The Task Force to Strengthen the Health and Promote the Environment of South Carolina

2100 Bull Street
Columbia, SC 29201

Behavioral Health Subcommittee

July 14, 2021

Minutes

The SHaPE SC Behavioral Health Subcommittee met on **July 14, 2021, at 1:00pm at LRADAC**. The meeting was called to order and the following members were in attendance:

Attending in person:
Mark Binkley, Subcommittee Chair, Senior Executive Assistant to the State Director (DMH)
Gayle Aycock, President and Chief Executive Officer, LRADAC
Lee Dutton, Chief of Staff, SC Department of Alcohol and Other Drug Abuse Services (DAODAS)
Bill Lindsey, Executive Director, South Carolina Chapter of the National Alliance for Mental Illness
Amy McCulloch, Probate Judge for Richland County, Probate Judges Association

Attending virtually:
Laura Aldinger, Executive Director, Behavioral Health Services of South Carolina
Anna Marie Conner, Attorney/Team Leader, Disability Rights South Carolina
Beth Franco, Executive Director, Disability Rights South Carolina
Elizabeth Harmon, Executive Director, SC Behavioral Health Coalition
Joseph McLamb, Chief of Staff, South Carolina Department of Veterans' Affairs
Kacey Schmitt, Director of Social Work, SC Department of Health and Environmental Control (DHEC)
Anne Summer, Co-Chair, Policy, Legislative & Regulatory Committee, SC Behavioral Health Coalition
Gerald Wilson, Chair, SC Behavioral Health Coalition

Not in attendance:
Jarrod Bruder, Executive Director, SC Sherriff's Association
Sara Goldsby, Director, South Carolina Department of Alcohol and Other Drug Abuse Services
William Grimsley, Secretary of Veterans' Affairs, SC Department of Veterans' Affairs
Kenneth Rogers, State Director, DMH

Also, in attendance were Cassandra Harris, Director of Strategy and Engagement (DHEC), Saad Howard, Director of Continuous Quality Improvement (DHEC) and members of the public attending virtually.

Item 1: Call to Order/Welcome

Chairman Mark Binkley called the meeting to order and welcomed members to the second subcommittee meeting before moving to the main agenda items.

Item 2: Review Goals of Subcommittee

Chairman Binkley reviewed the three (3) overarching goals of the Behavioral Health subcommittee as a primer for discussing the questions provided in the *Subcommittee Input* document.

Item 3: Reference *Subcommittee Input* Questions #1 and #2

1A. *What are we currently doing well?*

Department of Mental Health (DMH)

Chairman Binkley shared a brief overview of strengths currently present in DMH's delivery of mental health services and operations. The overview included a visual representation of DMH's service availability (inpatient and community-based) throughout the state; the visual outlined target populations along with strategies used by DMH to address the needs of these populations. Services offered include prevention, early intervention, crisis care, behavioral health care in emergency departments, management of inpatient behavioral health services, and telehealth/telepsychiatry. Success in these areas is echoed in the agency's Annual Accountability Report and where the strength of community-based services is evident through partnerships with schools, law enforcement agencies, hospitals, community health centers, and community coalitions.

Organizationally, public mental health service delivery in South Carolina is coordinated under the jurisdiction of a single integrated state agency that allows for cohesive and consistent behavioral health practices throughout the State. Nationally, South Carolina is one of only a few States in which both its State Hospitals and its community mental health centers are directly operated by the State mental health agency.

Additionally, DMH services are very accessible geographically through its 16 mental health centers and their associated clinic locations covering all 46 counties. The agency through its mental health centers operates a Statewide mobile crisis program which offers emergency psychiatric screening and assessment services. Mobile crisis services are available 24/7/365 through a single Statewide toll-free telephone number (833-364-2274). Furthermore, DMH has worked to expand access even further through mobile behavioral health clinics that bring mental health services to underserved communities throughout the state.

The objective of DMH's strategy is the prevention of avoidable emergency department visits, hospitalizations, and incarceration due to untreated behavioral health issues. DMH's strategy also includes the provision of robust community aftercare services. DMH aftercare and supportive services include assistance with patients' housing needs/rent support, vocational assistance, linkage to primary care and minimizing barriers to securing medications. These services enable those patients who are hospitalized to be discharged sooner that they would in their absence. Reducing lengths of stay in its State Hospitals enables DMH to treat more patients in its limited number of available beds.

DMH has had a program to increase the availability of safe and affordable housing for its patients in need for almost 40 years. Its current Permanent Supported Housing program is an evidence-based model. DMH also partners with the State Housing Authority and residential real estate developers of low and moderate housing to create additional affordable housing options for patients. To date, the agency has helped to create almost 3,000 units of affordable housing for its patients throughout the State.

Department of Alcohol and Other Drug Abuse Services (DAODAS)

Subcommittee member Lee Dutton shared a brief overview of strengths currently present in DAODAS practices and operations. The primary strength cited is partnership with local providers through its "no wrong door" policy. DAODAS has grown its extensive network to over 135 providers, including 72 community-based Narcan distributors and six (6) recovery sites/centers. DAODAS has worked to ensure the delivery of core, evidence-based substance use disorder (SUD) services in every county in South Carolina and has even expanded services in many communities. Collectively, this results in approximately 49,000 individuals positively impacted annually (with about 33,000 enrolled in treatment).

The agency coordinates its work through four main tenets – (1) prevention, (2) intervention, (3) treatment, and (4) recovery. Towards this end, DAODAS collaborates with state agencies in supporting its mission; namely, the Department of Corrections in lowering the recidivism rate related to SUD and DHEC on a taskforce to address the opioid epidemic in South Carolina. Colocation, or proximity, of DHEC Health Departments and DMH and DAODAS sites makes it easier for DHEC Social Workers to refer more seamlessly. DAODAS has also foster linkages with DMH through collaboration on the *SC Hopes* hotline.

1B. *What are the drawbacks or challenges with how current services are delivered?*

- Transportation challenges for clients and patients was cited as a challenge associated with access to the services of both DMH and DAODAS.
- Restrictive policies on some federal funding and funding mandates sometimes makes it difficult to plan for and execute an uninterrupted continuum of care for behavioral health services.
- Lack of reimbursement for some public behavioral telehealth services limits expansion into new modalities.
- Coordinating housing and employment opportunities often presents as a challenge for individuals completing behavioral health treatment.
- Turnover at DHEC, DMH and DAODAS County Authorities inhibits continuity and necessitates frequent reeducation of direct care staff.
- Agency bureaucracy leads to long lead times for signing and executing contracts with DHEC (can sometimes take months).
- The Medicaid IMD Exclusion which prohibits payment/coverage for Medicaid recipients in need of inpatient behavioral health services.
- Federal Mental Health and SUD block grant funding structure prohibits the blending of block grant funds to address the behavioral health needs of co-occurring patients across the state.
- Some private hospitals don't fully understand the commitment process for behavioral health patients received through the emergency department; some

patients are cleared medically without coordination for behavioral health and/or SUD services.
- Long wait times for DMH forensic behavioral health services was cited as a challenge by the subcommittee.
- Social Work services provided by DHEC are limited to specific services including tuberculosis, children and youth with special healthcare needs, etc. Also, the Social Work workforce at DHEC is relatively small (2-5 Social Workers per Region).

1E. *What are the current gaps in providing services?*
- DAODAS is behind in providing school-based services; such services are not currently in the appropriations for the agency.
- An opportunity exists to expand behavioral health services in jails and prisons across the state.
- Investments in workforce development for behavioral health and SUD professionals can be improved.
- Lack of system interoperability between behavioral health and SUD agencies makes it difficult to coordinate care for comorbid individuals. Prohibitions related to 42 CFR.

2A. *Generally, what do you see as the greatest challenges to delivering effective, efficient and accessible services in the future?*
- Staffing and other resource constraints (i.e., compensation) offer the greatest roadblocks to maximizing service delivery and integration.
- Stigma associated with receiving behavioral health services was cited as the primary challenge within the current system and one that will need to be addressed in the future.
- Lack of integration of core behavioral health and general health services was also discussed as a major challenge, especially as it is a recognized means of improving both the effectiveness and the efficiency of healthcare services.

Item 4: Reference *Subcommittee Input* Question #3 (Recommendations for a "Bright Tomorrow"); General Discussion and Initial Thoughts

3A. *How would you preserve what you identified above as currently working well?*
- Continue collaboration across agencies, community organizations, and other stakeholders to minimize silos and promote the continuum of care.
- Continue to leverage partnerships and available resources that offer employment and housing support for individuals receiving behavioral health services.
- Increase the availability of diversionary courts, such as mental health courts and drug courts, to increase participation by defendants with behavioral health disorders in effective treatment and reduce criminal recidivism and court- and corrections-related costs.

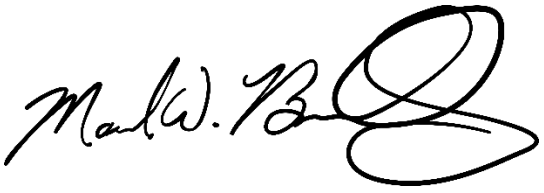
3B. *What structural or functional changes would you recommend making within the existing agency structure (i.e., without consolidating and/or separating any existing agencies)?*
- Identify and leverage opportunities to co-locate behavioral health and general health services in communities across the state. Co-location will do much to address and remedy stigma challenges associated with receiving behavioral health care. Co-

location may also improve the integration of primary and behavioral healthcare, make it easier to treat comorbid patients more seamlessly. Integration of primary and behavioral healthcare has been shown to significantly improve the overall health outcomes of patients while reducing health care costs.

- Evaluate use of paraprofessionals and new innovative ways to staff behavioral health services (i.e., peer support specialists, community health workers, etc.).
- Address information-sharing roadblocks related to 42 CFR Part 2, as appropriate, that would allow for easier treatment and communication between providers treating the same individual for their mental health and SUD needs.
- Support to repeal or modify the federal IMD Exclusions that prohibits payment/coverage for Medicaid recipients in need of inpatient behavioral health services.
- Leverage the state Behavioral Health Coalition to strengthen the relationship and collaboration with the state hospital association to maintain behavioral health services as a core priority.
- Advocate for adequate reimbursement for behavioral health services provided in the private hospital setting; such action is likely to increase the availability and access for inpatient and residential behavioral health services, when needed.
- Explore ways to improve the ability for all State operated or supported healthcare providers, and specifically DHEC, DMH and DAODAS (including its county authorities) to share patient information electronically. At a minimum, secure direct messaging for care coordination between primary care, behavioral health, and SUD services, as needed.

Being no further business, Subcommittee Chair Binkley adjourned the meeting at 2:41 pm.
The next Behavioral Health Subcommittee meeting will be held at the **DMH, 2414 Bull Street Columbia, SC 29202, in August 2021 (date to-be-determined).**

Recordings of Task Force and Subcommittee meetings can be found here.



Mark Binkley, Behavioral Health Subcommittee Chair, SHaPE SC
Senior Executive Assistant to the State Director, S.C. Department of Mental Health
July 19, 2021