



**Blueprint for Resilience:  
Services for Children,  
Adolescents and their Families**

*July 1, 2004- June 30, 2009*

*From: Recovery and Resilience:  
A Life in the Community for Everyone  
Strategic Plan  
South Carolina Department of Mental Health*

**August, 2004**

Cover Art by Brian Marks 2004  
Part of the SCDMH Art of Recovery Series



August, 2004

"Early detection, assessment, and links with treatment and supports can prevent mental health problems from worsening," The President's New Freedom Commission on Mental Health.

The *Blueprint For Resiliency*, a strategic plan that will improve the lives of our children and establish a foundation for our system of care, will address early detection, assessment, treatment and needed supports that will promote the mental health of our children. The Blueprint is our plan to design and implement a comprehensive spectrum of mental health and other services which are organized into a network to meet the needs of our children and their families.

Over the past, focus groups were convened in communities across our state to collect first-hand information from families, children and interested stakeholders. This plan is not the Department of Mental Health's plan; it is our families' plan. Together, we can transform our system and reduce fragmentation, improve access and build the needed partnerships that our children deserve. The core values of the plan are based on the evidence-based system of care philosophy, and specify that services need to be community-based, child-centered, family-focused, and culturally specific.

I personally want to thank everyone who participated in the planning process, and I want to assure you that this plan can and will be achieved. We can and will restore hope and dreams to thousands of children who suffer from mental illnesses.

Thank you,

George P. Gintoli  
State Director

ADW 11



# Blueprint for Resilience: Services for Children, Adolescents and their Families

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Note: The Goals for Adult Services are contained in a companion document:

***Making Recovery Real: Services for Adults  
Recovery and Resilience:  
A Life in the Community for Everyone  
Strategic Plan  
South Carolina Department of Mental Health***

## INTRODUCTION

The previous statewide planning process for the Department of Mental Health was commissioned in 2001, by George Gintoli, State Director of Mental Health. He and the SC Mental Health Commission sought a framework that would guide the department over the next few years of system change. To reflect the importance of local care, that effort was called the Community Development Planning Process. Its product was the 2002 publication of a working document entitled, **MAKING RECOVERY REAL.**

Those 2002 goals were evaluated in 2004 and the following progress was noted:

- 74% of the goals and objectives were fully met
- 21% were partially met (above 50% complete)
- only 5% were not met (as indicated by less than 50% goal attainment).

In 2004, it was time to update the state's vision for services for adults and for children, adolescents, and their families, and to incorporate the recently issued goals of the President's New Freedom Commission. Thus, the New Freedom Commission Mental Health Goals were used to structure the report. These six goals are as follows: <sup>1</sup>

Goal 1: Americans Understand that Mental Health is Essential to Overall Health

Goal 2: Mental Health Care is Consumer and Family Driven

Goal 3: Disparities in Mental Health Services are Eliminated

Goal 4: Early MH Screening, Assessment, and Referral to Services are Common Practice

Goal 5: Excellent Mental Health is Delivered and Research is Accelerated

Goal 6: Technology is Used to Access Mental Health Care and Information

It was envisioned that together, the children's plan entitled *Blueprint for Resilience*, and the Adult services plan *Making Recovery Real 2004* comprise SCDMH's strategic plan, called ***Recovery and Resilience: A Life in the Community for Everyone.***

The 2004 task was approached in much the same way as the initial plan. A combination of distance education technology and local, face-to-face meetings were used. These enabled the delivery of a single set of messages once from Columbia, and yet allow maximum potential to local sites to plan according to their unique needs. The central messages from Columbia were these: (1) The current state of the state in terms of services and needs; (2) the commitment of DMH to evidence based practices and Mr. Gintoli's vision for the department; and (3) the kinds of practices that can yield tangible results for consumers and their families.

Over the course of several months, numerous activities were held and over one thousand individuals provided feedback. We are thankful for the participation of consumers and families and reaffirm our hopes and intentions to utilize this information to build the best possible recovery system for South

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<sup>1</sup> New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America: Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

Carolínians in need of mental health services. The following is a list of the major events and reports<sup>2</sup> that have led to this plan:

- Dec. 5: Agency-Wide New Freedom Goals Meeting
- March 26: 17 Family Forums on System of Care
- April 2: Central Office Kick-Off Focus Groups
- April 12-16: 17 Focus Groups on Adult MH Service needs
- May 11: Expanded Assembly critiques draft of priorities/goals
- June 30: State Planning Council goals for children & adults
- July 1: Blueprint for Resilience, the Children, Adolescent and Family developed under contract with the USC, Institute for Families in Society

Wherever possible, the Mental Health State Planning Council's recommendations have been integrated into this document. A top priority of the Planning Council is that "core basic" services for both adults and children be available at all mental health centers. The Council's overall recommendation for adult programs is that they include sufficient case management to support the housing, education, clinical treatment, vocational rehabilitation, medical and other support services necessary for community living and recovery. The Planning Council opposes reducing any inpatient psychiatric beds for adults or children until more community services are in place.

As its sub-title, *A Life in the Community for Everyone*, indicates, this plan seeks to provide a framework by which all citizens of South Carolina will have access to excellent mental health services.

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<sup>2</sup> These events and reports are documented in a companion document, Summary of 2004 SCDMH Strategic Planning Events. It is available on the SC DMH Website along with the ***SCDMH PROGRESS REPORT ON "MAKING RECOVERY REAL, 2002"*** and other related documents.

## MISSION, PRIORITIES, VALUES OF SCDMH

The mission, priorities and values that drive the goals in this strategic plan are the ones adopted by the South Carolina Department of Mental Health in 2000. These are as follows:

### OUR MISSION

To support the recovery of people with mental illnesses.

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### OUR PRIORITIES

The S.C. Department of Mental Health gives priority to adults, children, and their families affected by serious mental illnesses and significant emotional disorders. We are committed to eliminating stigma and promoting the philosophy of recovery, to achieving our goals in collaboration with all stakeholders, and to assuring the highest quality of culturally competent services possible.

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### OUR VALUES

All programs and services for adults provided by the S. C. Department of Mental Health will operate according to these principles:

#### **Respect for the Individual**

Each person who receives our services will be treated with respect and dignity, and will be a partner in achieving recovery. We commit ourselves to services that:

- honor the rights, wishes and needs of each individual;
- promote each individual's quality of life;
- focus on each individual's strengths in the context of his or her own culture;
- foster independence and recovery;
- demonstrate the value of family inclusion and the benefits of strong family support.

#### **Support for Local Care**

We believe that people are best served in or near their own homes or the community of their choice. We commit to the availability of a full and flexible array of coordinated services in every community across the state, and to services that are provided in a healthy environment. We believe in services that build upon critical local supports: family, friends, faith communities, healthcare providers, and other community services that offer employment, learning, leisure pursuits, and other human or clinical supports.

#### **Commitment to Quality**

We will be an agency worthy of the highest level of public trust. We will provide treatment environments that are safe and therapeutic, and work environments which inspire and promote innovation and creativity. We will hire, train, support and retain staff who are culturally and linguistically competent, who are committed to the recovery philosophy, and who value continuous learning and research. We will provide services efficiently and effectively, and will strive always to provide interventions that are scientifically proven to support recovery.

## **Dedication to improved public awareness and knowledge**

We believe that people with mental illnesses, trauma victims, and others who experience severe emotional distress are often the object of misunderstanding and stigmatizing attitudes. Therefore, we will build formal partnerships with the state's educational leadership and institutions to enhance curriculum content in mental health. We will work with employers, sister agencies, and public media to combat prejudice born of ignorance about mental illnesses. And we expect our own staff to be leaders in the anti-stigma campaign.

## **Additional Concepts**

In addition to the agency vision, priorities and values statements, this strategic plan adheres to the following concepts:

**Recovery :** "Recovery is real!!" When Dr. Pat Deegan<sup>3</sup> delivers that line as she recounts the experiences of being diagnosed with schizophrenia and her journey into recovery, the listener is galvanized by her excitement. A new awareness results, a changes way of looking at mental illnesses and the people they impact. SCDMH embraces this concept and organizes its services in a way to facilitate recovery and empowerment.

**Consumer-driven Services:** Consumers must lead the planning, delivery, and evaluation of their own care and treatment; thus they are regarded as equal partners in all decision-making.

**Cultural Competence:** All action must occur in a manner that respects the cultural tradition and heritage of the adult and his or her family. Staff will be culturally and linguistically competent and have access to specialized support as necessary, such as language interpretation, consultation from experts, and information regarding particular cultural groups. Cultural groups include those identified by ethnicity (e.g. African American, Latino/a, Native American, or Asian-Pacific Islander), ability (e.g. those who are deaf or mobility impaired), gender, socioeconomic class, religion, national origin, immigrant status, military participation, or other affiliations.

**Timeliness of Service:** Adults will be assessed and served promptly.

**Ease of Access:** The department will make services accessible to adults with respect to location, schedule, child-friendly environments, and operations.

**Quality of Services:** Priority will be placed on provision of services and programs that have scientific evidence supporting their effectiveness and cost efficiency. Personnel will be competent, qualified through training, education, and experience. They will have access to specialists for complex or rare conditions. Each Community Mental Health Center will demonstrate commitment to client outcome monitoring and program evaluation.

**Accountability:** Each Community Mental Health Center will demonstrate efficient use of financial resources and commitment to quality monitoring.

**Leadership:** Anyone in governance, leadership, or management positions with the Department of Mental Health will demonstrate proactive commitment to effective adult services and programs.

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<sup>3</sup> Deegan, P. (2001). *Recovery is Real!* Video produced by the DNH Office of Consumer Affairs and the SC Center for Innovation in Public Mental health, 2100 Bull Street. Columbia, SC 29202.

# *Blueprint for Resilience*

**South Carolina Department of Mental Health**

**Division of Children, Adolescents, and Their Families**

**Strategic Plan**

**July 1, 2004 – June 30, 2009**

**U.S. New Freedom Commission on Mental Health  
Vision Statement**

We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports - essentials for living, working, learning, and participating fully in the community.

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## **South Carolina Department of Mental Health**

### **Vision Statement Regarding Children, Adolescents, and Their Families**

*We envision a future when children who face emotional disturbance or mental illness will be resilient and participate fully in their communities through school, work, play, creativity, and service. They will be safe, healthy, productive, and out of trouble. They will receive skilled care from a family supported by effective resources that are individualized, family-focused, culturally competent, close to home, and coordinated through a comprehensive community-based system of care.*

### **Statement of Principles**

All programs and services for children, adolescents, and their families provided by the S. C. Department of Mental Health will operate according to these principles:

#### **Consumer Rights**

##### **Respect for and Dignity of the Child**

All action will center on the unique needs and assets of each individual child, who is regarded as a human *being* with dignity and rights, not simply a human “becoming” whose value is to be realized at some point in the future. Action will be based on individualized, culturally competent, developmentally responsive planning and service delivery that fosters the rights, privacy, needs, and desires of each child, without stigma.

##### **Resilience**

Each child is born with a capacity for resilience that enables successful adaptation in the face of adversity. All action will aim to foster the child and family’s resilience by promoting social competence, problem-solving skills, confidence, autonomy, cultural strength, and a sense of purpose in the child.

##### **Family-Driven Services**

Families must lead the planning, delivery, and evaluation of treatment for their children; thus they are regarded as equal partners in all decision-making. In each case family will be defined by the parties being served, within their cultural context.

## **Community-Based Care**

### **Family-Based Care**

Children have a right to live in a family environment that supports their mental health. All action will aim to protect and support stable family-based caregiving, in the child's home, or, in rare cases, in a home-like alternative setting.

### **Local Care and Natural Support Systems**

Children are most resilient when served in or near their own homes and communities. All actions will recognize that children's mental health is powerfully influenced by their relationships with family, friends, faith communities, and other community resources that offer opportunities for play, learning, creativity, work, and other pursuits. Particular effort will be devoted to assuring maximal development of resources in rural communities.

### **Least Restrictive Environment**

Children have constitutional rights to exercise certain liberties, including interacting with people in typical environments. In rare cases, children may need to have their liberties temporarily restricted for their own or others' well being. In all cases, any action to place a child in an atypical environment will be based on choosing a setting that is least restrictive while meeting the needs of the child. Hospitalization, institutional care, and residential out-of-home care are to be reserved for extreme circumstances only.

### **Stability**

All action will aim to promote stability in the child's living environment. Staff will anticipate crises and use services to help children remain at home, minimize placement disruptions, and avoid the inappropriate use of the justice system. Staff will anticipate and appropriately plan for transitions in children's lives, including transitions to new schools, placement away from and return to home, family relocation, and transition to adult services.

## **System of Care**

### **Comprehensive Array of Resources**

Each Community Mental Health Center will facilitate access to a complete and flexible array of services that include unduplicated assessment, developmentally appropriate outpatient treatment in individual, group, and family modalities, services to help the child maintain a stable family placement, respite services, recreation, crisis residential services, longer-term residential services, and acute inpatient services.

### **Community Building and Interorganizational Partnerships**

Given that *every* child needs a family, school/child care, and primary health care provider, and that many children need services from other providers, such as those providing health, social, child welfare, juvenile justice, alcohol and other drug, developmental disabilities, early childhood, youth development, and other services, each Community Mental Health Center will coordinate effectively with providers to assure that children and families receive coordinated case assessment, planning, management, delivery, and outcome evaluation. Each Community Mental Health Center will advocate for the development and accountable provision of adequate resources by other partner organizations.

## **Accessibility**

### **Cultural Competence**

All action must occur in a manner that respects the cultural tradition and heritage of the child and family. Staff must work constantly to be culturally and linguistically competent and have access to specialized support as necessary, such as language interpretation, consultation from experts, and information regarding particular cultural groups. Cultural groups include those identified by ethnicity (e.g., African American, Latino/a, Native American, or Asian-Pacific Islander), ability (e.g., those who are deaf or mobility impaired), gender, socioeconomic class, religion, national origin, immigrant status, military participation, or other affiliations.

### **Timeliness**

Children will be assessed and served promptly.

### **Ease of Access**

The department will make services accessible to families with respect to location, schedule, child-friendly environments, and operations.

## **Quality**

### **Effective and Efficient Practices**

Priority will be placed on provision of services and programs that have scientific evidence or outcome data supporting their effectiveness and cost efficiency. Personnel will be competent, qualified through training, education, and experience. They will have access to specialists for complex or rare conditions. Each Community Mental Health Center will demonstrate commitment to client outcome monitoring and program evaluation.

### **Accountability**

Each Community Mental Health Center will demonstrate efficient use of financial resources and commitment to quality monitoring.

### **Leadership**

Anyone in governance, leadership, or management positions with the Department of Mental Health will demonstrate proactive commitment to effective children, adolescent and family services and programs.

## **Prevention and Early Intervention**

### **Prevention**

Each Community Mental Health Center will participate in community efforts to promote healthy infant and early childhood social and emotional development. They will also contribute to community efforts to educate children of all ages and families about ways to manage life transitions, trauma, and other situations to prevent possible onset of mental health problems.

### **Early Intervention**

Each Community Mental Health Center will participate in community efforts to intervene when risk factors emerge, to prevent deterioration and problems such as poor school performance, problems with the law, and low productivity associated with untreated or serious conditions.

**Recommendations:**

- 1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.
  - 1.2 Address mental health with the same urgency as physical health.
- 

**South Carolina Department of Mental Health  
Division of Children, Adolescents, and Their Families**

**Goal One**

**SCDMH will provide services in ways that help South Carolinians understand that mental health care is essential to the overall health and development of their children.**

**1A. COMMUNITY CARE**

**SCDMH will provide services for children, youth, and their families in naturalistic, community-based, least restrictive settings whenever possible.**

**1A – a. Every community mental health center will provide or ensure access to a range of core services to children, youth, and their families. These services will be designed in ways that fit local needs and include:<sup>4</sup>**

- **Assessment (including testing and evaluation by professionals skilled in child and youth mental health practice);**
- **Case management services;**
- **Crisis residential treatment;**
- **Intensive family services (such as family preservation, family reunification, and multi-systemic therapy);**
- **School-based services/day treatment;**
- **Wraparound services;**
- **Respite care and/or temporary de-escalation services;**
- **Acute inpatient hospitalization;**
- **Outpatient treatment (including individual, group, and family counseling and clinical, psychiatric, and nursing services);**
- **Residential treatment services; and**
- **Transitional services for older youth.**

**1A – a. Objectives:**

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<sup>4</sup>*This list of core services is based on the Children’s Committee of the State DMH Planning Committee, Commission on Accreditation of Rehabilitation Facilities (CARF) requirements, and recommendations regarding service priorities.*

1A – a1. By 6/30/09, every center will report all core services (from above list) are provided or available to persons served by their catchments areas.

1A – a2. Each year from 2005-2009, every center will report plans to overcome deficits in core services.

1A – a3. By 6/30/09, the disparities among centers in level of core services will be eliminated.

**1A – b. The SCDMH will provide resources to support the development and quality maintenance of the local core services in each community mental health center.**

**1A – b. Objectives:**

1A – b1. SCDMH budget allocations will give priority to core services (as listed above) over specialized services.<sup>5</sup>

1A – b2. SCDMH budget allocations will support recurring base funding for core services in amounts that are realistic relative to the revenue-generating capacity of the particular service, long-term potential for sustainability, applicability to local populations, and geographical and other factors that affect cost.

1A-b3. SCDMH will annually report on the ability of CMHCs to provide core services to the extent possible, given budget limitations.

1A-b4. SCDMH will provide grant development support to CMHCs for pursuit of external funds to support programs and services.

**1A – c. Whenever possible, SCDMH CAF services will be provided in typical settings where children, youth, and families congregate, e.g., home, child care programs, schools, prenatal and primary health care clinics, youth programs, faith centers, and programs for child and youth populations.**

**1A – c. Objective:**

**1A – c1. Outstationed CMHC CAF Workers**

Increase placement of CMHC CAF workers in community settings other than CMHC clinics<sup>6</sup> while maintaining essential clinical services at the CMHC.

**1A – c2. School-Based Services**

1A – c2a. Increase availability and effectiveness of school-based mental health services statewide by increasing the number of schools (baseline: 468 of 1,015

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<sup>5</sup> To monitor this objective, financial accounting will have to be developed that can track programs and services.

<sup>6</sup> Baseline is number of outstationed workers in 2003-04.

schools in Feb 2004 (38% of all schools)) with mental health professionals to 80% of all schools in SC by 6/30/09

1A – c2b. Increase the quality and effectiveness of school-based programs as indicated below.

- With adequate statewide resources, 70% of all school-based programs will operate at best practice standards<sup>7</sup> by 6/30/09 (baseline 34% in 2004).
- If adequate statewide resources are not available, 50% of all school-based programs will operate at best practices standards by 6/30/09.
- All school-based programs not operating at best practices standards will show evidence of working towards operating at best practices standards by 6/30/09.

### **1A – c3. Family Preservation and Multi-Systemic Therapy (MST)**

1A-c3a. By 6/30/2007, all CMHCs will establish and maintain family preservation services.

1A – c3b. Establish and sustain the availability of Multi-Systemic Therapy (MST) in 6 CMHC catchment areas by 6/30/09.

1A-c3b1. Establish SCDMH as a MST Licensed Training Organization with a licensed trainer on staff by 6/30/05.

1A – c3b2. Assess the suitability of MST for each of the other 11 CMHCs, including level of need and resources required to sustain the program, by 6/30/09.

### **1A – c4. Wrap Services**

1A – c4a. By 6/30/07, all CMHCs will provide or facilitate access to wrap services.

1A – c4b. By 6/30/09, 90% of all SCDMH wrap services will operate according to effective practice standards.

### **1A – c5. Treatment during Out-of-School Time**

1A – c5. By 6/30/05, SCDMH will have in place a plan for the establishment of treatment programs for periods when school is not in session (such as day treatment, summer camps, or other appropriate services).

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<sup>7</sup> Best practices standards are available in the SCDMH state office for school-based services.

**1A – d. SCDMH will work to reduce the rate of out-of-home placements and length of stay out-of-home for children with serious emotional and mental disorders.**

**1A – d. Objective:**

1A – d1. Using a reliable baseline count of children in out-of-home placements that will be established by September 30, 2004,<sup>8</sup> the rate of out-of-home placements made by CMHCs will decrease each year (the percentage decrease will vary depending on the baseline at each CMHC)<sup>9</sup>.

**1A – e. Any child who is assessed for mental health needs at a SCDMH community MH center who is in need of a full health screening will be referred to a medical home for screening. If the child does not have a medical home<sup>10</sup>, a medical home will be located for the child so that a full health screening may be obtained regardless of the identified need.**

**1A – e. Objective:**

1A – e1. By 9/30/09, 100% of children seen at any SCDMH facility who need a physical health screening will be referred for the screening.<sup>11</sup>

**1B. COORDINATED, SEAMLESS DMH SYSTEM**

**SCDMH will deliver services to children, adolescents, and their families through a coordinated, seamless system of 17 community mental health centers, state operated facilities, regional specialty programs, and contract providers.**

**1B – a. SCDMH will support its centers and facilities to assure each community has suitable crisis-stabilization and wrap services to meet the needs of children and youth presenting with emergency and traumatic episodes in hospital emergency rooms.**

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<sup>8</sup> SCDMH will need to establish an electronic record keeping system that can accurately and reliably track placements of children on a daily basis so that a baseline can be established and rates of out-of-home placement monitored.

<sup>9</sup> This indicator must differentiate those decisions made without DMH input (e.g., by court) and those made by DMH clinicians.

<sup>10</sup> Consistent primary health care provider.

<sup>11</sup> Monitoring this will require a modification on the Assessment Form.

**1B – a. Objectives:**

1B – a1. Number of children presenting at emergency rooms with mental health conditions (as reported in the SC BCB Office of Research and Statistics hospital data system) will decrease by 50% over five years, with a baseline of 3,486 children with 1.2 average number of visits per child per year (2002).<sup>12</sup>

1B – a2. By 6/30/09, 100% of children who need crisis stabilization or wrap services will receive the service through their community mental health center or accessible regional alternatives.

**1B – b. As a safety net for children and youth whose cases are managed by community mental health centers, SCDMH will operate its own secure residential treatment services, including inpatient hospitalization and residential treatment, in close proximity to acute hospitalization support, for children and youth with complex disorders who are a danger to themselves or others and have failed to make progress in community-based settings or residential treatment programs.**

**1B – b. Objectives:**

1B – b1. SCDMH will provide a sufficient number of secure residential treatment beds for complex cases (baseline in 2004: Residential Treatment Facility beds [16 male adolescent, 16 female adolescent], Inpatient Hospitalization beds [16 latency age, 16 adolescent], and 20 alcohol/drug treatment beds).

1B – b2. SCDMH through its treatment programs and CMHC services will demonstrate interventions to assure that no child or adolescent in need of secure mental health care will be placed in a juvenile or criminal detention facility as a result of rejection by or unavailability of an appropriate treatment facility (recognizing that the decision regarding placement may be out of SCDMH control).

1B – b3. SCDMH will recruit and retain providers who have the expertise and experience to meet the needs of the most complex child and youth mental health conditions in inpatient and outpatient settings.

1B – b4. The SCDMH inpatient facility will report complete compliance at all times with safety and treatment hazard prevention standards stipulated by the Joint Commission on Accreditation of Healthcare Organizations (JACHO).

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<sup>12</sup> Source: W. Bailey, SC Division of Research and Statistics, “Visits to SC Emergency Departments by Children 0-17 with a Primary Diagnosis of Mental Health and/or Substance Abuse”

**1B – c. In support of children and youth with services managed by community mental health centers, SCDMH will provide a state and, when appropriate, regional system of specialty services, training, and consultation for cases with rare or complex conditions or special needs, to include (at a minimum),**

- **Children with co-occurring conditions such as communications disorders, mental retardation, pervasive developmental disorders, or other disabilities;**
- **Services for children who are very young (birth-6);**
- **Adjudicated youth with mental health needs;**
- **Children in the child welfare system (protective services, foster care, adoption);**
- **Children and families in need of assessment and trauma recovery services related to assault and/or neglect;**
- **Recent immigrants and those with English language barriers;**
- **Youth in transition to adulthood (18-21); and**
- **Children of adults with serious mental illness.**

**1B – c. Objectives:**

IB - c1. SCDMH state office will provide specialty resources (to include training, case assessment and consultation, mentoring, program development, and other interventions) in a timely manner to enhance the capacity of CMHC CAF personnel to respond to children with rare or complex conditions.

1B – c2. **Children with co-occurring conditions** such as communications disorders, mental retardation, pervasive developmental disorders, or other disabilities

1B – c2a. SCDMH will maintain a state specialty resource for children with mental retardation who have co-occurring mental health needs.

1B – c2b. By 9/30/09, all CMHCs will participate in BabyNet to the extent that funds are available.

1B - c2c. By 9/30/05, SCDMH and the SC Dept. of Disabilities and Special Needs will develop guidelines for CMHCs regarding interagency case coordination.

1B – c2. **Services for children who are very young (birth-6)**

1B – c2a. SCDMH will operate a state diagnostic and treatment-planning program for children under age six.

1B – c2b. By 6/30/06, every CMHC will have a plan for assessment and treatment of children under age six.

1B – c2c. By 9/30/09, SCDMH will assure that all CMHCs will have a CAF staff member who has been trained in Parent-Child Interactive Therapy (PCIT), an evidence-based practice for young children.

**1B – c3. Adjudicated youth with mental health needs**

1B – c3. By 6/30/06, SCDMH will have a CAF specialist assigned full- or part-time to each of the regional offices of the SC Dept of Juvenile Justice (same position as 1B-c9).

**1B – c4. Child welfare services**

1B – c4. By 6/30/09, SCDMH will have a CAF specialist assigned full- or part-time to each of the 46 county offices of the Dept of Social Services, Child Welfare Services.

**1B – c5. Trauma services**

1B – c5. By 6/30/09, all CMHCs will provide screening, diagnostic assessment, and treatment for the trauma related symptoms in children and adolescents.

**1B – c6. Recent immigrants, refugees, and those with English as another language**

1B – c6. Each year, all CAF programs at CMHCs and SCDMH facilities will report access to language interpreters for persons served in need of translation services.

**1B – c7. Services for youth in transition to adulthood**

1B – c7a. By 12/31/04, each CMHC shall designate at least one person to be the transition services coordinator for that MHC (may be part-time or full-time).

1B – c7b. By 12/31/05, each CMHC will have a plan for services to youth in transition to adulthood.

1B – c7c. By 12/31/09, each CMHC will have access to services for youth in transition to adulthood.

**1B – c8. Children of adults with serious mental illness**

1B – c8a. By 6/30/09, 5 CMHCs will operate programs for children of adults will serious mental illness.

1B – c8b. By 6/30/09, SCDMH will assure that all CMHCs will have CAF personnel trained in responding to children of adults with serious mental illness.

1B – c9. SCDMH will create a mechanism for CAF program specialists to serve as technical advisers and resource brokers regarding special populations (including children placed in out-of-home care) and use of private providers for the community mental health centers.

1B – c10. In conjunction with the Children’s Committee of the State Planning Council for SCDMH, (see 1C-c1) SCDMH will plan and report progress regarding services to children and youth in all the categories listed above as well as any other needed services.

## **1C. LEADERSHIP**

**SCDMH leadership, infrastructure, and processes of governance and management will consistently support programs for children, adolescents, and their families.**

**1C – a. Every community mental health center director will demonstrate commitment to child, adolescent, and family programs.**

### **1C – a. Objectives:**

1C – a1. By 6/30/09, 100% of community mental health centers will have budget and staff allocations that support equitable resources for CAF programs relative to adult programs (resources will be based on an objective measure agreed upon by CMHC directors).

1C – a2. By 6/30/05, 100% of community mental health center directors will demonstrate that they hold annual meetings with families of children served to discuss the CMHC’s direction, budget, and effectiveness.

**1C – b. At the state office and in each community mental health center, the CAF director will be a member of the governing council and management team.**

### **1C – b. Objective:**

1C – b1. 100% of state and community governing and management groups will have CAF representation.

**1C – c. The SCDMH state commission, director, and governing council, with advice of the state planning council, will use data about services, outcomes, and expenditures to evaluate how each center and facility is performing and to make plans for SCDMH CAF system improvement.**

**1C – c. Objective:**

1C – c1. Annually, within three months of the end of the fiscal year, each center will submit to its board and management team, and each state CAF facility and the state CAF office will submit to the commission, governing council, and planning council, a CAF system progress report and the governing and management groups will respond with a written evaluation of the report, including recommendations for improvement

The report will include:

- Statement of progress for each of the goals and objectives in this strategic plan;
- The core services each center has in place for CAF, the services provided at each facility, or the services provided by state and regional programs;
- The number of children, by age and diagnosis, served by each CAF service during the reporting period;
- The number of children on any waiting list for each CAF program (“waiting list” to be defined by CAF council);
- The average length of time between referral to the center and first appointment;
- Average frequency of contact for each child and family served; and
- Any plans and timelines for developing additional CAF services.
- Efforts made toward assuring cultural competence.

**1C – d. The SCDMH financial planning and budgeting process for CAF programs and services will be based on the needs of children, youth, and their families in the geographic catchment area.**

**1C – d. Objectives:**

1C – d1. By 6/30/05, SCDMH will establish needs-based guidelines for allocating resources to CMHC CAF programs and services.<sup>13</sup>

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<sup>13</sup> This should be based on recommendations from CAF directors, CMHC directors, and CMHC administrators.

1C – d2. By 6/30/05, SCDMH will establish program budgeting and expenditure reporting so that the costs of CAF programs and services can be established and linked to outcomes for cost-effectiveness studies.

1C – d3. By 6/30/09, children will be served equitably throughout the state, as indicated by a) share of resources committed to CAF services relative to adult services, b) elimination of disparities in services to the CAF target population among CMHC catchment areas and among rural-urban areas within catchment areas.

## **1D. UNIVERSAL ACCESS**

**SCDMH will reduce access barriers to mental health care for children, youth, and their families.**

**1D – a. SCDMH will cooperate with consumer advocates to advocate that no child with mental health needs is unserved or underserved for reasons of inability to pay for care by promoting universal, comprehensive, continuous insurance coverage.**

### **1D – a. Objective:**

1D – a1. Each year, SCDMH will make public information available to consumer advocates about insurance coverage for children served by the SCDMH system, including those in inpatient and outpatient programs.

**1D – b. SCDMH managers will assure that cultural competence is embedded into all organizational components of the SCDMH CAF system.**

### **1D – b. Objective:**

1D – b1. Each year, the SCDMH CAF program and the Columbia Behavioral Health System children's programs will report compliance with the SCDMH Cultural Competence Strategic Plan and CARF standards for cultural competence and will make plans for improvements as needed.<sup>14</sup>

1D-b2. The report will explain how cultural competence has been embedded in all clinical services and any new services to meet the needs of given racial and ethnic groups.

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<sup>14</sup> Note: This report can be integrated with the center report for Adult Services Cultural Competence.

**1D – c. SCDMH will conduct a study to determine feasible ways to enable families who use SCDMH CAF services at state facilities or CMHCs to exercise choice about their mental health care providers, including mixed public agency and/or private providers, in their child’s care plan and process.**

**1D – c. Objective:**

1D – c1. By 12/31/05, SCDMH will complete a study of consumer choice options in the CAF programs and services.

**1D – d. SCDMH will emphasize child and youth mental health and risk factors, not disorders, in public awareness information.**

**1D – d. Objective:**

1D – d1. Each year, as part of its annual report, the SCDMH CAF program will summarize themes in the agency’s public awareness materials.

**Recommendations:**

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

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**South Carolina Department of Mental Health  
Division of Children, Adolescents, and Their Families**

**Goal Two**

**SCDMH will manage its programs to be effective parts of comprehensive community-based systems of care through which resources for children, youth, and their families are individualized, family-focused, culturally competent, close to home, and coordinated.**

**2A. INDIVIDUALIZED SERVICES**

**SCDMH will assure that each child served by SCDMH has an individualized care plan that is**

- **Responsive to the unique assets and needs of the child and family;**
- **Culturally competent;**
- **Outcome-based;**
- **Coordinated with and not duplicative of other plans for the child;**
- **Compliant with the Olmstead Act (i.e., based on least restrictive care); and**
- **Managed during a child's out-of-home stay and after discharge as well as during community-based care (i.e., when out-of-home care is necessary, it is fully coordinated with community-based care);**

**2A – a. SCDMH quality assurance programs will assure that all children served have an individualized care plan.**

**2B – a. Objective:**

2A – a1. SCDMH quality assurance reviews will report that 100% of children served have individualized care plans.

## **2B. FAMILY-DRIVEN SERVICES**

**SCDMH will assure that each child, youth, and family caregiver is fully involved in care planning, delivery, and monitoring.**

**2B – a. SCDMH centers and facilities will offer, in developmentally appropriate ways, direct information about effective treatment options so that children, youth, and their family caregivers can make fully informed decisions.**

### **2B – a. Objectives:**

2B – a1. SCDMH centers and facilities will make available “user friendly” descriptions of service options to children, adolescents, and their families.

2B – a2. Case plan documents will provide for parent/guardian and child/youth signatures to signify that they agree or disagree with the plan options.

**2B – b. SCDMH will promote maximum feasible participation, in developmentally appropriate ways, by children, youth, and their parents/guardians in decisions and choices about preferred intervention strategies.**

### **2B – b. Objectives:**

2B – b1. Each treatment plan and progress note based on team meetings will show child/youth’s and parent/guardian’s participation, as indicated by signatures.

2B – b2. Once a year, SCDMH will randomly sample youth and their families (using the Youth Services Survey –YSS and the Youth Services Survey-Family-YSS-F) in center and facilities treatment regarding satisfaction with participation in service decisions.

**2B – c. SCDMH will coordinate with family advocates, such as family members with prior experience, to assist families in interacting effectively with complicated service systems such as healthcare, education, juvenile justice, child welfare, and substance abuse treatment.**

### **2B – c. Objectives:**

2B - c. Annual feedback from families, through surveys or focus groups, will indicate that all CMHCs and SCDMH facilities are coordinating with family advocates in at least 75% of cases.

**2B – d. SCDMH will assure that representatives of families with children and youth in treatment will participate on governing and planning groups for the state office, CMHC, and CAF facilities.**

**2B – d. Objectives:**

2B - d. Annual reports indicate that governing and planning group membership lists and records show family representatives are actively participating in leadership and other authoritative roles.

**2C. COMPREHENSIVE COMMUNITY SYSTEMS OF CARE**

**SCDMH will promote the development of effective interagency systems of care in all regions of the state.**

**2C – a. Each community mental health center will create interagency procedures and routine practices to encourage the coordination and collaboration among providers in different systems while assuring case confidentiality.**

**2C – a. Objectives:**

2C – a1. Using state guidance and training provided by SCDMH, annually every community mental health center will certify that all personnel in CAF services and programs have been trained in systems of care and guidelines for interagency collaboration specific to its catchment area.

2C – a2. Each CMHC will demonstrate policies and procedures to guide interagency case staffing and monitoring.

**2C – b. SCDMH will support comprehensive local systems of care development through**

- **Support of consumer and family advocate participation and leadership in the development of comprehensive systems of care;**
- **Pursuit of federal and foundation-funded demonstration grants; and**
- **Dissemination of findings about effective practices for systems of care development.**

**2C – b. Objectives:**

2C – b1. 100% of participant lists for planning and governing groups convened to establish or oversee community systems of care will indicate substantial participation by youth and family members served in the SCDMH system.

2C – b2. The amount of federal and foundation funding for developing comprehensive systems and the state infrastructure to support systems of care will increase from 3 communities in 2004 to 5 communities in 2009.

2C – b3. Each year, SCDMH will convene an annual training conference on comprehensive systems of care for children and youth with mental health problems and will make available audiovisual materials and other training options for those who cannot attend the conference.

2C – b4. SCDMH will maintain a website (as part of the SCDMH website) with information specific to South Carolina that can be used by community participants seeking to establish effective comprehensive systems of care.

2C-b5. SCDMH will provide staff support to CMHC and CBS CAF programs for grant development.

**2C – c. Every community mental health center will demonstrate effective interagency agreements so that by January 2009, services will be universally available through systems that are:**

- **Based in all school districts;**
- **Serving children in the child welfare system;**
- **Serving children in the juvenile justice system;**
- **Serving children with alcohol and other drug use problems; and**
- **Serving youth ages 18-21 through programs involving coordination of SCDMH CAF and Adult Services.**

**2C – c. Objective:**

2C – c1. Using state guidance, by 6/30/06, every community mental health center will have a formal agreement regarding case coordination with, at a minimum, the following organizations in its catchment area, regardless of where the services are provided:

- Department of Social Services;
- Department of Juvenile Justice;
- Department of Disabilities and Special Needs;
- Each school district;
- Programs for children with disabilities;
- Agencies for alcohol and other drug services;
- Emergency medical services, including emergency rooms; and
- Victim services organizations.

**2C – d. SCDMH will advocate for the governor, through the S. C. Department of Health and Human Services, to develop an interagency plan for the mental health care of children and youth.**

**2C – d. Objectives:**

2C – d1. By 12/31/05, South Carolina will have an interagency plan for the mental health care of children and youth.

2C – d2. By 6/30/06, South Carolina will have an interagency budget, based on the interagency plan, for the mental health care of children and youth.

**2D. CONSUMER RIGHTS**

**SCDMH will proactively protect the rights of child and youth consumers and their families.**

**2D – a. All SCDMH CAF personnel will demonstrate knowledge about and skills in child, youth, and family caregiver rights and responsibilities.**

**2D - a. Objective:**

2D – a1. By 12/31/04, 100% of CMHCs will have a system to training all CAF personnel regarding client rights and responsibilities, including resolution of conflicts.

**2D – b. SCDMH will advocate for the protection of rights for children and youth with mental health needs in other services systems.**

**2D - b. Objectives:**

2D - b. The SCDMH CAF Director and CMHC CAF directors will participate in state and local interagency partnerships to assure that the needs of children are met.

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**South Carolina Department of Mental Health  
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**Goal Three**

**SCDMH will proactively seek to eliminate racial/ethnic, socioeconomic, and geographic disparities in access to mental health care services for children, youth, and their families.**

**3A. CULTURALLY COMPETENT PRACTICES**

**All CAF personnel in SCDMH centers and facilities and those providing services on contract to SCDMH will demonstrate knowledge about mental health disparities by race/ethnicity, socioeconomic status, rural-urban location, and sexual orientation and will demonstrate knowledge and skill in responding to the disparities through culturally competent practices.**

**3A. Objectives:**

3A – a. 100% of all CAF personnel will perform at a satisfactory or higher level on the SCDMH Employee Performance Measurement System criterion for “cultural competence,” which is included as an essential objective for all CAF personnel.

3A – b. All CMHC CAF programs will demonstrate compliance with the state and CMHC Cultural Competence Plans.

3A – c. SCDMH will make training in cultural competence for CAF programs available to all CAF employees annually.

3A – d. Standards for monitoring SCDMH contractors who provide CAF services will assure they are culturally competent.<sup>15</sup>

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<sup>15</sup> This will require developing standards for contractors.

### **3B. DIVERSE STAFF**

**CAF personnel in SCDMH centers and facilities and those providing services on contract to SCDMH will represent the racial, ethnic, and cultural diversity of the area served by the center or facility.**

#### **3B. Objectives:**

3B – a. At each CMHC and CAF facility or program, the percentage of employees by race/ethnicity and gender will be comparable to the SERVED population.

3B – b. SCDMH will work with SC colleges and universities to create incentives for members of minority groups to pursue training in the mental health professions.

**3C. REDUCE DISPARITIES IN MOST RESTRICTIVE ENVIRONMENTS**  
**SCDMH will develop culturally competent programs to divert children with mental health problems from the juvenile justice system, where children from minority groups are over-represented.**

#### **3C. Objectives:**

3C – a. Each year, in collaboration with SC Dept. of Juvenile Justice and local school districts, SCDMH will identify youth served by DJJ who have mental health needs, by diagnosis, race/ethnicity, and gender.

3C – b. By 6/30/09, each CMHC will have access to an effective program that diverts children and youth from the juvenile justice system.

**3D. REDUCE DISPARITIES IN CHILD WELFARE SYSTEM**  
**SCDMH will cooperate with SCDSS to develop culturally competent programs for parents with mental health problems to divert children from the child welfare system, where children from minority groups are over-represented.**

#### **3D – a. Objective:**

3D – a1. By 6/30/07, in collaboration with the SC Department of Social Services, SCDMH will study the causes of disproportionate minority representation in out-of-home placement for children with mental disorders and develop a plan of action to reduce the disparities.

U.S. New Freedom Commission on Mental Health  
**Goal 4**  
*Early Mental Health Screening, Assessment, and Referral to  
Services Are Common Practice.*

Recommendations:

- 4.1 Promote the mental health of young children.
  - 4.2 Improve and expand school mental health programs.
  - 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
  - 4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.
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**South Carolina Department of Mental Health  
Division of Children, Adolescents, and Their Families**

**Goal Four**

**SCDMH will promote the routine practice of early mental health screening, assessment, and referral.**

**4A. PUBLIC AND PROFESSIONAL EDUCATION ABOUT PREVENTION  
AND EARLY INTERVENTION**

**SCDMH will promote understanding by parents, youth, and professionals who come into routine contact with children about the prevention, early identification, and treatment of children's mental health needs.**

**4A – a. All SCDMH public awareness information will include information about children, adolescents, and their families.**

**4A – a. Objective:**

4A – a. The annual report of SCDMH CAF programs will include a report about SCDMH public awareness information.

**4A – b. SCDMH will distribute information about and tools for early identification of child and youth mental health problems to parents and child caring professionals in typical settings where children are.**

**4A – b. Objective:**

4A – b. The annual report of SCDMH CAF programs will include a report about number of print materials distributed, by location, and release of information through the website and other media.

**4A – c. SCDMH will train professionals from multiple disciplines in skills to promote children's mental health and train them to recognize early symptoms of emotional or behavioral needs. Such training will focus on developmental and cultural differences in cognitive, social, emotional, and behavioral functioning, and understanding these issues in familial and ecological context.**

**4A – c. Objective:**

4A – c1. The annual report of SCDMH CAF programs will include a report about number of training events and audience characteristics.

**4A – d. SCDMH will support efforts to train primary healthcare providers and educational personnel in ways to enhance child mental health and recognize early indicators of mental health problems in children with special healthcare needs, children of fragmented families, and children of parents with mental health and/or substance abuse disorders.**

**4A – d. Objective:**

4A – d. SCDMH will train child caring professionals from multiple disciplines about EPSDT<sup>16</sup> and its utility for assessing and treating mental health needs of children.

**4A – e. By 6/30/09, SCDMH will establish a Center on the Promotion of Mental Health, to focus on promotion of emotional and social development and primary prevention of childhood mental health problems.**

**4A – e. Objective:**

4A – e. SCDMH will train child caring professionals about EPSDT and its utility for assessing and treating mental health needs of children.

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<sup>16</sup> Early Periodic Screening, Diagnosis, and Treatment

**Recommendations:**

- 5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.
- 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
- 5.3 Improve and expand the workforce providing evidence-based mental health services and supports.
- 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

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**South Carolina Department of Mental Health  
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**Goal Five**

**SCDMH will assure that services to children, youth, and their families are delivered through excellent, effective practices.**

**5A. QUALITY CARE**

**SCDMH quality standards and monitoring of services to children, youth, and their families will assure that care that is safe, effective, patient-centered, timely, efficient, and equitable.**

**5A. Objectives:**

5A – a. All residential and hospital facilities operated by SCDMH or on contract for services to children and youth served by SCDMH will meet the standards of the Joint Commission on Accreditation of Healthcare Organizations (JACHO).

5A – b. All outpatient child and adolescent services operated by SCDMH, other than those provided at CMHCs, will meet the standards of the Joint Commission on Accreditation of Healthcare Organizations (JACHO).

5A – c. By 9/30/09, all core CAF programs at Community Mental Health Centers will meet the standards of the Commission on Accreditation of Rehabilitation Facilities (CARF).

5A – d. All providers on contract to SCDMH for services to children and youth will report all critical incidents and use of physical restraints to SCDMH State Office and the parent or guardian within 24 hours of occurrence.<sup>17</sup>

## **5B. EVIDENCE-BASED AND EFFECTIVE PRACTICES**

**Each SCDMH community mental health center and facility will demonstrate efforts to adopt evidence-based and emerging best practices for services to children, youth, and their families.**

**As of 2003, *evidence-based practices* (EBPs) with regard to children, youth, and families include:<sup>18</sup>**

- **Specific medications for specific conditions,**
- **Cognitive and interpersonal therapies for depression,**
- **Preventive interventions for children at risk for serious emotional disturbances,**
- **Treatment foster care,**
- **Multi-systemic therapy,**
- **Parent-child interaction therapy,**
- **Medication algorithms,**
- **Family psycho-education,**
- **Assertive community treatment, and**
- **Collaborative treatment in primary care.**

**As of 2004, *emerging best practices* include:**

- **Consumer operated services,**
- **Jail diversion and community re-entry programs,**
- **School mental health services,**
- **Trauma-specific interventions,**
- **Wraparound services,**
- **Multi-family group therapies, and**
- **Systems of care for children with serious emotional disturbances and their families.**

**5B - a. All SCDMH CAF programs and services will demonstrate increasing use of evidence-based and effective practices.**

### **5B – a. Objectives:**

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<sup>17</sup> The federal regulations for Medicaid define restraint and seclusion; this definition is to be used for group homes as well as residential treatment and inpatient programs.

<sup>18</sup> Sources: President’s New Freedom Commission on Mental Health Report and “Turning Knowledge into Practice,” report of the American College of Mental Health Administration.

5B – a1. In its annual CAF program report, each CMHC will indicate progress toward evidence-based and effective practices.

5B – a2. In its annual CAF program report, each SCDMH inpatient facility for children and youth will indicate progress toward evidence-based and effective practices.

5B – a3. In its annual CAF program report, each SCDMH state or regional program will indicate progress toward evidence-based and effective practices.

**5B – b. The SCDMH Office of Best Practice, Planning and Evaluation will provide specialized information about effective CAF services and programs.**

**5B –b. Objectives:**

5B – b1. By 12/31/04, the Office of Best Practice, Planning and Evaluation will have a plan for how CAF effectiveness information can be gathered and disseminated.

5B – b2. By 12/31/05, SCDMH will provide routine reports of inputs and outcomes to CMHCs and other SCDMH CAF programs.

**5B – c. SCDMH will give priority to development and maintenance of core services while increasing use of evidence-based practices when feasible, given resource constraints.**

**5B –c. Objectives:**

5B – c1. Each CMHC will demonstrate no reduction in core services related to introduction of new evidence-based and effective practices.

5B – c2. Each CMHC and other SCDMH CAF treatment programs will demonstrate outcomes linked to core services, promising practices, and evidence-based practice.

**5C. DISSEMINATION OF NEW KNOWLEDGE**

**SCDMH will disseminate information to centers and facilities regarding policies and programs that are most cost-effective.**

**5C – a. The SCDMH Office of Best Practice, Planning and Evaluation will maintain a website of up-to-date information and links about evidence-based and effective CAF practices**

**5C – a. Objective:**

5C – a. By 12/31/04, SCDMH OBPPE will maintain web-based information about SCDMH evidence-based programs and effective CAF practices along with links to other helpful sites.

## **5D. ACCOUNTABILITY**

**SCDMH will require that all centers and facilities and organizations that provide services through contracts will use outcome and process measures to ensure accountability.**

**5D – a. By 6/30/07, SCDMH CAF will use a system-wide outcome monitoring plan that is compatible with the interagency outcome plan being developed through the SC Department of Health and Human Services and capable of producing cost-effectiveness information.<sup>19</sup>**

### **5D – a. Objectives:**

5D – a1. By 6/30/05, SCDMH CAF programs will adopt a system-wide outcome monitoring plan that includes use of CAFAS (Child and Adolescent Functional Assessment Scale).

5D – a2. By 6/30/06, each CMHC and CAF facility will report annual outcomes related to provision of CAF services.

5D – a3. By 6/30/07, each CMHC and CAF facility will report annual cost-effectiveness indicators through a system that links outcomes and costs.

## **5E. FAMILY SATISFACTION**

**SCDMH will require that its centers and facilities and organizations that provide services through contracts will have clearly defined processes through which child, youth, and family services participants can express their level of satisfaction with and any concerns about services.**

**5E – a. By 12/31/04, SCDMH CAF programs at CMHCs and facilities will routinely collect participant satisfaction information from children, youth, and families.**

### **5E – a. Objective:**

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<sup>19</sup> See background in the appendix to this plan.

5E – a. Each year, at least 80% of child, youth, and family caregiver participants in CMHC CAF services and SCDMH CAF facilities who respond to the YSS and YSS-F surveys will report high levels of satisfaction with services.

**5E – b. SCDMH will maintain a client/family advocate office to respond to concerns and grievances from child, youth, and family caregiver participants in CMHC CAF services and SCDMH CAF facilities.**

**5E – b. Objective:**

5E – b. Each year, the SCDMH client/family advocate's office will report satisfactory resolution of concerns in 90% of cases.

## **5F. SKILLED WORKFORCE**

**SCDMH will improve and expand the workforce providing evidence-based and effective mental health services and supports to children, youth, and their families.**

**5F – a. SCDMH will establish and maintain an effective recruitment and retention program to assure adequate availability of well-trained child mental health specialists, to include psychiatrists, nurses, social workers, and psychologists.**

**5F – a. Objective:**

5F – a. By 6/30/09, the SCDMH Division of Human Resources, in cooperation with the SCDMH CAF Director, will develop a Workforce Development Plan that includes appropriate incentives for recruitment, retention, and development of a skilled CAF workforce, to include salary, flextime, and other incentives.

**5F – b. SCDMH will provide training to new professionals and existing professionals in CAF programs and will evaluate the effectiveness of the training.**

**5F – b. Objectives:**

5F – b1. Annually, the SCDMH Office of Best Practice, Planning and Evaluation will assess the training needs of all CMHC CAF programs and COLUMBIA BEHAVIORAL HEALTH SYSTEM CAF outpatient and inpatient programs and will produce an annual training plan based on results by January 1 of each year.

5F – b2. The SCDMH Office of Best Practice, Planning and Evaluation will provide training to SCDMH CMHCs and CAF facilities personnel regarding evidence-based and effective practices as indicated by an annual record of training events.

5F – b3. 90% of participants in SCDMH CAF training will report new knowledge acquired as a result of the training.

5F – b4. 90% of participants in SCDMH CAF training will report satisfaction with the training.

**5G. RESEARCH AND PROFESSIONAL EDUCATION**  
**SCDMH will maintain academic – practice partnerships with the state’s**  
**universities and colleges to support SC-based research and education**

**5G. Objective:**

- 5G – a. The SCDMH will maintain contracts for education of CAF specialists with
- USC School of Medicine;
  - Medical University of South Carolina;
  - USC College of Social Work;
  - USC College of Nursing;
  - Medical College of Georgia.

*Technology Is Used to Access Mental Health Care and Information.*

**Recommendations:**

- 6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
- 6.2 Develop and implement integrated electronic health record and personal health information systems.

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**South Carolina Department of Mental Health  
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**Goal Six**

**SCDMH will maximize use of technology to improve access to, coordination of, and information about services to children, youth, and their families.**

**6A. STANDARDIZED INFORMATION SYSTEM**

**SCDMH will participate in interagency efforts to develop a common electronic case record and outcome monitoring system.**

**6A – a. SCDMH will contribute toward interagency planning for a standardized referral, assessment, treatment, and planning process.**

**6A – a. Objective:**

6A – a. SCDMH CAF representatives will participate fully in efforts coordinated by the SC Dept. of Health and Human Services and state Division of Research and Statistics to establish a standard interagency case recording and tracking system (Electronic Health Record – HER).

**6A – b. SCDMH will contribute toward development and use of standard assessment and outcome measures.**

**6A – b. Objective:**

6A – b. SCDMH CAF representatives will participate fully in efforts coordinated by the SC Dept. of Health and Human Services and state Division of Research and Statistics to standardized information systems.

**6A – c. SCDMH will contribute toward development and use of standard service definitions (e.g., emotional disturbance, level of care, critical incident, and others).**

**6A – c. Objective:**

6A – c. SCDMH CAF representatives will participate fully in efforts coordinated by the SC Dept. of Health and Human Services and state Division of Research and Statistics to develop interagency standards for service definitions.

## **6B. ELECTRONIC RECORDS**

**SCDMH will develop and implement an integrated electronic case record and reporting system to produce useful information for case and program planning, evaluation, and fiscal accountability.**

**6B – a. SCDMH will routinely produce the data reports requested by SCDMH planning groups and managers for use in planning and management of CAF programs, services, and facilities.**

**6B – a. Objectives:**

6B – a. (See also objective 1C-c). By 12/31/04, a record keeping and reporting system will be established to report:

- The core services each center has in place for CAF, the services provided at each facility, or the services provided by state and regional programs;
- The number of children, by age and diagnosis, served by each CAF service during the reporting period;
- The number of children on any waiting list for each CAF program (“waiting list” to be defined by CAF council);
- The number of and caseload size of CAF FTEs assigned by each CMHC;
- The number, diagnosis, characteristics of, and county of children and youth served by SCDMH facilities and state-operated outpatient programs;
- The expenditures for each CAF service or program at CMHCs, facilities, and other outpatient programs, by source of revenue; and
- The average length of stay at each level of care for all children in out-of-home placement.

**6B – b. SCDMH will operate a fiscal accounting system that provides prompt, accurate reimbursement or compensation to CAF services providers.**

**6B – b. Objective:**

6B – b. By 6/30/05, SCDMH will work with SC Dept of Health and Human Services to develop a billing system for contracted Medicaid services that reduces the amount of time between filing and reimbursement, including putting “254 forms” on-line

## **6C. TELECOMMUNICATIONS**

**SCDMH community mental health centers and facilities will use health technology and telehealth to provide long distance clinical care and consultation, especially for:**

- **consumers in rural areas;**
- **populations with rare or complex needs; and**
- **family members and providers in various parts of the state who are involved in a common case.**

### **6C. Objectives:**

6C – a. By 6/30/05, SCDMH will operate a high quality Telemedicine / TeleNetwork that connects all 17 centers, SC hospitals, and SCDMH headquarters for use by physicians/clinicians and staff to:

- Conduct DMH psychiatric pre-admission screening for Hall, Bryan, or Harris facilities (this will reduce patient transport, as recorded by the travel and time saved);
- Communicate expertise from one site to another; and
- Facilitate communication among consumers and family members separated by distances.

6C – b. By 12/31/05, each CMHC and CAF facility will have receiver and sender equipment that functions at a level suitable for case consultation.

6C – c. By 12/31/05, data about numbers and types of cases will indicate that all SCDMH CMHCs and facilities use health technology and telehealth to provide long distance consultation, especially for:

- Children and families in rural areas;<sup>20</sup>
- Populations with rare or complex needs; and
- Family members and providers located in various parts of the state who are on a common case.

6C – d. Every six months the SCDMH Governing Council will review a report on the usage of Telemedicine, conference calls, and closed circuit broadcasts and will make necessary changes for access and cost effectiveness.

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<sup>20</sup> Recognizing that some rural areas do not have appropriate access service, plans will make telecommunications resources available as close as possible to rural areas.

## **6D. DISTANCE EDUCATION**

**SCDMH will use distance education technology and high-speed electronic systems to disseminate information about the latest evidence-based practice guidelines, best practice models, ongoing clinical trials, scientific research, and other mental health information.**

### **6D – a. Objective:**

6D – a. Whenever cost effective and feasible, SCDMH CAF training will use the SCETV closed circuit system or other electronic systems to disseminate the latest information and guidelines.

**Overview of Objectives: Blueprint for Resilience CAF Strategic Plan**

#	Pres' New Freedom MH Goals	Objective	Gov. Council & Key persons	PDCA Time-line
<b>1a COMMUNITY CARE</b>				
1	1A a1 1A a2 1A a3	<b>Community Services/Core Svc:</b> a1. Core Svc Availability, a2. Core Svc Availability plan, a3. Disparities among centers in level of core services will be eliminated.		
2	1A b1 1A b2 1A b3	<b>Resources for Core Svc at CMHC's:</b> b1. SCDMH budget allocation priorities to core services. b2. SCDMH budget allocations will fund core services. b3 Annual report on CMHC core svc. b4. Grant development support		
3	1A - c1. 1A - c2. 1A - c3. 1A - c4 to c5	<b>CAF services provided in typical child &amp; youth settings:</b> c1. Increase out-stationed CMHC CAF Workers, c2. School-Based Services, c3. Family Preservation & Multi-Systemic Therapy (MST), c4. Wrap Services, c5. Treatment during Out-of-School Time		
4	1A - d1.	<b>Reduction of out-of-home placements and length of stay</b>		
5	1A - e1.	<b>Full health screenings or Medical homes</b> available via DMH referrals with assistance from PHCA.		
<b>1B. COORDINATED SEAMLESS SYSTEM</b>				
6	1B - a1 1B - a2	<b>COORDINATED, SEAMLESS MH Services</b> a1. crisis-stabilization a2. wrap services available.		
7	1B - b1 1B - b2 1B - b3 1B - b4	<b>SCDMH will operate its own secure residential treatment services, including inpatient hospitalization and residential treatment, in close proximity to acute hospitalization support</b> b1. sufficient number of beds, b2. Avoid placement of children in inappropriate placements, b3 Trained and able providers, b4. Safe and accredited facilities.		
8	1B - c1 1B - c2 1B - c3 1B - c4 1B - c5 1B - c6 1B - c7 1B - c8 1B - c9 to 11	<b>Specialty Resources:</b> c1. Specialty resources to respond to children with rare or complex conditions, c2. Resources for children with co-occurring conditions, c3. Services for very young (birth-6), c4. Adjudicated youth, c5. Child welfare services, c6. Trauma services, c7. Access to language interpreters, c8. Services for youth in transition to adulthood, c9. Children of adults with serious mental illness, c10. Technical adviser system for special populations c11. Report to State Planning Council re: Specialty Resources.		
<b>1C. LEADERSHIP</b>				
9	1C-a1 1C-a2	<b>CAF budgets:</b> a1. CMHCs will have budget and staff allocations that support equitable resources for CAF programs relative to adult programs, a2. CMHC directors will demonstrate that they hold annual meetings with families of children served to discuss the CMHC's direction, budget, and effectiveness.		
10	1C-b 1C-b1	<b>b. CAF on Governing Council:</b> the CAF director will be a member of the governing council and management team (state and local). b1. 100% of state and community governing and management groups will have CAF representation.		
11	1C-c 1C-c1	<b>c. CAF system improvement plans.</b> The SCDMH state commission, director, and governing council, with advice of the state planning council, will use data about services, outcomes, and expenditures to evaluate how each center and facility is performing and to make plans for SCDMH CAF system improvement. c 1 – Progress Report		
12	1C-d1 1C-d2 1C-d3	<b>1C – d. Equitable budgets:</b> d1.Needs based allocations d2. CAF reports by program budgeting and expenditure, d3. Children will be served equitably		
<b>1D. UNIVERSAL ACCESS</b>				
13	1D-a1	<b>Reduce access barriers to MH care:</b> a1. Each year, SCDMH will make		

		public information available to consumer advocates about insurance coverage for children served by the SCDMH system, including those in inpatient and outpatient programs.		
14	1D-b1 1D-b2	<b>b. Cultural Competence</b> b1. Annual CAF program and the CBHS children’s programs will report compliance with the SCDMH Cultural Competence Strategic Plan and CARF standards for cultural competence and will make plans for improvements as needed. -b2. Document how cultural competence is embedded		
15	1D-c1	c1. <b>Consumer choice options report:</b> SCDMH will complete a study of consumer choice options in the CAF programs and services.		
16	1D-d1	d1. <b>MH Awareness:</b> CAF program annual report will summarize themes in the agency’s public awareness materials esp re:health & risk factors		
<b>2A INDIVIDUALIZED SERVICES</b>				
17	2A-a1	a1. <b>Individualized care plans:</b> SCDMH quality assurance reviews will report that 100% of children served have individualized care plans.		
<b>2B FAMILY DRIVEN SERVICES</b>				
18	2B-a1 2B-a2	a1. <b>Service options made known:</b> SCDMH centers and facilities will make available “user friendly” descriptions of service options to children, adolescents, and their families. a2. <b>Family signs plan:</b> Case plan documents will provide for parent/guardian and child/youth signatures to signify that they agree or disagree with the plan options.		
19	2B-b1 2B-b2	b1. <b>Family Participation in Treatment Plan:</b> Each treatment plan and progress note based on team meetings will show child/youth’s and parent/guardian’s participation, as indicated by signatures. b2. <b>Family Satisfaction:</b> Once a year, SCDMH will randomly sample youth and their families (using the Youth Services Survey –YSS and the Youth Services Survey-Family-YSS-F) in center and facilities treatment regarding satisfaction with participation in service decisions.		
20	2B-c1	c1. <b>Family Advocate Participation:</b> Annual feedback from families, through surveys or focus groups, will indicate that all CMHCs & DMH facilities are coordinating with family advocates in at least 75% of cases.		
21	2B-d1	d. <b>Families as leaders:</b> Annual reports indicate that governing and planning group membership lists and records show family representatives are actively participating in leadership and other authoritative roles.		
<b>2C COMPREHENSIVE COMMUNITY SYSTEMS OF CARE</b>				
22	2C-a1 2C-a2	<b>Staff training in interagency procedures and collaboration.</b> :a1. CAF staff trained in systems of care and guidelines for interagency collaboration a2. CMHCs use policies and procedures to guide interagency case staffing and monitoring.		
23	2C – b1 2C – b2 2C – b3 2C – b4 to b5	<b>System of Care development:</b> b1. Family Participation, b2. System of Care Increased Funding, b3 Annual SOC Training , b4. Website for SOC community participants b5 Staff support for Grant development		
24	2C – c1.	<b>Formal Agreements</b> CMHCs have effective formal agreements for case coordination w/ DSS, DJJ, DDSN, School Districts, DAODAS, EMS, victim services, and other programs for children w/ disabilities;		
25	2C-d1 2C-d2	<b>d 1 Interagency plan,</b> d2. interagency budget		
<b>2D. CONSUMER RIGHTS</b>				
26	2D	a 1 <b>Staff training</b> re: rights, responsibilities and conflict resolution b. CMHCs have <b>Interagency partnerships</b> to assure that the needs of children are met.		
27	3A-a 3A-b 3A-c 3A-d	<b>CULTURALLY COMPETENT PRACTICES</b> a. All CAF personnel will perform at a satisfactory or higher level on the SCDMH Employee Performance Measurement System criterion for “cultural competence,” b. All CMHC CAF programs will demonstrate compliance with the state and CMHC Cultural Competence Plans. c. Training in cultural competence for		

		CAF programs will be available annually. d. Standards for monitoring SCDMH contractors who provide CAF services will assure they are culturally competent.		
28	3B-a	<b>DIVERSE STAFF:</b> a. Composition of staff will reflect population served by race/ethnicity and gender		
29	3B-b	<b>b. Minority incentive training programs:</b> SCDMH will work with SC colleges and universities to create incentives for members of minority groups to pursue training in the mental health professions.		
30	3C-a 3C-b	<b>Reduce disparities in restrictive environment:</b> a. In collaboration with SC Dept. of Juvenile Justice and local school districts, SCDMH will identify youth served by DJJ who have mental health needs, by diagnosis, race/ethnicity, and gender. b. CMHCs will have access to an effective program that diverts children and youth from the juvenile justice system.		
31	3D-a1	<b>Out of Home Disproportionate Study:</b> a1. In collaboration with the SC Department of Social services, SCDMH will study the causes of disproportionate minority representation in out-of-home placement for children with mental disorders and develop a plan of action to reduce the disparities.		
<b>EDUCATION RE: PREVENTION AND EARLY INTERVENTION</b>				
32	4A-a 4A-b 4A-c 4A-d 4A-e	<b>The annual report of CAF programs</b> will include a report about: a. SCDMH public awareness information. b. number of print materials distributed, by location, and release of information through the website and other media. c. number of training events and audience characteristics. <b>Training :</b> d. for child caring professionals from multiple disciplines about EPSDT <sup>21</sup> and its utility for assessing and treating mental health needs of children, and e2. SCDMH will establish a Center on the Promotion of Mental Health, to focus on promotion of emotional and social development and primary prevention of childhood mental health problems.		
33	5A-a 5A-b 5A-c	<b>Quality Care:</b> a. Residential & hospital facilities meet JACHO standards. b. All outpatient child and adolescent services meet JACHO standards. c. All core CAF programs at CMHCs will meet CARF standards. d. All providers on contract to SCDMH for services to children and youth will report all critical incidents and use of physical restraints to SCDMH State Office and the parent or guardian within 24 hours of occurrence.		
34	5B-a1 5B-a2 5B-a3	<b>5B. EVIDENCE-BASED AND EFFECTIVE PRACTICES</b> CMHCs (a1) , inpatient facilities(a2) and state and regional programs (a3) will report: progress toward evidence-based and effective practices.		
35	5B-b1 5B-b2	<b>Best Practices:</b> b 1 The Office of Best Practice, Planning and Evaluation will have a plan for how CAF effectiveness information can be gathered and disseminated. b2. By 12/31/05, SCDMH will provide routine reports of inputs and outcomes to CMHCs and other SCDMH CAF programs.		
36	5B-c1 5B-c2	<b>Core services and outcomes:</b> c1. Each CMHC will demonstrate no reduction in core services related to introduction of new evidence-based and effective practices. c2. Each CMHC and other SCDMH CAF treatment programs will demonstrate outcomes linked to core services, promising practices, and evidence-based practice.		
<b>5C. DISSEMINATION OF NEW KNOWLEDGE</b>				
37	5C - a	<b>Best Practice Website:</b> a. The SCDMH Office of Best Practice, Planning and Evaluation will maintain a website of up-to-date information and links about evidence-based and effective CAF practices		
<b>5D. ACCOUNTABILITY</b>				
38	5D-a	<b>OUTCOME MONITORING COST-EFFECTIVENESS</b> a1. CAF programs will adopt a system-wide outcome monitoring plan that includes use of CAFAS (Child & Adolescent Functional Assessment Scale) a2. Each CMHC and CAF facility will report annual outcomes related to provision of CAF services.		

		a3. Each CMHC and CAF facility will report annual cost-effective-ness indicators through a system that links outcomes and costs.		
<b>5E. FAMILY SATISFACTION</b>				
39	5E-a	<b>a. Participant satisfaction:</b> CAF programs at CMHCs and facilities will routinely collect participant satisfaction information from children, youth, and families.		
40	5E-b	<b>CAF Advocacy Office:</b> b. SCDMH will maintain a client/family advocate office to respond to concerns and grievances from child, youth, and family caregiver participants in CMHC CAF services and SCDMH CAF facilities.		
<b>5F. SKILLED WORKFORCE</b>				
41	5F-a	<b>Recruitment and Retention:</b> a. SCDMH will establish and maintain an effective recruitment and retention program to assure adequate availability of well-trained child mental health specialists, to include psychiatrists, nurses, social workers, and psychologists.		
42	5F-b1 5F-b2 5F-b3 5F-b4	<b>5F – b. SCDMH will provide training to new professionals and existing professionals in CAF programs and will evaluate the effectiveness of the training.</b> b1. Annually, the SCDMH Office of Best Practice, Planning and Evaluation will assess the training needs of all CMHC CAF programs & CBHS CAF outpatient and inpatient programs and will produce an annual training plan based on results by January 1 of each year. b2. The SCDMH Office of Best Practice, Planning and Evaluation will provide training to SCDMH CMHCs and CAF facilities personnel regarding evidence-based and effective practices as indicated by an annual record of training events. b3. 90% of participants in SCDMH CAF training will report new knowledge acquired as a result of the training. b4. 90% of participants in SCDMH CAF training will report satisfaction with the training.		
<b>5F. SKILLED WORKFORCE</b>				
43	5G	<b>RESEARCH AND PROFESSIONAL EDUCATION</b> a. The SCDMH will maintain contracts for education of CAF specialists with USC School of Medicine; Medical University of South Carolina; USC College of Social Work; USC College of Nursing; Medical College of Georgia.		
<b>6A. STANDARDIZED INFORMATION SYSTEM</b>				
44	6A-a 6A-b	<b>Common electronic case record and outcome monitoring system.</b> a. SCDMH will contribute toward interagency planning for a standardized referral, assessment, treatment, and planning process. b. SCDMH will contribute toward development and use of standard assessment and outcome measures. c. SCDMH will contribute toward development and use of standard service definitions (e.g., emotional disturbance, level of care, critical incident, and others).		
45	6B-a 6B-b	<b>6B. ELECTRONIC RECORDS</b> - SCDMH will develop and implement an integrated electronic case record and reporting system to produce useful information for case and program planning, evaluation, and fiscal accountability. a. SCDMH will routinely produce the data reports requested by SCDMH planning groups and managers for use in planning and management of CAF programs, services, and facilities. b. SCDMH will operate a fiscal accounting system that provides prompt, accurate reimbursement or compensation to CAF services providers., and, will work with SC Dept of Health and Human Services to develop a billing system for contracted Medicaid services that reduces the amount of time between filing and reimbursement, including putting “254 forms” on-line		
<b>6C. TELECOMMUNICATIONS</b>				
46		a. By 6/30/05, SCDMH will operate a high quality Telemedicine / TeleNetwork that connects all 17 centers, SC hospitals, and SCDMH headquarters for use by physicians/clinicians and staff to: <ul style="list-style-type: none"> <li>• Conduct DMH psychiatric pre-admission screening for Hall,</li> </ul>		

		<p>Bryan, or Harris facilities (this will reduce patient transport, as recorded by the travel and time saved);</p> <ul style="list-style-type: none"> <li>• Communicate expertise from one site to another; and</li> <li>• Facilitate communication among consumers and family members separated by distances.</li> </ul> <p>b. Each CMHC and CAF facility will have receiver and sender equipment that functions at a level suitable for case consultation.</p> <p>c. CMHCs and facilities use health technology and telehealth to provide long distance consultation, especially for:</p> <ul style="list-style-type: none"> <li>• Children and families in rural areas;</li> <li>• Populations with rare or complex needs; and</li> <li>• Family members and providers located in various parts of the state who are on a common case.</li> </ul> <p>d. Every six months the SCDMH Governing Council will review a report on the usage of Telemedicine, conference calls, and closed circuit broadcasts and will make necessary changes for access &amp; cost effectiveness.</p>		
<b><i>6D. DISTANCE EDUCATION</i></b>				
<b><i>47</i></b>	<b><i>6D</i></b>	<p><b>SCETV closed circuit training:</b> a. Whenever cost effective and feasible, SCDMH CAF training will use the SCETV closed circuit system or other electronic systems to disseminate</p>		

# **The Future of the William S. Hall Psychiatric Institute**

## **Where do we go from here?**

June, 2004

### **Introduction**

The William S. Hall Psychiatric Institute (WSHPI) has evolved dramatically over the past 30 years. At its inception, WSHPI was primarily a teaching institution with a clinical service mission tied only to teaching needs. Today, it is a component hospital of the Columbia Behavioral Health System (CBHS) with a clinical service mission vital to the needs of the SC Department of Mental Health. WSHPI's mission is to provide clinical services (inpatient, residential and outpatient) for children and adolescents with complex disorders and specialty needs, while maintaining the mission of training residents in psychiatry and child psychiatry, psychology and social work interns, and medical students. In the current climate of severe budget constraints and a major initiative to serve children as close to home as possible in the least restrictive environment, an assessment of the current needs in South Carolina for specialty services for children and adolescents is warranted. This document outlines the vision for how the William S. Hall Psychiatric Institute could be re-designed to better meet the needs of children and adolescents with mental and emotional disorders in the state, and the community mental health centers charged with their care.

### **Current Services**

WSHPI personnel include a diverse group of advanced child & adolescent mental health specialists in the fields of psychiatry, psychology, social work, and nursing. WSHPI is the only resource in South Carolina's public mental health system with such a concentration of expertise for assessment, consultation, and treatment, particularly with regard to complex and rare conditions.

WSHPI currently operates two residential and three acute inpatient units and has a large outpatient department. Units include:

1. The Children's Inpatient Unit (256), a 16 bed acute unit serving children ages 5 through 12 with a variety of emotional and mental disorders from throughout South Carolina.
2. Adolescent Inpatient Unit (154), a 16 bed adolescent acute intensive treatment unit which also provides forensic evaluations and rehabilitation services.
3. Adolescent Recovery Program (Unit 170): This is a 20 bed adolescent inpatient alcohol and drug dependence and dual diagnosis treatment program.
4. The Options Program on Unit 156 is a 20 bed residential treatment program for males ages 13-21 who are primarily involved with the juvenile justice system.
5. The Directions Program on Unit 160 is an 11 bed residential treatment program for females ages 13-21 who are primarily involved with the juvenile justice system.
6. Child and Adolescent outpatient Services include general psychiatric treatment and specialty services such as the Infant Clinic, Developmental Disorders Clinic, Diagnostic Preschool Day Treatment Program (2-5 year olds), the Deaf and Hard of Hearing Clinic, Child Psychiatry Forensic Services, the ARC (assessment and treatment of children who have been or are suspected of having been abused), the

Evaluation Clinic (a diagnostic assessment clinic for children with complex and confusing symptoms and problems).

## **SC DMH CAF Needs**

South Carolina is a substantially rural state. Expertise in child mental health assessment and treatment remains primarily located in the three major cities, Columbia, Charleston, and to a lesser extent, Greenville. In most rural areas child psychiatrists and other advanced child mental health professionals are either unavailable or are on part-time contracts and overwhelmed by the clinical needs of the children they are treating. Many children in the state are treated by general psychiatrists or even primary care physicians with little psychiatric training. Likewise, the level of training of other child mental health workers in rural and many urban areas is less than optimal. Expertise in evidenced-based treatments for children and adolescents is lacking in many sites. Likewise, few cities have the capacity to treat children and adolescents in acute hospital settings. CAF needs for South Carolina include:

1. Access to child psychiatry expertise, particularly in areas outside of urban centers.
2. Training and mentoring for child mental health workers in the basics of child development, psychopathology and evidenced-based treatments.
3. Advanced training and supervision in evidenced-based treatments such as cognitive-behavioral therapy, parent-child interaction training (PCIT), dialectical-behavioral therapy (DBT), multi-systemic therapy (MST), and functional family therapy.
4. Access to specialty assessment and treatment for children with developmental disorders, dual disorders, very young children, forensic issues, services for children who are deaf or hard of hearing or who have language problems, child abuse evaluations and treatment, and children who present with complex, serious symptoms or behaviors.
5. Access to acute psychiatric hospital beds for treating children and adolescents who are severely disturbed.
6. Access to residential treatment beds for children requiring out of home placement, including youth from DJJ with serious mental or behavioral disorders.
7. Access to specialized treatment for children with serious disorders whose family and natural support systems are particularly fragile or unsupportive.

## **Vision for the Future**

### Outpatient Services

WSHPI is ideally situated to meet the identified needs of the SC Department of Mental Health (SCDMH) and the Community Mental Health Centers (CMHC) serving children and adolescents in the state. Staff at WSHPI have a long history of serving children with the most complex and difficult psychiatric problems in the state. WSHPI also has a long and successful history of providing training and consultation for all levels of mental health staff from basic teaching and supervision to the most advanced treatment techniques. Finally, staff at WSHPI have expertise in the areas of highest need for the Department: developmental disorders, assessment and treatment of very young children and children who have experienced abuse or trauma, forensic issues, children with dual disorders, and children with language problems or who are deaf or hard of hearing.

To best serve these identified needs WSHPI should become the recognized state-wide resource for child and adolescent assessment, consultation, and treatment of specialty populations for

the community mental health system and SCDMH. In addition, WSHPI should assume a leadership role in providing training for child and adolescent mental health professionals in SCDMH, with a broad focus on both basic and advanced child mental health assessment and treatment. In order to accomplish these goals, WSHPI should change current operations as follows:

- Transfer children currently receiving general psychiatric treatment to the appropriate mental health center for on-going care. This would total approximately 350 children.
- To provide assessment and consultation to the community for children with complex or confusing presentations and for children who are not responding to treatment, WSHPI would:
  - Continue to provide local and regional on-site consultation evaluations and outcome monitoring for children with complex or confusing presentations and for children who are not responding to treatment.
  - Add a telepsychiatry consultation service for rural or geographically remote community mental health centers in need of such consultations.
  - Improve communication with CMHCs to ensure all are aware of the services offered. WSHPI should be seen as *the resource* for child and adolescent psychiatry consultation for the community mental health system and the SC Department of Mental Health.
- For community mental health centers with no or minimal access to child psychiatrists and for all 17 centers when a child psychiatrist who treats typical cases needs specialized consultation for rare or complex cases, WSHPI would begin a telepsychiatry consultation Service. This service would aim to help the centers improve their services for children and would provide training and supervision components.
- For specialty assessment and treatment areas, WSHPI would continue present services and add the potential for telepsychiatry consultation in the following areas:
  - Developmental Disorders (includes Autism Spectrum Disorders and Mental Retardation): assessment and on-going treatment
  - Infant and Very Young Children Program
    - Infant Clinic
    - Diagnostic Preschool Day Treatment Program
    - Parent-Child Interaction Training (PCIT) Program
  - The Assessment and Resource Center (ARC) for the assessment and treatment of traumatized or abused children and their families or caregivers
  - Child and Adolescent Forensic Psychiatry Services (provides both inpatient and outpatient evaluations)
  - The Deaf and Hard of Hearing Clinic
  - WSHPI would also establish a Dual Disorders Clinic for adolescents with comorbid psychiatric and substance use disorders
- WSHPI would become the primary child and adolescent mental health training vehicle for the SC Department of Mental Health. WSHPI would:
  - Re-establish the training program in basic child mental health for community mental health professionals. This training program received excellent reviews and was considered highly valuable, but was a victim of past budget cuts.

- Establish specialty training and case supervision programs in evidenced-based treatment for community mental health professionals in the following areas:
  - Parent-Child Interaction Training (expertise already exists)
  - Cognitive-Behavioral Treatment (expertise already exists)
  - Parent Training (expertise already exists)
  - Behavioral Therapy for Developmental Disorders (expertise already exists)
  - Dialectical-Behavioral Therapy (expertise already exists, but further training of WSHPI staff will be required)
  - Functional Family Therapy (expertise needs to be developed)
  - Multi-Systemic Therapy (expertise needs to be developed)
  - Post-trauma child and family treatment (expertise already exists)
  - Dual Diagnosis (substance abuse) Treatment (expertise already exists)
- Become the knowledge area experts for child mental health evidenced-based treatments, and establish new treatment and training programs as evidenced-based treatments become available. WSHPI would be the entity responsible for translating new research into practice in the SC Department of Mental Health.
- Contribute to development and implementation of outcome monitoring processes for evidence-based treatments

### Inpatient and Residential Services

Inpatient and residential treatment services for children and adolescents should be provided only when community treatment is not effective, and ideally should be provided as close to the child's home as possible. The SC Department of Mental Health must maintain a comprehensive continuum of care to assure that intensive out of home services are available when needed. A safety net of beds should be operated directly by the SCDMH to ensure this availability. The Department currently operates only 16 adolescent and 16 child acute inpatient beds. This is a very small number of beds for a state with a population of over 4 million, with over 1 million under the age of 18. During the high season for admissions (October through April) there is frequently a waiting list for children and adolescents to obtain an inpatient bed. During these times, an increase in beds available in the state is required. WSHPI is also a training site for psychiatry residents, psychology interns, and social work interns. Privatizing the inpatient and residential services at WSHPI will put future training for psychology interns and social work interns at risk of closing, and would put increased burden on psychiatry residency training.

WSHPI has made significant improvements in the treatment of children and adolescents on the inpatient and residential units over the past several years. The rate of seclusion and restraint has been significantly reduced following an initiative begun by management 18 months ago. WSHPI is striving to create a non-coercive, strength-based treatment model. This program reduces staff-patient conflicts, and creates an atmosphere of support and "coaching" of the children and adolescents to try to put into practice the new skills they are learning to manage behavior, communicate and problem solve. WSHPI is implementing a second phase of this initiative with consultation from a nationally recognized psychologist (Dr. Ross Greene) who has expertise in helping hospitals move to this treatment model.

A primary reason the state should continue to operate residential and inpatient beds is economic:

- Treating children is costly, and does not make private hospitals much money, so few incentives exist for maintaining beds in the private sector.
- The children served by WSHPI are the most demanding and expensive children to serve.
- Competition for private contracts is likely to be low. History has shown us that once the initial contract period expires, if there is no competition and no place for a state agency like SCDMH to treat the population, the contractor may ask for significant rate increases.
- If a contract is awarded, and the company is unable to competently treat the children (which happened with the only previous contract SCDMH has awarded for adolescent residential treatment), SCDMH would no longer have a program in which to place the children and would be challenged to find the expert personnel required to operate such a program.
- All other hospitals in the state receive payments from Medicaid and Medicare based on the DRG payment system. This pays for only about 4-5 days of hospitalization. Due to the extremely complex nature of the patients served at WSHPI, it generally takes between 20 and 30 days to stabilize these children to the point they can be safely discharged to a less restrictive environment. The inability to receive Medicaid for these extra days could be a significant financial burden for SCDMH.

Further justification for maintaining SCDMH inpatient and residential services will be detailed by the type of service.

- Children's Acute Inpatient Unit:
  - Capacity to treat children 12 and under is limited in SC. The expertise exists only in Columbia at Palmetto Baptist, and in Charleston at MUSC.
  - During high census times, there are no additional beds at these facilities.
  - These facilities also frequently send children to WSHPI when they are violent and unable to manage them.
  - Child Forensic inpatient evaluations are frequently ordered by the court systems. The only hospital with child forensic expertise in the state is WSHPI.
  - There is a high level of expertise in treating children with developmental disorders and mental retardation at WSHPI. These children require specialized treatment interventions.
- Adolescent Inpatient Unit:
  - This is a high management unit treating adolescents who are so violent and disruptive that other facilities are unable to treat them.
  - Adolescent Forensic inpatient evaluations are frequently ordered by the court systems. The only hospital with adolescent forensic expertise in the state is WSHPI.
  - There is a high level of expertise in treating children with developmental disorders and mental retardation at WSHPI. These children require specialized treatment interventions.
  - From October through April, adolescent beds in SC are full. WSHPI runs a waiting list during these times, as do the other hospitals treating adolescents. Unless new beds are opened in another facility, more adolescents will be forced to wait for beds in the emergency rooms or jails of SC.
- Residential Treatment Facility
  - WSHPI operates 31 beds in close proximity to the inpatient units. This allows for seamless movement to a higher level of care if needed during periods of acute exacerbation of symptoms.

- WSHPI is centrally located and in close proximity to Department of Juvenile Justice facilities. This also allows for greater cooperation and ease of transport.
  - WSHPI provides a sex offender treatment program. Expertise in this treatment is limited in SC.
- Adolescent Substance Abuse Recovery Unit
- This unit is a dual diagnosis unit treating serious psychiatric disorders in addition to substance use disorders.
  - There is a long waiting for both males (average 2-4 months) and females (average 1-2 months) in the state.
  - This unit nets approximately \$250,000 in revenue above expenses for the Department of Mental Health.

WSHPI strongly supports the evolution of treatment in the South Carolina mental health system toward a community based system of care. System of Care principles include treating children in the least restrictive environment and inclusion of the family as partners in the treatment process. For children in placement, the ideal is to maintain a child out of the home or community for the shortest possible time. WSHPI currently strives to include the family as much as possible in the treatment process. This is a challenge. Not only do children in need of WSHPI services have more complex and difficult conditions, they also tend to have more fragile family and support systems. Thus these families are frequently difficult to engage and bring to the treatment process.

Increased involvement of families has been a major quality initiative at WSHPI. In order to provide the best treatment, families and community providers should be involved in the treatment of any child in placement. Community treatment providers are vital to the process to participate in treatment planning, to ensure continuity of care, and to help engage and facilitate the involvement of families in treatment. WSHPI has strived to include the CMHC in the treatment planning process along with families. Only with this involvement can we create a truly seamless and efficient system. Significant progress has been made, but more work is needed. WSHPI plans to continue this initiative, and hopes to use telepsychiatry technology to make the inclusion of families and community providers easier and more efficient. The results of a more coordinated system will be better treatment, better outcomes, and shorter lengths of stay.

# Basics of System Transformation

*To transform the mental health care system, the Commission proposes a combination of goals and recommendations that together represent a strong plan for action. No single goal or recommendation alone can achieve the needed changes. No level or branch of government, no element of the private sector can accomplish needed change on its own. To transform mental health care as proposed, collaboration between the private and public sectors and among levels of government is crucial. ... The integrated strategy outlined in this Final Report can achieve the transformation that will allow adults with serious mental illness and children with serious emotional disturbances to live, work, learn, and participate fully in their communities. Indeed, as has long been the case in America, local innovations under the mantle of national leadership can lead the way for successful transformation throughout the country.*

President's New Freedom Commission on Mental Health

The President's New Freedom Commission on Mental Health called for change that **transforms** the system at every level. The vision, processes, and outcomes of mental health care delivery must be radically changed. This section of *Blueprint for Resilience* addresses A) the rationale behind South Carolina's transformative strategic mental health plan for children, adolescents, and their families. It B) identifies the target population, C) reviews background information regarding strategies in the strategic goals, discusses D) evidence-based practices and E) outcomes in child and adolescent mental health services, and F) offers system transformation principles.

## A. RATIONALE FOR THIS STRATEGIC PLAN

In a transformed children's mental health care system, all interventions will be individualized (based on natural supports & strengths), community-based (delivered in least restrictive and culturally relevant environments), and of high quality, leading to improved outcomes. All the stakeholders in the system of care must work to translate the vision, values & principles into a responsible, accountable system.

### Core concepts

This plan relies on certain core concepts and terms, notably: mental health, mental health interventions, systems of care, public mental health, and mental health planning.

#### Mental Health

The 1999 Surgeon General's Report offers these definitions:

Mental health: The successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem.

Mental illness: The term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alternations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.

The President's New Freedom Commission on Mental Health also included:

Serious emotional disturbance: A mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the DSM-III-R that results in functional impairment that substantially interferes with or limits one or more major life activities in an individual up to 18 years of age. Examples of functional impairment that adversely affect educational performance include an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears associated with personal or school problems.

Children may ...

- be mentally healthy with no signs of mental disorder or emotional disturbance;
- be at-risk for mental disorder or emotional disturbance based on certain attributes or environmental conditions;
- have discrete mental disorders or emotional disturbance; or
- have complex mental disorders or emotional disturbance.

A child with a discrete condition requires a particular service or support. A child with a *complex* condition typically has multiple disorders or lives in a complex environment, requiring multiple services and supports in a treatment package.

The President's New Freedom Commission on Mental Health offers these additional definitions:

Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.

Resilience means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses - and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resilience is fostered by a positive childhood and includes positive individual traits, such as optimism, good problem-solving skills, and treatments. Closely-knit communities and neighborhoods are also resilient, providing supports for their members.

## **Mental health interventions and practice**

“Interventions” are a range of planned actions designed to promote or alter a certain course, such as a child's healthy mental development. The interventions may be informal, such as a father's loving care for a child, or formal, such as a medication regimen for a disorder. The array of potential informal to formal interventions is vast, including individual, group, family, neighborhood,

community, and policy planned actions. Interventions are carried out through “practices,” which are the actions of individual participants in the system of care.

In a comprehensive approach to promoting mental health and recovery from mental illness, interventions are typically clustered into these categories:

- Prevention: Designed to promote resilience by strengthening protective factors in every child’s life;
- Early intervention: Designed to promote resilience and prevent disturbance or disorder by identifying and addressing risk factors as soon as they appear in a child’s life and strengthening protective factors in each at-risk child’s life;
- Treatment: Designed to reduce the effects of a mental disorder or emotional disturbance when they occur in a child’s life and to enhance reliance and recovery; and
- Recovery support: Designed to promote healthy management of a chronic mental disorder or emotional disturbance and attainment of a fulfilling quality of life.

Any effective intervention will fit the child and family’s need at a point in time, within their particular culture and community context.

### **System of Care for Children’s Mental Health**

The term “system of care” is widely used, although how it is used varies from one context to another.

Basic principles of “systems.” The individual child is born embedded in a social environment comprised of caregiving and threatening forces nested in the family, social network, neighborhood, broader community, and society (Bronfenbrenner, 1979; Germain, 1979; 1991). Typically, “system of care” refers to the elements of the formal and informal system that surrounds a child with nurturing and developmental support. Systems of care, like all social systems, are intricately complex and can be understood in terms of their structure and processes. Systems essentially are dynamic entities that maintain some degree of order and boundaries while perpetually changing. Elements within the system exchange resources, such as energy and information, among themselves and with the external environment. Systems have characteristics that are greater than and different from the sum of their parts. Every part of a system affects every other part of the system; they are interdependent. Within a system, some elements are organized into subsystems.

Describing a system of care involves identifying the components, attributing qualities to the parts and the whole system, describing how the relationships work among the parts and with the broader environment, and describing key characteristics of the broader environment. Structurally, the parts are people, including individuals and subsystems of people as small as a couple to as large as a community or organization. Systems and their parts may possess a vast array of qualities, illustrated by such terms as cohesive, unstable, well differentiated, enmeshed, flexible, chaotic, fragmented, or weakly bonded. Systems theory provides a framework for describing, understanding, and acting to change the dynamic processes and structure of human relationships. The language of systems theory permeates most helping professions.

“System of care” with regard to mental health. The term “system of care” is often used in the following contexts:

1. To refer to specific community-based initiatives, often funded by the federal government or other sources external to the community, that aim to operationalize the values and principles of *effective* systems of care;

2. To refer to the overall existing interagency system of mental health services for children (most often used by child advocates and preceded by terms such as “fragmented,” “chaotic,” and even “disastrous” when describing problems and “comprehensive,” and “coordinated” when describing effective alternatives).

3. To refer to categorical, agency-bound services for children, such as the “mental health system of care” or the “child welfare system of care.”

**In this plan,**

**The term “mental health system for children, adolescents, and their families” will refer to the system that is under the auspices of the S.C. Department of Mental Health.**

**The term “children’s services system” will refer to the interagency, comprehensive, community-based systems of which each community mental health center is a part.**

**The term “system of care” will refer to those interagency, comprehensive, community-based systems that are operating according to the principles of effective systems of care and actively striving toward development of a full array of community resources.**

Effective system of care. A system that incorporates the values and principles that have been shown to be effective, i.e., individualized, family-driven, community-based, coordinated, and culturally competent.

System components. These are the elements and subsystems that comprise the effective system of care. In an effective system, the components:

- Adhere to system values;
- Are provided in the child’s community, in naturalistic settings like home, school, child care, and in institutions or offices only when critically necessary;
- Include a range of specialized mental health professionals as well as paraprofessionals under supervision of trained mental health professionals;
- Include a range of public (e.g., mental health, juvenile justice, child welfare, education, alcohol and drug treatment, disabilities services) and private providers;
- Are based in evidence generated through community-based, not university clinic-based, research; and
- Are less expensive than institutional care.

## **The Public Mental Health System**

In South Carolina, the mental health system is comprised of an array of public and private providers, with no authoritative oversight or coordinated planning. The President’s Commission on Mental Health has called for states to develop comprehensive interagency mental health plans, but South Carolina has not yet initiated such a process, which would require executive or legislative action.

The S. C. Department of Mental Health (SCDMH) is responsible for the *public* mental health system. Created by the S. C. General Assembly, the SCDMH is charged with developing a comprehensive system that includes medical care and treatment along with community services, mental health education, consultation, professional training, and research. SCDMH services are available to anyone in the state. For over two decades, the SCDMH has been committed to providing

care through community-based systems of care. SCDMH has authority over the seventeen community mental health centers and the Columbia Behavioral Health System, a centralized group of hospital and residential care facilities that serves as a specialized resource when restrictive environments are necessary for the safety of the patient and others.

SCDMH has responsibility for coordinating with other public and private providers of mental health services. The core providers of public mental health services to children, other than SCDMH, are: the Dept. of Social Services, the Dept. of Alcohol and other Drug Services, the Dept. of Juvenile Justice, the Dept. of Disabilities and Special Needs, the Continuum of Care for Emotionally Disturbed Children, and the Dept. of Education (in support to local school districts). These organizations in turn contract with specialized vendors, typically private and not-for-profit organizations, for components of the care system. A substantial portion of the system is support by the Medicaid insurance program, administered by the S.C. Dept. of Health and Human Services. SCDMH relies on the voices of consumers as expressed through nonprofit advocate organizations such as Protection & Advocacy for People with Disabilities, Federation of Families-SC, National Alliance for the Mentally Ill (NAMI), S. C. Share, the Mental Health Association, and others.

The SCDMH authority and responsibility can be summarized according to this table:

SCDMH Responsibility for Planning

	Level of Planning for Mental Health Care		
	State	Local	Consumer
Intra-agency	Authority	Authority	Authority
Inter-agency	Participates, can informally lead	Participates, can informally lead	Participates, can informally lead

The purpose of this plan is to clarify and specify intra-agency SCDMH policy with regard to services for children, adolescents, and their families. This cannot be a plan for a coordinated children’s mental health system of care. That requires interagency system planning. This is a master plan from the state perspective. Each local community mental health center must develop its own plan for its operations and participation in a coordinated community system of care.

This IS a plan to advance the role of SCDMH as the leader in children’s mental health system development. Even though SCDMH cannot exert authority over other providers in the interagency system, SCDMH can encourage and cooperate with other entities. What SCDMH does is interdependent with other components of the system, whether organized or chaotic. If South Carolina’s public mental health system for children and adults were better funded and developed, children would be diverted from other state systems, e.g., child welfare, school special education, alcohol and drug treatment, and juvenile justice, and their parents would be diverted from addictions, the correctional system, chronic unemployment, and homelessness. So, this is a major step toward encouraging the state to transform its entire system.

**Mental Health Planning in South Carolina**

The S. C. Department of Mental Health is responsible for establishing values, practice principles, strategies, policies, strategies, and procedures that lead to the delivery of mental health interventions. The work is guided by several planning documents, including:

- Comprehensive multi-year strategic plan, known as the community development plan; the current one is titled “Making Recovery Real;”
- Annual state plan, prepared in compliance with requirements for federal block grant funding, based on federal fiscal year (October 1 – September 30);
- Annual state SCDMH budget, which becomes the basis for enacting strategic and program plans, submitted in accordance with the state fiscal year (July 1- June 30);
- Center-based plans and budgets;
- Program-based plans, e.g., demonstration community-based systems of care; and
- Consumer-based individualized care plans.

Within SCDMH, planning for services to Child, Adolescents and their Families (CAF) is coordinated with planning for adult services.

**This plan, *Blueprint for Resilience*, is a comprehensive multi-year strategic plan for CAF interventions. It will be merged with the plan for adult services to form the comprehensive strategic and community development plan for the agency.**

In addition, the SCDMH CAF programs and facilities operate in accordance with the SCDMH Cultural Competence Plan (2003-2005) and the Best Management Practices criteria (as required by Proviso 72.90, FY03 Appropriations Act).

Of course, plans become realized through the business plans and budgets that support them. Thus the SCDMH budget and the SC Department of Health And Human Services plans and standards for Medicaid, the insurance program for most of the children and families served at SCDMH, guide the actual implementation of the plans.

## B. POPULATION

The South Carolina public mental health system is comprised essentially of children and youth in need of mental health care (including their families) and providers, with support from and accountability to the public. The current and projected assets and vulnerabilities of each form a basis for the strategic goals.

### Children, Youth, and Families

Children include anyone residing in South Carolina between the ages of birth and 17, although for prevention, the group would include parents during the prenatal period. Consumers also include people ages 18-21 who are in the transitional period from adolescence to young adulthood.

Families include anyone with primary caregiving responsibility for children. This includes members of the child's household as well as family members who may live separately from the child (such as those who are away in military service or in hospitals or prisons). The primary caregiver may be a biological, foster, or adoptive parent, grandparent, or other relative or a designated guardian.

From a prevention perspective, the target population is *universal*: all children. For mental health, children need healthy births and caregivers, secure attachments, consistent parental guidance, quality care and education, and freedom from violence and exploitation at home and in their communities. Their families need community support in the form of quality child care and schools, health and mental health care for family members of all ages, advice and support for handling transitions and trauma, and easy access to culturally competent help when they need it.

From an early intervention perspective, children and youth from all socioeconomic classes and diverse cultural backgrounds may have risk factors that threaten their mental health. The target population includes those with established risk factors, which include: family history (self or caregiver) of mental illness, alcohol or drug abuse, crime, victimization, exposure to traumatic event(s), persistent poverty, homelessness, developmental disabilities, and others.

Given the large potential target population and the limited resources of the S. C. Department of Mental Health, interventions will target these priority groups:

Children ages birth through 17 ....

- *At-risk* of emotional disturbance or mental disorder;
- *With* emotional disturbance or mental disorder;
- *With severe and persistent (serious) or multiple* emotional disturbance or mental disorder(s).

Severe & persistent: has a diagnosis of emotional, behavioral or mental disorder; has limited functioning in family, school or community environments, is involved with two or more community agencies for specialized care, and has the presence of the disability for at least a year or intense manifestation of symptoms and functional impairment);

Multiple: Presence of co-occurring disorders, most commonly an emotional, mental, or behavioral disorder with a...

- Medical condition
- Mental retardation
- Learning disabilities
- Autism and other communications disorders, and/or
- Alcohol and other drug abuse.

The SCDMH recognizes that certain subpopulations have needs that can only be addressed by specialized services. These special populations include:

- Children with co-occurring conditions such as communications disorders, mental retardation, pervasive developmental disorders, or other disabilities
- Services for children who are very young (birth-6)
- Adjudicated youth with mental health needs
- Children in the child welfare system (protective services, foster care, adoption)
- Children and families in need of assessment and trauma recovery services related to assault and/or neglect
- Recent immigrants and those with English language barriers
- Youth in transition to adulthood (18-21)

SCDMH operates according to a Cultural Competence Plan to assure that all participants in SCDMH programs and services receive appropriate care and barriers to access are minimized.

The South Carolina Department of Mental Health makes needed services available to any citizen of South Carolina without regard to their ability to pay. Some consumers have private insurance, or they are eligible for Medicaid or Medicare. For consumers who do not have insurance but are unable to cover the full charges, the Department's mental health centers have a hardship reduction policy which can result in reducing the fees charged to eligible consumers to an affordable amount.

### **Needs of Children, Youth, and Families**

The following tables summarize the frequency of problems that children, youth, and families bring to the mental health system and characteristics of the population served. These tables include children served at community mental health centers (CMHCS) as well as those served through inpatient and outpatient programs at the William S Hall Psychiatric Institute (WSHPI), a division of SCDMH Columbia Behavioral Health Systems.

A survey of CMHCs in spring 2004 indicates that providers are seeing more children at younger ages with more serious problems. A synopsis of the survey is attached ("Survey of Community Mental Health Centers Regarding Child, Adolescent and Family Services Programs"). The assets and needs identified in the survey have been infused into the strategic goals and benchmarks in the strategic plan.

**Table 1. SCDMH: COMMUNITY MENTAL HEALTH SERVICES  
TOTAL NUMBER SERVED FOR AGES 0-17  
APRIL 1, 2003 - MARCH 31, 2004**

	CURRENT AGE				
	TOTAL	0-3	4-6	7-12	13-17
<b>TOTAL</b>	<b>34,702</b>	<b>391</b>	<b>2,586</b>	<b>14,123</b>	<b>17,602</b>
<b>LIVING ARRANGEMENT</b>					
LIVES WITH RELATIVE AND IS INDEPENDENT <sup>1</sup>	966		55	414	490
LIVES WITH NON-RELATIVE AND IS INDEPENDENT <sup>1</sup>	70		3	22	52
LIVES WITH RELATIVE AND IS DEPENDENT <sup>2</sup>	29,103	210	2,183	12,325	14,385
LIVES WITH NON-RELATIVE AND IS DEPENDENT <sup>2</sup>	525	6	42	194	283
HOMESHARE	9			5	4
YOUTH SUPERVISED INDEPENDENT LIVING-LEVEL I	25			2	23
YOUTH SUPERVISED INDEPENDENT LIVING-LEVEL II	22			4	21
FOSTER CARE	1,580	121	178	593	688
HOMELESS IN A SHELTER	22		3	11	8
HOMELESS ON THE STREET/PARK, ETC.	2			1	1
RESIDES IN A SECURE INCARCERATED ENVIRONMENT	58			3	55
THERAPEUTIC FOSTER CARE-LEVEL I	505	19	52	163	271
THERAPEUTIC FOSTER CARE-LEVEL II	28		2	5	21
THERAPEUTIC FOSTER CARE-LEVEL III	30			6	24
COMMUNITY RESIDENTIAL CARE FACILITY-STANDARD TYPE	34			9	25
COMMUNITY RESIDENTIAL CARE FACILITY-TYPE 2	6		2	1	3
COMMUNITY RESIDENTIAL CARE FACILITY-TYPE 3	4		1		3
GROUP HOME – MODERATE	631	1	20	92	518
GROUP HOME - HIGH MANAGEMENT	174			25	149
RESIDENTIAL TREATMENT FACILITY	77			8	69
RESIDES IN AN INPATIENT SETTING	35	2		5	28
NOT COLLECTED/NOT AVAILABLE/NOT REPORTED	595	15	34	188	358
CODED INCORRECTLY	198	17	11	47	123
<b>ETHNIC GROUP</b>					
WHITE	17,272	160	1,356	6,864	8,892
BLACK	16,200	184	1,091	6,756	8,169
HISPANIC	394	17	43	147	187
ASIAN	40			14	26
AMER INDIAN	85	1	7	27	50
OTHER	711	29	89	315	278
<b>GENDER</b>					
FEMALE	13,281	193	936	4,729	7,423
MALE	21,419	198	1,650	9,392	10,179
UNKNOWN	2			2	
<b>PRIMARY PAYOR SOURCE</b>					

	CURRENT AGE				
	TOTAL	0-3	4-6	7-12	13-17
CHAMPUS	157	1	8	47	101
INSURANC	2,078	4	101	751	1,222
MANAGED	53		1	23	29
MEDICAID	29,075	331	2,256	12,204	14,284
MEDICARE	2			1	1
SELF PAY	3,337	55	220	1,097	1,965
<b>DIAGNOSTIC GROUPING</b>					
MENTAL RETARDATION	58	1	5	20	32
ATTENTION DEFICIT	11,516	22	901	6,392	4,201
CONDUCT	7,673	43	451	2,483	4,696
AUTISM/PDD	229	3	34	106	86
SPECIFIC DEVELOPMENT	98	9	15	33	41
OTHER CHILDHOOD DIS	249	5	39	111	94
EATING/SLEEPING DISORDERS	42	2	5	12	23
DRUG ABUSE	77			2	75
ALCOHOL ABUSE	8	1			7
OTHER MENTAL DISORDERS DUE TO GMC	29		1	10	18
SCHIZOPHRENIC	29			9	20
SCHIZOPHRENIFORM	5				5
SCHIZOAFFECTIVE	16				16
DELUSIONAL	4			1	3
OTHER PSYCHOTIC	182		3	53	126
BIPOLAR	566	3	11	140	412
MAJ DEPRESSIVE	912		3	103	806
DYSTHYMIA	387		1	87	299
ANIXETY	1,605	18	124	661	802
SOMATOFORM	9		1	5	3
DISSOCIATIVE	2			1	1
SEXUAL	11			1	10
PERSONALITY	363		17	83	263
ADJUSTMENT	3,343	19	330	1,445	1,549
NON-PSYCHOTIC	2,858	3	39	682	2,134
NON MH PROBLEMS	2,918	140	400	1,152	1,226
NO MENTAL DISORDER	266	10	32	101	123
DIAGNOSIS DEFERRED	1,247	112	174	430	531

<sup>1</sup>Lives with a relative in a household and performs a majority of their daily activities and personal care independent of help from others.

<sup>2</sup>Lives with a relative in a household and is dependent on help from others in household in performing a majority of their daily activities and personal care.

**Table 2. WSHPI OUTPATIENT SVCS  
TOTAL NUMBER SERVED FOR AGES 0-17  
APRIL 1, 2003 - MARCH 31, 2004**

	TOTAL	CURRENT AGE			
		0-3	4-6	7-12	13-17
<b>TOTAL</b>	<b>779</b>	<b>42</b>	<b>162</b>	<b>351</b>	<b>224</b>
<b>LIVING ARRANGEMENT</b>					
LIVES WITH RELATIVE AND IS INDEPENDENT <sup>1</sup>	1		1		
LIVES WITH NON-RELATIVE AND IS INDEPENDENT <sup>1</sup>	2			2	
LIVES WITH RELATIVE AND IS DEPENDENT <sup>2</sup>	632	38	144	303	147
LIVES WITH NON-RELATIVE AND IS DEPENDENT <sup>2</sup>	1				1
FOSTER CARE	45	3	12	14	16
RESIDES IN A SECURE INCARCERATED ENVIRONMENT	2				2
THERAPEUTIC FOSTER CARE-LEVEL 1	7			2	5
COMMUNITY RESIDENTIAL CARE FACILITY-STANDARD TYPE	3			2	1
COMMUNITY RESIDENTIAL CARE FACILITY-TYPE 2	1		1		
GROUP HOME – MODERATE	33		1	6	26
GROUP HOME - HIGH MANAGEMENT	19			6	13
RESIDES IN AN INPATIENT SETTING	1				1
NOT COLLECTED/NOT AVAILABLE/NOT REPORTED	29	1	3	15	10
CODED INCORRECTLY	3			1	2
<b>ETHNIC GROUP</b>					
WHITE	319	18	69	137	95
BLACK	425	20	86	197	122
HISPANIC	7	1	2	4	
AMER INDIAN	2			2	
OTHER	26	3	5	11	7
<b>GENDER</b>					
FEMALE	385	23	79	166	117
MALE	394	19	83	185	107
<b>PRIMARY PAYOR SOURCE</b>					
CHAMPUS	9		2	4	3
INSURANC	50	2	9	27	12
MEDICAID	621	31	125	282	183
SELF PAY	99	9	26	38	26
<b>DIAGNOSTIC GROUPING</b>					
ATTENTION DEFICIT	147	2	12	84	49
CONDUCT	50	2	15	14	19
AUTISM/PDD	32	1	3	18	10
SPECIFIC DEVELOPMENT	19	6	4	4	5
OTHER CHILDHOOD DIS	8		3	2	3
EATING/SLEEPING DISORDERS	3	1	2		

	TOTAL	CURRENT AGE			
		0-3	4-6	7-12	13-17
OTHER MENTAL DISORDERS DUE TO GMC	2			1	1
SCHIZOPHRENIC	1				1
SCHIZOAFFECTIVE	1				1
OTHER PSYCHOTIC	2			1	1
BIPOLAR	4			1	3
MAJ DEPRESSIVE	11			2	9
DYSTHYMIA	2			1	1
ANIXETY	44	8	6	18	12
SOMATOFORM	1		1		
PERSONALITY	4		2	1	1
ADJUSTMENT	47		1	24	22
NON-PSYCHOTIC	12		1	4	7
NON MH PROBLEMS	190	4	47	98	41
NO MENTAL DISORDER	18	2	3	10	3
DIAGNOSIS DEFERRED	181	16	62	68	35

<sup>1</sup>Lives with a relative in a household and performs a majority of their daily activities and personal care independent of help from others.

<sup>2</sup>Lives with a relative in a household and is dependent on help from others in household in performing a majority of their daily activities and personal care.

**Table 3. SCDMH: INPATIENT FACILITIES  
TOTAL NUMBER SERVED FOR AGES 0-17  
APRIL 1, 2003 - MARCH 31, 2004**

	TOTAL	CURRENT AGE GROUP			
		0-3	4-6	7-12	13-17
<b>TOTAL</b>	<b>493</b>	<b>1</b>	<b>12</b>	<b>133</b>	<b>347</b>
<b>ETHNICITY</b>					
WHITE	259	1	6	69	183
BLACK	213		6	57	150
HISPANIC	6			2	4
AMER INDIAN	3			1	2
OTHER	12			4	8
<b>GENDER</b>					
FEMALE	180		3	28	149
MALE	313	1	9	105	198
<b>CATCHMENT AREA IN REGION ORDER</b>					
AIKEN BARNWELL	16		1	2	13
COLUMBIA AREA	84		1	17	66
LEXINGTON COUNTY	40		3	21	16
ORANGEBURG	13			6	7
ANDERSON OCONEE PICKENS	52			18	34
BECKMAN	14		1	4	9
GREENVILLE/PIEDMONT	33			7	26
SPARTANBURG	37			4	33
CATAWBA	33		1	5	27
PEE DEE	49		3	14	32
SANTEE WATEREE	35			16	19
TRI COUNTY	10			4	6
BERKELEY COUNTY	7	1			6
CHARLESTON/DORCHESTER	18				18
COASTAL EMPIRE	9				9
WACCAMAW	32		2	13	17
NOT REPORTED	11			2	9

In addition, the following information provides a synopsis of CAF client characteristics:

**Table 4. Children & Adolescents in SCDMH Service Population**

### **Access to Care<sup>1</sup>**

1. SCDMH Annualized Inpatient Admissions Rate (FY 2003) for Children and Adolescents: 4.81 Admissions Per 10,000 Estimated Population
2. SCDMH Average length of stay for Children and Adolescents (discharges) in the FY 2003 reporting period: 40.1 days
3. SCDMH Average length of stay for Children and Adolescents (residents) in the FY 2003 reporting period: 95.1 days
4. SCDMH Continuity of Care: Days between inpatient discharge and date receiving a clinical service in a community mental health center: 4.3 days (both C&A and Adult data)

### **Outcomes of Care<sup>2</sup>**

Over 60% of children who receive SCDMH services improve their emotional and behavioral functioning (e.g., increase on CAFAS)<sup>22</sup>; about 44% show a significant improvement.

<sup>1</sup> Source: SCDMH Dashboard Indicators, June 2004

<sup>2</sup> Source: SCDMH Accountability Report, FY 2003

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<sup>22</sup> Child and Adolescent Functional Assessment Scale

**Table 5. Number of Children in Out of Home Placement by CMHC, 1<sup>st</sup> Quarter 2004  
Number of Children in Out-of-Home Placement - 1<sup>st</sup> Quarter 2004<sup>1, 2</sup>**

	<b>January 2004</b>	<b>February 2004</b>	<b>March 2004</b>
Aiken-Barnwell	4	5	5
Anderson-Oconee-Pickens	17	17	17
Beckman	20	19	18
Berkeley	8	8	8
Catawba	46	47	50
Dorchester-Dorchester	21	22	20
Coastal Empire	2	2	2
Columbia Area	20	24	24
Greenville	14	14	13
Lexington	15	11	12
Orangeburg	8	3	3
PeeDee	18	17	21
Piedmont	6	6	3
Santee Wateree	17	18	17
Spartanburg	9	8	8
Tri-County	6	6	5
Waccamaw	17	17	17
<b>TOTAL</b>	<b>248</b>	<b>244</b>	<b>243</b>

<sup>1</sup>SCDMH: CAF Office

<sup>2</sup>Totals are based on the Lead Agency Report of Clients. Totals exclude children placed at WSHPI.

**Table 6. CAF Open Beds Report (April 12, 2004): Summary<sup>1</sup>**

<b>Type of Bed</b>	<b>Open Beds</b>	<b>Total Beds</b>	<b>Vacancy Rate</b>
<b>High Management</b>	179	831	22%
<b>Moderate Management</b>	63	351	18%
<b>RTF</b>	37	310	12%
<b>SIL</b>	28	124	23%
<b>TOTAL</b>	<b>307</b>	<b>1616</b>	<b>19%</b>

<sup>1</sup> Source: April 12, 2004 Open Beds Report, Carolina Medical Review

**Table 7. Number of Children referred from Dept. of Juvenile Justice as part of the “Subclass Juveniles” Identified by Selected Years<sup>1</sup>**

Year	DDSN	DMH	Total
1992	2	4	6
1993	3	25	28
1994	12	38	50
1995	8	41	49
1996	7	70	77
1997	7	63	70
1998	10	69	79
1999	7	50	57
2000	8	46	54
2001	8	72	80
2002	7	52	59
2003	8	95	103
<b>TOTAL</b>			<b>712</b>

**Table 8. Number of State Agencies Providing Services to Children 0-17 Identified in 2003 Medicaid Claims Data with a Primary Diagnosis of Mental Health/Substance Abuse<sup>1,2</sup>**

Number of State Agencies Providing Services	Number of Children
0	18,424
1	52,980
2	10,765
3	1,479
4	154
5	7
6	1
	83,810

<sup>1</sup> State Agency defined by the owner of the service provider

<sup>2</sup> Source: SC Budget & Control Board

**Table 9. CHILDREN IN EMERGENCY ROOMS<sup>1</sup>**

In 1997, 2,682 youth with these primary diagnoses presented at a SC hospital emergency room. In 2002, the number was 3,486, an increase of 29%.

Similarly the number of visits to SC emergency rooms by youth with these primary diagnoses has grown by 35%--from 2,983 in 1997 to 4,025 in 2002.

<sup>1</sup> Source: SC Budget & Control Board

**Providers**

The SCDMH system for services to children, youth, and families includes:

- 17 community mental health centers (a report of a survey of the CMHC CAF programs, conducted in April 2004, is attached);
- Columbia Behavioral Health System, Harris Psychiatric Hospital, and Morris Alcohol and Drug Addiction System (operate residential, hospitalization, and specialty programs and services);
- A network of programs and care providers on contract to the SCDMH for provision of various CAF services, such as residential treatment programs, therapeutic foster care, and other specific services;
- Collaborative services with other public agencies, delivered through interagency agreements and protocols for coordinated services;
- Community boards and state planning groups that include advocates and family representatives;

Table 10 indicates how many full-time equivalent (FTE) positions are available at each CMHC and Table 11 indicates the funding level for the state.

**Table 10. FTE's by Community Mental Health Centers FY 2003**

<b>CMHCs</b>	<b># of FTE's</b>
Aiken-Barnwell	33
Anderson-Oconee Pickens	55
Beckman	47
Berkeley	33
Catawba	68
Dorchester-Dorchester	188
Coastal Empire	31
Columbia Area	47
Greenville	51
Lexington	57
Orangeburg	38
PeeDee	50
Piedmont	37
Santee Wateree	27
Spartanburg	33
Tri-County	12
Waccamaw	109
WSHPI	27
Central Office Projects & Grants	5
<b>Total</b>	<b>948</b>

**Table 11. SCDMH Children’s Programs & Services - Expenditures Fiscal Year 2002-2003<sup>1</sup>**

	State	Federal	Other	Local	Total
Inpatient	\$9,030,306	\$3,482	\$7,646,219	\$0	\$16,680,007
Community Services	\$18,038,059	\$5,648,748	\$33,325,400	\$3,762,708	\$60,774,914
<b>TOTAL</b>	<b>\$27,068,365</b>	<b>\$5,652,230</b>	<b>\$40,971,619</b>	<b>\$3,762,708</b>	<b>\$77,454,922</b>

<sup>1</sup> Office of Data, Outcomes, and Evaluation (SCDMH)

### Needs of providers

Assessing and treating children, youth, and their family systems is complex, difficult work requiring specialized skills, given diverse developmental stages, mental health conditions, and cultural characteristics. The SCDMH must recruit and maintain a highly qualified workforce that has up-to-date knowledge and skills and practices according to quality standards.

More than 90 percent of the SC population resides in a mental health professional shortage area.<sup>23</sup> Only Charleston, Dorchester, Horry, and Lexington counties are not designated as shortage areas (Richland County’s status is listed as undetermined, but within the search category for designated). Rural areas are particularly underserved.

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<sup>23</sup> The Shortage Designation Branch in the HRSA Bureau of Health Professions National Center for Health Workforce Analysis develops shortage designation criteria and uses them to decide whether or not a geographic area or population group is a Health Professional Shortage Area or a Medically Underserved Area or Population.

## C. STRATEGIES

Strategies in a mental health system of care are broad approaches to guide interventions. Three factors particularly influence the selection of strategies.

- 1) The array of services included in the system's infrastructure;
- 2) Scientific evidence about the cost effectiveness of interventions (practices); and
- 3) System factors, that is, the structure of the system and the processes by which it operates.

### Array of Services

An effective system of care will balance mental health promotion, mental illness prevention and early intervention, mental health treatment, and universal access to care.

The components of various community and statewide subsystems in the S. C. Department of Mental Health's system of care for children, adolescents, and their families (CAF) include:

- **Community system facilitation** (at the state and community center levels)
  - Policy development
  - Personnel development
  - Collaboration at the management and policy levels
- **Prevention**
  - Mental health education for universal populations
  - Consultations to child-caring personnel in general child care settings, schools, pediatric care settings, families
  - Paraprofessional home visitation for infants and children zero to six
- **Early intervention**
  - Mental health education for at-risk populations
  - Assessment for referred infants and children zero to six
  - Consultation to child-caring personnel in programs for identified at-risk children and youth, e.g., therapeutic nurseries, juvenile justice, alcohol and drug treatment,
  - Nurse home visitation for infants and children zero to six
- **Screening, assessment, and referral**
- **Intake mechanisms** (common)
- **Therapeutic case management:** Graded interventions (least intrusive first); Follow through
- **Family support**
  - Respite
  - Peer support
  - Case advocacy
- **Immediate crisis response**

Emergency assessment  
Mobile crisis outreach  
Short-term child and family stabilization through support  
Respite services

- **Treatment** (in order from least to most restrictive care)
  - Outreach Treatment  
DMH personnel stationed in community settings (e.g., child’s home, schools, health clinics, alcohol & drug treatment centers, DJJ centers, supervised independent living)
    - Therapeutic case management
    - Medication management
    - Intensive Family-based services
    - Individual Counseling
    - Family counseling
    - Group Counseling
    - Skill development and psychoeducational groups
    - Interagency collaboration at the case level
    - Employment development for older youth
    - Wrap-around (these type services, bundled, designed to prevent out-of-home placement)
    - Day treatment (integrates education with other therapeutic interventions)
    - Multi-systemic Therapy (MST)
    - Outpatient sexual offender treatment
  
  - Center-Based Outpatient Treatment
    - Medication management
    - Individual Counseling
    - Family counseling
    - Group Counseling
    - Skill development and psychoeducational groups
  
  - Out-of-home Treatment (known as “beds”)
    - Low management  
Therapeutic foster care  
Group home
  
    - Acute care: Disturbances such as psychosis or suicidal ideation/gesturing; children considered a danger to themselves or others due to crisis condition; acute care is short-term and for crisis stabilization; child then moves to more or less restrictive environment, depending on progress; also used for certain comprehensive evaluations
      - Hospital diversion program (small, individualized treatment setting with around the clock monitoring)
      - Hospital-based acute care

- Moderate, high and ultra-high management  
24-hour awake staff, medical and psychiatric back-up, in-house crisis back-up, array of in-house assessment and treatment services

Therapeutic foster care

Group home treatment

Residential treatment [providers may be general or psychiatric hospitals or other programs under psychiatric supervision]

Hospitalization (reserved for youth who require around the clock medical monitoring for drug overdoses, suicide attempts, or complex and uncontrollable behaviors that might cause harm to them or others and cannot be stabilized in a smaller and more individualized treatment setting)

a) Separate psychiatric service

b) Service in a general hospital (medical-surgical)

Secure treatment for adjudicated youth – those with mental disorders who have committed a delinquent or criminal act and are sentenced by the court

## D. EVIDENCE-BASED PRACTICES

Systems of care must be comprised of *effective* services and supports if children and their families are to benefit. The American College of Mental Health Administration (ACMHA) defines “evidence-based practices” as “those clinical and administrative practices that have been proven to consistently produce specific, intended results (Hyde, Falls, Morris, & Schoenwald, 2003).

According to the ACMHA, *evidence* refers to:

*... scientific controlled trials and research, expert or user consensus, evaluation data, or anecdotal information that shows or suggests an identifiable result happened or is likely to happen when a clearly defined practice or protocol is employed for a particular well-described population with similar characteristics.*

Scientific evidence *refers to:*

... results from a study or research project that has a rigorous controlled design (including clearly articulated hypothesis and rigorous methodology along with controlled conditions and random assignments to various comparison conditions), with experimental and control groups, that includes sufficient subjects to overcome the possibility that the result could have occurred by chance, and is repeated with the same result in multiple sites with different researchers and different experimental and control groups.

### Some Definitions

To guide discussions related to “Best Practices” within the SCDMH, the following definitions are offered. The definitions are based primarily on the work of the Hyde, Falls, Morris, and Schoenwald (2003).<sup>24</sup> A graphical representation of the terms appears on the following page (see Figure 1).

### Best Practices

This is a term that is often used interchangeably with “evidence-based practice” but should more properly be used as an “umbrella” term under which more discrete definitions could fall. The continuum of best practices includes three levels of practice, measured in relation to the degree of scientific rigor which has been applied to recovery-consistent mental health practices. A “best practice” can be thought of as a practice that best meets the needs and supports the recovery of the consumer being served within the resources (technical, human and financial) of the provider; in those instances where there is a strong science base for a specific intervention, the “best” practice should be as close to the evidence-based model as circumstances allow. Put another way, it is the practice that is best for this situation at this time, given all of the many factors that may weigh in.

**Evidence-Based Practices** (EBP) are interventions for which there is **consistent scientific evidence** showing that they improve client **outcomes**. An EBP meets the following criteria:

- It has been studied, using appropriate scientific methodology;
- It has been replicated in more than one geographic or practice setting, with consistent results;

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<sup>24</sup> Hyde, P.M., Falls, K., Morris, J.A., Schoenwald, S.K. (2003). Turning knowledge into practice: A manual for behavioral health administrators and practitioners about understanding and implementing evidence-based practices. The Technical Assistance Collaborative (TAC), Boston. A PDF version of this manual is available at [www.tacinc.org](http://www.tacinc.org) or [www.acmha.org](http://www.acmha.org).

- It has been recognized in scientific journals by one or more published articles.
- It is manualized; and
- It produces specific outcomes.

**Promising Practices** meet these criteria:

- There is some body of evidence, either evaluation studies or expert consensus;
- The experts believe the practice is likely to raise to the next level when scientific studies can be conducted;
- It has been endorsed by one or more groups whose opinions matter (professional societies such as the APA, organized advocacy organizations such as the National MHA or NAMI, or consumer organizations such as the National Empowerment Center or the National Consumer Clearinghouse, etc.); and,
- It produces specific outcomes.

**Emerging Practices** are the practices that are just becoming distinct and recognizable among the rich and varied experiences of consumers and clinicians in the practice world, or innovators in academia or policy settings. It's very hard to be specific about criteria here but these general conditions apply:

- It has a name and is able to be described as distinct from other practices;
- At least one expert, group of researchers, or other credible individuals have endorsed the practice as worthy of attention;
- The practice seems, at least on the surface, like a logical approach to dealing with a problem; this is sometimes referred to as a “face validity” —on its “face,” it makes sense; and,
- It produces specific outcomes.

The National Registry and Dissemination of Effective Programs (NREP), SAMHSA (Substance Abuse and Mental Health Administration) recognizes three types of science-based programs:

- **Promising programs:** those that have generally been well-implemented and evaluated but whose results are not consistently positive across domains of measurement or populations.
- **Effective programs** are well-implemented, well-evaluated, and have demonstrated consistent positive outcomes across domains of measurement and/or replications; and
- **Model programs** share the characteristics of effective programs but include the proviso that program developers work with CSAP (Center for Substance Abuse Prevention) in the active dissemination of the program.

Evidence exists regarding the effectiveness of many parts of the mental health system, including prevention, early intervention, treatment, change processes for systems, and policies to support cost-effective practice, including funding policies. Evidence may indicate strong, moderate, or weak effects on client outcomes. Only a few practices have been subjected to rigorous study. Many have simply not been studied well – that does not mean they are not effective. Others have been studied and been shown to have few or no beneficial effects. Some have been shown to cause harm (e.g., inappropriate restraint, medication, or out-of-home care).

An over-arching finding in the area of children's mental health is that home- and community-based interventions produce better long-term benefits. To state the obvious, children develop through the life course. Even if an intervention shows immediate effects in an isolated environment while the

child is removed from naturalistic setting for a period of time, if the benefit has no carry-over into the child's natural life, then it is cost-ineffective.

Whether a practice gets adopted depends on many factors, such as:

- **Affordability:** The most effective practices are not always the least expensive, although many are more affordable than alternative care;
- **Population reach:** Decision-makers must decide whether the best benefit is achieved by reaching large numbers of children with fewer, less intensive services or a few children with more intensive services; comparative data about relative cost-benefit of programs is hard to find;
- **Feasibility:** Meeting the conditions under which the practice is effective may be difficult, e.g., insufficient availability of personnel with core competencies;
- **Fit:** Some practices have not been tested for cross-cultural relevance or fit to the population, such as urban neighborhood-based programs that do not convert well to scattered rural communities or addressing children with co-occurring conditions; and
- **Relevance:** Some effective practices are for specific conditions with particular populations, not for diverse children with complex conditions.

### **Evidence-Based Practices in Children's Mental Health**

The President's New Freedom Commission Report noted that effective, state-of-the-art treatments vital for quality care and recovery are now available for most serious mental illnesses and serious emotional disorders. Yet these new effective practices are not being used to benefit countless people with mental illnesses. The Commission included this partial list of *evidence-based practices* (EBPs) in the area of children's mental health:

- Specific medications for specific conditions,
- Cognitive and interpersonal therapies for depression,
- Preventive interventions for children at risk for serious emotional disturbances,
- Treatment foster care,
- Multi-systemic therapy,
- Parent-child interaction therapy,
- Medication algorithms,
- Family psycho-education,
- Assertive community treatment, and
- Collaborative treatment in primary care.

Along with EBPs, the mental health field has also developed promising but less thoroughly documented *emerging best practices*, such as:

- Consumer operated services,
- Jail diversion and community re-entry programs,
- School mental health services,
- Trauma-specific interventions,
- Wraparound services,
- Multi-family group therapies, and
- Systems of care for children with serious emotional disturbances and their families

## E. OUTCOMES

Outcomes should be based in community planning and specific programs, although certain uniform outcomes and measures across the system can be established. For example, overarching outcomes across the statewide system could include:

- Children are at home, in a healthy and supportive family environment;
- Children are in school or vocational training and making developmentally appropriate progress;
- Children are refraining from risk-taking behaviors and not in trouble with the law;
- When children are in out-of-home care, they are safe, in least restrictive environments, and free from excessive restraint or medication;
- Children and families are satisfied with the care they receive from SCMDH

Clinical outcomes for children are different depending on age and developmental ability. For most children and adolescents, the CAFAS (Child and Adolescent Functional Assessment Scale) is used. It is a widely adopted tool that allows assessment of children across environments and at different ages.

In addition, SCDMH annually surveys consumers to assess their levels of satisfaction with the system. And outcomes related to system performance, called “dashboard indicators,” are calculated on a monthly basis. These include inpatient admission rates, inpatient length of stay, days between discharge and clinic appointment, percentage of adult clients who are employed, housing status, readmissions within thirty days, restraint rate, seclusion rate, and expenditure/revenue indicators.

SCDMH has participated with an interagency initiative of the SC Dept. of Health and Human Services to test an interagency system for outcome assessment, the “Children’s Behavioral Health Outcomes Pilot Project.” The effort started with older children in more restrictive care, i.e., residential treatment facilities, high management group homes, moderate management group homes, therapeutic foster care homes, and supervised independent living. The group identified these overarching outcomes:

- 1) Children are free of abuse, neglect, or victimization by caregivers or other adults while in residential treatment;
- 2) Children do not engage in serious risk-taking behaviors while in residential treatment;
- 3) Children are free of significant physical injury while under supervision of a residential treatment program;
- 4) Children are free from violence by other residents while in residential treatment;
- 5) Children are free of inappropriate use of seclusion or restraint while in residential treatment;
- 6) Children have improved mental health and are free of substance abuse;
- 7) Children attend school or vocational training; and
- 8) Children’s therapeutic needs are satisfactorily met while in residential treatment.

This effort is still underway.

A useful outcomes plan for the SCDMH CAF system will need to address:

- Children and adolescents in all types of care (preventive, early intervention, community-based, residential);
- Short- and long-term results;
- 1) child-focused outcomes, 2) family focused outcomes, and 3) community-focused outcomes;<sup>25</sup>
- Results that are specific to subpopulations (e.g., by age group, diagnosis, type treatment); and
- Measurement plan that includes measures of child/family status and services delivery per case.

Getting to outcomes requires an infrastructure and processes to gather and USE data to manage, improve, market, and sustain services and programs. SCDMH is in the early stages of developing a useful system for assessing and using outcomes data.

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<sup>25</sup> The Rosenblatt and Attkisson (1993) typology identifies five outcome categories: clinical status, functional status, life satisfaction and fulfillment, welfare and safety, and satisfaction with services. Within this framework, the sources of outcome information are interpreted through four social contexts of an individual's experience: the personal life of an individual, the family life of an individual the work and school life of an individual, and the individual's life within the community.

## F. TRANSFORMATION PRINCIPLES

*Changing practice is a formidable task that occurs at a painstakingly slow pace, often requiring not only changes in practice behaviors, but restructuring programs and allocating an infusion of upfront resources. In addition, implementation of new practices can be especially difficult in an environment of shrinking state and local budgets and competing priorities. Implementation often involves significant organizational change, provider re-training and changes in public and private reimbursement.*

Huang, Hepburn, & Espiritu, National Technical Assistance Center for Children's Mental Health, Georgetown University, 2003

*"Community-Based Theories of Change" investigates how human service organizations carry out their mission and goals, how they transfer their policy agendas across stakeholders, and how they sustain their service strategies over time. Cross-site analysis of six community comprehensive service reform efforts indicated that two organizational facilitators support attainment of the reform effectiveness:*

***Leadership and Communication.***

*Without these facilitators, the reform is impeded.*

Hodges, Hernandez, Nesman, & Lipien, 2002,  
*Creating Change and Keeping It Real: How Excellent Child-serving Organizations Carry Out Their Goals.* University of South Florida.

Delivering an effective mental health system for children, adolescents, and their families is not just about *what* we do, but *how* we do it. In the early years of mental health services, the prevailing model of service was for professionals to see children in medical-psychiatric clinics and hospitals. The CAF system has been moving toward community-based delivery for over three decades. The overarching goal is to *transform* the system into a fully community-based, family-driven, comprehensive, coordinated, culturally competent system of care that blends professional service with naturalistic and informal care to facilitate resilience in children. Letting go of the final vestiges of the old system and embracing the new will require commitment to a transformative system change process.

Transformation is needed at the system, program, and service delivery levels. Change has been happening incrementally, through revised policies here, a demonstration grant there, shifting funding streams everywhere. The *principles of practice*, that is, system of care practices at the service delivery level, are well disseminated. *Specific programs* to support the principles, particularly those that follow from demonstration grants or evidence-base practice studies, have likewise been spreading.

What has been slower to change are the infrastructure and processes that under gird the service delivery system. Resistance comes from financial policies embedded in categorical funding streams and insurance programs (particularly Medicaid), barriers to full family participation and leadership in children's care, challenges in blending multiple professional disciplines as well as paraprofessional models of care, difficulties in assuring accountability in a decentralized system, the

expense of emerging technology, fear of the flexibility required to individualize services, and “turf” rivalries among state-local, urban-rural, center-outstation, residential-community care, child-adult, and any other number of diverse affiliations. All of this and other sources of resistance can be overcome with careful planning, management, and accountability for change.

So how do great ideas get transformed into reality and sustained over time? Peter Drucker essentially says that effective organizations *work together* to

- Focus on mission,
- Pursue significant results
- Rigorously assess results.

That means that *everyone* involved in any way with the mental health system for children, adolescents, and their families manages his or her job in a way that reflects understanding of the mission, effective ways to pursue results, and knowledge about accomplishments. In other words, anyone in the SCDMH system should be able to give the same answer when asked:

***What is the mission of the SCDMH CAF system?***

***What are your major results?***

***What has SCDMH done to produce those results?***

Drucker also proposes that in effective organizations, every employee demonstrates:

- commitment,
- effective practice,
- passion,
- patience, and
- perseverance.

These characteristics pertain not only to the specialists in CAF services, but also to all who work in support of the system. An effective system for children, adolescents, and their families will require support from:

- Governance structure and processes;
- Leadership and management;
- Planning and evaluation;
- Fiscal planning (budgeting) and accounting;
- Personnel recruitment, development, and mentoring;
- Outcome and quality monitoring;
- Information technology;
- Interorganizational collaboration;
- Public relations and education.

Transformation begins with a tangible organization-wide commitment to the mission, vision, strategic goals, and outcomes of the SCDMH system for children, adolescents, and their families. Sustainable effectiveness happens when the people involved feel continually affirmed through information about their accomplishments and inspired by the spirit of their leaders and colleagues.

# Family Forum System of Care Survey

March 26, 2004

## Summary Results

All (n=17) Community Mental Health Centers hosted Family Forums on the evening of March 26, 2004. Following a closed circuit television presentation by Jane Addams of the national Federation of Families and SCDMH Director George Gintoli, attendees participated in focus groups at each center.<sup>1</sup>

## Analysis: Common Themes

**Question 1. What services and support are working well to help your child or youth to function successfully in their family, school and community?**

Wrap services  
School-based services  
Individual Counseling  
Family Counseling  
Family preservation services  
Medication  
Specific mental health centers  
Programs unique to specific counties (e.g., Parents as Teachers, Children's Day Treatment Program)

**Question 2. How could services work better to help you be able to keep your child or youth at home and successfully involved with their family, school and community?**

Increased communication between agencies/more collaboration  
More MH workers in schools and/or better school services  
Training of school personnel (teachers, resource officers, administrators) & law enforcement:  
More youth programs, including after-school & summer programs  
More information needed regarding specific issues/info center  
More access to services  
Support groups for parents  
Respite/Crisis Intervention  
Sites closer to where people live  
Transportation  
Earlier intervention  
More hospital beds

**Question 3: Do you feel the people who serve you work together on behalf of your child or youth?**

Out of 77 respondents (groups and individuals), 56/77 responded “YES,” 4/77 responded “sometimes,” and 17/77 responded “No.”

Those who responded “NO” mentioned gaps in services and more collaboration between agencies is needed.

**Question 4: If you were given a limited amount of money to spend on services and supports, what would you buy that would help your child be successful at home, in school and the community?**

More programs and services (e.g., after school programs, better classes)

More educational services for my child

Increased access to psychiatrists/psychologists (e.g, evening hours, more of them in general):

Respite

Mentor

Parent Education

Teacher Education

Crisis Services

Transportation:

Closer facilities

Books, educational information

Basic needs

Supplies (e.g., computer)

Tutors

**Question 5. Do service providers ask you about your child’s needs?**

Out of 78 respondents (groups and individuals), 62/78 said YES, 15/78 said NO, and 1/78 said Sometimes.

**Question 6. Do your care planning meetings include representatives from all agencies with your child or adolescent is involved?**

Out of 72 respondents (groups and individuals) 45/72 said YES, 25/72 said NO, and 1/72 said “sometimes” and 1/72 said this wasn’t applicable to the families of the group.

**Question 7. Do your care planning decisions include youth and families as equal members? Are youth and families listened to?**

On this question, results were somewhat mixed. Although majority (63/80) said yes, many of the groups interviewed had mixed feelings and 16/80 responded “No”

**Question 8. What things do youth (ages 14-21) need in order to live and function in the community as they move into adulthood?**

Most respondents felt that the following things were needed in order to help youth transition to adulthood: adult daily living skills (e.g., managing money, paying bills), coping skills (e.g., anger management), social skills, job training/education, job opportunities, opportunities to participate in extracurricular activities, supervision/support, psychological/psychiatric services, and planned parenting/sex education.

**Question 9. Many services currently focus on the child or youth. What does your family as a whole need?**

Most respondents felt that the following things were needed by their family: financial resources, legal resources, more counseling, support groups, increased access to social, recreational and health services, respite, education about the role of the family, crisis services

**Question 10. If you could have 3 things you need in order to help you be able to keep your child at home, and successfully in their family, school and community, what would those be?**

Most respondents identified the following: more counseling (more psychologists/psychiatrists), more support groups, mentoring, more financial resources for their family, better educational services, respite

**Question 11. What services are needed in order to:**

- **Help children or youth remain at home?**
- **Help children or youth be successful in school?**
- **Help children or youth be successful in the community?**

The respondents identified with the following themes: respite care/crisis care, better training for educators/police officers, better educational services (e.g., different discipline procedures, smaller classes, tutoring), community education regarding mental illness, after school programs, psychological services, collaboration among service providers

**Question 12. Describe the qualities you think make a system or provider effective and helpful to you as a family member?**

The respondents identified the following themes: competency, therapeutic skills (e.g., sensitivity, listening, empathy), cultural competence, collaborative, good attitude, trustworthy, flexibility

<sup>1</sup> Please note: For questions 3 and 5-7, these numbers are based on responses given by those who filled out individual surveys and/or the consensus of each focus group. For example, if the group consensus during one focus group was “yes,” it counted as one response. A person may have participated in the focus group and also completed an individual survey.

# Survey of Community Mental Health Centers Regarding Child, Adolescent and Family Services Programs

## Summary:

Survey sent to 17 CMHCs in March-April, 2004; N=15 CMHCs responded

## Analysis: Common Themes

### 1. Target population

#### **a. Describe the population (ages less than 21) that your CMHC actually serves, e.g.,**

##### ***- Trends in diagnosis***

Largest diagnostic group is ADHD, but serve a broad range of needs (anxiety disorders, oppositional defiant disorder, conduct disorders. Increase in younger children with significant mental health needs (e.g., bipolar disorder, major depression, multiple diagnoses, multiple agency involvement)

##### ***- Major referral sources***

Primary referral sources are schools, DSS, DJJ, pediatricians and other physicians, families

##### ***- Trends in the population***

Younger children receiving services; children with more severe needs and in need of more intensive services; increase in services to Hispanic population

#### **b. Describe the child and adolescent population that your agency has difficulty serving, i.e., what are the unmet mental health needs among children, youth, and families in your community?**

Inadequate beds for crisis care and acute care; inadequate resources for wrap services

Difficulty meeting needs of very young clients, clients with mental retardation, youth in transition, families with multiple needs, sexual abuse/offender population

### 2. Array of programs and services

#### **a. Briefly describe your centers CAF program and services. Include recent data on service utilization**

Services include primary (core) mental health services (outpatient services, intensive family services, school-based services, wrap services, etc.). Centers do not report having acute inpatient services nor residential services within the array of services.

**b. Identify any planned changes in your services array.**

Increases in wrap services, intensive family services (MST, family preservation) and school-based services

**3. Service coordination and inter agency collaboration**

**a. Describe the key ways your CMHC collaborates with other public and private child- and family-serving organizations in your community**

Primary collaborative efforts include interagency staffing, case consultations, and case management with other child/family serving agencies

Working with advocacy groups

MOAs with child/family serving organizations

**4. Financing**

**a. Describe core-funding streams for your services and programs.**

In addition core state and county funding, the primary financing is viewed as Medicaid and grants and contracts (federal, foundation, local agencies)

**b. Describe any problems with financing services.**

Diminishing/inadequate core funding to support programs

Fee recovery/collections

**c. What, if any, recommendations do you have to support adequate financing of CAF services?**

More support is needed in securing grants.

More blended funding efforts with other child and family serving agencies.

More state funding is needed

Gaining legislative support

**5. Stigma**

**a. Describe ways your CMHC is addressing reduction of stigma related to mental health services for children and youth.**

Public forums that provide education, awareness, etc. (health fairs, mental health walk, community meetings)

Working with advocacy groups

Providing services in community (e.g., schools, primary care offices, homes, neighborhood centers)

***b. What else would you recommend be done?***

State level efforts (e.g., media campaign, programs) to address stigma

**6. Cultural competence**

***a. Describe how your CMHC assures its services are as culturally competent as possible.***

Training (mandatory) is primary mechanism used to assure cultural competence. Cultural competence committees, cultural competence plans and cultural competence led staff organize such training efforts.

The annual cross-cultural conference is viewed a major resource.

Supportive services (e.g., translators, bi-lingual services)

Recruitment and retention of ethnic/minority staff

***b. What support do you need to assure cultural competence?***

More support from state office (e.g., formal training, funds, recruitment/retention efforts)

**7. Outcome and quality monitoring**

***a. Describe your CMHC's process to monitor outcomes and quality***

CAFAS [Child Adolescent Functional Assessment Scale] is primary outcome measure; GAF [Global Assessment of Function] is also an outcome measure.

Satisfaction surveys

Consumer involvement

QA committee/staff monitor quality issues

***b. What barriers have you encountered in developing and managing an outcome and quality monitoring system?***

Need to develop a system that is staffed with trained personnel to support getting to meaningful outcomes.

Very time consuming process; inefficient for clinicians to serve as data managers

***c. What do you need to monitor outcomes and quality routinely?***

Need to develop an outcome system. General dissatisfaction with measures used, lack of support for data collection, feedback from outcome data collected.

## 8. Governance and management

### *a. Describe what works well about the current governance and management of your CMHC CAF programs and services.*

Having CAF director on management and executive committees at local CMHCs

Having the support of CAF Council through state office

Team approach

Direct communication

Direct supervision

### *b. Do you recommend any changes in governance and management of CAF programs and services?*

Need CAF representation (local and state) on executive and management levels

More resources in state CAF office (lead persons for various program areas, regional coordinators)

More family advocates

## 9. WS Hall Psychiatric Institute

*As you know, the facilities at Hall Psychiatric Institute must cease to be used for mental health services, because the state is planning to sell the property. What recommendations do you have for the future of the child, adolescent, and family programs that have been located at Hall? In the future, what should be the relationship of the programs that have been at Hall to your CMHC CAF programs and services?*

Must maintain the services provided by Hall

Must have acute inpatient and RTF services

Regional services are needed (especially needed in upstate)

Outpatient resources should be transferred to cmhcs that will serve these clients

## 10. If you could change anything about CMHC CAF services and programs, what would you change?

**Choose three highest priority actions that need to be taken.**

Increase school-based services

Increase wrap services

Increase diverse community-based services

Increase services to family members, including respite

Make it easier to access beds for acute care (include addressing funding mechanisms for doing so)

More staffing

**11. If you were Director of the State Department of Mental Health, what one critical action would you take to support CMHC CAF programs?**

Not eliminate programs at Hall. Must have access to quality acute care. Do not close programs without community resources being in place

Renegotiate MOA with DJJ re; sub-class population  
Clarify who will be served by all mental health facilities

Talk with and listen to CAF staff (e.g., learn what is working locally before making changes, not eliminating positions \_\_e.g., regional coordinators) without discussions at local levels)

Adequate/appropriate financing of children/family services

**12. Please rate the capacity <sup>1</sup> to provide the following services:**

**a. Family focus (families are maximally involved and have their needs met)** 3.75

**b. Individualized services (responsive to unique needs of each child and family)** 4.11

**c. Cultural competence (children and families receive services that are responsive to their status related to race, religion, language, national origin, gender, socioeconomic status, and community location)** 3.6

**d. Interagency cooperation (schools, DSS, health agencies, DJJ, DDSN, DAODAS, other key agencies work closely with CMHC)** 4.46

**e. Community-based (child and family receive services within close geographic proximity to the child's home)** 4.18

**f. Accessibility of services (i.e., location, schedule, cost)** 3.96

**g. Least restrictive services, (i.e. children and families are served in settings that maximize freedom of choice and are in normative environments (e.g., schools))** 3.93

**h. Vendors or private providers (CMHC can contract with or refer to qualified providers to meet child or family's needs)** 3.25

<sup>1</sup>Answers for Q.12 are based on 1-5 Likert scale: 1= No capacity, 2= Minimal capacity, 3= Moderate capacity,

4= Very good capacity, 5= High capacity