South Carolina
Department of Mental Health
DMH

The Trifecta: Mental Health, Poverty, and COVID-19

SEACAA Poverty Symposium
September 14, 2021

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State Director, South Carolina
Department of Mental Health

Today's Tasks

Discussion of why I chose to be here, today

Defining Mental Health

Mental health and trauma

Structure of Mental Health in South Carolina

Discussion of COVID-19 and its societal impact

Interface of poverty and mental health

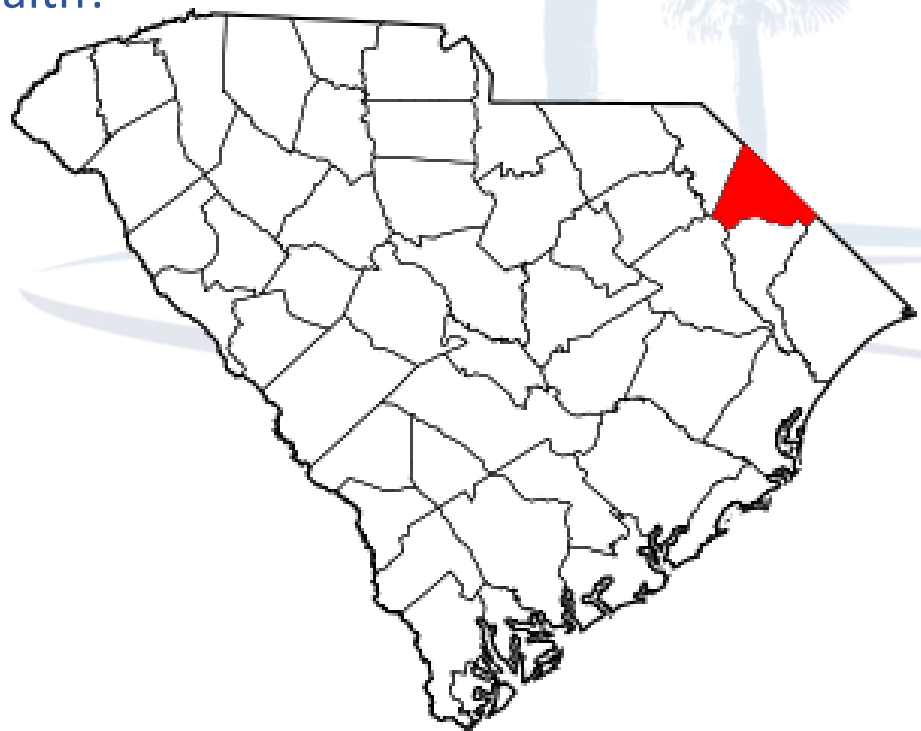
Case studies and discussion

Why am I here?

- I get to come to Myrtle Beach
  - It is 60 minutes from home
  - It provides me with a degree of grounding
  - It makes me feel blessed and grateful for the opportunities that I have been afforded

Dillon, South Carolina

Crime states: F grade (94% of cities are safer)
Racial makeup: 52% B, 44% W
Juvenile Justice office: #1 Disproportionate Minority Confinement
2nd worst school district in the state
What about mental health?



Why am I here?

- I am intrigued by the idea of poverty
  - How do you define it?
  - How are the poor perceived and how do they perceive themselves?
  - How does one become “un-poor”?
  - How do systems and individuals help and/or harm?
- I see myself as a disciple for mental wellness
- The empowerment of others is my life’s work

The day that I discovered that I was poor

My Life's Work

- Poverty vs. Resilience
  - How do you define it? vs. How does it define you?
  - How do I perceive myself? How do I perceive others?
  - How did I become "un-poor"? Is it a transferable "skill"
  - How do systems and individuals help and/or harm? Can I learn to harness systems
- I see myself as a disciple for mental wellness
- The empowerment of others is my life's work

Mental Health vs Wellness

- Defining Mental Health (DSM-5)
- Mental health and trauma
- Stress reaction vs mental illness
- Trauma
  - Type 1- Single Event, usually relatively recent
  - Type 2- Repeated, frequently distant
- Family and intergenerational issues
- Vicarious trauma and mental health

Serving South Carolina Since 1828

South Carolina was one of the first states in the nation to provide state funding for the care and treatment of people with mental illnesses.

In 1821, the State Legislature appropriated funding for the construction of the South Carolina Lunatic Asylum. DMH's first patient was admitted to in 1828. The DMH bicentennial, 2021.

Inpatient occupancy peaked in the 1960s, when the average daily population at the SC State Hospital and Crafts-Farrow State Hospital totaled more than 6,000 patients.

The South Carolina Community Mental Health Services Act (1961) and the federal Community Mental Health Act of 1963 led to deinstitutionalization, the movement of patients from inpatient hospitals to community-based, outpatient treatment settings.

DMH Today

The DMH system is comprised of:

16 community outpatient mental health centers, and 40+ satellite clinics

3 licensed hospitals, serving adults, children, adolescents, and individuals with addictive disease:

- G. Werber Bryan Psychiatric Hospital (Hall C & A, Forensics, and Adult Civil)
- Patrick B. Harris Psychiatric Hospital
- Morris Village Alcohol and Drug Addiction Treatment Center;

Four nursing homes, including three for veterans;

A Sexually Violent Predator Treatment Program.

The Agency serves approximately 100,000 patients per year, approximately 30,000 of whom are children.

DMH is one of the largest healthcare systems in South Carolina.

All DMH centers, hospitals, and facilities are fully accredited

DMH Today

Since its inception, DMH has treated more than 4 million patients.

DMH services are made possible by approximately 6,000 FTEs, who facilitate daily operations.

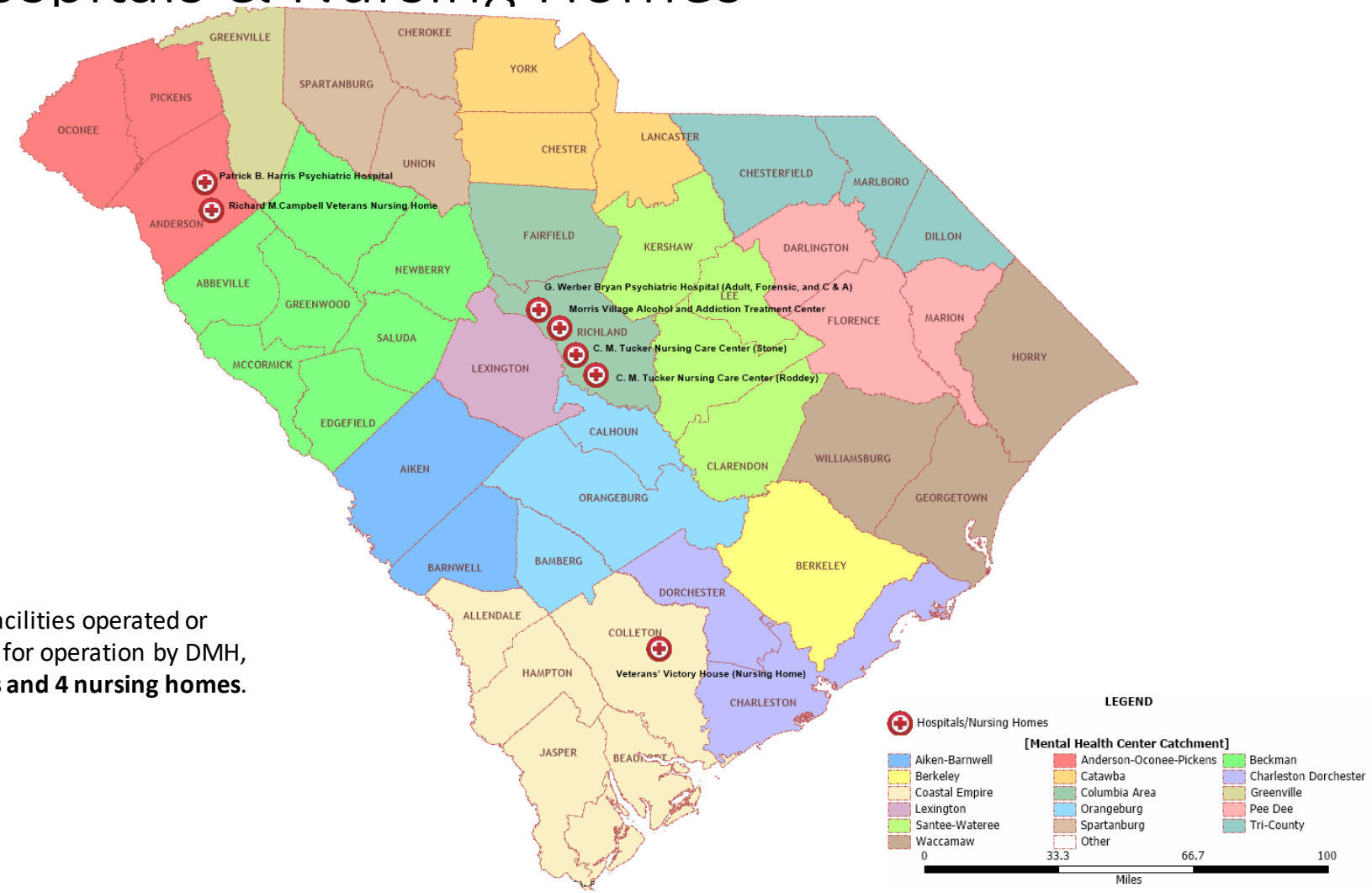
DMH's FY21 operating expenditures were approximately $460,000,000.

DMH's FY20 projected operating expenditures are anticipated to be approximately $475,000,000.

The Agency is governed by the South Carolina Mental Health Commission. Seven commissioners, each representing a SC Congressional district, are appointed by the Governor, with the advice and consent of the SC Senate, and serve terms of five years.

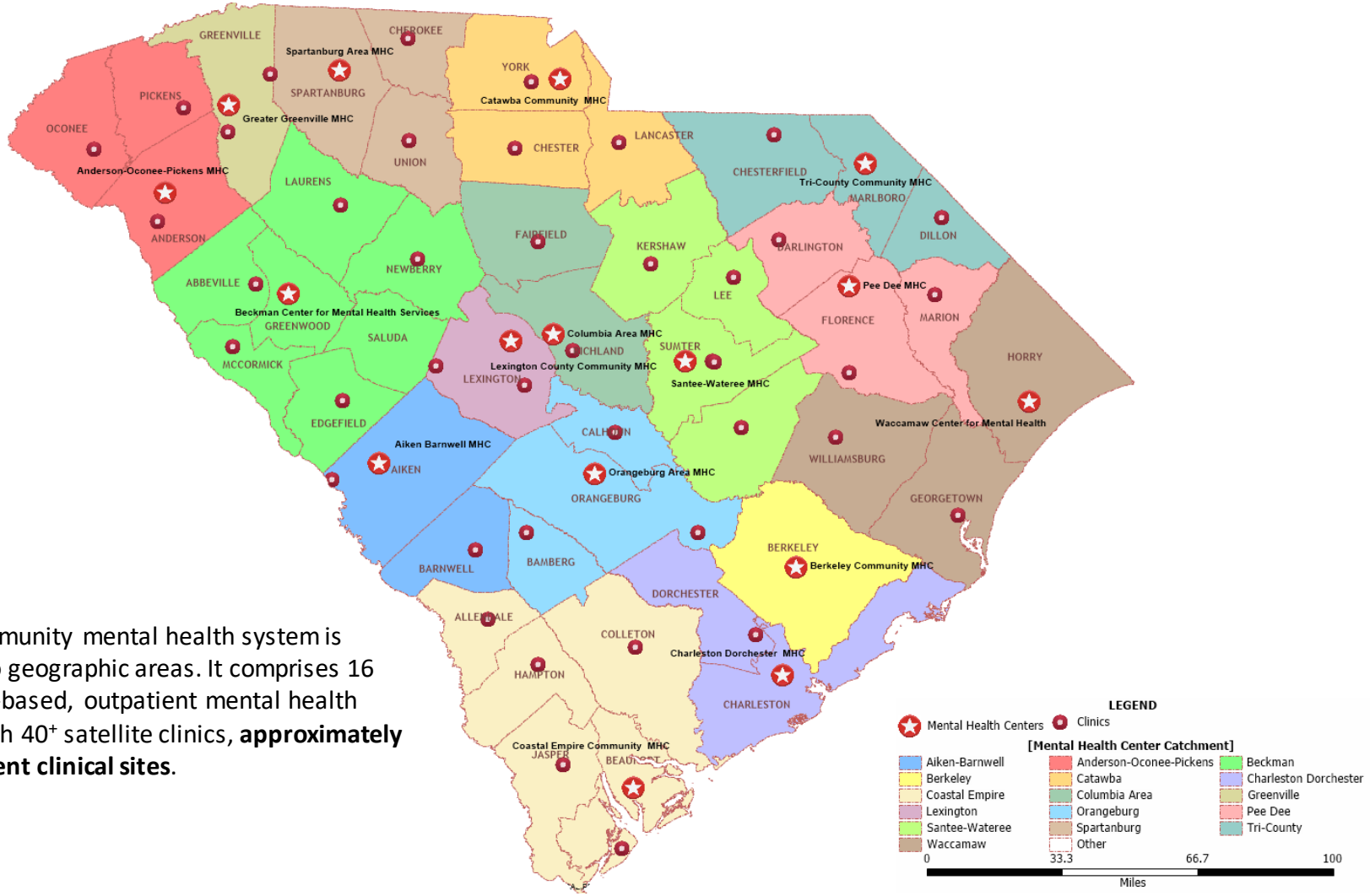
The Mental Health Commission appoints the DMH state director.

Hospitals & Nursing Homes



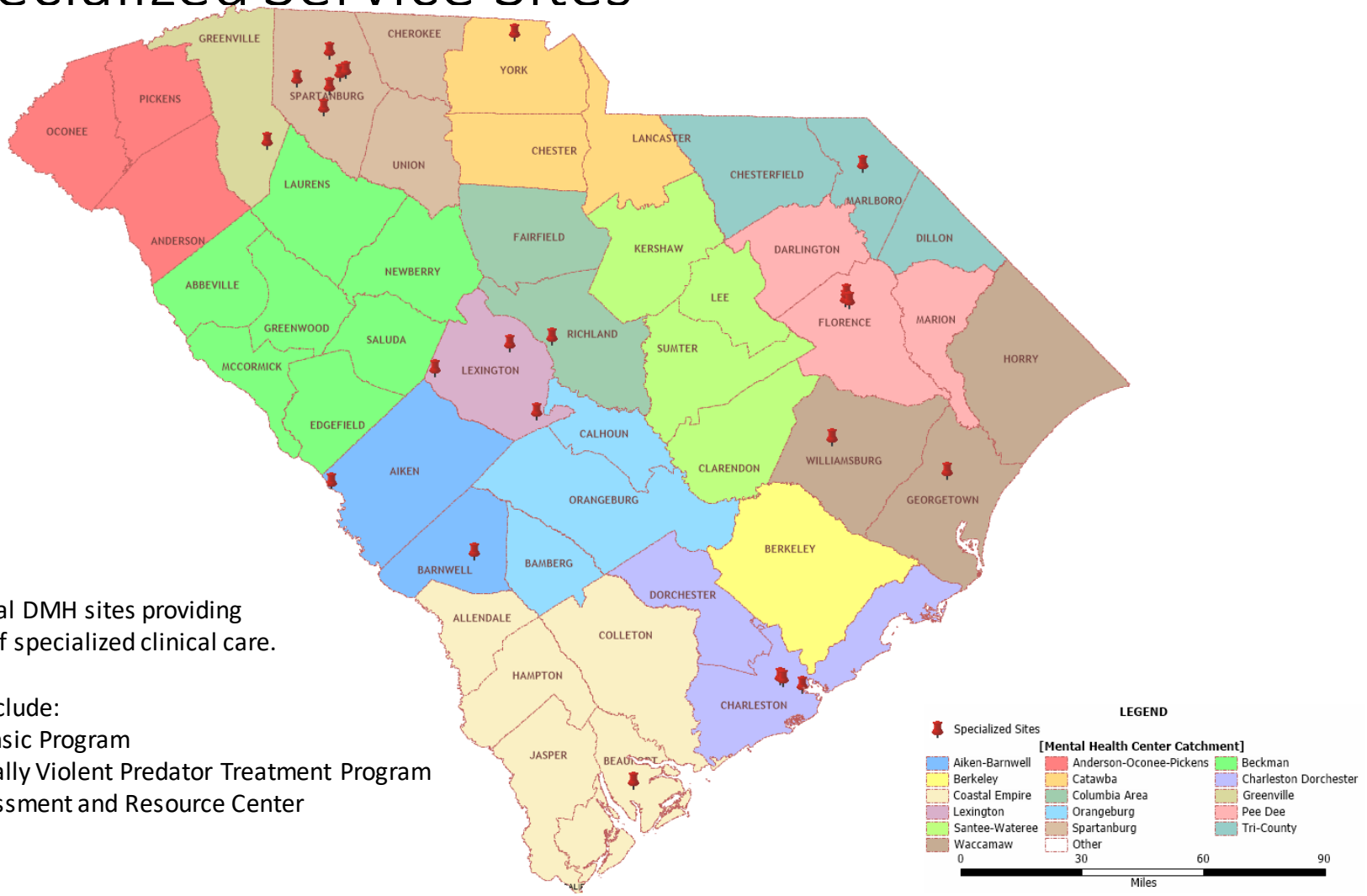
Inpatient facilities operated or contracted for operation by DMH, **3 hospitals and 4 nursing homes**.

Outpatient Clinical Sites: Centers and Clinics



DMH's community mental health system is divided into geographic areas. It comprises 16 community-based, outpatient mental health centers, with 40+ satellite clinics, **approximately 60 outpatient clinical sites**.

Specialized Service Sites

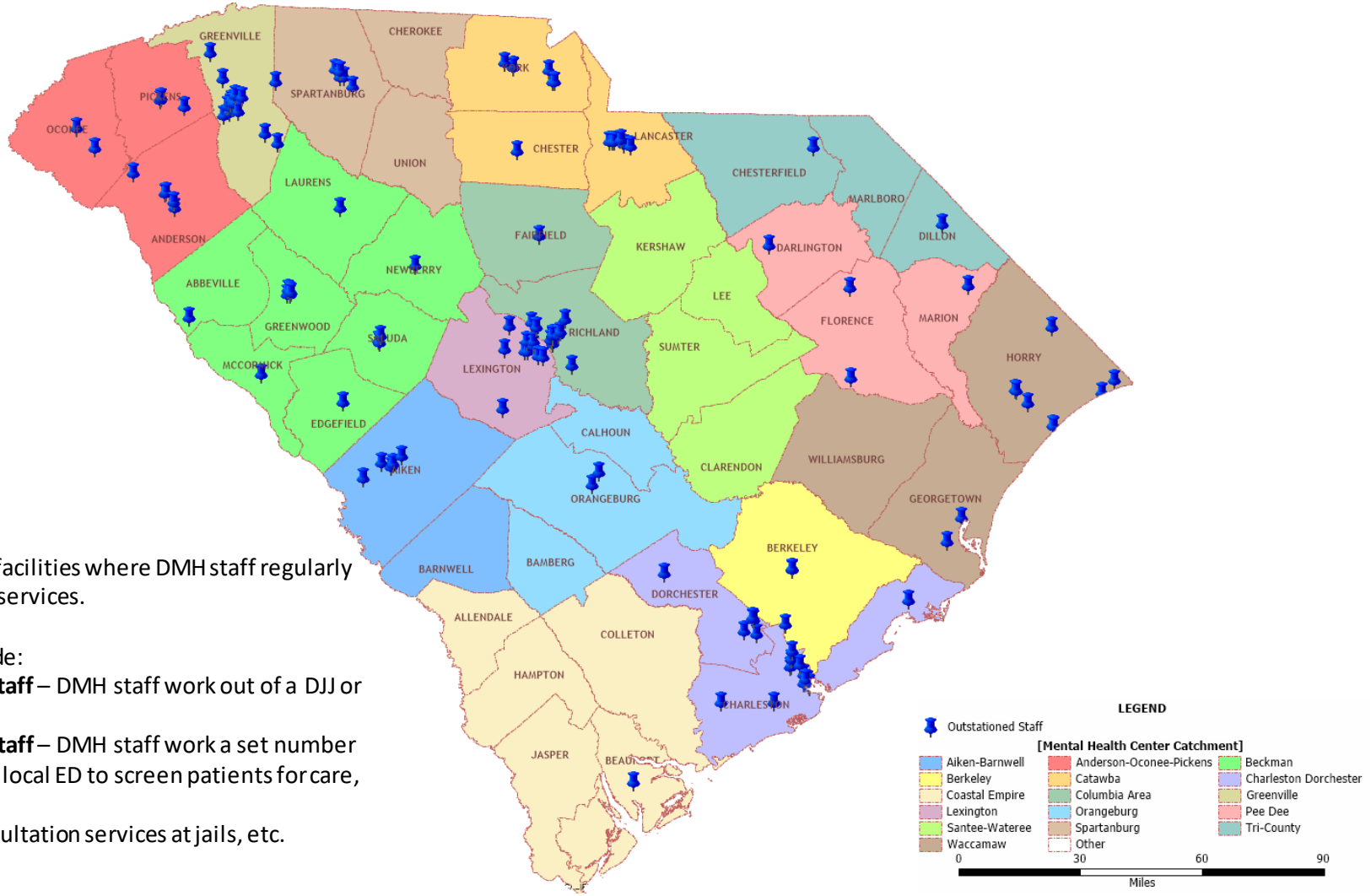


20+ additional DMH sites providing some type of specialized clinical care.

Examples include:

- The Forensic Program
- The Sexually Violent Predator Treatment Program
- The Assessment and Resource Center

Out-stationed Staff Sites

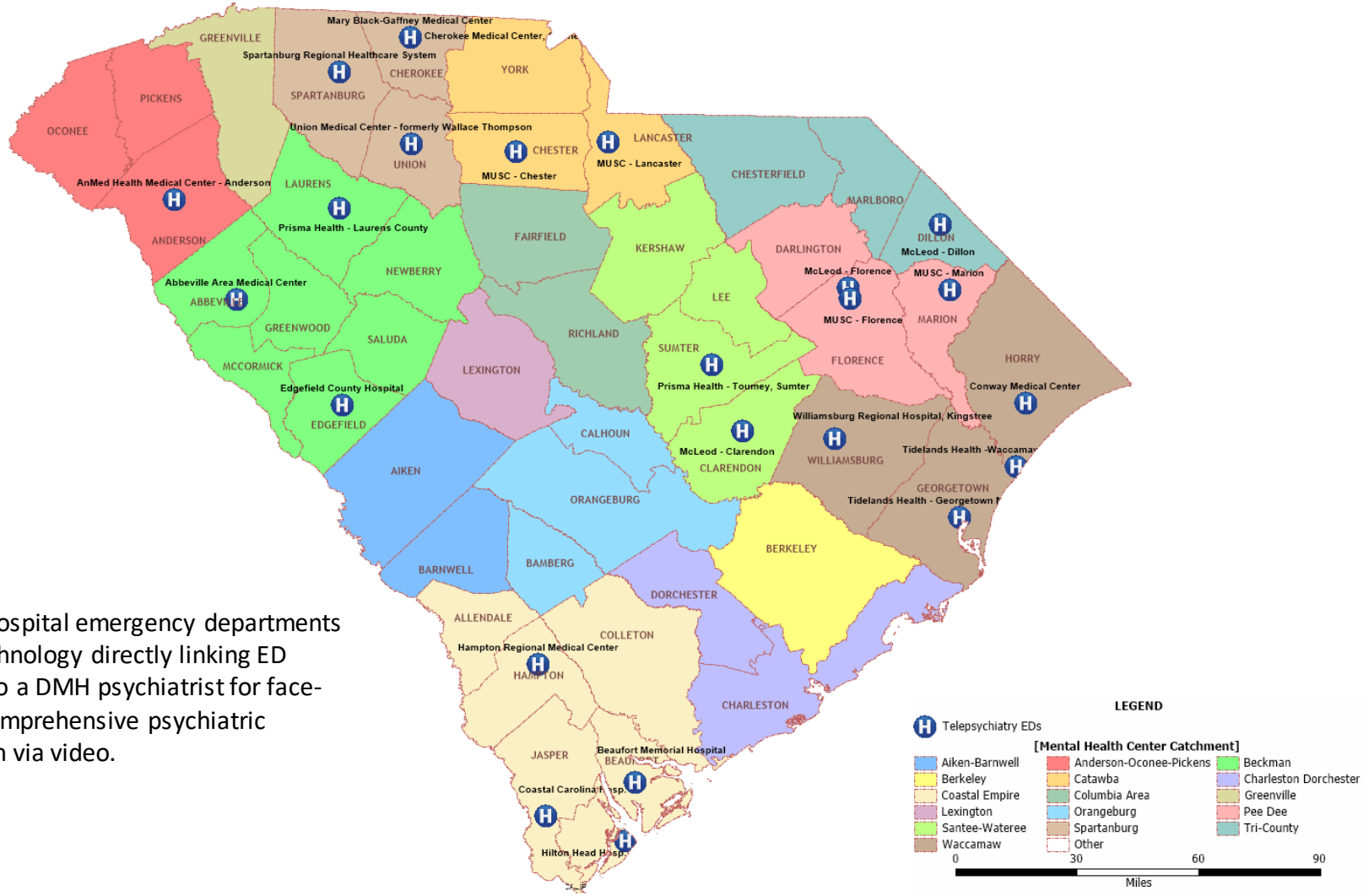


150+ non-DMH facilities where DMH staff regularly provide clinical services.

Examples include:

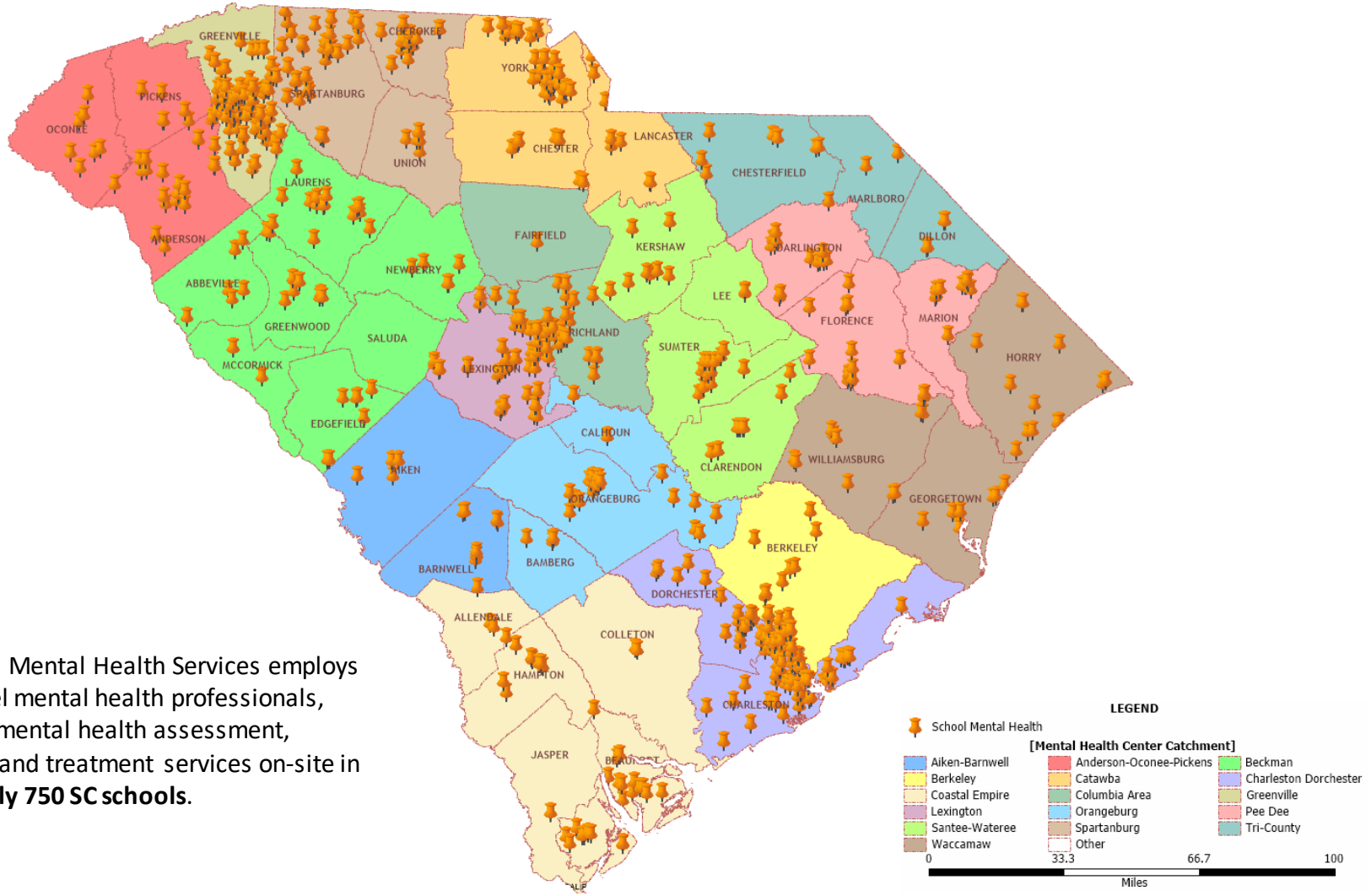
- **Co-located staff** – DMH staff work out of a DJJ or DSS office
- **Embedded staff** – DMH staff work a set number of hours at a local ED to screen patients for care, etc.
- Regular consultation services at jails, etc.

EDs Utilizing DMH Telepsychiatry



23 local hospital emergency departments utilize technology directly linking ED patients to a DMH psychiatrist for face-to-face comprehensive psychiatric evaluation via video.

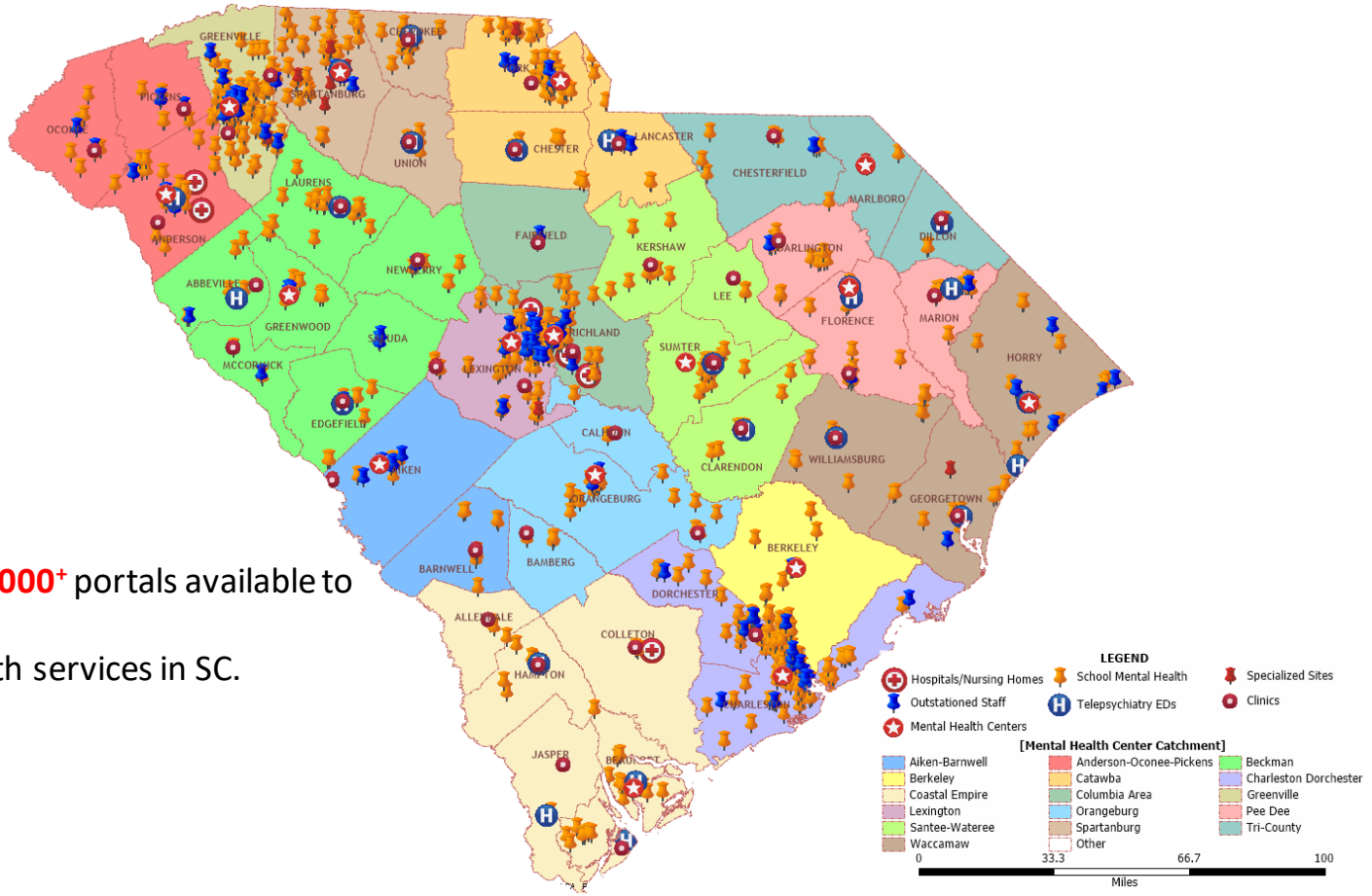
School Mental Health Services



DMH's School Mental Health Services employs Master's-level mental health professionals, who provide mental health assessment, intervention, and treatment services on-site in **approximately 750 SC schools**.

1,000+ Portals to Access DMH Services

There are **1,000+** portals available to access DMH
mental health services in SC.



Outpatient Services

- Outpatients Served
  - In FY20, DMH community mental health centers provided more than 1.5 million clinical services.

- Productivity and access to community mental health services are increasing.

- Access Standards
  - Patients in crisis can been seen by a Mental Health Professional on the day they walk in.

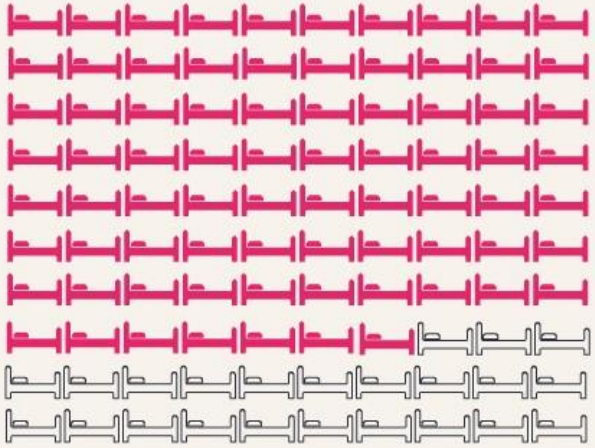
  - Centers continue to improve access to services through shorter wait-times for appointments with counselors and psychiatrists.

History of Crisis/Emergency Services

- Began in the 1960s with the rise of Emergency Psychiatry
- Triggered by deinstitutionalization
- Urbanism
- Social determinants: poverty, unemployment, homelessness
- Accessibility, convenience and anonymity
- 1980s rise of community policing meant that more people were coming into the ED with police rather than family
- Challenges related to the current political climate
  - 1837 Charleston Police Department founded

TREATMENT OPTIONS DOWN

A 2017 study from the National Association of State Mental Health Program Directors looks at U.S. inpatient psychiatric beds, including state and county facilities, hospitals and residential treatment centers:



▼ 77.4%
in inpatient psychiatric capacity

Modern Healthcare

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PAYMENT

January 04, 2019 12:00 AM

Funding cutoff looms for model mental health clinics

HARRIS MEYER

TWEET | SHARE | SHARE | EMAIL

Emergency Department Visits

- Overall ED volume has been constant over the past decade, but mental health visits have increased by 60%
- Most low volume have pediatric policies and procedures in place. This is more than 50% of US EDs
- ED visits for suicidal thoughts have doubled in the past decade
  - 580,000 to 1.2 million
  - 4600 die each year as a result of suicide
  - Median age 13, but 43% were ages 5-10
  - Only 2.1% were hospitalized
- Increased disparities in rural areas

Crisis Services Defined

- **24-Hour crisis lines** are often the first point of contact. Telephone crisis services provide assessment, screening, triage, preliminary counseling, and information and referral services.
- **Walk-in crisis services**, such as clinics or psychiatric urgent care centers offer immediate attention. They focus on resolving the crisis in a less intensive setting than a hospital, though they may recommend hospitalization when appropriate.
- **Mobile crisis teams** intervene wherever the crisis is occurring, often working closely with the police, crisis hotlines and hospital emergency personnel. Mobile teams may act as gatekeepers for inpatient hospitalization and can also connect an individual with community-based programs and other services.

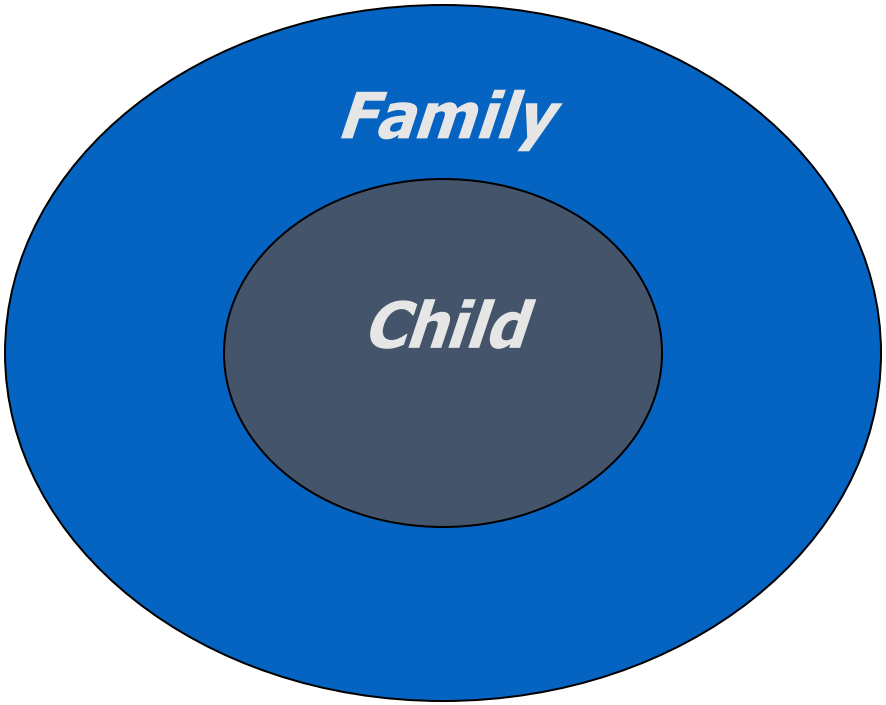
Independence

Adult Crisis vs Child Crisis

- **24-hour crisis lines** generally do not have child trained providers
- **Walk in clinics** generally have daytime hours (8:30-5:00)
- **Mobile Crisis teams** may not have the expertise or range of services to address child and adolescent issues

Dependence

Community Systems



Interdependence

Community Systems

Case 1

Mary is a 7-year-old girl who lives with her mother and father in substandard housing in a rural community. Her parents were both 17 years old at the time of her birth. Her mother completed high school, but father dropped out of school upon completion of the 11th grade. Mother has a history of depression that was first diagnosed at age 12. She has had several jobs but has not been able to sustain employment for greater than one year. Father has been working as a mechanic at a local garage, but recently lost his job due to lack of business. The family has struggled with food insecurity as a result of father's job loss.

The child's teacher notice that she was hungry and notified the school social worker who made a report to the local social services agency.

Challenges with Case 1

- The definition of crisis is frequently vague
- Rural vs Urban challenges
- Interface between 3-4 systems that have competing priorities

Case 2

Johnny is a 15-year-old male who was recently detained in a local juvenile justice facility for assault and battery. The incident occurred as the youth was walking home with his mother from the store. Several youth were making inappropriate comments to his mother and he attacked one of the young men in the group.

The youth's older brother, who was a member of a local gang, was shot and killed one year ago. The brother died in Johnny's arms. He did not receive care following the incident. He was was seen at a local juvenile justice facility 6 months ago and diagnosed with Major Depressive Disorder, PTSD, and Cannabis Use Disorder

A school resource officer is called to break up a fight between Johnny and another youth.

Challenges with Case 2

- Safety for others
- Re-experiencing trauma
  - 20% of youth have a mental health disorder
  - 50% of mental health disorder occur before 14 and 75% by age 24
  - 70% of these youth receive no care
  - The delay between symptom onset and treatment is 10 years
    - 37% drop out of school
    - 70% detained in juvenile justice
    - Suicide is the 3rd leading cause of death
- What is the role of law enforcement?
- Issues of race and ethnicity

The Transformation of Mental Health

Transformation

- Increasing the presence of telehealth services
- Availability of child trained providers on crisis lines
- Integrated (Whole Person) Care
- Logical funding model for crisis services
- Standardized approach to pediatric crisis services.

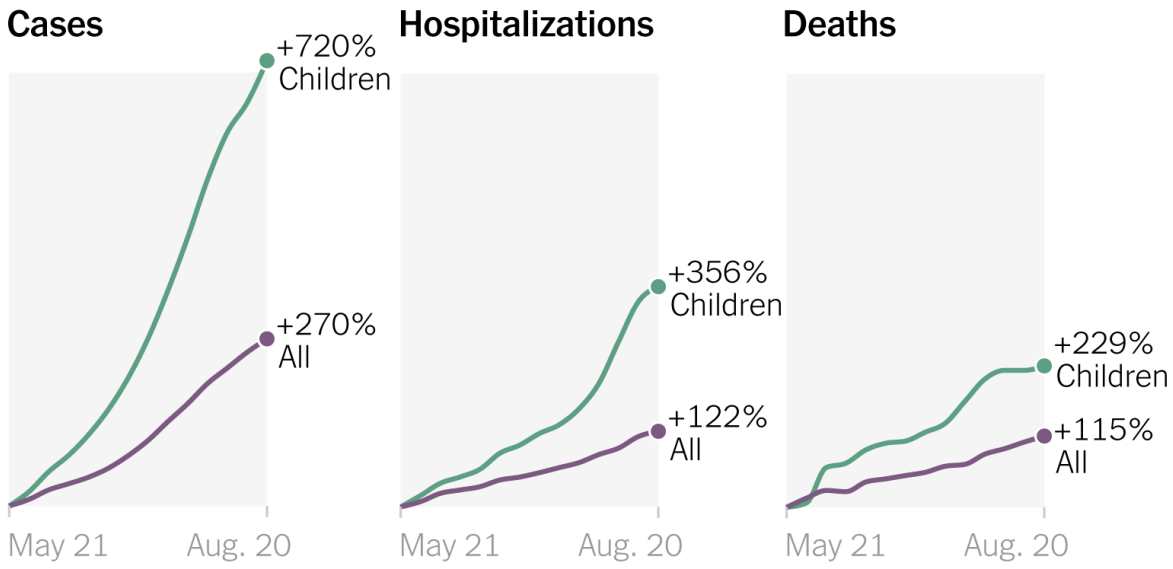
COVID-19 Highlights

- COVID-19 has significantly impacted children and adolescents physical and mental health.
- Black, Latinx and Native American youth have been disproportionately affected by the pandemic.
- Poverty and financial inequality have further exacerbated the effects of the pandemic among poor youth.

Background

- Depression and anxiety have been noted with H1N1, Ebola, and prior flu epidemics.
- Black, Latinx, and Native Americans were 2-5x more likely to be hospitalized or die.
- The contagious nature of Delta has led to increased fear, especially in minority communities.
- Pandemic overlapped with a collective outcry against racism and inequality.
- Until the Delta variant, this was primarily a disease that was limited to the adult population.

Trending COVID in Youth



American Academy of Pediatrics, 2021

Psychological Challenges

- Increased domestic violence
- Increased family psychological distress
- Increased demand for mental health services
- Increase parental distress

Educational Challenges

- Significant negative impact on school readiness
- Virtual learning increased distress
- Increasing educational gaps
- Family loss (death, jobs, family)
- Loss of skills
  - White students 1-3 months behind
  - Students of color 3-5 months behind

Health Disparities

- MIS-C more common in child cases
- Pediatric disparities are similar to those of adults
- Essential workers and public facing jobs are more at risk
- AA and Latinx youth are more likely in multigenerational homes

Social Isolation

- Social isolation for extended time is linked to increased mental health issues
- Worsening of current symptoms (PTSD, ADHD, Developmental Disorders)
- Lack of peer interaction – decreased cognition, developmental changes, and emotional changes
- Increasing use of technology

Institutionalization

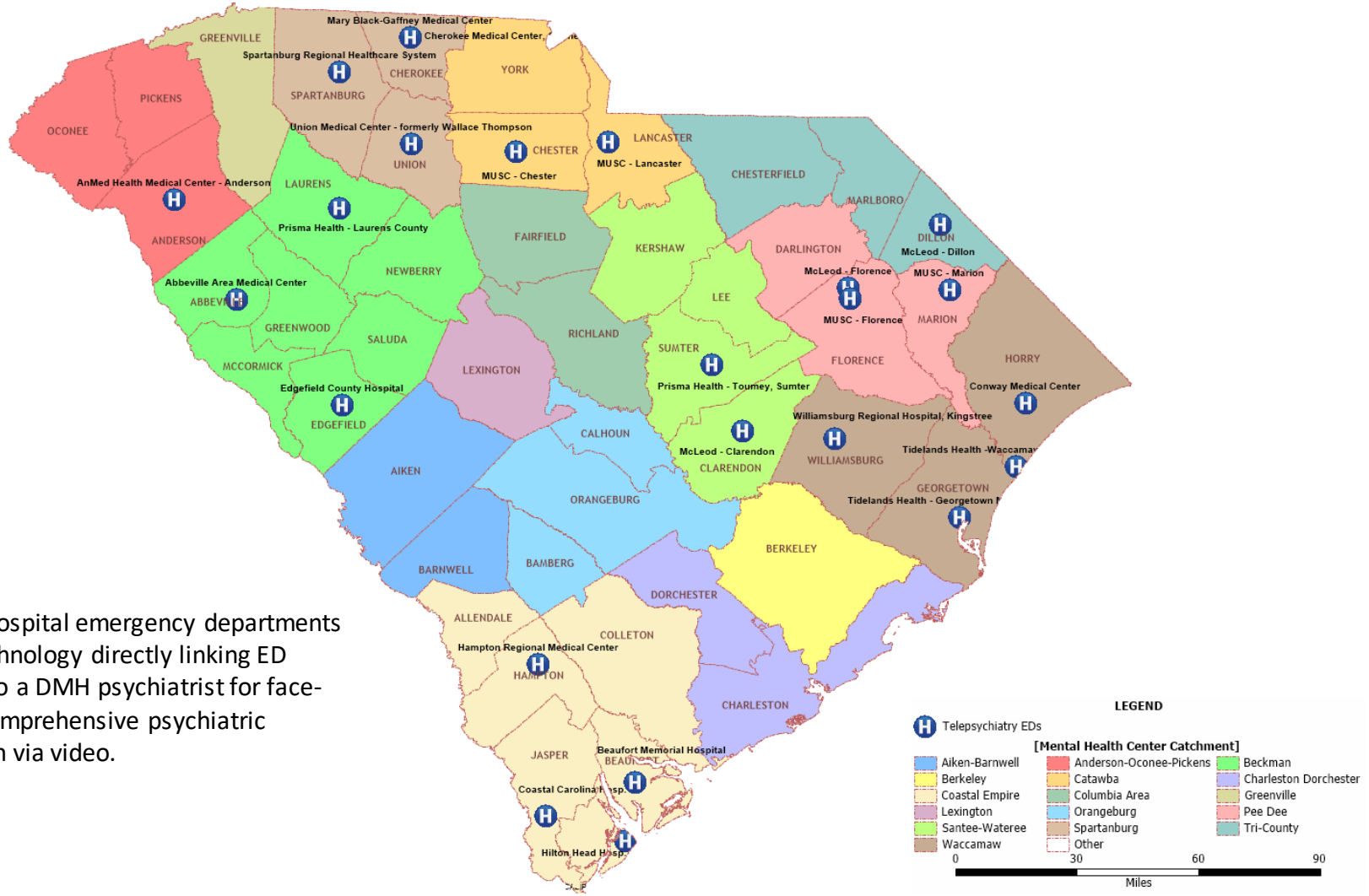
- Juvenile Justice-communal settings-increased risk of outbreaks
- Frequently overlooked pediatric populations
- Shuttering or programs that cater to institutionalization of youth
- Limiting population which have an impact on care that is available

Other Issues

- Financial inequality
- Economic instability
- Technology barriers
- Community health carriers

Telepsychiatry

EDs Utilizing DMH Telepsychiatry



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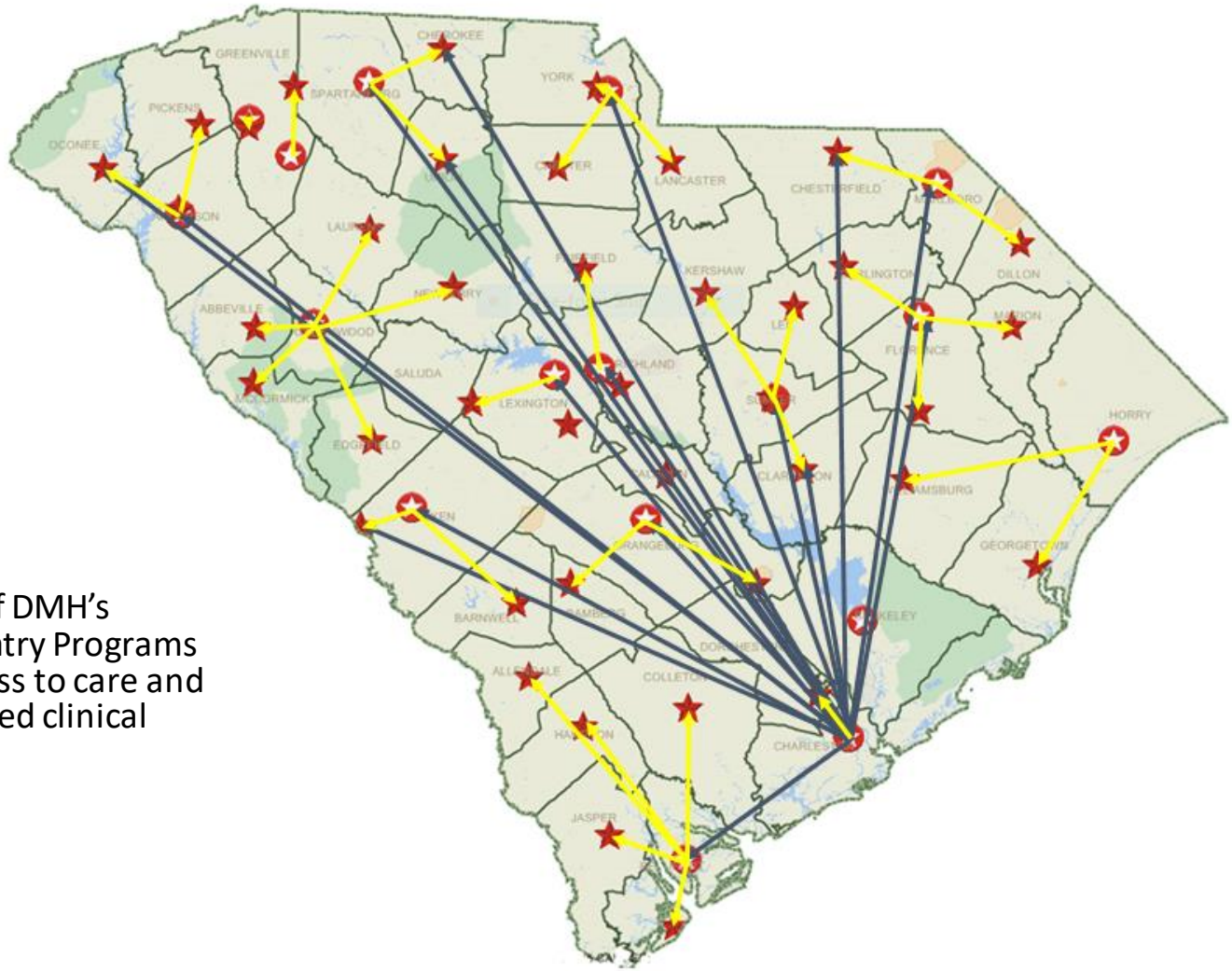
Community Telepsychiatry



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

Largest DMH Telepsychiatry Programs

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

ED Telepsychiatry

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

Community Telepsychiatry

- More than 70,000 psychiatric treatment services provided since inception
- Approximately 1,800 psychiatric treatment services provided per month
- More than 50 telepsychiatrists in full and part-time capacities
- 16 participating community mental health centers and 42 mental health clinics

Timeline

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

1996

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

2007

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

2009

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

2013

The Community Telepsychiatry Program began in August 2013.

2017

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

2018

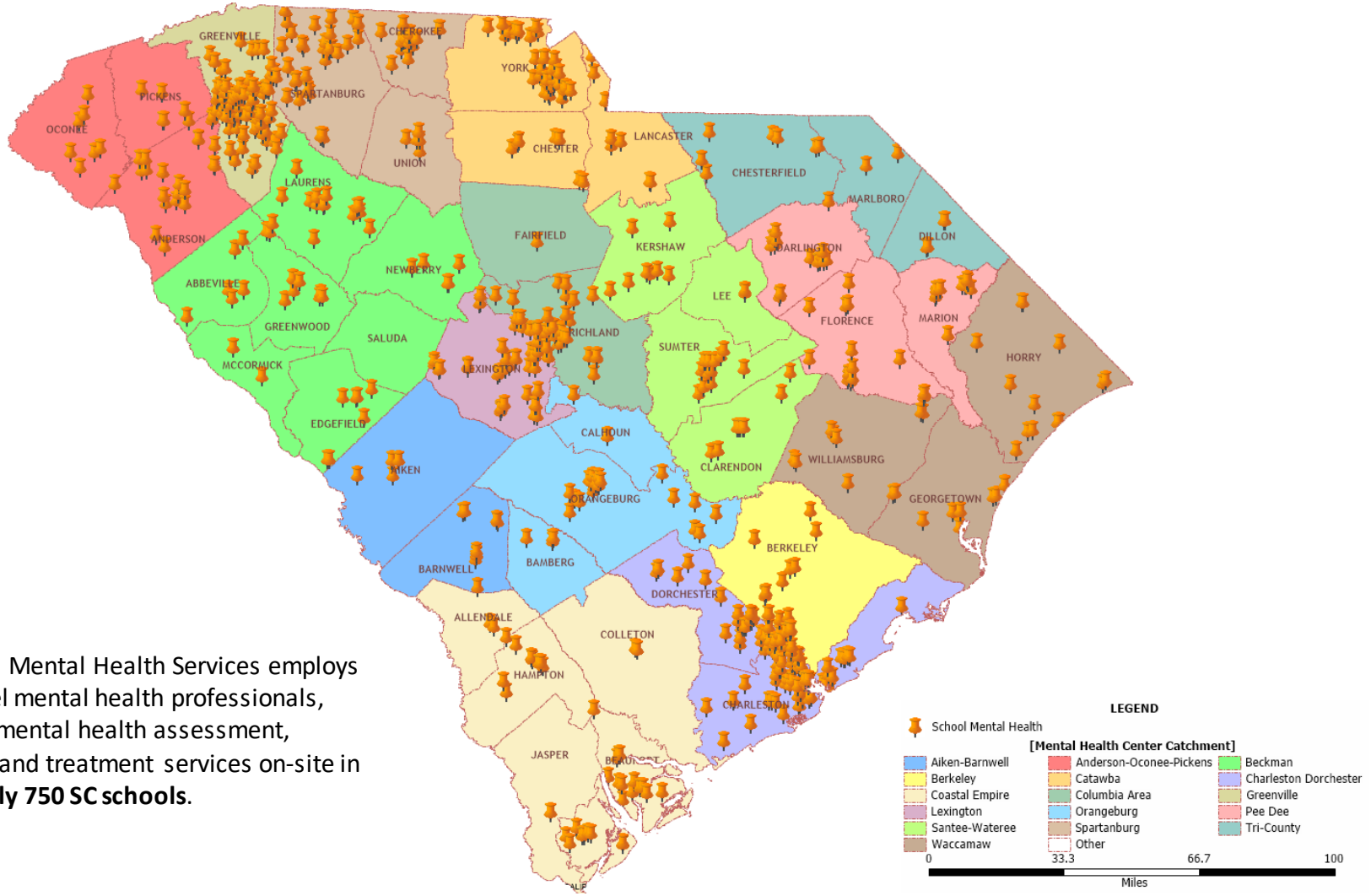
In October 2018, DMH delivered its 100,000th psychiatric service rendered via telehealth.

School Mental Health Services (SMHS)

- Approximately 1/3 of the clinical services provided by DMH are provided to children.

- DMH School Mental Health Professionals (MHPs):
  - Are Master's-level clinicians embedded in schools who specialize in the provision of mental health care.
  - Provide individual, family, & group treatment sessions in a familiar environment.
  - Establish collaborative relationships that engage school, family, & community.
  - Train school staff about mental health issues, prevention, & early intervention efforts.

School Mental Health Services Locations



DMH's School Mental Health Services employs Master's-level mental health professionals, who provide mental health assessment, intervention, and treatment services on-site in **approximately 750 SC schools**.

School Safety Efforts

- The Department of Education (DOE), DMH, and the South Carolina Law Enforcement Division (SLED) are working together to advance school safety through training of teachers and the placement of more Safety Resource Officers and School Mental Health Professionals.
- SMHS will expand through collaboration and cost share agreements with Mental Health Centers and local school districts. Technology, such as telepsychiatry, may assist with this expansion effort.

March 2018, Governor McMaster's School Security Summit. Held in collaboration with the USC's Children's Law Center and the Joint Citizens and Legislative Committee on Children to discuss best practices for keeping SC schools and children safe.

SC Joint Council on Children & Adolescents

- The Joint Council was established in 2007 as a collaborative effort to develop a statewide system of care that ensures the efficient, effective delivery of services for children and adolescents. Unique in its membership, the Joint Council was created by the directors of DMH, DAODAS, and DJJ and has expanded to include many other directors and executive leadership of the state's child-serving agencies.
- Mission: identify and research issues related to children's issues, provide information and recommendations for policy and legislation to the Governor and General Assembly.
- The Committee on Children publishes an Annual Report to the Governor and the General Assembly. Research and staff support for the Committee on Children is provided by the Children's Law Center, University of South Carolina School of Law.
- Among other things, the Council organizes an Annual Cultural & Linguistic Competency Summit to enrich cultural knowledge of staff from agencies and organizations statewide.
- Initiatives of the Joint Council on Children & Adolescents have included:
    - No Wrong Door, a common, statewide approach to screen and refer clients for appropriate service interventions regardless of where they enter the system of care.
    - GAIN-SS, a universal screening tool for early identification and referral for treatment of substance abuse, mental health, and co-occurring issues.
    - Cross-agency workforce development, which provides cross-training of substance abuse, mental health, and social service professionals and promotes quality standards in training and ongoing supervision opportunities.
    - Promotion of culturally competent services and appropriate adherence to SAMHSA's Guiding Principles of Family-Driven Care.
    - Adoption of core competencies for the child and adolescent professional workforce.
    - Adoption of the "Trauma-Informed System of Care" initiative proposed by the Joint Citizens and Legislative Committee on Children.
    - Recommendation of the Cognitive Behavioral Therapy (CBT) model as the evidence-based program for the treatment of co-occurring disorders in youth.
    - Creation of the "Breaking Boundaries" initiative, which completed a strategic plan to guide the statewide implementation of a System of Care approach for youth and families.

New & Expanding Initiatives

Crisis Stabilization Services

- FY18, DMH spent approximately $11 Million on Crisis Stabilization expenditures statewide.
- All DMH community mental health centers and clinics provide crisis services according to the needs of the communities they serve.
- Crisis Stabilization Centers enhance community infrastructure and partnerships for operational and programmatic short-term temporary crisis respite for SC citizens.
- The Charleston community, through a funding partnership with MUSC, Roper Saint Francis, Charleston Center, the Charleston County Criminal Justice Coordinating Council, the Charleston County Sheriff's Office, the Berkeley Mental Health Center, and the Charleston-Dorchester Mental Health Center, opened the Tri-County Crisis Stabilization Center, a 10-bed center on June 5, 2017 .
- The Department is pursuing community partnerships and programmatic designs to meet the crisis respite needs in Greenville, Spartanburg, and Anderson.

Tri-County Crisis Stabilization Center Data

June 5, 2017 to July 5, 2019

				Diversions		
Time frame	Referrals	Admissions	Triage	MH hosp	ED	Jail
6/5/17 to 7/5/19	1808	1144	143	1083	384	29

2.81	Avg length of stay
4.21	Avg daytime census

Crisis Stabilization Services

- The Charleston community, through a funding partnership with MUSC, Roper Saint Francis, Charleston Center, the Charleston County Criminal Justice Coordinating Council, the Charleston County Sheriff's Office, the Berkeley Mental Health Center, and the Charleston-Dorchester Mental Health Center, opened a 10-bed center on June 5, 2017.

- TCSC in addition to providing intensive psychiatric and clinical services, also offers adjunct services on site including PRS, CPSS, Care Coordination services, Vocational services/referrals and Entitlements (to include SOAR). As of June 2019, TCSC also started receiving referrals from Trident Hospital.

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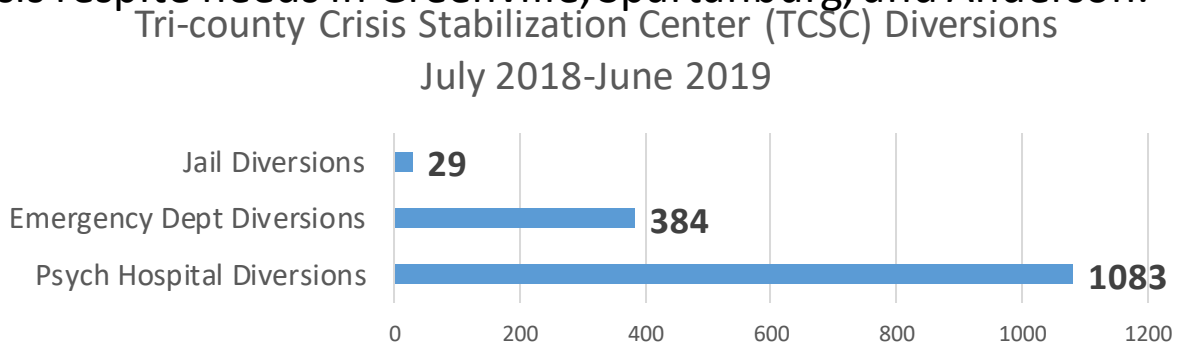

Mobile Crisis Services

- To provide crisis response services, Mobile Crisis is staffed by regional teams: Coastal, Pee Dee, Midlands, and Upstate.

- Mobile Crisis Mental Health Professionals:
  - Respond to calls from family members, neighbors, patients themselves, treatment providers, law enforcement, EMS, etc.;
  - May provide triage over the phone;
  - May provide assessments and recommendations via telehealth and on-site, at the request of law enforcement;
  - May help facilitate both voluntary and involuntary admissions to hospitals;
  - Ensure continuity of care for DMH patients with open cases by connecting patients to outpatient and community resources;
  - Serve as community liaisons.

- Requires strong partnerships with local law enforcement offices and probate courts, local emergency departments, and inpatient facilities
- Goal: to make this service available to anyone in SC experiencing psychiatric crisis.

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

Office of Suicide Prevention (OSP)

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

ZEROSuicide IN HEALTH AND BEHAVIORAL HEALTH CARE ask? ask about suicide SUICIDE safeTALK suicide alertness for everyone ASIST suicide to Hope aiding recovery and growth

OSP School Mental Health Services

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

OSP Zero Suicide (ZS) Program

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

Actions to address suicide prevention

- SC Suicide Prevention Coalition
  - Is a partnership including DMH, and the South Carolina chapters of the American Foundation of Suicide Prevention (AFSP) and Mental Health America (MHA).
  - Its goal is to develop a State plan to address suicide prevention.
  - The Coalition, chaired by DMH State Director John H. Magill, consists of lawmakers and leaders of non-profit organizations and the public and private sectors.
- SC Youth Suicide Prevention Initiative
  - Suicide is the 2nd leading cause of death nationally and in South Carolina for ages 10 to 24.
  - In 2015, DMH received an award of $736,000 per year for five years from SAMHSA, which launched the SC Youth Suicide Prevention Initiative.
  - The goal of SCYSPI is to provide an intensive, community-based effort to reduce suicide attempts and suicides among youths and young adults, aged 10 to 24, by 20% statewide by 2025.

Housing Programs

- Currently, 1,100+ housing units available to patients across the state.
- Continue to expand the number of housing units for patients with proceeds of the sale of the Bull Street property, which includes funding new integrated/scattered site units and the rehabilitation of existing units across the state.
- Community Housing Program uses over $1.9 million in state funds annually for rental assistance, security and utility deposits, utility costs, and furnishings. Currently, this program is assisting 293 units/496 patients and their family members at an average cost/unit of <$6,500.
- DMH also administers HUD grants that provide over $1.1 million annually for rental assistance for almost 200 formerly homeless patients and their family members in five counties. DMH also partners with the State Housing Authority to provide "bridge" rental assistance for up to 50 units/66 patients and their family members in Richland and Lexington Counties.
- DMH is currently in the 1st year of a 5-year SAMHSA grant, Treatment for Adults Experiencing Homelessness in South Carolina, which provides $1 million per year for evidence-based treatment and other best practice services for adults with serious mental illnesses or co-occurring serious mental illnesses and substance use disorders who are experiencing homelessness.

Clinical Care Coordination (CCC)

- Launched in 2013, this patient-centered, assessment-based, multidisciplinary approach provides intensive case management services to individuals with high-risk, multiple, chronic, and complex conditions.

- Patients receive a comprehensive care assessment to identify medical, dental, housing, employment, education, behavioral, & other community support needs.

- 49 care coordinators link patients to needed resources and monitor their progress until successful completion. All DMH Mental Health Centers, most satellite clinics, Bryan Psychiatric Hospital, and Harris Psychiatric Hospital have at least one care coordinator on-site.

- **To date, CCC has served 52,427 individuals**.
  - FY14 - 2,328
  - FY15 - 6,222
  - FY16 - 8,981
  - FY17 - 9,846
  - FY18 - 8,358
  - FY19 - 7,425

- Each individual received an average of 8.8 services while his or her case was open.

Community Long-Term Care Coordination (CLTC)

- Launched in 2017, CLTC offers an alternative to nursing home placement for Medicaid-eligible participants with significant health conditions who are at least 18 years of age with long-term care needs.
- Nursing staff with the South Carolina Department of Health and Human Services screen applicants, determining if a person's needs can be met in his or her home rather than a nursing home. If appropriate for home services, the applicant selects a Community Long-Term Care agency.
- CLTC case managers provide referrals for services and monitor the participant's progress as well as the provided services to ensure needs are appropriately met.
- Possible services participants may receive include: adult day health care, attendant care, companion services, home-delivered meals, personal care services, respite care, personal care, environmental modification, & other support services.
- 9 case managers cover all counties in South Carolina. As of July 16, 2019, 595 participants have been served.

It Takes a Village

SC's comprehensive mental health service delivery structure.

- South Carolina's robust public system is only part of the State's mental health service delivery structure, which also includes private, non-profit and for-profit outpatient and residential programs and individual hospitals and hospital systems.

- Well over 10,000 licensed professionals actively work in the Mental Health field in SC.

Statewide, Non-DMH Psychiatric Services (Excluding Alcohol and Drug Treatment)

- Inpatient
  - SC has 38 facilities with 1,600 + licensed beds offering psychiatric treatment:
  - 24 inpatient settings
  - Other examples include:
  - Military/Veterans Administration Facilities
  - 12 Residential Treatment Facilities
  - * MUSC has over 80 inpatient psychiatric beds

- Outpatient
  - SC has130+ outpatient service locations, including 14 Military/Veterans Administration sites.

  - SC has more than 30 College Counseling Centers
  - SC has more than 30 Pastoral Counseling Centers
  - SC has more than 30 Mental Health Support Groups (e.g., NAMI, SHARE, MHA, etc.)

Statewide, Non-DMH Alcohol and Drug (A & D) Treatment Services

- Inpatient
  - SC has13 Non-DMH A & D inpatient facilities with over 200 licensed beds (e.g., Phoenix Center, New Life Center, etc.)

- Outpatient
  - SC has 100 + Non-DMH A & D outpatient service locations (e.g., DAODAS, Recovery Concepts, etc.)
  - SC has over 600 substance abuse Support Groups (e.g., AA, NA, etc.)
  - Clinical outpatient services and outpatient clinical research

DMH Tomorrow

Future Challenges

Future Challenges

- Workforce Development
  - Chronic shortage of psychiatrists, nurses, and other certified MHPs
- Forensic Services
- Budget
- Bi-directional alignment between Mental Health Care Providers and Primary Health Care Providers
- Expansion of School-based Services
- Expansion of Telepsychiatry – in Emergency Departments and the Community
- Establishment of more Crisis Stabilization Centers
- Law Enforcement Training
  - Crisis Intervention Training (CIT) for first responders
- Community Crisis Response and Intervention (CCRI)
- Veteran Nursing Home Development

Innovative Service Expansion Through Telehealth

- DMH seeks to mitigate recruitment and retention difficulties and augment the shortage of psychiatrists by creating a varied roster of clinical care providers; specifically, utilizing Advanced Practice Registered Nurses (APRN) and Mental Health Professionals (MHP) in the delivery of telepsychiatry services.

- DMH's current focus is on APRNs and MHPs, but its expectation is to design the telehealth provider network of the future.

- DMH expects to:
  - Increase medication adherence rates
  - Reduce healthcare over-utilization (including emergency department utilization and inpatient hospitalization)
  - Create a multi-layered model of clinical service delivery via telehealth
  - Redistribute physician time to other activities that increase access to care, including initial evaluations
  - Create a 3 to 1 ratio of clinical providers for certain service lines
  - Create a Mental Health Professional protocol detailing optimal role in telehealth
  - Inform South Carolina's Telemedicine Act and Nurse Practice Act

For more information go to www.scdmh.net