing psychiatric emergencies in the emergency department and facilitates linkage to the Telepsychiatry program.
- The second MHP provides services to those in need of urgent care and brief treatment in LC4.
- Since the collaboration began, 2,374 consults have been provided in the emergency department.

Collaboration: Harris Psychiatric Hospital & AnMed Health

- In March of 2013, Harris Psychiatric Hospital entered into an agreement with AnMed Health in Anderson to bring 15 acute inpatient beds back online at Harris. In October of 2014, the capacity was expanded to 20 acute inpatient beds.
- The agreement includes the emergency departments at AnMed, Oconee Memorial, Cannon Memorial, and Baptist-Easley hospitals. In October of 2014, Spartanburg Regional Medical Center was added to the partnership agreement.
- Patients screened and admitted to Harris from these locations receive services from a private psychiatrist on the AnMed medical staff.
- 4 private psychiatrists have agreed to rotate and cover the admissions to the 20 beds outlined in the agreement.
- Without this collaboration, the Upstate region of South Carolina would have 20 fewer beds to serve psychiatric patients. These beds have provided care to more than 400 patients since March 2013.
- This is the first collaboration where private psychiatrists provide services to involuntarily committed psychiatric patients within a public mental health system, highlighting the determination of the DMH to develop public/private partnerships to enhance the delivery of behavioral health services within the state.

Collaboration: National Guard Project

- DMH has partnered with the South Carolina National Guard (SCNG) to give priority and provide outpatient mental health services to soldiers, using a linkage of DMH and SCNG liaisons to facilitate treatment at local mental health centers.
- Since April 2014, the SCNG staff has referred 36 soldiers and three family members to local DMH centers or clinics for treatment.
- DMH and SCNG staff have participated in two statewide conferences on understanding military culture and have held several individual meetings to establish an acceptable referral protocol, understand military culture, and ensure continuity of soldiers' treatment.
 - SCNG staff presented to the DMH Multi-Cultural Council (May, 2015)
 - DMH staff has attended the Mental Health Summit: A Community of Care: Building Connections at the VA Hospital for four years.

National Guard Project, cont.

- In 2015, DMH, SCNG staff, and community partners took part in Star Behavioral Health training, hosted by Aiken-Barnwell and Charleston-Dorchester MHCs, respectively, to obtain a better understanding of military culture and reduce the stigma of mental health treatment.
- Launched in 2011, the Star Behavioral Health Providers program trains civilian mental and behavioral health professionals on the unique aspects of military life. It is a collaborative effort of the Center for Deployment Psychology, which provides training, and the Military Family Research Institute at Purdue University in Indiana.
- The program helps service members and those who care about them locate trained civilian behavioral health professionals who better understand challenges associated with military service.
- Once mental health professionals complete these courses, their names are added to the Military Family Research Institute's confidential registry, which can be searched by reserve and guard members as well as veterans.

Collaboration: Behavioral Health for First Responders

- In July of 2013, DMH joined the South Carolina State Firefighters' Association (SCSFA), the South Carolina Fire Academy (SCFA), and the National Fallen Firefighters Foundation (NFFF), in launching a pilot program to provide behavioral health support to South Carolina's 17,500 firefighters.
- The goal is to ensure that behavioral health interventions are available to firefighters when needed and that the care provided represents best-practices.
- The program provides clinical intervention; firefighter peer teams provide first-tier response, and DMH provides second-tier clinical support.
- The program is the first of its kind in the nation, and will serve as a national and international model.
- Appropriately trained DMH staff are available at the following centers, under this regional pilot program:
 - Beckman CMHS
 - Berkeley MHC
 - Charleston/Dorchester MHC
 - Columbia Area MHC
 - Pee Dee MHC

Collaboration: University of SC School of Medicine

- DMH has contracts with the University of South Carolina School of Medicine (USCSOM) and the Department of Neuropsychiatry and Behavioral Science.
- There has been a long collaborative relationship between DMH and the Department of Neuropsychiatry and Behavioral Science at the USCSOM, which provides clinical consultation and training delivery to DMH staff on a range of clinical topics
- DMH provides clinical rotation for 1st, 2nd, 3rd and 4th year medical students from the School of Medicine. The medical students are assigned DMH physician preceptors and rotate through the centers and facilities.
- There are four fully accredited Psychiatric Residency Fellowship Training Programs (Child, General, Forensics and Gero-Psych) that rotate through DMH centers and facilities, which the Agency supports via contract.

Collaboration: Medical University of South Carolina (MUSC)

- Residents from the MUSC Residency Training Program receive educational experiences and supervision in Psychiatry, through scheduled rotations at the Charleston Dorchester Mental Health Center (CDMHC).
- CDMHC is involved with learning collaborative between DMH, the Crime Victim's Center at MUSC and the Dee Norton Low country Children's Center. This initiative revolves around Trauma Focused Cognitive Behavioral Therapy (CBT).
- Forensic fellows from MUSC receive training in the Charleston Mental Health Court Program.
- Medical Students and Physician Assistant students rotate regularly through CDMHC throughout the academic year.
- DMH has a contract with MUSC to provide forensic evaluation of adult criminal defendants in eight counties in the low-country of South Carolina. These counties include Charleston, Dorchester, Beaufort, Allendale, Colleton, Hampton, Jasper, and Berkeley.

Collaboration: Disaster Preparedness & Response

- DMH is part of the SC Emergency Planning Committee for People with Functional Needs, a committee comprising organizations and agencies that came together after Hurricane Hugo to:
 - Improve emergency and disaster planning, policy development, and response to the functional needs of individuals and communities.
 - Educate and promote the participation of state, local, and voluntary agencies, people with functional needs, and emergency management organizations in preparing for emergencies and disasters.
- This committee was among the first organized in the country to act as a resource for state leadership in planning for and responding to people with functional needs.

Disaster Preparedness & Response, cont.

- DMH sends staff to State Emergency Operations Center (SEOC)
- Tasked with providing information and resources to local Emergency Operations Centers (EOCs) and key Emergency Support Functions staff.
- Does NOT manage incidents but supports those who do.
- Immediate Response:
 - Information and Planning (Public Information Phone System)
 - Health and Medical (site for potential evacuees, special medical needs shelters)
 - Support DMH mental health centers – Until staff affected by disaster are able to return to work.

Long Term Recovery – Crisis Counseling Teams:

- Strengths-based
- Outreach-oriented
- Assumes natural resilience & competence
- Culturally competent
- Not diagnostic nor clinical
- Non-traditional settings
- Bolster Community Support Systems

Collaboration: Veterans Policy Academy

In August 2008, South Carolina joined nine other states and federal groups in Bethesda, MD for a Substance Abuse and Mental Health Services (SAMHSA) sponsored summit dedicated to assisting veterans and their families in returning to civilian life by identifying and providing needed services in a variety of areas.

Comprising more than 50 organizations, including military, legislative, veterans' groups, state agency and non-profit representatives, Team South Carolina has developed a 6 priority item Action Plan to identify and coordinate existing services and improve the integration of said services. The team meets regularly and expands with every meeting.



Members signed a SC Veterans Policy Academy Covenant on June 1, 2009 at a formal ceremony held at the Greater Columbia Chamber of Commerce.

In 2011, the Veterans Policy Academy identified the areas of employment for returning/retiring veterans, and communication/access to services as the two main focuses of its mission.

While DMH and State Director John H. Magill still participate in the Academy, coordination is currently under the auspices of the Greater Columbia Chamber of Commerce, where it remains active under the leadership of General George Goldsmith (Ret.).

Affiliations:

Working Together to Identify & Address Needs



John H. Magill

State Director of Mental Health

Affiliations

- The South Carolina Department of Mental Health has affiliations with more than 50 educational institutions in South Carolina and more than five other states.
- The DMH's affiliation with the University of South Carolina includes activity therapy, clinical counseling, medical students, nursing students, social work, psychology interns, psychology graduate studies, and residents and fellows in psychiatry.

Affiliations

- Allen University
- Anderson University
- Appalachian State University
- Argosy University, Atlanta, Georgia
- ATEC Technical College
- ATSU/SOMA Medical School-Mesa, Arizona
- AT Still Medical University
- Augusta State University
- Benedict University
- Campbell University, North Carolina
- Capella University
- Central Carolina Technical College
- Citadel
- Clemson University
- Columbia International University
- Coker College
- ECPI University
- Erskine College
- Florence-Darlington Tech. College
- Fortis College/Education Affiliates
- Francis Marion University
- Furman University
- Gardner Webb
- Greenville Technical College
- Horry Georgetown Technical College
- Lander University School of Nursing
- Liberty University
- Limestone College
- Low Country Technical College
- Medical University of South Carolina
- Mesa University, Arizona
- Midlands Technical College
- Northeastern Technical College
- Orangeburg Calhoun Tech. College
- Piedmont Technical
- Presbyterian College of Pharmacy
- Regent University, Virginia Beach
- Rush University Medical Center
- South Carolina State University
- South University
- Tri County Technical
- Trident Technical College
- University of Akron
- University of North Carolina
- University of North Dakota
- University of South Alabama
- University of Southwest Hobbs, New Mexico
- USC (Activity Therapy, Clinical Counseling, Medical Students, Social Work, Psychology Interns, Psychology Grad. Studies)
- USC – Lancaster
- USC – Upstate
- USC School of Medicine - Neuropsychiatry & Behavioral Science Residency Training Programs (Child, General, Geropsychiatric and Forensics)
- Vanderbilt University
- Walden University
- Webster University
- Williams Corley University
- Winthrop University
- Wofford College
- York Technical College

Affiliations: Advocacy Organizations

DMH works closely with independent advocacy organizations to improve the quality of lives for the persons with mental illness, their families, and the citizens in SC.

- **AFSP-SC** – the American Foundation for Suicide Prevention SC
- **FAVOR** - Faces and Voices of Recovery
- **The Federation of Families** for Children’s Mental Health - SC
- **MHA-SC** - Mental Health America of South Carolina
- **NAMI-SC** - the National Alliance for the Mentally Ill in South Carolina
- **P&A** - Protection and Advocacy for People with Disabilities
- **SC SHARE** - SC Self Help Association Regarding Emotions, the state’s only patient-run advocacy organization

Affiliations: Interagency

■ SC Departments of:

- Alcohol and Other Drug Abuse Services
- Corrections
- Disabilities and Special Needs
- Education
- Emergency Management
- Employment and Workforce
- Employment Security Commission
- Health and Environmental Control
- Health & Human Services
- Juvenile Justice
- Social Services
- Vocational Rehabilitation

■ SC:

- Alzheimer's Association
- American College of Mental Health Administrators
- American Red Cross
- Assistive Technology Program
- Christian Action Council
- Commission for the Blind
- Commission on Minority Affairs
- Development Disabilities Council

- Disabled American Veterans
- Independent Living Council
- Lieutenant Governor's Office on Aging
- Mental Illness Recovery Center, Inc. (MIRCI)
- Migrant and Health Program
- National Association of Consumer/Survivor Mental Health Administrators
- National Association of State Mental Health Program Directors
- National Center for Missing & Exploited Children
- Santee-Lynches Council on Government
- School for the Deaf & the Blind
- Southeastern Kidney Council
- Substance Abuse and Mental Health Services Administration
- The National Research Institute
- The Salvation Army
- United Way Association of South Carolina
- United Way of the Midlands
- USC: Center for Public Health Preparedness
 - Arnold School of Public Health
- Veterans Administration

Affiliations: Joint Council on Children & Adolescents

For the past four years, the Joint Council on Children & Adolescents has led efforts to improve services for children and youth needing treatment services across systems to include mental health, substance use and care coordination.

The body was established in August 2007 as a mechanism for transforming the service delivery system of youth and their families. The Council’s mission requires participating agencies to commit to the delivery of cost effective, quality service which emphasizes a “No Wrong Door” approach.

Unique in its membership, the Joint Council comprises agency directors of:

| | | |
|--|---|------------------------------|
| SC Department of Mental Health | Commission of Minority Affairs | SC Children’s Trust |
| SC Department of Alcohol & Other Drug Abuse Services | Behavioral Health Services Assoc. of SC | Children’s Law Center |
| SC Department of Juvenile Justice | SC Faces and Voices of Recovery | Duke Foundation |
| SC Department of Social Services | Federation of Families of SC | SC Sisters of Charity |
| SC Department of Disabilities & Special Needs | National Alliance of Mental Illness of SC | Blue Cross Blue Shield |
| SC Department of Education | SC Primary Health Care Association | Family Connections |
| Governor's Office Continuum of Care | Two parents of children with serious mental illness | University of South Carolina |

Updated November 2013

Joint Council on Children & Adolescents, cont.

The Joint Council has recently revised its bylaws to incorporate “System of Care” and “Trauma-Informed Care” language.

Products of the “Trauma-Informed Care” initiative, include six hour training on eight trauma-informed core competencies approved by the Joint Council. These trainings are provided to the public at no cost and are presented in regions across the state.

Through the Breaking Boundaries planning grant, SC has created a statewide strategic plan to implement a best practices, child and family-centered approach to services and supports. With the full support of the Joint Council on Children and Adolescents, and a broad base of involvement from agencies, organizations, youth, and families, the state has moved towards the next phase of implementation.



Blue Ribbon Programs

Outstanding Areas of DMH's Service Array



John H. Magill

State Director of Mental Health

Blue Ribbon Programs: The Assessment & Resource Center

The Assessment & Resource Center is a Children's Advocacy Center (CAC), accredited through the National Children's Alliance in Washington, DC. It is the only state-funded CAC in South Carolina.

DMH collaborates with the USC School of Medicine's Department of Pediatrics and Palmetto Health Children's Hospital to provide integrated services for children suspected of being sexually or physically abused.

The Assessment & Resource Center also provides ChildFirst training in forensic interviewing techniques for law enforcement and child protection professionals, in partnership with the Children's Law Center of the University of South Carolina School of Law.

The Center, which is a program under DMH's Columbia Area Mental Health Center, serves approximately 700 children each year.

The Assessment & Resource Center provides:

- Forensic interviews and medical exams
- Court preparation for children
- Expert testimony in Family and Criminal Court
- Victim advocacy
- Focused therapeutic and educational interventions



The Assessment & Resource Center, cont.

Outcomes

- In calendar year 2014, The Assessment & Resource Center provided 396 forensic interviews and 388 medical examinations to children, of whom:
 - 388 were suspected of having been sexually abused
 - 240 were suspected of having been physically abused
 - 180 were suspected of having been abused by neglect, drug endangerment, domestic violence or having witnessed a violent crime.
- During this period, The Center provided best-practice interventions to more than 50 children and families, including court preparation, parent-child interaction therapy, clarification therapy, and reunification therapy.
- 10-15 cases are reviewed every three weeks at meetings of the Richland County Multi-disciplinary Child Abuse Investigation Team.



Statewide Training: *ChildFirst South Carolina*

- This training is a 5-day, multi-disciplinary child abuse course.
- From its inception in 2001 to May 2015, *ChildFirst South Carolina* has trained:
 - 310 Law Enforcement Officers
 - 292 Child Protective Service case workers
 - 290 Children's Advocacy Center interviewers
 - 44 prosecutors
 - The Center also provides ongoing training to medical residents, child life students, and nursing students.

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Blue Ribbon Programs: Child & Family Services

Children, Adolescents and their Families (CAF) Services

CAF Services develops and aspires to implement a seamless statewide system of caring for the children, adolescents and families of South Carolina including ensuring the use of best practices when appropriate and possible.

Best Practice programs includes: Multi-Systemic Therapy (MST), School-based Services, Trauma-Focused Cognitive Behavioral Therapy and Parent-Child Interaction Therapy (PCIT).

The CAF Division assumes a leadership role and provides staff support to the Joint Council on Children and Adolescents, providing a “No Wrong Door” collaborative to increase access to services and supports for families living with mental health, substance abuse and co-occurring concerns, as well as through the Palmetto Coordinated System of Care.

The CAF Division serves as the central hub of communication for local CAF directors, providing consultation services, technical assistance, and serves as a monthly forum for the discussion and problem solving of issues relative to Children's Services.

Blue Ribbon Programs: Parent-Child Interaction Therapy

- Parent-Child Interaction Therapy (PCIT) is an empirically supported treatment for young children (ages 2 to 7) with emotional and behavioral problems.
- Emphasis is on improving the parent-child relationship and changing parent-child interaction patterns.
- PCIT draws on attachment and social learning theories, and treatment can last from 14 to 20 weeks.
- This treatment model is divided into 2 phases:
 - Child Directed Interventions (CDI) - promotes secure attachment as it restructures the parent-child relationship.
 - Parent Directed Interventions (PDI) - parents learn to use effective and consistent contingency strategies to manage their child's behavior.
- In PCIT, the therapist coaches the parent in real time and in specific skills as the parent engages in interaction with his or her child.

Parent-Child Interaction Therapy, cont.

PCIT at DMH:

- The Charleston Dorchester MHC has 2 rostered PCIT therapists.
- A Duke Endowment grant the Center participated in has provided it with the capability to train PCIT therapists in-house.
- The Duke Evidence-based Practice Implementation Center (EPIC) selected 4 clinicians and one senior leader from Beckman Center for Mental Health Services (BCMHS) to participate in the Center for Child and Family Health PCIT of the Carolinas Learning Collaborative to provide PCIT in its Greenwood Clinic.
- In 2015, BCMHS's program expanded to include the development of two additional sites as well as the training of 5 additional clinicians and one additional senior leader from the Center. Duke has trained one staff member to be an in-house trainer, who will training two additional BCMHS staffers in 2016.
- In addition, training was provided to two clinicians and a senior leader each from the Greenville and Lexington County Mental Health Centers.

Blue Ribbon Programs: Clinical Care Coordination

- In 2012, DMH began planning to create a new branch of service called Care Coordination, a patient-centered, assessment-based, multidisciplinary approach for individuals with high-risk, multiple, chronic, and complex conditions.
- In January of 2013, DMH launched the Office of Clinical Care Coordination with 19 internally transferred staff, with the goal of improving outcomes for patients and reducing healthcare costs.
- Provision of Care Coordination services results in:
 - Decreased re-hospitalizations and emergency room visits
 - Increased utilization of primary care physicians
 - Increased detection and treatment of Depression
- Because of its proven effectiveness, Care Coordination is now a **required service** for any provider that wishes to contract with Medicaid. Medicare and other major insurance companies are following suit.
- Care Coordinators (CCs) offer patients assistance with accessing various community resources that will support their recovery.
- Key features of the service include in-home visits and reporting and monitoring of patients' progress in collaboration with referral sources.

Clinical Care Coordination, cont.

- Each patient receives a comprehensive care assessment, which identifies any medical, dental, housing, employment, education, or other community support or advocacy service needs. The care coordinator, knowledgeable about the local community's resources, links the patient to those resources and then monitors until successful completion.

- Outcomes:
 - In FY 2015, 8,842 individual patients received services.
 - As of December 2015, the Office of Clinical Care Coordination comprised 46 Care Coordinators (CCs), 4 supervisors and 1 director.
 - There is at least one CC in each of DMH's 17 community mental health centers. All DMH satellite locations have access to Care Coordination services.
 - 33 Clinical Care Coordination staff members have received national certification by the University of Massachusetts School of Medicine/Primary & Behavioral Health Integration Center.

- The Office of Clinical Care Coordination has established several initiatives with the SC Department of Health and Human Services, and other partners including a pilot project with a Medicaid Managed Care Organization, and is working diligently to implement CCC services as patients transition to the community from hospitals and Corrections facilities.

Blue Ribbon Programs: Deaf Services

DMH's Deaf Services provides a continuum of outpatient and inpatient behavioral health services to persons who are Deaf and Hard of Hearing. The program uses innovative technological and human service program initiatives to ensure that all services are delivered in a cost-effective and timely manner throughout the state.

Components include:

- Outpatient services for children, families and adults, using itinerant counselors who are part of regional teams located across the state.
- School-based services in collaboration with the South Carolina School for the Deaf and the Blind.
- Residential services in supported apartments at locations across the state.
- 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. 80



Blue Ribbon Programs: Peer Support

In 2004, SC became the second state to negotiate a reimbursable Peer Support Service (PSS) with the Department of Health and Human Services.

The Certified Peer Support Specialist (CPSS) uses his or her own experiences with mental illness to help others acquire, develop, and/or expand their rehabilitation skills in order to move forward in recovery.

Since the service was authorized, a self-report service evaluation has been required to evaluate the effectiveness of PSS.

A recent Peer Support program evaluation, reviewing service patterns, usage, inpatient admission, and length of stay was conducted to determine whether and how PSS has impacted patients receiving the Service at DMH, and to compare the results with those of patients who had not done so.

The study found that patients who receive 50+ hours of peer support a year have a significant reduction in the need for inpatient care and/or crisis services and drastically decreased frequency to need to see a psychiatrist, nurse, or mental health professional.

Blue Ribbon Programs: Housing & Homeless Services



Leaphart Place Apartments, Lexington County - A Youth in Transition Program

- The DMH Housing & Homeless Program has funded the development of more than 1,600 housing units across the state for persons with mental illnesses.
- HUD Shelter Plus Care programs are located in 14 counties, and provide rental assistance to more than 350 patients and their family members who were formerly homeless.

Housing & Homeless Services, cont.

- The Health and Human Services Projects for Assistance in Transition from Homelessness (PATH) Formula Grant Program provides funding for targeted outreach and clinical services to persons with serious mental illnesses and co-occurring disorders who are homeless.
- Programs are currently located in the Columbia, Greenville, Spartanburg, Myrtle Beach, and Charleston areas. PATH staff provided outreach and clinical services to almost 3,000 individuals who were homeless last year.
- DMH is the lead agency for the SSI/SSDI Outreach, Access and Recovery (SOAR) initiative.
- SOAR, a SAMHSA best practice, is a partnership with the Social Security Administration and South Carolina Disability Determination Services that increases access to Social Security disability benefits for people with serious mental illnesses who are homeless or at risk of homelessness.
- To date, the approval rate for initial SOAR applications is 60%, and the average decision time last year was 123 days.

Housing & Homeless Services, cont.

CABHI-SC

- In 2015, DMH received a grant of \$1.8 million per year for three years from the Substance Abuse and Mental Health Services Administration (SAMHSA), funding a new initiative, the Cooperative Agreement to Benefit Homeless Individuals for SC (CABHI-SC).
- CABHI's target population is individuals who are chronically homeless and have serious mental illnesses or co-occurring disorders, including veterans.
- The initiative includes several primary partners: the SC Coalition for the Homeless, Palmetto Health, and DMH's Greenville MHC, and intends to serve 109 individuals over the three-year grant period.
- Treatments sites will be located in Columbia and Greenville, and each will provide intensive services using the Assertive Community Treatment (ACT) modality.
- Other Evidence-based Practices to be implemented include Individual Placement and Support (IPS) and SOAR.

Blue Ribbon Programs:

Individual Placement & Supported Employment Program (IPS)

- This supported employment evidence-based program, located in nine DMH mental health center sites, partners with local Vocational Rehabilitation departments to provide opportunities for people with serious mental illnesses to obtain gainful employment in the community.
- In fiscal year 2015, the supported employment programs achieved a 55% average competitive employment rate for people with severe mental illness. During this period, IPS had a total of 337 new enrollees in its programs and 252 new job placements.
- Nationally, among the 22 states participating in the IPS Dartmouth/Johnson & Johnson studies, South Carolina was ranked third in the highest average employment rate.
- In 2008, Johnson & Johnson, Inc. awarded Charleston-Dorchester Mental Health Center (CDMHC) with the National IPS Program of the Year. CDMHC was selected for having the best supported employment outcomes (68% employment). The Center was chosen from a field of 14 other states. CDMHC also received a \$10,000 check for First Place and an award at the Johnson & Johnson Employment Conference.
- In 2014, Johnson & Johnson-Dartmouth selected DMH's Greenville Mental Health Center and its Vocational Rehabilitation partner to receive the Johnson & Johnson-Dartmouth Achievement Award. The Center was chosen from a field of 22 other states, and along with its partner, was presented with the award at the organization's annual awards ceremony in Lexington, Kentucky.

IPS, cont.

IPS: Return on Investment

- The average person employed through IPS programs earned an additional \$533 per month;
- The average annual change in the income of a person employed through the IPS program is \$6,391;
- A substantial decrease in hospital admissions and bed days utilization on the patients served one-year before receiving IPS services and one-year after receiving IPS services. At an average of nearly \$400 per day, this program has potentially saved approximately \$940,800 in inpatient hospital costs for that group of patients; and
- For every \$1.00 invested in the program, patients earn \$5.26.

Blue Ribbon Programs: ACT-like Programs

- Assertive Community Treatment (ACT) is based on long-standing research demonstrating that it is a highly effective, evidenced-based program in re-integrating people with severe mental illness into their communities.
- In South Carolina, specific modifications to the original ACT model were made based on a statewide research project. This project was designed to determine which of the original ACT components are critical for effectiveness and which can be altered to fit local needs while still producing positive outcomes. Based on the research, essential components of ACT were identified and a modified fidelity scale was developed to include these elements. In addition, an outcomes data collection protocol was implemented. Modifications to the original model were evident not only in South Carolina, but 32 other states.
- In FY 2013, nine DMH community mental health centers were implementing an ACT-like program.
- DMH has presented ACT-Like outcomes in two national ACT conferences in Chicago (2010) and New York (2011).
- The outcome data supports the goal of the delivery of effective programming and generation of positive outcomes with a modified version of the ACT evidence-based practice.
- Emergency room visits, hospital admissions, and hospital days (both within the DMH system and private hospitals) are the most notable positively impacted areas.

ACT-like Programs, cont.

| Performance Area | Measure | Program Outcome |
|-----------------------------------|--|--|
| SCDMH Hospital Admissions | Administrative Data (Client Information System) | The number of hospital admissions was reduced by 31.2% from the period one year prior to the ACT admission to the period one year after ACT admission. The number of clients hospitalized was reduced by 19.4% |
| SCDMH Hospital Days | Administrative Data (Client Information System) | The number of hospital days was reduced by nearly 67.6% from those in the year prior to ACT admission to those in the year after ACT admission. The number of clients hospitalized was reduced by 8.3% |
| Private Hospital Admissions | Hospital Data match through the South Carolina Healthcare Data Warehouse | The number of hospital admissions was reduced by 45% from those in the year prior to ACT admission to those in the year after ACT admission. The number of clients hospitalized was reduced by 45.1% |
| Emergency Room Usage | Hospital Data match through the South Carolina Healthcare Data Warehouse | The number of emergency room visits was reduced by 30.1% and the number of clients making those visits was reduced by 37%. |
| Client Functioning | GAF Scores collected from Survey (ACT Program Outcome Measure) and Administrative Data (Client Information System) | Global Assessment of Functioning (GAF) scores from baseline to six month follow up for 149 clients show a small difference in mean scores (52.89 to 55.28) but it is statistically significant difference using a paired samples t test ($t = 2.888$, $p = .004$) |

Blue Ribbon Programs: Project BEST

Bringing Evidence Supported Treatment (BEST) to South Carolina Children and Families

- Project BEST, under the auspices of the Medical University of South Carolina (MUSC), is a statewide, collaborative effort that uses innovative community-based dissemination, training, and implementation methods to dramatically increase the capacity of every community in South Carolina to deliver evidence-supported mental health treatments to children who have experienced trauma and/or abuse.
- The SC Trauma Practice Initiative (SCTPI), a partnership including DMH, the Project BEST/MUSC National Crime Victims Center, The Duke Endowment, SC Department of Social Services, and Dee Norton Lowcountry Children's Center, uses pooled state, federal, and foundation funds to facilitate "rostering" of approximately 300 DMH child clinicians statewide in Trauma-focused Cognitive Behavioral Therapy (TF-CBT).
- This accelerated workforce development effort began in December 2013 and will be completed in February 2016. Future phases of Project BEST training will focus on sustainability and fidelity monitoring/adherence.

Project BEST, cont.

- Trauma-focused Cognitive Behavioral Therapy (TF-CBT) is an evidenced-based treatment model endorsed by the SAMSHA National Registry of Evidenced-based Programs and Practice as the most effective treatment model for children ages 3-17 years old who have experienced a wide range of traumatic experiences and related emotional and behavioral problems.
- TF-CBT is a time-limited treatment intervention, supported by more than a dozen empirical studies demonstrating its clinical effectiveness in treating children who have experienced trauma. TF-CBT enables the clinician to more prescriptively target and treat trauma-related mental health symptoms.
- TF-CBT is administered by highly-trained clinicians who have completed a rigorous,9-month training curriculum under certified MUSC/Project BEST faculty trainers to ensure clinical skill mastery.
- Clinicians are “rostered,” having met fidelity standards to effectively deliver the TF-CBT intervention, and placed in the Project BEST database, which provides the state with a resource for accessing therapists qualified to deliver TF-CBT based upon nationally-accepted training standards established by the founders of the intervention.
- Training focuses on skill development through on-site, face-to-face instruction by Project BEST faculty, supplemented by delivery of TF-CBT services and monthly clinical consultation calls and collection of metrics to ensure skill mastery and treatment effectiveness.

Project BEST, cont.

Outcomes

- The SC Trauma Practice Initiative has had widespread impact on the state's mental health and child welfare service delivery systems. It involves approximately 624 multiagency staff statewide.
- Through the SCTPI's community-based learning communities, the local DMH and DSS leadership teams, along with other community partners, continue to work together to improve service delivery arrangements and care protocols for children who have experienced trauma and abuse.
- The exponential growth in the number of DMH clinicians rostered in TF-CBT clinicians is directly attributable to the SCTPI initiative, which currently accounts for 83% (n=186) of the Agency's rostered clinicians, with more expected to become rostered by the completion of the Initiative in February 2016.
- The magnitude of the SCTPI initiative is unprecedented for both DMH and Project BEST in terms of the huge number of clinicians trained and its comprehensive reach, ensuring that credentialed TF-CBT therapists are available to children in every community within the state.
- As of January 2016, DMH therapists comprise 53% (n=223) of the total Project BEST-rostered TF-CBT clinical workforce (n=420) statewide.
- DMH staff continue to lead the state in modeling exemplary service delivery and clinical practice related to TF-CBT Services, having received the following Project BEST Awards:
 - **2015 The BEST of Project Best Award**
 - **2015 Project BEST Champion Award**
 - **2014 The BEST of Project Best Award**

Blue Ribbon Programs: Trauma Initiative

The Substance Abuse Mental Health Services Administration (SAMHSA) reports that trauma is 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. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation.. The need to provide trauma informed care is increasingly viewed as an important component of effective behavioral health service delivery.

The DMH Trauma Initiative oversees the development and implementation of a statewide, patient-focused trauma initiative to foster the development of policies, procedures, and practices which ensure that:

- Patients with histories of trauma receive state-of-the-art assessment and treatment; and
- Practices in DMH centers and facilities do not create, nor recreate, traumatizing events for patients.

Trauma Initiative, cont.

2015 Trainings

- Intensive, hands-on Trauma-focused Cognitive Behavioral Therapy (CBT) training for Adult Services (a three day training): 32 DMH staff trained.
- Intensive, hands-on Trauma-focused CBT training for Children, Adolescent and Family Services (a three day training): 29 DMH staff trained.
- Trauma Informed Care trainings were provided via video conference and in person to 120 DMH staff.
- Feedback from these trainings is being used to develop an online training for all DMH staff.

Trauma Initiative, cont.

Trauma Informed Care Training

- A Trauma Informed Workgroup was established in 2012 by the SC Joint Council on Children and Adolescents Workforce Committee. Its goal was to develop training to ensure all child and adolescent clinical care providers are Trauma Informed.
- The Workgroup identified existing trauma-dedicated employees at two state agencies, DMH and the SC Department of Juvenile Justice (DJJ).
- Core competencies were Identified, including input from 12 child-serving agencies and organizations and were later endorsed by the Joint Council on Children and Adolescents.
- DMH and DJJ provided trainers, travel, equipment, and learning materials, and held Trauma Informed Care trainings from August of 2013 to December of 2015.
- More than 1,700 professionals from child serving agencies, childcare programs, law enforcement, hospitals/medical practices, family court systems, volunteer groups, and mentor programs have completed the training.

Blue Ribbon Programs: Dialectical Behavior Therapy

- Dialectical Behavior Therapy (DBT) is a cognitive behavioral treatment, originally developed to treat chronically suicidal individuals diagnosed with borderline personality disorder and is now recognized as the gold standard psychological treatment for this population. In addition, research has shown that it is effective in treating a wide range of other disorders, such as substance dependence, depression, post-traumatic stress disorder, and eating disorders.
- A one year program, DBT works with highly symptomatic patients, most of whom have an affective disorder as well as borderline personality disorder.
- DBT is a highly structured therapy that offers individual and group therapy, crisis phone consultation and consultation team for therapists. Skills training is a key component.

Blue Ribbon Programs: Dialectical Behavior Therapy

- In 1993, Columbia Area MHC (CAMHC) implemented the first DBT site in the state of South Carolina. It has been in operation for more than 22 years, remaining one of the only DBT programs in the state maintaining fidelity to the model.
-
- CAMHC's DBT program has been endorsed by the American Foundation for Suicide Prevention-SC Chapter and NAMI-SC for their work in the treatment and prevention of suicide.
- Currently, 10 DMH community mental health centers offer DBT or a DBT-like program.
- Patrick B. Harris Hospital offers an adapted skills training group on all four of its lodges.
- Bryan Psychiatric Hospital is currently piloting an adapted skills training group in its Forensic and Adult Services lodges.

Blue Ribbon Programs: Towards Local Care (TLC)

- Toward Local Care began in 1989, to:
 - Assist patients in transitioning from inpatient institutions into the community;
 - Help patients remain in their communities and avoid re-hospitalization;
 - Facilitate downsizing of the Agency's long-term psychiatric facilities, and
 - Reduce acute care psychiatric admissions.

- Every DMH community mental health center has a TLC program, with capacity ranges from 10-149. Program types include community care residence, Homeshare, supported apartments, rental assistance, and level of service.

- Since 1991, the process has been replicated 14 times and created 1,093 treatment and residential options for inpatient and high recidivist patients.

- As of July 2015, 3,972 patients have received TLC services.

- TLC programs continue to assist with transitioning patients from DMH inpatient facilities while also assisting local emergency departments, and assists community patients by providing residential and treatment environments to maintain community tenure.

Blue Ribbon Programs: Jail Diversion/Forensic Services

- The National Alliance on Mental Illness' Crisis Intervention Training (CIT) program helps to provide training and consultation to law enforcement regarding de-escalation of encounters with persons in psychiatric and/or emotional crises.
 - In fiscal year 2015, the CIT goal was to train 1,244 law enforcement officers.
 - In fiscal year 2015, 2,615 law enforcement officers in SC received CIT.
- Annual trainings promote opportunities for interagency cross-training and networking between criminal justice and behavioral health agencies.
- DMH Jail Diversion/Forensic Services provides consultation and promotes alliances and partnerships in local jurisdictions for coordination of services for offenders with mental illness.
- All 17 DMH community mental health centers and their clinics provide mental health services to jails, with services in 38 of the 46 counties in South Carolina.
- Mental health services in jails/detention facilities include:
 - Assessment and screening for inpatient admission
 - Medication monitoring
 - Referral, as needed, for offenders with mental illnesses to other community services and supports to prevent re-offending and involvement with Law Enforcement

Blue Ribbon Programs: Jail Diversion/Forensic Services, cont.

- Mental Health Court – SC has three mental health courts, in Charleston, Richland, and Greenville counties.
- Mental health courts have single dockets, which specifically address issues of persons with mental illnesses who become involved with Law Enforcement and the criminal justice system. The Probate Court serves as the lead agency, in partnership with DMH's community mental health centers and other stakeholders from the Public Defender's Office, the Solicitor's Office, DAODAS, and SC Probation, Parole and Pardon Services.
- Mental Health Courts are funded by county governments and DMH's community mental health centers.
- Services offered include:
 - Crisis management
 - Case management
 - Individual, family, and group counseling
 - Groups, in the areas of Criminal Thinking, Substance Abuse, and Anger Management

“Outside of the Box”

Patient Support
Compliance & Improvement
Community Education



John H. Magill
State Director of Mental Health

Patient Support: Community Placement

Having a stable and affordable place to live is one of the foundations of recovery!

Recognizing this, DMH sponsors or supports a variety of living arrangements for patients transitioning out of psychiatric hospital settings or receiving mental health services from one of its 17 community mental health centers.

■ DMH community residential options include

- the “Blue Ribbon” **Housing & Homeless Program**, which has funded the development of more than 1,600 housing units across the state for persons with mental illnesses.
- the “Blue Ribbon” **TLC Program**, which includes community care residences, Homeshare, supported apartments, rental assistance, and supportive services.
- **Community Residential Care Facilities (CRCFs)**, DHEC-licensed facilities that offer room, board and a degree of personal care for two or more people. DMH provides outpatient mental health services to 1,276 (8%) residents who live in CRCFs in South Carolina.

Patient Support: Volunteer Program

- DMH encourages volunteer involvement and the development of community resources to enhance the state's mental health care programs and to build closer ties with the community.
- All DMH Mental Health Centers and Hospitals have volunteer programs, coordinated by staff called Community Resource Developers.
- Volunteers:
 - Are an integral part of DMH's programs
 - Enhance care and build closer ties between the community and the mental health system
 - Provide extra support to patients and their families
 - Help dispel stigma and misconceptions that often surround mental illness

Patient Support: Patient Advocacy

- DMH's Client Advocacy Program is designed to:
 - prevent patient rights violations and advocate for the provision of quality of care in a humane environment.
 - review, investigate and resolve patient rights complaints or issues.
 - monitor the number and types of complaints to identify systemic areas of concern.

- All DMH inpatient and outpatient facilities have an assigned advocate.

- Advocates:
 - inform patients about their rights, help them speak for themselves, or speak on their behalf.
 - assist patients with questions and complaints about rights and services.
 - bring issues to Agency officials for resolution.

- If a patient or a family member has a question or concern regarding rights, an assigned advocate will interview the patient, staff, and others, as necessary. The advocate will then review records, documents, or policies and attempt to negotiate a satisfactory result on behalf of the patient.

Patient Support: Client Advisory Boards

Client Advisory Boards (CABs) exist to provide mechanisms for positive collaboration and communication, and to empower patients at all Departmental levels.

They provide unique and independent opportunities for input and involvement in the areas of planning, policy-making, program evaluation, and service provision.

Most states have a statewide or regional CAB, but South Carolina's DMH is among just a few state systems that have mandated the establishment of CABs at each center and hospital.

Along with local CACs, CAB members comprise the Statewide Client Advisory Board, which meets every other month.

Compliance & Improvement: Compliance

- DMH voluntarily implemented its Compliance Program in 1999, using the guidance of the Office of the Inspector General (OIG) of the US Department of Health and Human Services. The purpose of this program is to develop and implement internal controls that promote adherence to applicable federal and state laws and identify and address areas of risk.
- The Compliance Plan addresses all aspects of the Department's operations to, including its governance and leadership, inpatient and outpatient services, finance, reimbursement and patient's resources, human resources, privacy and security, Medicaid and Medicare, information technology and legal.
- The Compliance process includes audits of all facilities to ensure conformance with the DMH Compliance Plan, which is available on the DMH Intranet so all staff may review and be informed of the expectations of the Agency. All staff are required to take training on Compliance at the beginning of employment and annually thereafter.
- All facilities and Centers have a Compliance Officer and Compliance Committee chaired by their Compliance Officer and all Compliance activities are coordinated through the DMH Compliance Officer.

Compliance, cont.

- DMH's Compliance Committee provides oversight to Compliance activities in the various components of DMH and is chaired by the State Director and co-chaired by the DMH Compliance Officer. The Committee includes the deputy directors of Administration, Community Services, Medical Affairs, and Inpatient Services, and the directors of Finance, Reimbursement, General Counsel, and Human Resources.
- The DMH Compliance Officer is responsible with keeping the SC Mental Health Commission abreast of the performance of the different components of DMH, through periodic reports or on an as-needed basis.
- In addition to the annual review of facilities' performance according to the Compliance Plan, the 17 CMHCs are audited to ensure compliance with state and federal regulations and third party payers.
- This process is carried out by the DMH Office of Quality Management and requires each Center to submit a Corrective Action Plan to address areas needing improvement. As needed, training is provided to ensure staff understand standards and to promote conformance.
- DMH Centers conduct quarterly audits as part of a self-review process. Center Quality Assurance Coordinators are responsible for conducting these audits. These activities include the review of medical records, desk audits, focused audits as needed, and review of specific performance indicators such as access, effectiveness and appropriateness of care and conformance to third party payers and accreditation requirements.

Compliance & Improvement: QMAC

DMH's Quality Management Advisory Committee (QMAC) includes:

■ Compliance

- Promotes and monitors DMH adherence to state and federal laws and regulations, as well as to requirements of third party payors for the delivery and billing of quality services.

■ Quality Assurance:

- establishes methods and procedures to ensure that services provided are of the highest quality.
- Systematically monitors performance against established standards for practice and implements actions for improvements as needed to ensure that service delivery is appropriate and meets the needs of patients.
- Audits DMH community mental health centers, inpatient facilities and Reimbursement Division for compliance, primarily with billing rules and standards.

■ QMAC's primary focus is understanding reimbursement issues for DMH services, and:

- ensuring the Agency's clinical programs meet the current requirements.
- remaining alert about the ever changing reimbursement standards for providers of clinical services.

■ Over time, QMAC began to broaden its focus and now routinely identifies opportunities for improvement in the delivery of services.

Compliance & Improvement: Internal Audit

- DMH's Office of Internal Audit serves as an independent function to examine and evaluate Agency activities as a service to the South Carolina Mental Health Commission and the DMH State Director.
- Its overall objectives are to:
 - Evaluate internal controls and safeguard Agency assets.
 - Test for compliance with State, Federal, and Agency requirements.
 - Identify opportunities for revenue enhancement, cost savings, and overall operational improvements.
 - Coordinate audit effects (when requested) with the SC Office of Inspector General, State Auditor's Office, Legislative Audit Counsel, and other external auditors.
 - Deter and identify theft, fraud, waste and abuse.
 - Protect the assets of the State of South Carolina.
- As a result, the Office of Internal Audit provides analyses, recommendations, counsel, and information about activities or processes reviewed, usually in the form of an audit report.

Compliance & Improvement: Multi-Cultural Council

The Department considers cultural competence part of its mission, believing that cultural competency is driven by leadership, and should be staff and patient-oriented. DMH understands that services are more effective when they are provided within the most relevant and meaningful cultural, gender-sensitive, and age-appropriate context for the people being served.

The Department believes that Multiculturalism should be embedded in all organizational units and that continuous efforts must be made to recruit, retain and develop a culturally diverse workforce.

The DMH Multicultural Council is charged with the responsibility of advising and guiding Agency 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 local communities.

Community Education: 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

Community Education: Speakers' Bureau

- The DMH Speakers Bureau comprises Agency professionals who speak on mental health issues, at no cost, to groups and organizations throughout the state. The purpose of the service is to raise awareness of mental health issues and enhance community education related to services and programs available through the DMH.

Speakers available through this Bureau represent a number of areas of professional expertise. Topics Include:

- Children's Mental Health Issues
 - Client/Patient Advocacy and Rights
 - Homelessness and Mental Illness
 - Substance Abuse and Treatment
 - The Art of Recovery Program
 - The Telepsychiatry Consultation Program
 - Disaster Preparedness and Mental Health
 - Other topics, upon request
-
- Civic clubs, community groups, schools, and other organizations are encouraged to contact the DMH Office of Public Affairs to schedule speakers.

Community Education: State Director Outreach Program

Civic Clubs and Media

- During FYs 13, 14, and 15 DMH State Director John H. Magill addressed 42 civic organizations. These meetings were attended by more than 2,250 civic club members.
- Magill has addressed Rotary Clubs in Orangeburg, Florence, Murrell's Inlet, Goose Creek, Spartanburg, Beaufort, Bluffton, Sumter, Greenwood, Clemson, Easley, Hilton Head Island, Anderson, Camden, Myrtle Beach, Cheraw, Bennettsville, Aiken, Lancaster, Columbia, Simpsonville, Union, Chester, Walhalla, Mauldin, Surfside, Pawley's Island, Moncks Corner, Walterboro, and Greenville.
- He also presented to the Rock Hill Kiwanis Club, the Greenwood Lions Club, and the Charleston Exchange Club.

State Director Outreach Program, cont.

Civic Clubs and Media, cont.

- As part of this initiative, Magill and DMH center directors met with editors, publishers, and/or reporters representing 10 SC newspapers, and along with Orangeburg Area MHC Director Willie Priester, gave a television interview to *New Perspectives*, a Public Access production.
- Magill also met with administrators of 20 hospitals, 11 state legislators, the leadership of five Alcohol and Drug Treatment facilities, and community leaders from seven organizations with ties to mental health care.

Profile Updates

- In 2011, DMH created 25 documents to spotlight the services and staff at each of the Agency's treatment facilities: 17 community mental health centers, four hospitals, and four nursing homes. These profiles are updated annually.
- To view these profiles, as well as profiles of DMH Commissioners, and SC Mental Health Advocates, visit: <http://www.state.sc.us/dmh/profiles/profiles.html>

Planning for the Future



John H. Magill

State Director of Mental Health

Planning for the Future: Staff Training

■ Computerized Online Learning Modules (CLMs)

- Provide training to staff to meet regulatory/accrediting standards while minimizing travel to and from Columbia.
- Currently DMH has 176 modules online.
- Tailored curricula have been developed for staff who provide care to meet the special needs of our patients.
- The estimated resulting cost-savings (in man-hours) is approximately \$5 million annually.
- There are also curricula online for public safety staff, administrative staff, certified nursing assistants, mental health specialists, and staff who work with patients with alcohol and other drug problems.

■ Other Online Resources for Staff

- Free or low cost Continuing Education Credit are offered, via Distance Learning.
- Staff are sent updated offerings monthly.
- Staff are able to take the continuing education offerings online as time permits, at home or at work.

Staff Training, cont.

DMH's clinical staff of physicians, nurses, social workers, and psychologists provides diagnostic and therapeutic services upon which its patients and their families depend. The skills of the clinical staff enhance patient care throughout this unified system of care.

DMH understands that the single-most important service the Agency provides is compassionate care that respects patients' dignity and individuality. Clinical staff serve in a variety of inpatient and outpatient care areas throughout our state, affording them the opportunity to use their full range of skills.

DMH understands that collaboration is invaluable in providing the best possible care to our patients. As such, the Agency encourages its staff to pursue and participate in research opportunities.

Staff Training: Executive Leadership Development

- In 2008, DMH implemented an Executive Leadership Development Program to groom new leadership candidates for the agency; five participants completed the course.
- In 2009, another program was conducted, with 7 professionals completed the course.
- In 2010, the Agency devised a Special Executive Leadership Development Program, the focus of which was to prepare future leaders by tapping into the corporate knowledge and expertise of 12 of the agency's current leaders. This knowledge and expertise was captured, preserved, and passed on through a manual, which was developed in-house.
- The 2011 Executive Leadership Development Program focused on the Agency's physicians as leaders in behavioral healthcare; 10 physicians completed the program.
- In 2013, DMH designed and implemented an Executive Leadership program focused on preparing future leaders at its community mental health centers. 12 DMH professionals completed the program.
- 2014's Program focused on the Agency's Division of Inpatient Services. 12 DMH professionals completed the program, which focused on preparing future leaders in this Division.
- A 2016 Executive Leadership curriculum is currently in development.

Planning for the Future: *FIN Initiative*

- The Future is Now (FIN) initiative launched in August of 2012, as a result of DMH's ongoing long-term planning efforts.
- The Future is Now (FIN), was a blueprint for the DMH community mental health centers (CMHCs) to provide timely access and effective treatment to patients. It established a timeline and the necessary steps to create a cohesively aligned system of care to survive in a changing market, driven by cost control and payment for performance.
- As a result of this initiative, data indicates:
 - Quicker access to treatment across all DMH CMHCs
 - Efficiency of operations has been enhanced in:
 - Productivity
 - Caseload Management
 - Standards and Expectations for Clinical Supervisors
 - Levels of Care
 - Provision of evidence-based Training

Planning for the Future: Telemedicine

Goals

- Increasing the availability of 24/7 mental health consultation services in hospital emergency departments (ED) in need of psychiatric consultation;
- Promoting electronic interconnectivity among EDs to further increase interdependence;
- Sharing knowledge of this innovative mental health service with a high realization of hospital and community cost savings;
- Contributing to the broad statewide application of a telemedicine Electronic Medical Record system;
- Serving as advocates for the promotion and utilization of the Palmetto State Providers Network – a statewide fiber optic system designed to network urban/rural medical facilities;
- Providing a productive focal point for other agencies to embrace, promote, and duplicate telemedicine-based services; and
- Promoting the mission/vision of the program to use as a foundation in achieving tomorrow's mental health service delivery system today.
- Expanding Center-to-Center and Center-to-Clinic Services to all DMH locations, by purchasing telepsychiatry equipment for all 17 MHCs.

Planning for the Future: Grants Administration

- The DMH Office of Grants Administration, formed in 2008, looks for funding opportunities and manages federal and non-federal grants in all aspects of grant management for the Department of Mental Health.
- Grants Administration worked with the South Carolina Enterprise Information System (SCEIS) to implement the grant module in SAP to improve grant tracking and greater fiscal accountability in both federal and non-federal grants for DMH.
- Grant status, as of December 14, 2015, is as follows:
 - 30 Total Grants \$23,198,167 total dollar value
 - 23 Federal Grants \$21,207,989 total dollar value
 - 7 Non-federal Grants \$ 1,990,178 total dollar value

Planning for the Future: Boards & RAI

Center Board Training & Resource Acquisition Initiative (RAI)

- During 2014 and 2015, State Director Magill facilitated Center board trainings at DMH community mental health centers across the State.
- Historically, DMH operations have relied on three prongs of funding: Federal, State, and County, all three of which are necessary for DMH to operate successfully. In many counties, financial support (county appropriations) has declined over the years, while DMH Centers and Clinics continue to provide outstanding quality services; and in most cases are expanding services.
- Board members are encouraged to look for opportunities to advocate for mental health services and solicit support from their local County government. During RAI training, board members are given information and tips to facilitate advocacy efforts.
- After receiving RAI training, Center boards host informational meetings for County Council members to strengthen community relationships and foster collaboration.

Awards & Recognition



John H. Magill

State Director of Mental Health

Recent Awards & Recognition

2015

- Harris Hospital is recognized as a Top Performer on Key Quality Measures for 2014 by The Joint Commission. The award recognizes accredited hospitals and critical access hospitals that attain and sustain excellence in accountability measure performance, based on an aggregation of accountability measure data reported during the previous calendar year.
- DMH's Telepsychiatry Consultation Program is recognized as a Statewide Telehealth Program of Excellence at the 4th Annual Telehealth Summit.
- The Ash Center for Democratic Governance and Innovation at the John F. Kennedy School of Government of Harvard University recognizes DMH's Telepsychiatry Consultation Program as part of its 2015 Bright Ideas program, honoring government programs at the forefront in innovative action.

2014

- Stone Veterans Pavilion is ranked as one of the top nursing care facilities in South Carolina and the nation by both the Centers for Medicare and Medicaid Services and *US News and World Report*, earning the facility a 5-star rating - the highest obtainable.

Recent Awards & Recognition

2014, cont.

- Charleston Dorchester MHC receives the Connect 4 Mental Health Community Innovation Award, which recognizes organizations across the US that innovate and collaborate to address serious mental illness in their communities.
- Johnson & Johnson-Dartmouth selects Greenville MHC as recipient of the 2014 Achievement Award for its IPS program (in collaboration with vocational rehabilitation partner, the South Carolina Vocational Rehabilitation Department).

2013

The Joint Commission recognizes Patrick B. Harris Psychiatric as a Top Performer on key Quality Measures for 2012 in its *Improving America's Hospitals* annual report.

2012

DMH's Telepsychiatry Consultation Program receives the SC Office of Rural Health's Annual Award.

2011

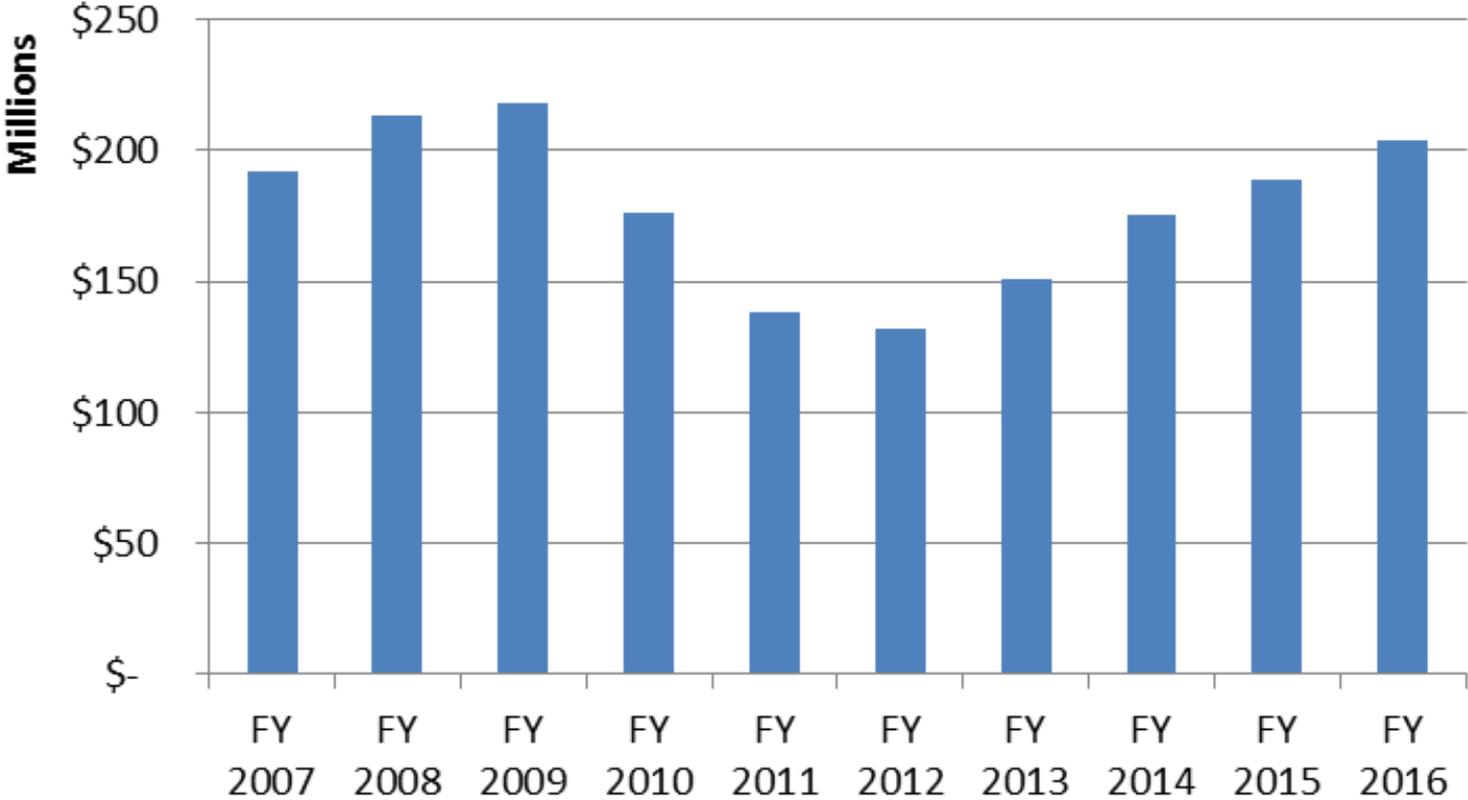
The American Psychiatric Association awards DMH and the Dept. of Neuropsychiatry and Behavioral Science of the USC School of Medicine the Psychiatric Services Achievement Award Silver Medal for the Telepsychiatry program.

Budget



Budget: History of State Funding

Recurring General State Funds



Budget: State Appropriation History

| Fiscal Year | State Appropriations |
|-------------|----------------------|
| FY 2007 | \$ 191,793,392 |
| FY 2008 | \$ 213,724,472 |
| FY 2009 | \$ 217,892,366 |
| FY 2010 | \$ 176,001,571 |
| FY 2011 | \$ 137,889,163 |
| FY 2012 | \$ 131,596,677 |
| FY 2013 | \$ 150,669,318 |
| FY 2014 | \$ 175,310,415 |
| FY 2015 | \$ 188,913,720 |
| FY 2016 | \$ 203,582,260 |

Looking Forward



Looking Forward: New Patients

As stigma decreases and awareness about the importance of mental health and treatability of mental illness increases, as we make strides in research and technology, the number of those seeking services will surely grow. Consider the following:

- The current state of the US and local economies and the associated impacts on individuals and families;
- The number of troops returning from deployment overseas; they and their families need support, often years afterward;
- More individuals are seeking treatment for addiction disorders and co-occurring disorders;
- The development of more and better diagnostic tools, e.g. co-occurring disorders;
- The passage of mental health parity bills in both South Carolina and in the US Congress;
- Increased awareness of the efficacy of mental health treatment and decrease in stigma will result in more people coming forward to receive the help they need, and
- Technological advances and improvements will impact all aspects of healthcare: e.g. telepsychiatry, the electronic medical record.

As South Carolina becomes more diverse, we must adapt our resources to serve individuals of various cultures and backgrounds. To that end, the DMH is dedicated to providing culturally competent services.

Looking Forward: The Sale of “Bull Street”

- **February, 2007** – The Supreme Court issues a declaratory judgment stating that the Bull Street property is subject to a charitable trust, and the proceeds from any sale of the property must go to DMH in trust for the care and treatment of the mentally ill.
- **December, 2010** – DMH signs a contract with Hughes Development Corporation (Hughes) of Greenville, SC to purchase the property in a phased manner over 7 years for \$15 million.
- **July, 2013** – The City of Columbia and Hughes sign a Development Agreement, confirming the re-zoning of the property to permit mixed uses – retail, residential and commercial – to be developed on the property. The Agreement also commits the City to fund substantial infrastructure improvements, such as installing water and sewer lines, as the property is developed.
- **October, 2014** – DMH deeds the first parcels of the property into private ownership, and receives the first installment (\$1.5 Million) of the \$15 Million purchase price.



Did you know?

- Since opening its first hospital in 1828, DMH has served approximately 4 Million South Carolinians in its inpatient and outpatient facilities.
 - 3 Million patients have been served in DMH outpatient community mental health centers.
 - 1 Million patients have been served in DMH inpatient facilities (hospitals and nursing homes).
- DMH is one of the largest hospital and community-based systems of care in South Carolina:
 - Each year DMH provides more than 500,000 inpatient bed days.
 - Almost half of DMH inpatient bed days are for nursing home residents.



For more information, contact:

Tracy L. LaPointe, Public Information Director
DMH Office of Public Affairs
(803) 898-8582 • 1(800) 763-1024

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 behavioral health 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 behavioral health 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.

The state's priorities and goals must be supported by a data-driven process. 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](#), the annual [State and National Behavioral Health Barometers](#), 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.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's population- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. 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](#)¹ 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.

¹ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

Section II – 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.

A Comprehensive Assessment

Beginning in January 2015, SCDMH formalized an extensive review of its operations under Chapter 2, Title 2 of the 1976 Code (Legislative Oversight of Executive Departments), as added by the South Carolina Restructuring Act of 2014 which provides a framework for systematic oversight of government agencies by the South Carolina General Assembly at least once every seven years. Pursuant to Section 2-2-30 of the 1976 Code, the South Carolina Senate scheduled seven state agencies for oversight review during 2015. SCDMH was one of the seven identified by the South Carolina Senate.

Beginning in February 2015, SCDMH expanded the content of its 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 initial information request under the authority of an oversight review – SCDMH is not yet scheduled for its individual review.

During this formalized review process, SCDMH articulated certain opportunities in its operations that would lead to cost savings and increased efficiencies. Many of the articulated opportunities illuminated unmet service needs and critical gaps within the current system.

It should be noted that many of the opportunities were not short-term goals, but rather, long-term objectives and consequently remain relevant in FY2018 and thereafter. A description of each opportunity is provided below. Each has been updated as appropriate.

Expand Training Opportunities – SCDMH has a commitment to staff development and training. There is an online learning management system in place which allows staff to participate in trainings that are required by regulatory and accrediting agencies. In excess of one hundred fifty (150) training modules are offered online to meet The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), Occupational Safety and Health Administration (OSHA) and the Department of Health and Environmental Control (DHEC) standards. Curriculums have been developed for staff which outlines those modules that are required for their particular job duties and responsibilities. These online trainings allow staff to participate in the required training in-place as schedules permit, eliminating the need to travel to attend the trainings in a traditional classroom setting and the associated loss in productivity during travel times.

Finalize Implementation of Electronic Medical Record – The Department's goal is to provide technologically-appropriate resources for the efficient and effective provision of care for patients receiving inpatient services. Electronic Medical Records reduce required storage space for physical storage media (i.e. paper records), assimilate various components of a patient's medical record into a single access point, reduce the cost of record transference, improve overall operating efficiency, increase portability and accessibility of

health information, reduce medical errors, provide for ease of updating to current technologies including coding, and will transition the Department into compliance with Medicare and Medicaid preferred technologies.

Expand Use of Telepsychiatry – The SCDMH telepsychiatry program addresses the overcrowding of psychiatric patients in local hospital emergency departments (“ED”). It is a cutting-edge statewide service delivery model that provides remote access for EDs in rural areas of South Carolina to psychiatrists whenever psychiatric consultation services are required. And it is the first of its kind nationally, and has been widely recognized for its effectiveness. Just as with the previously mentioned program, which is still expanding, SCDMH has implemented the use of telepsychiatry in its Community Mental Health Centers (CMHC) and Inpatient Facilities. The CMHCs program utilizes telepsychiatry in a two-fold manner: Center-to-Clinic and Center-to-Center. Center-to-Clinic Telepsychiatry connects the primary CMHC with its satellite mental health clinics. Center-to-Center Telepsychiatry connects the CMHCs to each other. In addition, the Inpatient Facilities are able to capitalize on the use of telepsychiatry, as well. This expanded use of technology, in the form of telepsychiatry, provides the opportunity for the Department’s 17 CMHCs, 43 Mental Health Clinics, and multiple Inpatient Facilities to utilize a common pool of physicians to deliver services to clients and patients without the loss of productivity associated with travel time, and to deliver services to clients and patients in rural areas where physician availability may be non-existent.

Expand Use of School-Based Services – SCDMH school-based mental health (SBMH) services improve access to needed mental health services for children and their families. The information exchange and collaboration that develops between school teachers, school counselors and administrators and school based mental health staff improves early identification and treatment for children in need; and, for those children and families in need of services, the SBMH program services increase school attendance, reduce discipline referrals and decrease drop-out rates. These positive outcomes for the student and their families also positively correlate to a decreased risk for violence in the school and community.

Expanded Use of Mental Health Professionals (MHP) in Emergency Departments – The MHP provides consultative services to patients experiencing psychiatric emergencies in the emergency department and facilitates linkage to appropriate resources. Evidence supports the assertion that MHPs placed in Emergency Departments to augment the mental health resources currently available have a direct impact on the overall treatment of patients presenting with possible mental health issues. MHPs support the determination process for appropriateness for inpatient admission, and therein the absolute number of patients admitted versus those discharged the same day, and they positively affect the overall effectiveness of navigating patients presenting with potential mental health issues through the Emergency Department process. These placements create partnerships between SCDMH and the placement hospitals and leverage the resources of all.

Enhance Workforce Development – SCDMH continues to pursue creative solutions to recruitment, retention, and graduate medical education. Its Talent Acquisition and Retention Program (TARP) is one example of SCDMH’s efforts to address workforce development.

Increase Community Supportive Housing – SCDMH has a long history of making efforts to foster more permanent supportive community housing for its patients. Appropriate housing is often the single biggest factor in determining whether a patient with serious psychiatric impairments is able to be successfully discharged or is able to remain successful in their recovery in the community.

Enhance Partnerships – The South Carolina Department of Mental Health has affiliations with more than 50 educational institutions in South Carolina and more than five other states. SCDMH also works closely with independent advocacy organizations to improve the quality of lives for persons with mental illness, their families, and the citizens in South Carolina.

Expand Emergency Psychiatric Services – In addition to the SCDMH Emergency Department Telepsychiatry Consultation Program, SCDMH, through its Community Mental Health Centers, utilizes a number of measures to divert individuals in a behavioral health crisis from community hospital emergency departments. The crisis intervention measures include entering into contracts with hospitals with community psychiatric beds to admit patients referred by CMHCs; funding all or part of a mental health professional’s salary to provide on-site consultation to hospital emergency departments; and funding the mobile crisis program at Charleston-Dorchester CMHC.

By articulating the opportunities in its operations, SCDMH was also able to articulate the return on investment realized by addressing the gaps.

The mission of the South Carolina Department of Mental Health is to support the recovery of people with mental illnesses. It gives priority to adults, children, and their families affected by serious mental illnesses and significant emotional disorders. The Department is committed to eliminating stigma and promoting the philosophy of recovery, to achieving its goals in collaboration with all stakeholders, and to assuring the highest quality of culturally competent services possible.

As the sole provider of mental health services in many of the counties in South Carolina, and as the primary provider in many other counties where the private sector provides limited duplication, the emphasis for the Department is two-fold: expand access to mental health services as measured by the number of new cases opened; and increase encounter rates as measured by the increase in the volume of services provided (billed), the increase in the number of assessments provided for which a subsequent service was not provided (not billed for reasons such as initial assessment with subsequent referral), and the increase in the number of interactions that occur under alternative circumstances (to include for example, but not be limited to, services delivered under contract to detention centers, services provided en masse during catastrophic events, and services otherwise not recorded in the Department’s clinical information systems). This emphasis is framed in the context of ensuring the best and most appropriate use of all funding sources and seeking the highest return on investment where such measurement is appropriate (in the many rural areas of South Carolina, return on investment is secondary to maintaining a presence regardless of cost).

Expanding access and increasing encounter rates increases the chance that services will be delivered in the most appropriate setting and by the most appropriate provider; ultimately, resulting in a decrease in the cost of care to the whole healthcare system. For example, when access and services are available in an alternate location, patients are less likely to utilize emergency departments as their primary healthcare provider.

Returns can be maximized when each component of the service delivery continuum is engaged and acting collaboratively and cooperatively.

SCDMH also articulated possible solutions to either alleviate, or eliminate, the gaps.

When applicable, the Department will utilize existing resources, or request additional resources through the budget request process for state appropriations, to expand existing programs. For those efforts that have been identified as offering promising returns, the Department will conduct an internal evaluation of applicability and feasibility and, when deemed appropriate for implementation, either utilize existing resources, or request additional resources through the budget request process for state appropriations, to provide the funding.

SCDMH also had the opportunity to articulate emerging issues that it anticipated may have an impact on its operations in the next five years. The list below has been refined from the first list. Note that many of the original issues are still relevant.

- Affordable Care Act and corresponding legislation
- Population growth

- Continued growth in the Forensic and Sexually Violent Predator programs
- Cost of housing and appropriate services
- Aging workforce
- Shortage of clinicians
- Market-based compensation
- Use of telehealth
- Workforce development
- Third party contracting
- Growth in mandated program populations
- Certification of electronic medical record
- Implementation of electronic medical record in inpatient settings
- Deferred maintenance
- Backfill service gaps for Veterans Administration behavioral health needs
- Realignment of Mental Health Block Grant funding
- Outsourcing Sexually Violent Predator Program operations
- Outsourcing Veterans Administration nursing home operations

The list of emerging issues provides SCDMH with a construct of possible unmet service needs and gaps that could pose potential threats to the current system. However, each item on the list also presents an opportunity for enhancement or improvement to the current and future system.

Possible Unmet Service Needs or Gaps (To Include, But Not Be Limited To)

From the list of identified opportunities, a list of possible unmet service needs or gaps emerges.

- Reduced productivity due to offline training time
- Decreased efficiency due to outdated program practices
- Service gaps in rural areas of the state
- Service gaps to children in light of partial deployment in school-based programs
- Insufficient mental health coverage in emergency departments
- Limited pool of qualified mental health professionals
- Insufficient housing resources (units and rental assistance)
- Insufficient cross collaboration between behavioral health providers
- Insufficient resources to expand crisis intervention programs

FY2018 Budget Requests

SCDMH's FY2018 budget requests to the Governor of the State of South Carolina and the General Assembly of South Carolina, which were submitted in September 2016, 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 FY2018 budget requests are listed below.

Forensics

- This is a legislatively mandated inpatient program. The Forensics Program is comprised of the Department's secure hospital for adult patients committed following adjudication by a Court of General Sessions as being incapable of standing trial due to a mental illness [S.C. Code Ann. §44-23-430] or committed to SCDMH following a finding of Not Guilty by Reason of Insanity [S.C. Code Ann. §17-24-40]. It also includes an Evaluation Service, which conducts court ordered evaluations of criminal defendants' capacity to stand trial. [S.C. Code Ann. §44-23-410 - 20]
- The annualized request represents the amount needed by the Department to adequately fund program operations with recurring state appropriations, for the annual cost of adding 32 beds for Forensic

patients, and to increase supervised community residential services for Forensic patients once discharged.

Sexually Violent Predators Program

- The census of the program is steadily increasing, and additional funding is being requested to offset the increased costs based on the projected increase in the number of civilly committed residents.

Inpatient Clinical and Medical Services

- This request represents the financial impact of the South Carolina Department of Mental Health's efforts to adequately fund program operations with recurring state appropriations, and to maintain services at current levels. The requested amount represents FY2017 annualizations.

Long-Term Care Services

- This request represents the projected cost of adequately funding its four (4) nursing homes with recurring state appropriations, including increases in expenses associated with the Department's two (2) contracted State Veterans Nursing Homes.

Information Technology

- The annualized request represents the annualized funds being expended to securely maintain and support the Department's Inpatient Electronic Health Record (EHR), its Community Mental Health Electronic Medical Record (EMR), its Telepsychiatry services and its network infrastructure system. The requested amount represents FY2017 annualizations.
- The new funds request represents the projected increased costs to support its network infrastructure, including contractual software maintenance, software product costs, training, and funds associated with vacant and requested Information Technology staff positions and salary realignments.

FLSA – Crisis/On-Call

- The Fair Labor Standards Act – Regulatory Changes
 - The FLSA has traditionally exempted certain groups of employees from overtime pay requirements – one such exemption relates to employees working in jobs that the FLSA describes as executive or professional.
 - The change in the Department of Labor's FLSA exemption rules is an increase in the minimum weekly salary to the 40th percentile of weekly earnings for full-time salaried workers.
 - The proposed regulatory changes will have a substantial future impact on operations and finances.
 - The salary level for exemption from overtime will almost double.
 - More of SCDMH's employees will be entitled to overtime.
- Although the Department is modifying its after-hours Crisis services to minimize impact of the change, it anticipates that some increased payment of overtime will be necessary to continue to provide Statewide after-hours crisis response.

Public Safety

- Over 90% of the patients in the agency's three (3) hospitals are involuntary, admitted because they were posing a risk of harm to themselves or others. The DMH Office of Public Safety provides necessary security at the agency's inpatient facilities, including responding to emergencies on patient units. Because of the nature of the patients treated, DMH Public Safety employs certified law enforcement officers.
- Certified Public Safety Officers are also required when transporting patients who have outstanding criminal charges, as well as when transporting residents of the Department's Sexually Violent Predator Program.

- The salaries paid by the Department to its Public Safety Officers have increasingly lagged behind the salaries being paid by other State agencies which employ certified officers, as well as the salaries offered by local law enforcement agencies. This has resulted in high turnover of DMH Public Safety Officers and numerous vacancies. In order to meet its critical responsibilities, the Department incurs significant overtime costs in this function.
- This request would permit the Department to increase Public Safety salaries, thereby aiding in recruitment and retention, and reducing overtime.

Community Housing

- SCDMH has a long history of developing more permanent supportive community housing for its patients. Appropriate housing is often the single biggest factor in determining whether a patient with serious psychiatric impairments is able to be successfully discharged from the hospital, and is able to remain successful in their recovery in the community.
- The Housing and Homeless Program has funded the development of more than 1,600 housing units across the state for people with mental illnesses.
- The program administers grants that provide permanent supportive housing for formerly homeless clients and their family members; outreach and clinical services for people with severe and persistent mental illness; and technical assistance and training needed to increase access to Social Security disability benefits for people who are homeless, or at risk of homelessness and have mental illnesses, and co-occurring disorders.
- The program works in collaboration with the Department of Housing and Urban Development, the Department of Health and Human Services, the South Carolina Housing Finance and Development Authority, and the Social Security Administration.
- The request would increase funds for patient rental assistance, which costs between \$8,000 to \$10,000 annually per patient assisted.

School-Based Services

- SCDMH school based mental health services improve access to needed mental health services for children and their families.
- The request for funding is based on an estimate of the total funds required to expand the scope of this program, which is estimated to be \$25,000 per school-based counselor.

Capital Requests

Harris Hospital Heating and Air Conditioning Renovations
NE Campus Electrical Distribution System Renovations
Anderson-Oconee-Pickens Mental Health Center Construction
Catawba Mental Health Center Construction
Community Buildings Deferred Maintenance
Inpatient and Support Buildings Deferred Maintenance
Columbia Area MHC Phase III Construction
Campbell Veterans Nursing Home Renovations

One-Time Requests

Forensics
Inpatient Clinical and Medical Services
Long-Term Care
Public Safety
Certification of State Match

Decision-Support through Data Management

By means of consistent evaluation of data resources, and interpretation of the data related thereto, SCDMH was well-positioned to articulate its strengths, weaknesses, opportunities, and threats throughout its critical review, and is well-

positioned to measure its performance as it encounters and addresses the 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 that is used in conjunction with CIS.
- AvatarPM – AvatarPM is a vendor supported inpatient billing system used in SCDMH inpatient facilities.
- 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.

Other 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 listed below.

Community Mental Health Services – All CMHCs

Number of New Cases (New/Readmissions)

Number of Billable Hours (Children and Adults)

Number of Overall Services (Children and Adults)

Number of Clients Served (Children and Adults)

Percent of Intakes Meeting Access Standards

Percent of Notes Meeting Collaborative Documentation Standards

Average Percentage of CMHCs Meeting Productivity Standards

Inpatient Services

Number of New Admissions/Readmissions

Number of Discharges

Number of Patients Served (Children and Adults)

Number of Division of Inpatient Services (DIS) Bed Days

DIS Average Daily Census

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.

- Shortening the length of time for admission to forensic hospital
- Increased productivity and access standards
- Increased deployment of telepsychiatry programs
- Continued deployment of the SC Youth Suicide Prevention Initiative

- Increased number of school-based programs
- Continued deployment of CABHI-SC
- Development of crisis stabilization centers in communities
- Increased number of embedded mental health professionals
- Support and retention of staff
- Maintenance of accreditation in CMHCs and Inpatient Facilities
- Maintenance of the extensive portals of entry to access SCDMH services

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: Baseline Performance Measures
Priority Type: MHS
Population(s): SMI, SED, Other

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: Employees Trained Related to Strategic Goals
Baseline Measurement: Total Number of Hours of Training (Baseline = 4,100)
First-year target/outcome measurement: 4,250
Second-year target/outcome measurement: 4,250

Data Source:

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

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None

Indicator #: 2
Indicator: SCDMH Patient Total Employment
Baseline Measurement: Percent Employed as Compared Internally and to National Average Low and National Average High (Baseline = 12%)
First-year target/outcome measurement: 12%
Second-year target/outcome measurement: 12%

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: SCDMH Patient Competitive Employment

Baseline Measurement: Percent of Patients Employed Competitively as Compared Internally and to Traditional Employment Programs and IPS Benchmark (Baseline = 50%)

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 #: 4

Indicator: Life Expectancy - Skilled Nursing Facilities - Roddey Pavilion

Baseline Measurement: Life Expectancy as Compared Internally and to National Average (Baseline = 3 Years)

First-year target/outcome measurement: 3.0

Second-year target/outcome measurement: 3.0

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

Indicator #: 5

Indicator: Life Expectancy - Skilled Nursing Facilities - Stone Pavilion

Baseline Measurement: Life Expectancy as Compared Internally and to National Average (Baseline = 3 Years)

First-year target/outcome measurement: 3.0

Second-year target/outcome measurement: 3.0

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

Indicator #: 6

Indicator: Hospital Restraint Rate

Baseline Measurement: Inpatient Restraint Rate as Compared Internally and to National Average (Baseline = 0.12 per 1,000 Inpatient Hours)

First-year target/outcome measurement: Less Than 0.10 per 1,000 Inpatient Hours

Second-year target/outcome measurement: Less Than 0.10 per 1,000 Inpatient Hours

Data Source:

SCDMH – Division of Inpatient Services

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None

Indicator #: 7

Indicator: Hospital Seclusion Rate

Baseline Measurement: Inpatient Seclusion Rate as Compared Internally and to National Average (Baseline = 0.23 per 1,000 Inpatient Hours)

First-year target/outcome measurement: 0.15 per 1,000 Inpatient Hours

Second-year target/outcome measurement: 0.15 per 1,000 Inpatient Hours

Data Source:

SCDMH – Division of Inpatient Services

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None

Indicator #: 8

Indicator: 30-Day Hospital Readmission Rate

Baseline Measurement: 30-Day Hospital Readmission Rate (Baseline = 5.00%)

First-year target/outcome measurement: 5.00%

Second-year target/outcome measurement: 5.00%

Data Source:

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

Description of Data:

Client-Level Data Summarized Into Aggregate Outcomes

Data issues/caveats that affect outcome measures::

None

Indicator #: 9
Indicator: Patient Satisfaction Rate - Adult
Baseline Measurement: MHSIP Survey Results (Baseline = 88%)
First-year target/outcome measurement: 88%
Second-year target/outcome measurement: 88%

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

Indicator #: 10
Indicator: Patient Satisfaction Rate - Youth
Baseline Measurement: MHSIP Survey Results (Baseline = 85%)
First-year target/outcome measurement: 85%
Second-year target/outcome measurement: 85%

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

Indicator #: 11
Indicator: Patient Satisfaction Rate - Youth Families
Baseline Measurement: MHSIP Survey Results (Baseline = 86%)
First-year target/outcome measurement: 86%
Second-year target/outcome measurement: 86%

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

Indicator #: 12
Indicator: Total Number Served
Baseline Measurement: Total Number of Individuals Served by SCDMH Community Mental Health Services (Baseline = 82,000)
First-year target/outcome measurement: 82,000
Second-year target/outcome measurement: 82,000

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 #: 13
Indicator: Children and Youth Served
Baseline Measurement: Total Number of Individuals Served by SCDMH Community Mental Health Services (Baseline = 27,000)
First-year target/outcome measurement: 27,000
Second-year target/outcome measurement: 27,000

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 #: 14
Indicator: Persons Visiting SC ERs with a Primary Diagnosis of MH or SA and Seen by SCDMH within the Past Three Years
Baseline Measurement: Number of Individuals Visiting SC ERs with a Primary Diagnosis of MH or SA and Seen by SCDMH within the Past Three Years (Baseline = 24%)
First-year target/outcome measurement: Less than 25%
Second-year target/outcome measurement: Less than 25%

Data Source:

South Carolina Department of Mental Health (SCDMH)

Description of Data:

Compilation of Externally-Sourced Data

Data issues/caveats that affect outcome measures::

None

Indicator #: 15
Indicator: ED Patients - 24-Hour Wait
Baseline Measurement: Number of Individuals Waiting in ER Longer than 24 Hours (Baseline = 1,499)
First-year target/outcome measurement: Less than 1,500 Annually
Second-year target/outcome measurement: Less than 1,500 Annually

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 #: 16
Indicator: SCDMH Hospital Admissions
Baseline Measurement: Number of Psychiatric Hospital Admissions (Baseline = 675 Annually)
First-year target/outcome measurement: 675
Second-year target/outcome measurement: 675

Data Source:

Avatar – Inpatient Information System

Description of Data:

Client-Level Data Summarized Into Aggregate Outcomes

Data issues/caveats that affect outcome measures::

None

Indicator #: 17
Indicator: Computerized Training for Employees
Baseline Measurement: Number of Staff Training Programs Available by Computer (Baseline = 200)
First-year target/outcome measurement: 200
Second-year target/outcome measurement: 200

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 #: 18
Indicator: Participating Hospitals - ED Telepsychiatry Consultation Program
Baseline Measurement: Number of Participating Hospitals - ED Telepsychiatry Consultation Program (Baseline = 23)

First-year target/outcome measurement: 23

Second-year target/outcome measurement: 23

Data Source:

SCDMH – Office of Medical Affairs (ED Telepsychiatry Consultation Program)

Description of Data:

Internally-Generated Subject-Specific Information Resources

Data issues/caveats that affect outcome measures::

None

Indicator #: 19

Indicator: School-Based Services - Total Schools

Baseline Measurement: Number of Schools in School-Based Program (Baseline = 500)

First-year target/outcome measurement: 500

Second-year target/outcome measurement: 500

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

Indicator #: 20

Indicator: CMHC Appointment Timeframes

Baseline Measurement: Clients Seen at Each CMHC will Meet the Appointment Timeframes as Determined by Need (Emergent, Urgent, Routine) (Baseline = 90%)

First-year target/outcome measurement: 90%

Second-year target/outcome measurement: 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 #: 21

Indicator: CMHC Billed Hours

Baseline Measurement: Hours of Billed Services in Community Mental Health Services (Baseline = 985,000)

First-year target/outcome measurement: 985,000

Second-year target/outcome measurement: 985,000

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 #:

22

Indicator:

CMHC New Cases

Baseline Measurement:

Total Number of New Cases (New Cases/Readmissions) in Community Mental Health Services (Baseline = 42,000)

First-year target/outcome measurement:

42,000

Second-year target/outcome measurement:

42,000

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 #:

23

Indicator:

ED Patients - Total

Baseline Measurement:

Number of Individuals Waiting in ER (Baseline = Less Than 2,000 Annually)

First-year target/outcome measurement:

Less Than 2,000

Second-year target/outcome measurement:

Less Than 2,000

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 #:

24

Indicator:

Inpatient Services - Total Bed Days

Baseline Measurement:

Total Number of Inpatient Bed Days (Baseline = 520,000)

First-year target/outcome measurement:

520,000

Second-year target/outcome measurement:

520,000

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 #: 25
Indicator: Forensic Inpatient Services
Baseline Measurement: Number of Forensic Admissions (Baseline = 200)
First-year target/outcome measurement: 220
Second-year target/outcome measurement: 220

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 #: 26
Indicator: Community Telepsychiatry Program
Baseline Measurement: Number of CMHCs Providing Services via Telepsychiatry (Baseline = 15)
First-year target/outcome measurement: 15
Second-year target/outcome measurement: 15

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 #: 27
Indicator: CMHC Emergency Preparedness
Baseline Measurement: CMHCs will Meet the New Regulatory Requirements for Emergency Preparedness as Per 42 CFR-485.920 (Baseline = 0%)
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 #: 28

Indicator: SCDMH Emergency Preparedness

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

Priority #: 2

Priority Area: Comprehensive Assessment

Priority Type: MHS

Population(s): SMI, SED, Other

Goal of the priority area:

SCDMH identified certain opportunities in its operations that would lead to cost savings and increased efficiencies. Many of the identified opportunities illuminate unmet service needs and critical gaps within the current system.

Objective:

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

Strategies to attain the objective:

The strategy is defined by the Performance Indicator and may vary depending upon the nature of the effort, but all are related to the enhancement of the overall mental health continuum.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Expand Training Opportunities

Baseline Measurement: Increase in Productivity Due to Offline Training Resources (As Measured by Person-Hour Cost Savings)

First-year target/outcome measurement: Provided as Reference Information for Possible Future Emphasis for SCDMH

Second-year target/outcome measurement: Compare to Prior Year's Results

Data Source:

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

Description of Data:

SCDMH has a commitment to staff development and training. There is an online learning management system in place which allows staff to participate in trainings that are required by regulatory and accrediting agencies. In excess of one hundred fifty (150) training modules are offered online to meet The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), Occupational Safety and Health Administration (OSHA) and the Department of Health and Environmental Control (DHEC) standards. Curriculums have been developed for staff which outlines those modules that are required for their particular job duties and responsibilities. These online trainings allow staff to participate in the required training in-place as schedules permit, eliminating the need to travel to attend the trainings in a traditional classroom setting and the associated loss in productivity during travel times.

Data issues/caveats that affect outcome measures::

None

Indicator #: 2
Indicator: Finalize Implementation of Electronic Medical Record
Baseline Measurement: Completion of Implementation Process
First-year target/outcome measurement: Provided as Reference Information for Possible Future Emphasis for SCDMH
Second-year target/outcome measurement: Compare to Prior Year's Results

Data Source:

SCDMH – Division of Inpatient Services

Description of Data:

The Department's goal is to provide technologically-appropriate resources for the efficient and effective provision of care for patients receiving inpatient services. Electronic Medical Records reduce required storage space for physical storage media (i.e. paper records), assimilate various components of a patient's medical record into a single access point, reduce the cost of record transference, improve overall operating efficiency, increase portability and accessibility of health information, reduce medical errors, provide for ease of updating to current technologies including coding, and will transition the Department into compliance with Medicare and Medicaid preferred technologies.

Data issues/caveats that affect outcome measures::

None

Indicator #: 3
Indicator: Expand Use of Telepsychiatry
Baseline Measurement: Deployment of Telepsychiatry Resources Across the Mental Health Continuum
First-year target/outcome measurement: Provided as Reference Information for Possible Future Emphasis for SCDMH
Second-year target/outcome measurement: Compare to Prior Year's Results

Data Source:

South Carolina Department of Mental Health (SCDMH)

Description of Data:

The SCDMH telepsychiatry program addresses the overcrowding of psychiatric patients in local hospital emergency departments ("ED"). It is a cutting-edge statewide service delivery model that provides remote access for EDs in rural areas of South Carolina to psychiatrists whenever psychiatric consultation services are required. And it is the first of its kind nationally, and has been widely recognized for its effectiveness. Just as with the previously mentioned program, which is still expanding, SCDMH has implemented the use of telepsychiatry in its Community Mental Health Centers (CMHC) and Inpatient Facilities. The CMHCs program utilizes telepsychiatry in a two-fold manner: Center-to-Clinic and Center-to-Center. Center-to-Clinic Telepsychiatry connects the primary CMHC with its satellite mental health clinics. Center-to-Center Telepsychiatry connects the CMHCs to each other. In addition, the Inpatient Facilities are able to capitalize on the use of telepsychiatry, as well. This expanded use of technology, in the form of telepsychiatry, provides the opportunity for the Department's 17 CMHCs, 43 Mental Health Clinics, and multiple Inpatient Facilities to utilize a common pool of physicians to deliver services to clients and patients without the loss of productivity associated with travel time, and to deliver services to clients and patients in rural areas where physician availability may be non-existent.

Data issues/caveats that affect outcome measures::

None

Indicator #: 4
Indicator: Expand Use of School-Based Services
Baseline Measurement: Deployment of School-Based Resources Across the Mental Health Continuum
First-year target/outcome measurement: Provided as Reference Information for Possible Future Emphasis for SCDMH
Second-year target/outcome measurement: Compare to Prior Year's Results

Data Source:

SCDMH – Division of Community Mental Health Services

Description of Data:

SCDMH school-based mental health (SBMH) services improve access to needed mental health services for children and their families. The information exchange and collaboration that develops between school teachers, school counselors and administrators and school based mental health staff improves early identification and treatment for children in need; and, for those children and families in need of services, the SBMH program services increase school attendance, reduce discipline referrals and decrease drop-out rates. These positive outcomes for the student and their families also positively correlate to a decreased risk for violence in the school and community.

Data issues/caveats that affect outcome measures::

None

Indicator #: 5
Indicator: Expanded Use of Mental Health Professionals (MHP) in Emergency Departments
Baseline Measurement: Deployment of Mental Health Professional Resources Across the Mental Health Continuum
First-year target/outcome measurement: Provided as Reference Information for Possible Future Emphasis for SCDMH
Second-year target/outcome measurement: Compare to Prior Year's Results

Data Source:

SCDMH – Division of Community Mental Health Services

Description of Data:

The MHP provides consultative services to patients experiencing psychiatric emergencies in the emergency department and facilitates linkage to appropriate resources. Evidence supports the assertion that MHPs placed in Emergency Departments to augment the mental health resources currently available have a direct impact on the overall treatment of patients presenting with possible mental health issues. MHPs support the determination process for appropriateness for inpatient admission, and therein the absolute number of patients admitted versus those discharged the same day, and they positively affect the overall effectiveness of navigating patients presenting with potential mental health issues through the Emergency Department process. These placements create partnerships between SCDMH and the placement hospitals and leverage the resources of all.

Data issues/caveats that affect outcome measures::

None

Indicator #: 6
Indicator: Enhance Workforce Development
Baseline Measurement: Provision of Opportunities to Positively Impact Recruitment and Retention
First-year target/outcome measurement: Provided as Reference Information for Possible Future Emphasis for SCDMH
Second-year target/outcome measurement: Compare to Prior Year's Results

Data Source:

Description of Data:

SCDMH continues to pursue creative solutions to recruitment, retention, and graduate medical education. Its Talent Acquisition and Retention Program (TARP) is one example of SCDMH's efforts to address workforce development.

Data issues/caveats that affect outcome measures::

None

Indicator #: 7

Indicator: Increase Community Supportive Housing

Baseline Measurement: Increase in the Possible Opportunities for Housing Placements

First-year target/outcome measurement: Provided as Reference Information for Possible Future Emphasis for SCDMH

Second-year target/outcome measurement: Compare to Prior Year's Results

Data Source:

SCDMH – Division of Community Mental Health Services

Description of Data:

SCDMH has a long history of making efforts to foster more permanent supportive community housing for its patients. Appropriate housing is often the single biggest factor in determining whether a patient with serious psychiatric impairments is able to be successfully discharged or is able to remain successful in their recovery in the community.

Data issues/caveats that affect outcome measures::

None

Indicator #: 8

Indicator: Enhance Partnerships

Baseline Measurement: Presentation of Opportunities to Enhance Partnerships with Other Entities

First-year target/outcome measurement: Provided as Reference Information for Possible Future Emphasis for SCDMH

Second-year target/outcome measurement: Compare to Prior Year's Results

Data Source:

South Carolina Department of Mental Health (SCDMH)

Description of Data:

The South Carolina Department of Mental Health has affiliations with more than 50 educational institutions in South Carolina and more than five other states. SCDMH also works closely with independent advocacy organizations to improve the quality of lives for persons with mental illness, their families, and the citizens in South Carolina.

Data issues/caveats that affect outcome measures::

None

Indicator #: 9

Indicator: Expand Emergency Psychiatric Services

Baseline Measurement: Deployment of Emergency Psychiatric Service Resources Across the Mental Health Continuum

First-year target/outcome measurement: Provided as Reference Information for Possible Future Emphasis for SCDMH

Second-year target/outcome measurement: Compare to Prior Year's Results

Data Source:

South Carolina Department of Mental Health (SCDMH)

Description of Data:

In addition to the SCDMH Emergency Department Telepsychiatry Consultation Program, SCDMH, through its Community Mental Health Centers, utilizes a number of measures to divert individuals in a behavioral health crisis from community hospital emergency departments. The crisis intervention measures include entering into contracts with hospitals with community psychiatric beds to admit patients referred by CMHCs; funding all or part of a mental health professional's salary to provide on-site consultation to hospital emergency departments; and funding the mobile crisis program at Charleston-Dorchester CMHC.

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: 400

Second-year target/outcome measurement: 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::

SCDMH will work with Dr. Meera Narasimhan and her team at the University of South Carolina, School of Medicine to determine those outcome measurements appropriate to demonstrate the efficacy of the Traditional and CSC Programs beyond reporting only the number of patients served.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period for state fiscal years 2018/2019.

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

| 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 | | | | | | | |
| 3. Tuberculosis Services | | | | | | | |
| 4. Early Intervention Services for HIV | | | | | | | |
| 5. State Hospital | | | \$96,891,008 | \$0 | \$174,404,406 | \$2,900,000 | \$10,470,398 |
| 6. Other 24 Hour Care | | \$0 | \$30,037,474 | \$45,558,044 | \$51,349,730 | \$0 | \$12,587,742 |
| 7. Ambulatory/Community Non-24 Hour Care | | \$12,758,908 | \$121,007,356 | \$12,469,636 | \$169,949,956 | \$6,089,378 | \$40,286,370 |
| 8. Mental Health Primary* | | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| 9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)** | | \$1,487,156 | \$0 | \$0 | \$0 | \$0 | \$0 |
| 10. Administration (Excluding Program and Provider Level) | | \$142,520 | \$0 | \$0 | \$75,206,868 | \$0 | \$3,366,286 |
| 11. MHBG Total (Row 5, 6, 7, 8, 9 and 10) | \$0 | \$14,388,584 | \$247,935,838 | \$58,027,680 | \$470,910,960 | \$8,989,378 | \$66,710,796 |

* 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 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

1 – ESTIMATES ONLY: The information presented above represents a 24-month period (July 1, 2017 – June 30, 2019). 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 approximate Total Expenditures and 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 2018 Mental Health Block Grant Estimated Allotments” file for purposes of completing the FY2018-2019 MHBG planned expenditures (Table 2) and related planned expenditures.

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

| Activity | A. MHBG | B. SABG Treatment | C. SABG Prevention | D. SABG Combined* |
|---|------------------|-------------------|--------------------|-------------------|
| 1. Information Systems | | | | |
| 2. Infrastructure Support | \$140,520 | | | |
| 3. Partnerships, community outreach, and needs assessment | | | | |
| 4. Planning Council Activities (MHBG required, SABG optional) | \$2,000 | | | |
| 5. Quality Assurance and Improvement | | | | |
| 6. Research and Evaluation | | | | |
| 7. Training and Education | | | | |
| 8. Total | \$142,520 | \$0 | \$0 | \$0 |

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

ESTIMATES ONLY: The information presented above represents a 24-month period (July 1, 2017 – June 30, 2019). 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

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁵ 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.²⁶ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁷

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.²⁸ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁹ 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.³⁰

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health 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.³¹ SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³² 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 behavioral health include: developing models for inclusion of behavioral health 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.³³ 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 behavioral health 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 homes³⁴ and ACOs³⁵ may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health 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.³⁶ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁷

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁸ 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.³⁹ 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.⁴⁰ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.⁴¹ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health 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.⁴² 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 behavioral health 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.⁴³ 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.⁴⁴ 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.

²⁵ 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

²⁶ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁷ 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/>

²⁸ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <http://www.cdc.gov/socialdeterminants/Index.html>

²⁹ <http://www.samhsa.gov/health-disparities/strategic-initiatives>

³⁰ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

³¹ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. <http://www.nami.org/Content/ContentGroups/CAAC/FG-Integrating.pdf>; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.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>

³² Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³³ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://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/docs/default-source/policy/ata-best-practice--telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

³⁴ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

³⁵ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

³⁶ 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>

³⁷ 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); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

³⁸ 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>

³⁹ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

⁴⁰ 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

⁴¹ 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

⁴² 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-BHWORX/PEP13-RTC-BHWORX.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>

⁴³ 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>

⁴⁴ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/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.

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, SC Department of Health and Human Services-Medicaid Agency, South Carolina Healthy Connection PRIME Health Plans, and the Healthy Options Program participating hospitals.

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 17 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 (SCHIE) 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 SCHIE/DIRECT Messaging initiative among 17 CMHCs, the SCDMH Office of Clinical Care Coordination and local SCHIE participating providers (e.g. hospitals, federally qualified health centers, rural health clinics, primary care partners and alcohol and other substance use disorder providers.)

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

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 behavioral health providers screen and refer for:

a) Prevention and wellness education Yes No

b) Health risks such as

i) heart disease Yes No

ii) hypertension Yes No

viii) high cholesterol Yes No

ix) 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?

SCDMH participated in the National Academy for State Health Policy Learning Collaborative: Supporting State Strategies to Design and Delivery Whole-Person Care in Ambulatory Settings, in partnership with the SC Medicaid Agency, SC Department of Alcohol and Other Drug Abuse Services, University of South Carolina Medical School and representation from consumer advocacy organizations. The collaborative effort provided a platform for the state to explore alternative reimbursement strategies for integrated care service delivery. As a result of the consultative collaborative, SCDMH was better positioned to: strategically engage in localized population health management integration opportunities, expand integrated workforce development training resources for both primary and behavioral health providers and plan for the inclusion of quality improvement metrics (HEDIS) through its contracted relationship with Medicaid managed care organizations.

Please indicate areas of technical assistance needed related to this section

Not Applicable

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](#)⁴⁵, [Healthy People, 2020](#)⁴⁶, [National Stakeholder Strategy for Achieving Health Equity](#)⁴⁷, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health 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)⁴⁸.

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."⁴⁹

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 status⁵⁰. 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 populations⁵¹. 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, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health 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.

⁴⁵ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴⁶ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁷ <http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁴⁸ <http://www.thinkculturalhealth.hhs.gov>

⁴⁹ http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁰ <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

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, LGBT, 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 behavioral 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? Yes No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) standard? Yes No
6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? Yes No

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

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 (SCDMH) 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, SCDMH 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, the 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 behavioral health 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 behavioral health 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. NREPP 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. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

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 General⁵², The New Freedom Commission on Mental Health⁵³, the IOM⁵⁴, and the NQF⁵⁵. 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."⁵⁶ 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 behavioral health 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](#))⁵⁷ are best practice guidelines for the SUD treatment. The CSAT 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](#))⁵⁸ was developed to help move the latest information available on effective behavioral health 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 behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, 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.

⁵² 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

⁵³ 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.

⁵⁴ 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.

⁵⁵ National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁵⁶ <http://psychiatryonline.org/>

⁵⁷ <http://store.samhsa.gov>

⁵⁸ <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) Leadership support, including investment of human and financial resources.
- b) 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) 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.

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 is the role of SCDMH's Division of Evaluation, Training, and Research.

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

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 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 outcome 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.

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). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). 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 CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the 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.

Charleston-Dorchester CMHC (CDCMHC) has two (2) FEP teams; one team provides services to patients who have experienced an FEP and have a schizophrenia spectrum disorder and the other serves patients who have experienced an FEP with any mental health diagnosis. Both teams have been trained in the EBT NAVIGATE treatment modality, which has proven to be a successful treatment for FEP patients with a schizophrenia spectrum disorder. The NAVIGATE team will maintain fidelity to the model and provide services only to those with a schizophrenia spectrum disorder. This team's staff structure was designed according to the NAVIGATE model. The original FEP team is not set up in the NAVIGATE structure with all members responsible for a different role in treatment/education, but will be providing as much of the NAVIGATE program as possible to patients, regardless. They will be serving patients outside the scope of NAVIGATE; people with FEP that do not have a schizophrenia spectrum disorder. They also may serve patients not wanting all the services and treatment involved with the NAVIGATE program, but do have the inclusive diagnoses for NAVIGATE. This team will require additional treatment and educational tools to address the symptoms and recovery process associated with diagnoses outside the scope of NAVIGATE, as this population will have different needs. The NAVIGATE consultants are assisting CDCMHC staff in obtaining this information.

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

The South Carolina Department of Mental Health provides funding to the participating Community Mental Health Centers for the maintenance of the FEP Programs.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a 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.

The Traditional Program

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 Five 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. A description of each treatment modality, as presented in the original proposal, is provided below for ease of reference.

Motivational Interviewing (MI): From the practitioner perspective, "MI is a person-centered counseling style for addressing the common problem about ambivalence about change." From the technical perspective, "MI is a collaborative, goal style of communication with particular attention to the language of change. It is designed to strengthen personal motivation and commitment to a specific goal by eliciting and exploring the person's own reason for change within an atmosphere of acceptance and compassion." This evidence-based practice is very effective with adolescents and young adults.

Cognitive Behavioral Therapy (CBT): CBT is a form of psychotherapy that is present-focused, time limited and problem-solving oriented. Clients learn to "identify distorted thinking, modify thoughts, relate to others in different ways and change behaviors..." CBT is based on the cognitive model: the way we perceive situations influences how we feel emotionally. This evidence-based practice is useful with targeted populations.

In addition to each modality's individual benefits, the combination of the two also lends itself to ease of linkage with other program activities such as Dialectical Behavioral Therapy (DBT), Certified Peer Support Specialists (CPSS), Telemedicine, Mental Health Courts, Supported Apartments for Youth-in-Transition, Care Coordination for Youth and Families, and Individual Placement & Supported Employment (IPS). These value-added linkages enhance the total effectiveness of this approach – deploying a combined model of MI and CBT – and provide a return-on-investment that extends beyond the deployment of MI and CBT individually.

SCDMH has not changed its plan as outlined above since SAMHSA's guidance and approval was given. The memorandum dated September 17, 2014 from Geoff Mason, Deputy Director, Division of Community Mental Health Services, to Center Directors, Community Mental Health Centers, and the Request for Funding (RFF) remain the governing documents for the use of the Five Percent Set-Aside funds.

The CSC Program

As per the Guidance for Revision of the FY2016-2017 Block Grant Application for the New 10 Percent Set-Aside dated February 8, 2016, "The Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress through its FY 2016 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 is over the FY 2015 level. The appropriation bill specifically requires 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."

It is the understanding of SCDMH that States are still 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 with the FY2016 additional Set Aside funds for First Episode Psychosis (FEP) is to develop new activities; specifically, a Coordinated Specialty Care (CSC) Program. This program is 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.)"

The plan to implement The CSC Program is referred to as "The CSC Program – CDMHC."

Based on the FY2017 MHBG Allocation, SCDMH's annual obligation for the Ten Percent Set Aside for First Episode Psychosis (FEP) is \$791,804. This represents a \$48,226 increase in obligations to the Set Aside for First Episode Psychosis (FEP). It is the intent of the proposed itemized budget below for SCDMH to continue to fund its existing Set Aside for First Episode Psychosis (FEP) programs at current levels and utilize the remaining funds as program expenditures require, or to not draw down these funds.

The Traditional Program Budget

Charleston/Dorchester Community Mental Health Center \$125,408.00

Pee Dee Mental Health Center \$123,320.00

Lexington County Community Mental Health Center \$101,272.00

The CSC Program Budget

Charleston/Dorchester Community Mental Health Center \$393,578.00

Total Total Budget

Total Expenditures for Set Aside for First Episode Psychosis \$743,578.00

Please note that the current budgets for the FEP Programs have not been adjusted to account for the proposed 25% reduction in MHBG funds for FY2018-2019. SCDMH reserves the right to adjust said amounts based on the new ten percent value of the reduced MHBG award to the State of South Carolina.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

CDMHC will illustrate the effectiveness of both teams by looking at patient improvement via DLA-20 scores measured quarterly. Both teams will be consulting with the NAVIGATE trainers as part of the CDCMHC training contract. Although the original intent was to compare both teams, the knowledge gained in the NAVIGATE training about the inclusion diagnoses for NAVIGATE and the year of experience with referrals to the new teams led to the identification of the need to evaluate the effectiveness of two programs with different focuses. One team will follow NAVIGATE as intended and the other team will in effect be piloting an extended version of NAVIGATE that serves a wider population with additional treatment/educational tools added to cover the different needs of these patients. The outcomes may expand EBP options for young people experiencing FEPs associated with a variety of diagnoses.

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.

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

One CDCMHC team will follow NAVIGATE as intended and the other team will in effect be piloting an extended version of NAVIGATE that serves a wider population with additional treatment/educational tools added to cover the different needs of these patients. The outcomes may expand EBP options for young people experiencing FEPs associated with a variety of diagnoses. These potentially expanded EBP options could add substantially to the body of knowledge related to FEPs experienced by young people.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

Footnotes:

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 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, 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 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.

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

Please see Question 4.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? Yes No
2. Are there any concretely planned initiatives in our state specific to self-direction? Yes No

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

- a) How is this initiative financed:
Not Applicable
- b) What are the eligibility criteria?
Not Applicable
- c) How are budgets set, and what is the scope of the budget?
Not Applicable
- d) What role, if any, do peers with lived experience of the mental health system play in the initiative?
Not Applicable
- e) What, if any, research and evaluation activities are connected to the initiative?
Not Applicable
- f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

The mission of the South Carolina Department of Mental Health (SCDMH) is to support the recovery of people with mental illnesses. It gives priority to adults, children, and their families affected by serious mental illnesses and significant emotional disorders. SCDMH is committed to eliminating stigma and promoting the philosophy of recovery, to achieving its goals in collaboration with all stakeholders, and to assuring the highest quality of culturally competent services possible.

As the sole provider of mental health services in many of the counties in South Carolina, and as the primary provider in many other counties where the private sector provides limited duplication, the emphasis for SCDMH is two-fold: expand access to mental health services as measured by the number of new cases opened, and increase encounter rates as measured by the increase in the volume of services provided (billed), the increase in the number of assessments provided for which a subsequent service was not provided (not billed for reasons such as initial assessment with subsequent

referral), and the increase in the number of interactions that occur under alternative circumstances (to include for example, but not be limited to, services delivered under contract to detention centers, services provided en masse during catastrophic events, and services otherwise not recorded in SCDMH's clinical information systems). This emphasis is framed in the context of ensuring the best and most appropriate use of all funding sources and seeking the highest return on investment where such measurement is appropriate (in the many rural areas of South Carolina, return on investment is secondary to maintaining a presence regardless of cost).

While SCDMH is not opposed to self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services, in many cases, it is not practical to deploy such a system. It is also potentially contrary to the SCDMH statutory mandate (Section 44-15-80) that it shall "regulate fees for consultation and diagnostic services, which services may be provided to anyone without regard to his financial status when such person is referred by the courts, schools, health or welfare agencies..."

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

- SCDMH offers strengths-based, recovery-based systems of care that embody SAMSHA's Principles and Dimensions of Recovery in Behavioral Health.
- Mental Health Counselors, Nurses, Peer Support Specialists, Care Coordinators, and Psychiatrists assist the patients and their families/support networks to identify and work toward goals/aspirations for robust lives in communities of their choice.
- Community Mental Health Centers with supported apartments transition patients in/out of the supervised living setting to greater independence.
- SCDMH's IPS is a self-directed program in terms of each participant's preference for job guiding the entire support, placement and on-going support processes.

Please indicate areas of technical assistance needed to this section.

Not Applicable

Footnotes:

Environmental Factors and Plan

7. 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 behavioral health 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 behavioral health 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 behavioral health 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 programs requirements, including quality and safety standard? 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).

Please indicate areas of technical assistance needed to this section

Not Applicable

Footnotes:

Environmental Factors and Plan

8. 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](#)⁵⁹ 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.

⁵⁹ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

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

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.

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 to this section

Not Applicable

Footnotes:

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required 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-occurring 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 at 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 provide 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-occurring M/SUDs Yes No

Please describe as needed (for example, best practices, service needs, concerns, etc)

Best Practices:

Telepsychiatry

School-Based Services

Assessment/Mobile Crisis

The Assessment and Resource Center

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)

ACT-Like Programs

Project BEST

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.

ACT-like teams with low caseloads can see patients with a history of multiple hospitalizations (or ED visits) more frequently. Two (2) FEP teams focus on patients ages 15 to 40 experiencing psychosis and possibly hospitalization for the first time. The Programs use EBP's to provide treatment and education to patients and families to help each to better understand symptoms and be able to identify needs before reaching crisis levels. The Assessment Mobile Crisis (A/MC) team is available 24/7/365 to provide psychiatric assessments in the community with a goal of using resources to divert hospitalizations and ED visits, if appropriate. 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.

CDMHC has also recently started an innovative project with Charleston County EMS, where EMS contacts the Assessment Mobile Crisis team via video chat software to immediately assess mental health patients without having to deploy A/MC staff. With 80+ video assessments to date, this program has diverted over 50% of the calls from the EDs and hospitals.

Hospital/RCF Liaisons visit G. Werber Bryan Psychiatric Hospital at least monthly to screen patients for potential placement in our community. The liaisons visit local CRCF's advocating for the patients screened to be placed. Clinicians also have the ability to "meet the patients where they are," providing services in the community.

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 behavioral health 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 | 267,184 | Not Indicated |
| 2.Children with SED | 66,359 | 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 NRI, Inc. (NRI) provides to SCDMH an estimate of the prevalence in the state of SMI among adults and SED among children as outlined below per NRI.

"URS table 1 (Profile of the State Population by Diagnosis) specifies that prevalence estimates for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) will be completed for states by the Center for Behavioral Health Statistics and Quality (CBHSQ). As has been done in prior years, we have updated the state level estimates of the prevalence of adults with SMI and children with SED and are providing you with a copy of these estimates.

The attached Excel file includes state-by-state estimates of adults with SMI and children with SED using the official SAMHSA estimation methodology for the prevalence of SMI and SED. The SAMHSA estimation methodology was developed and tested by SAMHSA during the 1990s and was published in the Federal Register in 1998. The calculation of estimate of adults with SMI relies on state civilian population data for the 50 states and the District of Columbia and on resident population data for Puerto Rico, while the estimates for children with SED use a combination of state civilian population and poverty data."

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. The measures include the following.

- Community Mental Health Services – All CMHCs
- Number of New Cases (New/Readmissions)
- Number of Billable Hours (Children and Adults)
- Number of Overall Services (Children and Adults)
- Number of Clients Served (Children and Adults)
- Percent of Intakes Meeting Access Standards
- Percent of Notes Meeting Collaborative Documentation Standards
- Average Percentage of CMHCs Meeting Productivity Standards

- Inpatient Services
- Number of New Admissions/Readmissions
- Number of Discharges
- Number of Patients Served (Children and Adults)
- Number of Division of Inpatient Services (DIS) Bed Days
- DIS Average Daily Census

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

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

Describe your state's targeted services to rural and homeless populations and to older adults

Targeted Services to Rural Populations:

SCDMH's telepsychiatry programs have provided more than 60,000 psychiatric services.

As of April 2017, DMH's innovative and award winning Emergency Department Telepsychiatry Consultation Program has provided more than 33,000 psychiatric consultations 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.

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 28,000 psychiatric treatment services to SCDMH patients throughout South Carolina.

Targeted Services to Homeless Populations:

SCDMH continues to administer and provide state matching funds for four HUD Continuum of Care Permanent Supportive Housing grants that fund five programs located in six counties. These programs are administered in partnership with private nonprofit organizations and community mental health centers or private mental health care providers. These grants provide a total of over \$1 million for permanent supportive housing for almost 200 formerly homeless clients and their family members annually. SCDMH continues to administer the HHS PATH (Projects for Assistance in Transition from Homelessness) Formula Grant Program. The current PATH program allocation is \$680,567 that is matched by SCDMH and local nonprofit partner agencies by a 3:1 ratio. The PATH Program provides funding for targeted outreach and clinical services for persons with serious mental illnesses and co-occurring disorders who are primarily literally and chronically homeless. South Carolina currently has four PATH providers—Greenville Mental Health Center, Mental Illness Recovery Center, Inc., One80 Place in Charleston, and Waccamaw Center for Mental Health.

SCDMH also serves as the lead agency for the state's SOAR (SSI/SSDI Outreach, Access and Recovery) initiative, a partnership with the Social Security Administration, SC Disability Determination Services, and local homeless service provider agencies. This collaboration increases access to Social Security disability benefits for people who are homeless or at risk of homelessness and have mental illnesses and co-occurring disorders.

Targeted Services to Older Adults:

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) which reports to the SCDMH Medical Director.

All new staff receives an orientation to the agency and their job duties. They also receive training on a variety of issues including fire safety, HIPPA, security, cultural competence and others as required by regulatory and accrediting standards. This training is done on-line through an Online Learning Management System (LMS) and the training is registered on the staff members training transcript. There are over 200 modules/courses on line that staff has access to depending on their job duties. Some are a one-time requirement and others are required annually. Each of them have a post test and staff must make a score of 80% or more in order to demonstrate competency.

In addition, on the third Friday of each month, Psychiatric Grand Rounds are conducted. They focus on current evidence-based psychiatric best practices. Faculty from the University of South Carolina, School of Medicine (USC SOM) and in-house topic experts are the primary presenters. Grand Rounds are conducted live and they are also broadcast out to the Mental Health Centers and the Inpatient Facilities across the state. Additionally, there are at least 10 special trainings that are conducted each year by the faculty of the USC SOM. In September of each year, a day long program titled "A Psychiatric Update" is conducted. All of these trainings provide discipline specific continuing education credit that staff can use for re-licensure.

ETR also provide a three part Supervisory –Mini Series that is offered twice each year. The program is designed for the new supervisor or new employee who will be functioning in a supervisory role in the agency. The program is offered live and by video conferencing. All in-house resources are used making this a budget neutral endeavor.

Each year ETR conducts a 10 month long Mentoring/Succession Program. The purpose of the program is to develop a cadre of staff who will be able to fill leadership positions in the agency as senior staff retires. There is a total of 50 hours of in classroom instruction. Participants are given written assignments to complete. In addition, each class participant is assigned a mentor who they meet and work with at least one day a month and more often when possible at their work site. The mentoring program has been successful in graduating individuals who have been promoted to Center Directors, Facility Directors, Program Directors and other management positions within SCDMH.

The agency has an Executive Leadership Development Program. This program is designed to prepare staff for executive leadership positions in the agency as current leaders retire. The program is designed to help participants have a clearer understanding of the agency and the issues facing those in leadership roles. Participants are given required readings to complete. They are given a resource manual for their use and are required to complete a written project.

SCDMH has Certified Nursing Assistant Training Program. This is a 120 hour program which is certified by the SC Department of Health and Human Services. Sixty hours are spent in the classroom and sixty hours are spent on the nursing units. It is important to note that Health and Human Services only requires 100 hours of instruction in order to take the exam. SCDMH elected to make the program longer and believe that our patients will benefit. This program prepares selected staff to become certified nurse's aides. In order to do so they must pass a rigorous certification examination process conducted by outside examiners.

Each month staff is provided with a list of Distance Learning Opportunities that are web based trainings. These trainings offer free or low cost Continuing Education Credit. Staff can take them as their time permits. Licensed staff can earn credit that they can use toward re-licensure.

SCDMH provides Continuing Medical Education for physicians. It also provides Continuing Education for Social Workers, Licensed Professional Counselors and Marriage Family Therapists. SCDMH is also accredited by the SC Nurses Association to provide Continuing Education for nurses. The number of hours of credit awarded depends on the program offering. The programs must meet specific criteria/standards in order to give continuing education credit.

Each year ETR sponsors an Administrative Professional Workshop. The program is designed to provide the administrative staff with additional knowledge and skills that they can use in their work setting. It is provided live and by video conferencing.

Footnotes:

Environmental Factors and Plan

12. 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 2016-FFY 2017? Yes No

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

The SCDMH Quality Assurance Manual was revised in August 2016. This plan follows principles of Continuous Quality Improvement and outlines processes performance measurement.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

Footnotes:

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma⁶⁰ 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 behavioral health 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 behavioral health. 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 behavioral health 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 behavioral health 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 Trauma⁶¹ paper.

60 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.*

61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health 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 behavioral health providers? Yes No
3. Does the state have a plan to build the capacity of behavioral health 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.

The DMH Trauma Initiative oversees the development and implementation of a statewide, patient-focused trauma initiative to foster the development of policies, procedures, and practices which ensure that: patients with histories of trauma receive state-of-the-art assessment and treatment; and, practices in SCDMH centers and facilities do not create, nor recreate, traumatizing events for patients.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

Footnotes:

Environmental Factors and Plan

14. 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.⁶²

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.⁶³

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 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.

⁶² 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, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

⁶³ <http://csjjusticecenter.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 behavioral health 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, behavioral health 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 behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health 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 behavioral health 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?

The South Carolina General Assembly made legislative provision in its FY2017-2018 Appropriations Act, and previous such Acts, via Proviso 35.4 (DMH: Crisis Intervention Training) for the following: Of the funds appropriated to the department, \$170,500 shall be utilized for the National Alliance on Mental Illness (NAMI) SC for Crisis Intervention Training (CIT).

Berkeley Community Mental Health Center has added a Mobile Team to its Access/Admission/Emergency Services Program. A team of two mental health professionals will respond to psychiatric emergencies in the community with local law enforcement officers, capitalizing on any/all locations to intervene and engage individuals in crisis to provide and link them with appropriate community services. The Mobile Team, which operates during business hours to respond to situations identified by law enforcement, families, community partners and Center clinicians, is supported by the Berkeley County Probate Judge, DMH, and the numerous law enforcement agencies in the County. Berkeley CMHC joins DMH's Charleston-Dorchester MHC in providing Mobile Crisis support.

SCDMH has received a \$1 Million appropriation to develop crisis stabilization centers in communities. The Charleston community,

through a funding partnership comprising local hospitals, the Charleston-Dorchester Community Mental Health Center, law enforcement and others, will open a 10-12 bed center this year. Discussions are ongoing in Spartanburg, Anderson, and Greenville with local community stakeholders, including hospitals, law enforcement, county councils and local alcohol and drug agencies to look at the future development of crisis stabilization centers.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? Yes No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? Yes No
3. Does the state purchase any of the following medication with block grant funds? Yes No
 - a) Methadone
 - b) Buprenorphine, Buprenorphine/naloxone
 - c) Disulfiram
 - d) Acamprosate
 - e) Naltrexone (oral, IM)
 - f) Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? Yes No
5. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

Per Mental Health Block Grant (MHBG) 2018-2019 Behavioral Health Assessment and Plan Preparation - State Instructions this section is applicable only to the Substance Abuse Block Grant (SABG).

Environmental Factors and Plan

16. 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 behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.⁶⁴ 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 behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁶⁵,

"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 behavioral health 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. Please check those that are used in your state:

⁶⁴<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶⁵Practice Guidelines: Core Elements for Responding to Mental Health Crisis. 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 respond to the following items:

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) WRAP Post-Crisis
- b) Peer Support/Peer Bridgers
- c) Follow-up Outreach and Support
- d) Family-to-Family Engagement

- e) Connection to care coordination and follow-up clinical care for individuals in crisis
- f) Follow-up crisis engagement with families and involved community members
- g) Recovery community coaches/peer recovery coaches
- h) 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 implementation process.

For the Crisis Stabilization programs, SCDMH continues to provide financial support for crisis/co-occurring teams, purchase of local inpatient psychiatric bed days, mental health professionals co-located in emergency departments, detention centers, center-to-clinic telepsychiatry, hospital liaisons, mobile crisis, RV mental health services to rural areas, and peer support programs. Delivery of service can be where the individual is located or at the mental health center. These programs target individuals who overuse or inappropriately use crisis services. The goal is to divert the individual from using crisis services and engaging him/her in treatment to diminish the use of emergency rooms or on-call services. As much as the individual is willing to engage, the staff can engage the patient with psychiatric advance directives, safety planning, suicide prevention, peer support, care coordination, and family members as treatment approaches.

Additionally, SCDMH has encouraged communities to establish Crisis Stabilization Centers to provide residential stabilization on a short term basis, usually 3-5 days. This will provide local mental health centers/hospitals the ability to refer an individual who is unstable but not meeting inpatient care criteria, and emergency departments to discharge psychiatrically fragile individuals with assurances for treatment and safety of the individual for short term treatment and care. As treatment appropriate, care coordination and family members will be engaged to assist with treatment. Presently one crisis stabilization center is operational and three more are in the planning/partnering stage.

Another crisis initiative in implementation phase is the Community Crisis Response and Intervention service which will expand upon the current provision of after-hours crisis contact telephonically. This team will be able to provide on-site crisis assessment and referral in addition to following up with individuals and mental health centers for continuity of care. As treatment appropriate, community health care resources and community resources, along with care coordination and family members will be engaged to assist with treatment.

SCDMH also has a Youth Suicide grant initiative geared towards building community infrastructure and education on suicide and prevention.

While not a pure CIT team, law enforcement officers are trained in CIT through NAMI and may request mental health assistance with crisis situations.

Please indicate areas of technical assistance needed to this section.

Not Applicable

Footnotes:

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health 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 behavioral health 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, 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. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|---|--|--|
| • Clubhouses | Peer-run respite services | Whole Health Action Management (WHAM) |
| • Drop-in centers | • Peer-run crisis diversion services | • Shared decision making |
| • Recovery community centers | • Telephone recovery checkups | • Person-centered planning |
| • Peer specialist | • Warm lines | • Self-care and wellness approaches |
| • Peer recovery coaching | • Self-directed care | • Peer-run Seeking Safety groups/Wellness-based community campaign |
| • Peer wellness coaching | • Supportive housing models | • Room and board when receiving treatment |
| • Peer health navigators | • Evidenced-based supported employment | |
| • Family navigators/parent support partners/providers | • Wellness Recovery Action Planning (WRAP) | |
| • Peer-delivered motivational interviewing | | |

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?
SCDMH partners with SC SHARE, NAMI, Federation for Children and Families, Mental Health America, and SC Protection and Advocacy for People with Disabilities in the planning, implementation, or evaluation of the impact of the state's mental health system.
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

Footnotes:

Environmental Factors and Plan

18. 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 behavioral health 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 behavioral health 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.

Please respond to the following items

- 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
- Does the state have a plan to transition individuals from hospital to community settings? Yes No
- 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 agency's housing program works with private developers to provide partial funding for moderate and low income housing in return for access to a percentage - no more than 25% - of the units for patients referred by the agency's Community Mental Health Centers. When paired with the Department's rental assistance program, patients are assisted in gaining access to affordable, integrated, independent housing.

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

Please see above.

Please indicate areas of technical assistance needed related to this section.

Not Applicable.

Footnotes:

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health 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 community⁶⁶. 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 24⁶⁷. 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 death⁶⁸.

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 21⁶⁹. 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 costs⁷⁰.

According to data from the 2015 Report to Congress⁷¹ 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 behavioral health 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).

⁶⁶Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁷Kessler, 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.

⁶⁸Centers 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.

⁶⁹The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁷⁰Department 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 <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>

⁷¹http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

- Does the state utilize a system of care approach to support:
 - The recovery and resilience of children and youth with SED? Yes No
 - The recovery and resilience of children and youth with SUD? Yes No
- Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:
 - Child welfare? Yes No
 - Juvenile justice? Yes No
 - Education? Yes No
- Does the state monitor its progress and effectiveness, around:
 - Service utilization? Yes No
 - Costs? Yes No
 - Outcomes for children and youth services? Yes No
- Does the state provide training in evidence-based:
 - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? Yes No
 - Mental health treatment and recovery services for children/adolescents and their families? Yes No
- Does the state have plans for transitioning children and youth receiving services:
 - to the adult behavioral health system? Yes No
 - for youth in foster care? Yes No
- 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.)

SCDMH's Children, Adolescents and their Families (CAF) Services develops and aspires to implement a seamless statewide system of caring for the children, adolescents and families of South Carolina including ensuring the use of best practices when appropriate and possible.

Best Practice programs includes: Multi-Systemic Therapy (MST), School-based Services, Trauma-Focused Cognitive Behavioral Therapy and Parent-Child Interaction Therapy (PCIT).

The CAF Division assumes a leadership role and provides staff support to the Joint Council on Children and Adolescents, providing a "No Wrong Door" collaborative to increase access to services and supports for families living with mental health, substance abuse and co-occurring concerns, as well as through the Palmetto Coordinated System of Care.

The CAF Division serves as the central hub of communication for local CAF directors, providing consultation services, technical assistance, and serves as a monthly forum for the discussion and problem solving of issues relative to Children's Services.
- Does the state have any activities related to this section that you would like to highlight?

For the past four years, the Joint Council on Children & Adolescents has led efforts to improve services for children and youth

needing treatment services across systems to include mental health, substance use and care coordination.

The body was established in August 2007 as a mechanism for transforming the service delivery system of youth and their families. The Council's mission requires participating agencies to commit to the delivery of cost effective, quality service which emphasizes a "No Wrong Door" approach.

Unique in its membership, the Joint Council comprises agency directors of the following:

- SC Department of Mental Health
- SC Department of Alcohol & Other Drug Abuse Services
- SC Department of Juvenile Justice
- SC Department of Social Services
- SC Department of Disabilities & Special Needs
- SC Department of Education
- Governor's Office Continuum of Care
- Commission of Minority Affairs
- Behavioral Health Services Assoc. of SC
- SC Faces and Voices of Recovery
- Federation of Families of SC
- National Alliance of Mental Illness of SC
- SC Primary Health Care Association
- Two parents of children with serious mental illness
- SC Children's Trust
- Children's Law Center
- Duke Foundation
- SC Sisters of Charity
- Blue Cross Blue Shield
- Family Connections
- University of South Carolina

Please indicate areas of technical assistance needed related to this section.

Not Applicable

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention - Required 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 behavioral health 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 through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health 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.

The South Carolina Youth Suicide Prevention Initiative (SCYSPI) funded by the Garrett Lee Smith (GLS) State Suicide Prevention grant has begun activities to reduce the incidents of suicide in our state amongst ages (10-24). They include:

1. Training and education
2. Developing Coalitions and Partnerships
3. Awareness Events
4. Policy and Procedure Development and Review
5. Toolkit Development
6. Social Marketing Campaigns
7. Postvention Consultation

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 2016-FFY 2017 plan was submitted? Yes No

If so, please describe the population targeted.

In collaboration with tRMC Orangeburg Medical Center Emergency Department, Behavioral Health and Home Health, SCYSPI has developed a Model Protocol for Emergency Departments built around the Columbia Suicide Severity Rating Scale-screen version. The protocol engages multiple systems care as well as various follow-up and transition of care pieces. SCYSPI looks forward to piloting this protocol in both the Emergency Department at tRMC as well as its ambulatory care centers.

SCYSPI has worked diligently to begin implementing the ZEROsuicide model in Behavioral Health Care settings throughout our state. The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. It presents both a bold goal and an aspirational challenge. The initiative is thrilled to announce that they will begin piloting the ZEROsuicide approach in 3 SCDMH Centers, AOP, Lexington, and Santee-Wateree and the 3 inpatient hospitals; with the knowledge that this model will eventually be adopted in all SCDMH Centers throughout South Carolina.

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

The South Carolina Youth Suicide Prevention Initiative (SCYSPI) has used various multi-media platforms towards taking great strides in obtaining their overarching outreach and awareness goal of reaching 300,000 individuals by year 5 by reaching over 100,000 individuals across the state in 2016-2017. The SCYSPI team offers trainings in suicide prevention which support educational development across the lifespan, multi-disciplinary audiences, and community members. To current, SCYSPI has trained over 5,000 individuals in suicide prevention between years 2016-2017. The training number includes law enforcement, faith-based communities, medical systems, behavioral health systems, corrections, social services, and youth.

SCYSPI has developed a best practice Model Policy and Model Protocol for schools, informed and supported by The American Foundation for Suicide Prevention (AFSP) and the Suicide Prevention Resource Centers' standards of care, to enhance the health and wellness of our youth and families throughout the state. The Model policy and Protocol attends to all pertinent areas to reduce instances of suicidality in our state including: prevention, intervention, postvention, screening, multi-disciplinary crisis response teams, and comprehensive training for staff, faculty, youth, and parents. SCYSPI is proud to share that these models have already begun being implemented in various academic settings across our state.

Bamberg Job Corps, the only Job Corps in South Carolina, has adopted, with the support of National Job Corps Headquarters, the SCYSPI Model Policy and Protocol at their center in the low country to enhance their capacity to effectively support their youth population. Moreover, through the efforts of SCYSPI, Bamberg Job Corps has begun the training step in their suicide prevention action plan by having the entire staff trained in "ASK about Suicide to Save a Life". SCYSPI is looking forward to training all of the youth at Job Corps in "Teens for HOPE" in the upcoming months.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

Footnotes:

Environmental Factors and Plan

21. Support of State Partners - Required 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 behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

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?

The South Carolina Department of Mental Health (SCDMH) has a long history of collaboration with county and state emergency operations centers in planning for and responding to emergencies that result in mental health needs and/or impact persons with mental health conditions and their families and caregivers, and providers of mental health and substance abuse services. SCDMH also has a long history of engagement with volunteer and other emergency response organizations. Events of the immediate past few years, in conjunction with CMS' Final Rule, 42 CFR-485.920, have proven the benefit of such effective relationships and the need to continue to refine those relationships. While said partnerships are not new, necessarily, the situations in which these partnerships find themselves called upon are changing and evolving and require constant development over time.

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 Disabilities 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 Commission for Minority Affairs
South Carolina Department of Vocational Rehabilitation
South Carolina State Housing Finance and Development Authority
South Carolina Department of Disabilities and Special Needs
South Carolina Department of Alcohol and Other Drug Abuse Services

SCDMH also maintains contracts, memorandums of agreement, and other working-level documents with these agencies that demonstrate specific efforts and endeavors on which SCDMH and these agencies are partnered.

The Planning Council also includes representatives from two of the major public educational institutions in the state: Clemson University and the University of South Carolina.

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.

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

The South Carolina Interagency Council on Homelessness has expanded and includes representation from eight state agencies: The South Carolina Department of Mental Health, The South Department of Alcohol and Other Drug Abuse Services, The South Carolina Department of Corrections, The South Carolina Department of Education, The South Carolina Department of Health and Human Services, The South Carolina State Housing Finance and Development Authority, The South Carolina Department of Social Services, and The South Carolina Department of Health and Environmental Control. The Council meets every other month and focuses on achieving better statewide coordination among stakeholders to address homelessness and mental health/substance abuse issues.

Please indicate areas of technical assistance needed related to this section.

Not Applicable

Footnotes:

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or 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 a Behavioral Health Advisory/Planning Council (BHPC). 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 BHPC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**⁷²

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 behavioral health 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.

⁷²<http://beta.samhsa.gov/grants/block-grants/resources>

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)
 - 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 i 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 indicate 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.

Presented below are the duties and responsibilities of the Council, as per the South Carolina Mental Health State Planning Council Bylaws.

"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 plan 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 VIII. Committees, Section 2. Standing Committees further defines the duties and responsibilities of the Council:

"a. In addition to such committees specifically provided for, the Chair, with approval of the Council, shall appoint all standing committee members and chairs. The standing committees may include, but are not limited to the following:

1. Mental Health Block Grant Review

- i. The purpose of said standing committee is to include, but not be limited to, unless the matter at hand exceeds the scope of said standing committee, a review and provision of recommendations related to the Mental Health Block Grant Application and

supplemental Behavioral Health Report to be considered by the Council as a whole.

2. Advocacy

i. The purpose of said standing committee is to include, but not be limited to, unless the matter at hand exceeds the scope of said standing committee, an evaluation of the needs and gaps of mental health services across the mental health continuum, and, in utilizing such information to support its assertions, to advocate for support toward recovery for people with mental illnesses.

3. Outcomes Measurement

i. The purpose of said standing committee is to include, but not be limited to, unless the matter at hand exceeds the scope of said standing committee, the monitoring, review, and evaluation – not less than once a year – of the allocation and adequacy of mental health services within the state by means of outcomes measurement based on key performance measures and key results areas as determined by the Council with collaboration from the South Carolina Department of Mental Health and as subsequently provided by the South Carolina Department of Mental Health with subsequent recommendations from the Council as deemed appropriate.

b. Only those persons who have indicated their consent to serve, if elected, shall be nominated for, or elected, to such office."

See also Letter from South Carolina Mental Health State Planning Council Chairperson.

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

The South Carolina Mental Health State Planning Council (Council) is actively recruiting potential candidates for membership, including representation from the South Carolina Department of Education and the South Carolina Department of Social Services.

The Council is also considering revisions to its Bylaws that will facilitate continued participation of interested members whose terms might otherwise intermittently preclude them from membership.

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.⁷³

⁷³There 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.

Footnotes:

August 15, 2017

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

Dear Ms. Crocker:

The South Carolina Mental Health State Planning Council shares the same values as articulated by the South Carolina Department of Mental Health (SCDMH) and adopted by the South Carolina Mental Health Commission on March 5, 2002.

These include:

- Respect for the individual
- Support for local care
- Commitment to quality
- Dedication to improved public awareness and knowledge

The Block Grant funds services for patients all over the state needing outpatient care. Of note though, the Block Grant funding also allocates money through mental health advocacy organizations providing services as well. These grants range from: adding more peer support in the community, helping patients maintain and retain employment, assisting distressed children of abuse, creating a warm phone line of individuals with mental illness and their families.

As a council, we have built a cohesive bond of all those serving. There is very much a “we are all in this together” mentality of state employees from multiple agencies, (including SCDMH), patients and family members, as well as providers and others who serve together. As a council, we work together to monitor the services of SCDMH. One way we achieve this goal is getting extensive reports from the State Director and all of his Deputy Directors. We also focus on special programs within SCDMH, evaluating their effectiveness. Our council reviews the whole department and all services provided therein.

SCDMH provides information about all bills being considered at the State House involving behavioral health. We then discuss their merits as a group. We are vocal advocates for all patients facing mental health issues and their families. I, personally, met with the SC Senate Majority Leader, Shane Massey, discussing mental health issues and funding.

SCDMH and its staff are supportive of clients in recovery, including myself. A year ago last September, I was struggling with a severe depression but was able to share this information with the Council – as chair. I received support from our members and encouragement from senior leadership and the state director of SCDMH. I also spoke with the SC Mental Health Commission who oversees the Director of SCDMH. Their support and understanding of patients in recovery was evident by their remarks after my speech. The recovery environment in

SC allows for open expression of triumphs and tragedies with zero judgement for what may occur.

This is my second term as chair of the Council. Our goal is to keep the Council filled with strong leaders from all categories who donate their energy to ensure effective mental health services for SC. We have added many new members to the planning council who identify as individuals, family members of individuals and parents of children with SED.

I am confident to say that our Council excels – not because we are mandated by law to exist, but more importantly, our input is a valuable resource for SCDMH. We are appreciated and well respected. We are thankful for the partnerships we have formed in South Carolina. Our liaison, Stewart Cooner, was been promoted to Director of Telepsychiatry. Though his additional duties place him under another supervisor, and into a different division within SCDMH with many new added responsibilities, he remains our liaison and provides much needed administrative support.

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,

A handwritten signature in cursive script that reads "Jane B. Simpson". The signature is written in black ink and is positioned above the typed name and title.

Jane B. Simpson
Chairperson, SC Mental Health State Planning Council

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2017 End Year: 2019

| Name | Type of Membership | Agency or Organization Represented | Address,Phone, and Fax | Email(if available) |
|------------------------|--|--|------------------------|---------------------|
| Jack Balling | Family Members of Individuals in Recovery (to include family members of adults with SMI) | NAMI - Mid Carolina | | |
| Robert Bank, MD | State Employees | SC Department of Mental Health | | |
| Versie Bellamy | State Employees | SC Department of Mental Health | | |
| Mark Binkley | State Employees | SC Department of Mental Health | | |
| Tommy Bowen | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | | |
| Jenah Cason | Family Members of Individuals in Recovery (to include family members of adults with SMI) | SC Federation of Families | | |
| Nicholas Cooper-Lewter | Providers | | | |
| Rose de Campbell | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | | |
| Raj Gavurla | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | | |
| Marcy Hayden | Federally Recognized Tribe Representatives | SC Commission for Minority Affairs | | |
| Rosemary Hedden | Providers | Work-In-Progress | | |
| Joan Herbert | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | | |
| Patricia Hicks | Family Members of Individuals in Recovery (to include family members of adults with SMI) | | | |
| Lavinia Hoskinson | Parents of children with SED | | | |
| Louise Johnson | State Employees | SC Department of Mental Health | | |
| Freda S. King | State Employees | SC Department of Vocational Rehabilitation | | |
| Peter 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 | NAMI South Carolina | | |

| | | | | |
|-------------------|--|--|--|--|
| | SMI) | | | |
| Frankie Long | State Employees | SC Dpmt of Alcohol and Other Drug Abuse Services | | |
| Brett Macgargle | State Employees | SC Department of Juvenile Justice | | |
| John Magill | State Employees | SC Department of Mental Health | | |
| Pheobe Malloy | Parents of children with SED | | | |
| Geoff Mason | State Employees | SC Department of Mental Health | | |
| Sarah Parker | Parents of children with SED | | | |
| Bonnie Pate | Others (Not State employees or providers) | SC SHARE | | |
| Wendell Price | Providers | Clemson University | | |
| Krystal Reid | State Employees | SC State Housing Finance and Development Authority | | |
| 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) | | | |
| Natasha Scott | Others (Not State employees or providers) | Mental Health America of South Carolina | | |
| Lisa Simonds | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | | |
| Janie Simpson | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | | |
| Maryann Singer | 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 | | | |
| Sheri Smith | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | | |
| Philip Sturgell | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | | |
| Steven Van Hollen | State Employees | SC Department of Disabilities and Special Needs | | |
| Bob Walkup | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | | |
| Sissy Weaver | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | | |

| | | | | |
|------------|--|--|--|--|
| Dan Wilson | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | | |
| Mike Wnuk | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | | | |

Footnotes:

The South Carolina Mental Health State Planning Council (Council) is actively recruiting potential candidates for membership, including representation from the South Carolina Department of Education and the South Carolina Department of Social Services. The Council will request representation from the South Carolina Department of Education and the South Carolina Department of Social Services and anticipates that said representatives will be present at the March 21, 2018 meeting of the Council.

The Council is also considering revisions to its Bylaws that will facilitate continued participation of interested members whose terms might otherwise intermittently preclude them from membership.

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2017 End Year: 2019

| Type of Membership | Number | Percentage |
|---|-----------|---------------|
| Total Membership | 45 | |
| Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services) | 13 | |
| Family Members of Individuals in Recovery* (to include family members of adults with SMI) | 6 | |
| Parents of children with SED* | 4 | |
| Vacancies (Individuals and Family Members) | 0 | |
| Others (Not State employees or providers) | 2 | |
| Total Individuals in Recovery, Family Members & Others | 25 | 55.56% |
| State Employees | 12 | |
| Providers | 3 | |
| Federally Recognized Tribe Representatives | 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 | |
| Persons in recovery from or providing treatment for or advocating for substance abuse services | 1 | |

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Please see the section entitled Public Comment on the State Plan.

Footnotes:

Environmental Factors and Plan

23. 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.
 - c) Other (e.g. public service announcements, print media) Yes No

Footnotes:

Public Comment on the State Plan

Illustration 1. Notification on SCDMH Internet Site

| | | |
|--|---|--|
|  <p style="font-size: 1.2em; margin: 0;">South Carolina Department of Mental Health</p> |  | |
| Contact DMH FAQ News Services Site Map | | |
| <ul style="list-style-type: none"> <li style="background-color: #003366; color: white; padding: 2px;">About SCDMH <li style="background-color: #003366; color: white; padding: 2px;">Career Opportunities <li style="background-color: #003366; color: white; padding: 2px;">Centers and Hospitals <li style="background-color: #003366; color: white; padding: 2px;">Client Resources <li style="background-color: #003366; color: white; padding: 2px;">Clinical Information <li style="background-color: #003366; color: white; padding: 2px;">DMH Employees <li style="background-color: #003366; color: white; padding: 2px;">Online Bill Payment <li style="background-color: #003366; color: white; padding: 2px;">Procurement <li style="background-color: #003366; color: white; padding: 2px;">Publications <li style="background-color: #003366; color: white; padding: 2px;">Reports <li style="background-color: #003366; color: white; padding: 2px;">Services <li style="background-color: #003366; color: white; padding: 2px;">SC Information | <div style="background-color: #f0f0f0; padding: 5px; border: 1px solid #ccc;"> <p style="margin: 0;">News</p> <ul style="list-style-type: none"> ▪ The SCDMH FY18-19 Community Mental Health Services Block Grant Application is available for public comment. Click Here <p>The Grant Application includes SCDMH's FY18-19 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.</p> <p>For more information or to provide feedback, 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.</p> <p>Comments deadline: close of business, Wednesday, August 30, 2017</p> </div> <hr/> <div style="background-color: #f0f0f0; padding: 5px; border: 1px solid #ccc;"> <ul style="list-style-type: none"> ▪ News Release: Tri-County Crisis Stabilization Center Opens in Charleston, SC ▪ Notice: Bull Street Campus Visitation </div> <div style="background-color: #f0f0f0; padding: 5px; border: 1px solid #ccc;"> <p style="margin: 0;">Upcoming Events</p> <ul style="list-style-type: none"> ▪ SC Mental Health Commission: <ul style="list-style-type: none"> ▪ Next Scheduled Meeting - August 4 ▪ Commission Meeting Agenda ▪ SC Mental Health State Planning Council: <ul style="list-style-type: none"> ▪ 2017 SCMHSPC Schedule ▪ Next Scheduled Meeting - September 20, 2017 </div> <div style="background-color: #f0f0f0; padding: 5px; border: 1px solid #ccc;"> <p style="margin: 0;">Spotlight</p> <ul style="list-style-type: none"> ▪ DMH presentation: This .pdf highlights DMH's history, mission, accomplishments, blue ribbon programs, and projects/programs. ▪ DMH Blue Ribbon Presentations ▪ Affected by Hurricane Matthew? Get help from Carolina United - http://www.state.sc.us/dmh/united/ ▪ Connections: Stories of Recovery from Mental Illness ▪ DMH Profiles ▪ Visitors Survey - Inpatient Facility </div> <div style="background-color: #f0f0f0; padding: 5px; border: 1px solid #ccc;"> <p style="margin: 0;">Mental Health Information</p> <ul style="list-style-type: none"> ▪ Block Grant Application Part I ▪ Block Grant Application Part II ▪ 2017 Behavioral Health Report ▪ Care and Safety Concerns (JCAHO) ▪ National Health Service Corps Career Opportunities </div> | <div style="background-color: #f0f0f0; padding: 5px; border: 1px solid #ccc;"> <p style="margin: 0;">State Director's Column</p> <div style="text-align: center;">  <p style="font-size: 0.8em; margin: 0;"><i>John H. Magill, State Director</i></p> </div> </div> <hr/> <div style="background-color: #f0f0f0; padding: 5px; border: 1px solid #ccc;"> <p style="margin: 0;">Employee of the Year Mr. Christopher Carlton, Physical Plant Services</p> <div style="text-align: center;">  </div> </div> <hr/> <div style="background-color: #f0f0f0; padding: 5px; border: 1px solid #ccc;"> <p style="margin: 0; font-size: 0.8em;">2016 DMH Center and Facility Employees of the Year</p> </div> <hr/> <div style="background-color: #f0f0f0; padding: 5px; border: 1px solid #ccc;"> <p style="margin: 0; font-size: 0.8em;">2017 Hassenplug Award Winner - Alfare Fields and Nominees</p> </div> <hr/> <div style="background-color: #f0f0f0; padding: 5px; border: 1px solid #ccc;"> <p style="margin: 0; font-size: 0.8em;">Quick Links</p> <ul style="list-style-type: none"> ▪ Notice of Privacy Practices Policies ▪ Client Advocacy ▪ IRB Manual ▪ Laws Pertaining to Mental Health ▪ Free Resources ▪ Health & Human Services ▪ US Mental Health Sites <p style="margin: 0; font-size: 0.8em;">Report State Agency Fraud (Office of the Inspector General)</p> <div style="text-align: center; margin-top: 10px;">  </div> </div> |

Illustration 2. Public Notice

PUBLIC NOTICE: MENTAL HEALTH BLOCK GRANT APPLICATION AVAILABLE FOR COMMENT

The South Carolina Department of Mental Health's (SCDMH) fiscal year 2018-19 Community Mental Health Services Block Grant application is now available for public comment at the Department's web site:

http://www.state.sc.us/dmh/2017_Draft_blockGrantApplication.pdf

This Block Grant Application includes SCDMH's fiscal year 2018-2019 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 **Wednesday, August 30, 2017.**

###

Regarding steps the State took to make the public aware of the plan and allow for public comment:

- On August 7, 2017, members of the South Carolina Mental Health Commission were notified via email of the availability of the draft FY2018-2019 Mental Health Block Grant Application.
- On August 7, 2017, members of the South Carolina Mental Health State Planning Council (Council) were notified via email of the availability of the draft FY2018-2019 Mental Health Block Grant Application. Council members were also provided via email with a draft of the FY2018-2019 Mental Health Block Grant Application.
- On August 7, 2017, specific South Carolina mental health advocate organizations were notified via email of the availability of the draft FY2018-2019 Mental Health Block Grant Application.
- On August 7, 2017, members of the general public were notified of the availability of the draft FY2018-2019 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.
 - 14 daily newspapers were notified.
 - 49 non-daily newspapers were notified.
- On August 7, 2017, members of the general public were notified of the availability of the draft FY2018-2019 Mental Health Block Grant Application via creation of an event on SCDMH's Facebook page.
 - 71 people reviewed the entire post.
- On August 7, 2017, members of the general public were notified of the availability of the draft FY2018-2019 Mental Health Block Grant Application via SCDMH's internet and intranet home pages on which were placed banners of announcement.
- A Notice of Availability of Mental Health Block Grant Application and Report was placed in three newspapers representing the Upstate, Midlands, and Lowcountry regions of South Carolina: The Greenville News (December 2016, June 2017); The State Newspaper (December 2016, June 2017); and, The Post and Courier (December 2016, June 2017), respectively. Public comment was requested via letter, email, and telephone.
 - Please note that while these notices specifically cited the Uniform Application – FY2016-17 State Behavioral Health Assessment and Plan and the FY2017 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, 2017, no recommendations for modifications to the FY2018-2019 Mental Health Block Grant Application were offered by the South Carolina Mental Health State Planning Council.