Behavioral Health Services Work Group

Final Report: December 2012

Behavioral Health Services Work Group

Executive Summary

Under the direction of Governor Daugaard, behavioral health services in South Dakota transitioned from the Department of Human Services (DHS) to the Department of Social Services (DSS), effective April 14, 2011. The purpose of the behavioral health reorganization was to create a more integrated approach to behavioral health services in South Dakota.

Across the nation, there is a growing awareness that the majority of individuals accessing mental health or substance abuse services have co-occurring issues –both mental health and substance abuse needs. This is the expectation, not an exception, and treatment is most effective when services are integrated and provided simultaneously. In order to create an integrated administrative structure, the previous Divisions of Mental Health and Alcohol & Drug Abuse were eliminated, and two new divisions and one program were created:

- Division of Correctional Behavioral Health
- Division of Community Behavioral Health
- Behavioral Health Prevention Program

The new divisions and program house all mental health and substance abuse services that were in the former divisions, but they are now structured in an integrated manner. It's important to note **no services were eliminated as part of the reorganization.**

As part of the transition of behavioral health services to the Department Social Services, Gov. Daugaard also created a work group to help guide the long-term vision of the future behavioral health system. This Behavioral Health Services Work Group was led by Lt. Governor Matt Michels and met a dozen times throughout 2011 and 2012.

Along with Lt. Governor Michels, the Work Group included a broad array of stakeholder representation, including legislators, community mental health and substance abuse providers, Tribal providers, inpatient behavioral health providers, advocacy groups, county mental illness boards, the Unified Judicial System, Indian Health Services, the Department of Corrections, and the Department of Social Services. Work Group members were also responsible for taking information to their constituents for additional input.

The Work Group used a consensus building process to develop the goal areas and final recommendations. The Work Group was provided a draft of this report and asked to submit comments and suggestions prior to the report being finalized.

The Work Group began by reviewing the current structure of behavioral health services in South Dakota, including services provided through the Division of Community Behavioral Health and the Human Services Center, as well as services provided by Medicaid state plan providers.

Community Mental Health System

- 11 community mental health centers
- Services to over 17,000 individuals annually
- Services include psychiatry, medication management, case management, individual and group therapy
- SFY10 expenditures:
  - $16,478,911 Medicaid
  - $653,552 Federal Block Grant Funds
  - $337,371 Other Federal Funds
  - $8,253,995 General Funds

Community Substance Abuse System

- 57 substance abuse providers
- Services to approximately 15,000 individuals annually
- Services include prevention services, crisis intervention, assessments, individual and group counseling, day treatment, detox services, structured outpatient treatment, and inpatient treatment services
- SFY10 expenditures:
  - $5,499,390 Medicaid
  - $7,099,488 Federal and Other Funds
  - $5,835,749 General Funds

Human Services Center

- Services to approximately 2,000 individuals annually
- Services include inpatient psychiatric and substance abuse treatment to adults and adolescents who are involuntarily committed or are placed by the court system, DSS, or DOC
- SFY10 expenditures:
  - $9,445,645 Medicaid
  - $5,627,216 Medicare
  - $27,549,358 General Funds
  - $397,625 Federal and Other Funds

Medicaid State Plan Services

- SFY10 Services and Expenditures:

Psychology	3,609 individuals	$1,593,766
Other Mental Health	3,549 individuals	$2,119,534
Psychiatry	5,720 individuals	$1,581,262
Inpatient Psych	1,488 individuals	$6,259,653

- 7,221 individuals received one of these services
- 1,973 individuals received two of these services
- 841 individuals received three of these services
- 169 individuals received all of these services

In developing its recommendations, the Work Group focused on current services, gaps in services, and critical service needs.

In general, the final recommendations include:

- Emphasis on services provided in the least restrictive environment appropriate for a person's care and safety
- Creation of a regional approach to behavioral health care to ensure access to essential services
- Expansion of community crisis intervention services to allow for earlier interventions that can prevent costly out-of-home placements
- Expansion of supported housing services and supports, particularly for transition-age youth
- Expansion of care coordination services within substance abuse treatment
- Streamlining of involuntary commitment laws to allow for better integration and reduction in barriers to treatment
- Development of community nursing facility capacity to better serve individuals with dementia and challenging behaviors
- Modification of the intake process at the Human Services Center to develop the capacity to allow senior individuals to be admitted directly to a geriatric unit
- Reduction of inappropriate admissions to the Human Services Center by developing the capacity for HSC to provide psychiatric review and consultation services to nursing facilities
- Emphasis on a broad array of prevention services to support behavioral health and wellness and reduce substance use and mental health disorders
- Alignment of prevention strategies at the state level and integration of prevention efforts within communities

The recommendations endorsed by the Work Group represent a strong commitment to improving the behavioral health system in South Dakota. While there is much work to be done, the Work Group believes these recommendations create the framework for moving forward with improvements that will ensure essential behavioral health services are available across the state.

Behavioral Health Services Work Group

Work Group Overview

GUIDING PRINCIPLES

To create a framework to assist in discussions and the development of possible recommendations, the Work Group crafted a set of guiding principles to outline the key values within the behavioral health system. These principles included the following:

- Services are provided through the “no wrong door” approach
- Services focus on individualized recovery/resiliency driven outcomes
- Services are person-centered/family-driven
- People are served in the least restrictive environment appropriate for their care and safety
- People are served with dignity and respect in a culturally responsive manner
- Services are available and accessible statewide
- Communities are involved and invested in service delivery

A central theme in all Work Group discussion was ensuring the needs of individuals who receive behavioral health services are met in the least-restrictive environment possible. Related to this concept is the notion that children/youth should not have to enter state custody in order to receive appropriate treatment.

As part of the overall discussion of current services and system needs, the Human Services Center medical staff provided feedback on issues they believed the Work Group should be aware of. Concerns raised by this group focused on inappropriate admissions to the Human Services Center including individuals on five-day holds, individuals from jails, patients who are medically unstable when arriving at the Human Services Center due to complex medical issues, individuals with developmental disabilities versus psychiatric issues, individuals who are acutely intoxicated when they arrive at the Human Services Center, and the admission of and services to geriatric patients.

The utilization of electroconvulsive therapy (ECT) was also discussed as a well-established, approved treatment intervention for psychiatric conditions; however, challenges remain with current statues that classify ECT as experimental. Possible solutions to both inappropriate admissions and challenges with ECT, as suggested by the Human Services Center medical team, included reviewing the involuntary commitment statutes and ensuring the least restrictive options are used whenever possible, increasing the numbers of qualified mental health professionals available to conduct assessments for involuntary commitments, implementing a review team for geriatric admissions, and modifying current statutes regarding ECT.

In addition to the input provided by the Human Services Center medical team, the Work Group took other stakeholder input at various points throughout the process. For example, requests were made to consider expanding the statutes regarding mental illness holds to allow physicians to initiate such a hold in any location (versus in a hospital setting only) and to allow physician assistants to initiate holds. After lengthy discussion on these issues, it was concluded that they would not be part of the recommended changes. However, statutory changes requested regarding the groups of professionals who can be considered qualified mental health professionals were made in 2012 and will be part of the recommended changes in 2013. See page 12 for additional details.

Another area in which feedback was sought was around the use of the term *case management* as an essential service. Because this term has been used in the past to define a particular set of services, it was determined that a new term should be created to define the expanded set of services expected within this area. Consultation with consumers and advocates on their preferred term led to the use of *care coordination*.

GOALS

The Work Group created specific goal areas for improving the behavioral health system in South Dakota. These goals are listed below. Several components within each of the goal areas were discussed to clarify priority areas.

1. Increase access to services throughout the state
2. Build the capacity of local communities
3. Develop a strategic statewide prevention plan
4. Define the role of the Human Services Center

GOAL 1: INCREASE ACCESS TO SERVICES THROUGHOUT THE STATE

Several components were initially identified as critical components of access to services. These included:

- Assessing current services and identifying gaps
- Integrating and improving the involuntary commitment process
- Evaluating the process for accessing care on a voluntary basis to ensure the Human Services Center has the capacity to take voluntary patients
- Expanding community crisis response services
- Working with Tribes to assist them in providing services directly

As the Work Group discussed access to services throughout the state, it identified a critical component to access was the need for a more formal community crisis response system, including detoxification services, which are lacking in many areas of the state. This lack of critical crisis intervention services often results in inappropriate referrals and placements because the best option is not available. This discussion mirrored a conversation held by the Commitment Laws Subcommittee, which determined that it would be difficult to make significant changes to the commitments laws without addressing the overarching system's issues and lack of critical services.

In order to develop a system that would allow better access to behavioral health services, including critical crisis response services, the Work Group concluded a regional approach to behavioral health services is necessary. The first step in establishing a regional approach was identifying available services and service gaps by geographical area. Services considered during this analysis included:

- Community mental health centers
- Accredited outpatient substance abuse providers
- Inpatient mental health and substance abuse services
- Prevention services
- Tribal programs
- Indian Health Services
- Hospitals
- Veteran's clinics/services

- Homeless programs
- Transportation services
- Active county mental illness boards
- Key state services

The following were also considered during the analysis:

- Capacity of the services
- Access limitations
- Service gaps

An in-depth discussion on the potential regions, concluded with the selection of the five regional areas (Appendix A). These regions mirror the five call center regions developed for the Aging and Disability Resource Connections (ADRC). These regions were selected because they reflect locations where people access medical care and other necessary services across the state. As Work Group members discussed these regions, they also stressed the importance of developing critical care pathways within each region and across the state so appropriate linkages can be made between care providers.

In addition to the identification of behavioral health regions, the Work Group had numerous discussions on key services that should be available within these regions. As part of these discussions, Work Group members decided that the terminology “essential services” should be used to describe those services that must be available within each of the five regions. Once this terminology was agreed upon, the Work Group had further discussion on the essential services, and concluded with the following: prevention services, assessment and referral, community crisis intervention, care coordination, supported living services, inpatient specialty services, outpatient specialty services, and family supports.

Work Group members stressed that effective treatment must accompany any service expansion. Toward this end, the development of systems of care will be critical, along with the identification of measurable outcomes. Also discussed were various considerations for how to deliver essential services such as using technology, funding alignment for services, incentives for consumers to participate in services, and use of referral resources.

GOAL 2: BUILD CAPACITY OF LOCAL COMMUNITIES

The goal area of building the capacity of local communities to support behavioral health services focuses on the importance of communities being directly involved in efforts to improve the system. Work Group discussion in this area included the following:

- Identifying critical care pathways
- Integrating service delivery at the community level and ensuring coordination of care among local providers
- Ensuring long-term care and assisted living services have the capacity to provide a behavioral health component
- Reviewing the structure of the community mental health system versus private independent practice
- Ensuring community options are explored/used prior to residential services

GOAL 3: DEVELOP A STRATEGIC STATEWIDE PREVENTION PLAN

As the Work Group discussed the goal area of creating a prevention strategic plan, it was determined that this was another area that key stakeholders input was needed. A subcommittee comprised of members from the Behavioral Health Services Work Group, key stakeholders and prevention experts was assembled. The subcommittee recognized that prevention services must be based on evidence-based programs/promising practices and done in collaboration with other State entities. For further detail on the prevention subcommittee and the prevention strategic plan as approved by the Behavioral Health Services Work Group see page 25.

GOAL 4: DEFINE THE ROLE OF THE HUMAN SERVICES CENTER

As part of the discussion of both long-term care services and the goal area of defining the role of the Human Services Center (HSC), Work Group members agreed that the geriatric admissions to the state hospital requires more in-depth consideration.

As a result, a subcommittee was formed to examine if this population could be better served through less restrictive community-based services or if admission to HSC is the most appropriate option. See page 22 for details on this subcommittee.

SUBCOMMITTEE DEVELOPMENT

To assist the Work Group in researching and reaching the goals listed above, subcommittees relating to the following subject matters were established:

- Commitment laws
- Prevention services
- Geriatric services
- Essential services

All of the recommendations from the subcommittees were discussed by the Work Group prior to final approval. With the conclusion of the Work Group, next steps will include using the recommendations to assist in the development of the federally required behavioral health state plan. This plan will be submitted to the federal government. To develop this plan, the Behavioral Health Advisory Council will prioritize the Work Group recommendations, particularly those recommendations from the essential services subcommittee for future service expansion, including potential needs for increased funding. The council will also monitor progress of the achievement of goals within the plan. This council meets on a quarterly basis and provides a leadership role in advising the Division of Community Behavioral Health in the planning, coordination, and development of the behavioral health state plan and on statewide needs relative to treatment services. The membership of the Behavioral Health Advisory Council is appointed by the Governor and includes a broad array of key stakeholders such as providers, consumers, family members, advocates, the Unified Judicial System, Indian Health Services, and various state government departments. Membership for the Advisory Council has not been appointed yet. The Work Group recommends consideration for appointments to include representatives from the Behavioral Health Work Group.

In addition, the Department of Social Services incorporated several of the preliminary recommendations of the Work Group into the Department's strategic plan. Specific Department goals include "Ensure access to services for our customers" and "Foster partnerships to leverage resources for our customers". Within those goals, the department has established action steps specific to behavioral health, including the following:

- Utilize the results and recommendations of the Behavioral Health Services Work Group to develop essential services consistent with the principle of keeping individuals in their community in the least restrictive environment by July 2013.
- Utilize the recommendations of the Behavioral Health Services Work Group to develop or enhance service delivery models for individuals with behavioral health needs by July 2013 and ongoing.
- Provide transition services to youth who are aging out of state custody and returning to their home or community by January 2014.
- Work with local prevention coalitions to identify services needed for a full continuum of prevention, early intervention, and recovery support services by January 2013 and ongoing.
- Explore the feasibility for local community providers to support additional detox services across the state based on recommendations from the Behavioral Health Services Work Group by July 2013.
- Explore and evaluate the feasibility of increasing local crisis response models across the state by July 2013.
- Collaborate with community agencies to develop additional capacity to provide behavioral health/dementia services in long term care facilities by July 2012 and ongoing.

The DSS Management Team will review the other, now final, recommendations of the Work Group and incorporate them as objectives and action steps into these goal areas where appropriate. Progress on the Department's strategic plan is monitored quarterly.

Through the specific actions steps of the DSS strategic plan and the prioritization that the Advisory Council will complete, the recommendations of the Behavioral Health Work Group will proceed to the next phases of development. The Department will notify Work Group members of the quarterly Behavioral Health Advisory Council meetings as well as distribute meeting minutes. The Advisory Council meetings are open to the public so Work Group members will be able to attend, if desired. The Department will also provide an update on the status of the Behavioral Health Services Work Group recommendations to members in December 2013.

Behavioral Health Services Work Group

Work Group Membership

Name	Affiliation
Lt. Gov. Matt Michels	Governor's Office
Nancy Allard	Unified Judicial System
Phyllis Arends	NAMI
Vickie Claymore	Aberdeen Area IHS Behavioral Health
Ric Compton	Department of Social Services, Human Services Center
Terry Dosch	Council of Substance Abuse Directors & Council of Mental Health Centers
Ellen Durkin	Lower Brule Sioux Tribe
Shawna Fullerton	Department of Social Services, Division of Community Behavioral Health
Amy Iversen-Pollreisz	Department of Social Services
Denny Kaemingk	Department of Corrections
Robert Kean	SD Advocacy Services
Sen. Elizabeth Kraus	South Dakota Senate
Steve Lindquist	Avera Behavioral Health
Rep. Melissa Magstadt	South Dakota House of Representatives
Kim Malsam-Rysdon	Department of Social Services
Rep. Nick Moser	South Dakota House of Representatives
Betty Oldenkamp	Lutheran Social Services
Scott Peters	Minnehaha-Lincoln County Board of Mental Illness
Sen. Tim Rave	South Dakota Senate
Carol Regier	Keystone Treatment Center
Dr. Ramesh Somepalli	Department of Social Services, Human Services Center
Tom Stanage	Lewis & Clark Behavioral Health
Dr. Matt Stanley	Avera Behavioral Health
Gib Sudbeck	Department of Social Services, Prevention Program
Lynne Valenti	Department of Social Services
Tiffany Wolfgang	Department of Social Services, Division of Correctional Behavioral Health
Brenda Wood	City/County Alcohol and Drug Programs

Behavioral Health Services Work Group

Subcommittee: Commitment Laws

Subcommittee Members	Affiliation
Lt. Gov. Matt Michels	Governor's Office
Phyllis Arends	Nat'l Alliance for Mental Health
Greg Barnier	Pennington County Board of Mental Illness
Terry Dosch	Council Mental Health Center
Amy Iversen-Pollreisz	Department of Social Services
Robert Kean	Advocacy Services
Steve Lindquist	Avera Behavioral Health
Rep. Melissa Magstadt	South Dakota House of Representatives
Eric Matt	Governor's Office
Rep. Nick Moser	South Dakota House of Representatives
Scott Peters	Minnehaha-Lincoln County Board of Mental Illness
Carol Regier	Keystone Treatment Center
Greg Sattizahn	Unified Judicial System
Tom Stanage	Lewis & Clark Mental Health
Matt Stanley	Avera Behavioral Health
Lynne Valenti	Department of Social Services
Pam VanMeeteren	Department of Social Services

The members of the Commitment Law subcommittee were tasked with identifying statutes that were outdated, not reflective of current practice, or created a barrier to treatment. In addition, the subcommittee wanted to allow for better integration and streamlining of the commitment processes, particularly for those individuals with co-occurring mental health and substance abuse conditions. This was a significant task given that there had been no major revisions to the mental health statutes since 1991.

A thorough review of state statutes and extensive research of national policy led to two major behavior health statute packages. The first was introduced and passed during the 2012 legislative session, and the second will be introduced during the 2013 legislative season.

Behavioral Health Services Work Group

Final Recommendations: Commitment Laws

2012 LEGISLATIVE SESSION
The 2012 legislative action improved the following areas relative to substance abuse and mental health law. A brief explanation of each change is outlined below.

Involuntary Chemical Dependency Commitment
Prior to the changes made during the 2012 session, a petition for involuntary chemical dependency treatment required a certificate by a licensed physician and a certified chemical dependency counselor both of whom have examined the person within two days of filing the petition. This requirement was modified to require a petition be accompanied by a certificate of a licensed physician or a certified chemical dependency counselor who has examined the person within two days of the filing of the petition. The requirement for two examinations within two days of the filing of the petition was unnecessarily duplicative and burdensome to families who typically bear the costs for examinations and treatment. Moreover, it could be difficult to obtain both a physician and a certified chemical dependency counselor exam within the two-day period. Either professional has the expertise necessary to conduct the examination and set forth their clinical findings. This change streamlined the process and prevents unnecessary duplication.

The second change to the involuntary chemical dependency commitment statutes involved transporting a court-ordered person for a temporary commitment to receive a diagnostic examination. The law had been silent on transportation to the approved treatment facility, which created problems for families if the person refused to go to the facility despite the court's order. The law was amended to specifically provide that the court may include in its order an order for law enforcement to transport the person to the approved treatment facility, ensuring the individual in need of services arrives at the treatment facility.

Qualified Mental Health Professionals (QMHPs)
Changes made to the QMHP statutes, which allow certain groups of licensed professionals to perform evaluations as part of the mental health commitment process, included an exception regarding achieving the highest level of private practice licensure in one's field and extending its application to organizations that have a formal clinical supervision arrangement with a professional who is licensed at the private practice level.

The changes allow more people to obtain QMHP status without jeopardizing the level of professionalism required to fulfill the duties of a QMHP.

Outpatient Commitment Process
Several changes were made to the outpatient commitment statutes aimed at eliminating the current barriers to its use and effectiveness. The concept of chronic disability was added and a person can be subject to involuntary commitment if the person has a severe mental illness that causes such a chronic disability. The settings that a person can be committed or transferred to under an order of commitment was changed to include outpatient settings, thereby increasing the opportunities to use outpatient commitment and supporting the principle that treatment should be in least restrictive environment appropriate to meet the individual's needs. In addition an enforcement process for situations where individuals are failing to comply with the outpatient commitment order was added.

These additions to the law allow outpatient commitment to be an effective tool available to treat individuals with behavioral health conditions.

Voluntary Admission Process and Substituted Informed Consent
A new section of law was added to allow people who are 18 or older who have been determined incapable of exercising informed consent to be admitted for inpatient psychiatric treatment if the following criteria are met:

- Consent is obtained from a guardian or limited guardian with authority to make health care decisions; or
- Consent is obtained from an attorney-in-fact previously named in a written durable power of attorney; or
- Consent is obtained from a next of kin, as provided in the Health Care Consent Procedures Act, for up to 14 days; or,
- Consent is obtained from an attorney-in-fact under a Declaration of Power of Attorney for Mental Health Treatment.

Additionally, the legislation removed the requirement that the person deemed incapable of giving consent sign the authorization for admission.

These changes align decision-making authority for mental health treatment more closely with decision-making authority for other types of medical treatment. This lessens the stigma associated with mental illness while simultaneously balancing the rights of the individual with respect to inpatient psychiatric treatment.

Integrated Commitment Process for Medication/Treatment and Co-Occurring Disorders
To streamline the commitment processes and ensure people receive treatment as soon as possible in their hospitalization or commitment, the law was modified to give county mental illness boards the ability to hear petitions for authority to administer psychotropic medication, electroconvulsive treatment, and other medical treatment that may be necessary to treat the person's mental illness, including chemical dependency treatment, but only if the board first determined that the criteria for involuntary commitment were met and a commitment was ordered.

Emergency and Non-emergency Treatment
Several changes were made to the law with respect to emergency and non-emergency treatment. With respect to emergency treatment, the changes provided that psychotropic medication, electroconvulsive therapy, and any other medical treatment necessary to treat person's illness may be administered if the attending physician and one other physician determine that the treatment is necessary to prevent significant deterioration of the person's severe mental illness and that the person's potential for improvement would be significantly impaired if such treatment is not provided. The treatment may continue for up to ten days only.

With respect to non-emergency treatment, the changes combined several sections of code to clarify the decision-making authority and process with respect to non-emergency treatment. It preserves the individual's right to consent to treatment of the person's mental illness, as well as the ability to withdraw informed consent to treatment at any time.

Advanced Directives
The chapter on Declaration of Power of Attorney for Mental Health Treatment was repealed as it had very specific processes required to obtain a durable power of attorney for mental health treatment

decisions. Some of the requirements had proven to be onerous to meet, and as a result, this tool was used very infrequently. Also, many individuals choose to deal with health care decision-making as a whole and not separate out mental health treatment decisions from all other medical treatment decision-making. The durable power of attorney law was also amended to clarify that it may authorize the attorney-in-fact to consent to, reject, or to withdraw consent for health care, including any care, service, or procedure to maintain, diagnose, or treat a person's physical or mental condition.

Electronic Filing
Several changes were made to the service of process sections pertaining to the hearings procedures. The changes bring the law up to date with respect to advances in technology and current practice.

2013 LEGISLATIVE SESSION
The 2013 legislative action looks to make the following policy improvements.

Involuntary Treatment within Jails
Permit jails to involuntarily treat prisoners with psychotropic medication. This would allow a prisoner to be involuntarily treated with psychotropic medication if it is determined that the prisoner suffers from a severe mental illness, which is likely to improve with treatment, and that without treatment the inmate poses a likelihood of serious harm to self or others.

Qualified Mental Health Professionals
Modify the definition of qualified mental health professionals (QMHPs) to include:

- Physician assistants with mental health experience
- Advance practice nurses
- Federal government employees licensed in another state

Similar to the changes made during the 2012 legislative session, these changes will increase access to QMHPs, particularly in rural areas.

Mobile Crisis Team Referrals
Modify the statute regarding mobile crisis teams allowing a QMHP in a clinic or hospital to refer a person to a mobile crisis team as an alternative to a petition for commitment. Currently, only law enforcement officers can refer a person to a mobile crisis team. This expansion to QMHPs will help ensure individuals receive care in the least restrictive setting appropriate for their care and safety.

Emergency Intervention of Minors
Revise the statute related to the discharge of minors from inpatient mental health treatment to allow a hold to be placed on the minor if there is a need for emergency intervention. Currently, a parent who consented to the minor's admission has the right to affect an immediate discharge of the minor. The change would allow an exception to this for up to 24 hours when the facility director or attending psychiatrist has probable cause to believe the minor requires emergency intervention and should remain in the facility and initiates a mental illness hold.

Behavioral Health Services Work Group

Subcommittee: Essential Services

Name	Affiliation
Nancy Allard	Unified Judicial System
Phyllis Arends	NAMI
Vickie Claymore	Aberdeen Area IHS Behavioral Health
Ric Compton	Department of Social Services, Human Services Center
Terry Dosch	Council of Substance Abuse Directors & Council of Mental Health Centers
Shawna Fullerton	Department of Social Services, Division of Community Behavioral Health
Amy Iversen-Pollreisz	Department of Social Services
Robert Kean	SD Advocacy Services
Kim Malsam-Rysdon	Department of Social Services
Betty Oldenkamp	Lutheran Social Services
Tom Stanage	Lewis & Clark Behavioral Health
Dr. Matt Stanley	Avera Behavioral Health
Brenda Wood	City/County Alcohol and Drug Program

The Essential Services Subcommittee drafted definitions for each of the essential services, including service examples in each area. However, it's important to note that the list of examples is not an exhaustive list. In addition to drafting the essential services definitions, the subcommittee also identified target populations and recommendations for each essential service.

In order to establish recommendations around the essential services, subcommittee members reviewed multiple data sources to assess current service availability and conducted a gap analysis. A breakout of current essential service availability by region was particularly useful in identifying areas lacking critical services. For example, Region 2, which encompasses the central part of South Dakota, does not have any detox services and only one safe room bed. The subcommittee determined this level of crisis intervention service was inadequate for the area.

Some of the key areas discussed by the subcommittee regarding the definitions and recommendations are listed below.

Primary prevention

Definition: Primary prevention services help prevent the onset of use/misuse of alcohol and drugs and promote mental health. Examples include school-based prevention/promotion, suicide prevention, education through primary care services, and anti-stigma education.

Discussion points:

- Should be based on evidence-based programs/promising practices
- Are often targeted at youth through school-based programs
- Suicide prevention activities should be included along with mental health promotion curriculums
- Education through primary care can be an effective primary prevention strategy

- Evidence-based primary prevention services are currently provided in several parts of the state; continuation and expansion of these services should be supported by community coalitions

The subcommittee recognized that prevention services are most effective when they are promoted and supportive by communities. Current primary prevention services are supported in this manner. Existing state-level resources should also be aligned to support the development of community coalitions.

Early intervention services

Definition: Early intervention services identify and support individuals who are identified as having minimal but detectable signs or symptoms foreshadowing substance use and/or mental health disorders, but who do not currently meet diagnostic criteria that would indicate a need for treatment. Also includes linking individuals to further assessment services and/or other needed services and supports. Examples include:

- Screening/brief intervention in early childhood, school, and primary care settings
- Education services to children/youth in school settings
- Education to parents of at-risk youth
- Linkages to assessment and referral, and linkages to other services and supports

Discussion points:

- Critical to identify individuals who are having minimal signs or symptoms that foreshadow substance use/mental health disorders
- Screening and brief intervention are part of early intervention
- Linkages to assessment services and other services and supports are an important component

Since there is not a formal mechanism in place for early intervention services within schools, partnerships between schools, early childhood providers, and substance use/mental health providers should be encouraged to create a framework for screenings and risk assessment of substance use/mental health issues.

Recovery supports

Definition: Recovery supports are non-clinical assistance and support services provided to individuals with substance use and/or mental health problems aimed at assisting them in achieving long-term recovery. Examples include:

- Peer-based services (including survivor outreach for family members who have experienced a loss due to suicide)
- Support services to support the chronic nature of substance use/mental health problems (geared at keeping people engaged after completion of more formal treatment services)
- Support services targeted to individuals who have been in inpatient levels of care (geared at handling environmental issues as they transition to community settings)

Discussion points:

- Include non-clinical assistance and support services to assist individuals in achieving long-term recovery
- These services are typically peer-based

Because the availability of recovery support services is currently limited, focus should be on raising awareness of and connecting people with available services.

Assessment and referral

Definition: Assessment & referral refers to the information gathering process to determine need for behavioral health treatment and other services and supports and assistance to access needed services.

Discussion points:

- Importance of initial assessment as well as ongoing assessment
- Need for sharing of assessment information to reduce duplication
- Targeted at individuals seeking state-funded services

The subcommittee felt it was important to create integrated assessment services for substance use and mental health providers. Therefore, the group recommends supporting the development of an integrated set of criteria that should be included during the initial assessment process.

Community crisis intervention

Definition: Community crisis intervention provides immediate, community-based responses to individuals at risk of harm to themselves or others which includes basic assessment and provision of a safe environment on a short-term basis. Examples include:

- Mobile crisis
- Crisis care centers
- Safe rooms
- Detoxification services (non-medically managed)

Discussion points:

- Regular (non-medically managed) detoxification services should be part of this service and available in every region
- Should be driven by risk

The recommendations support an expansion of behavioral health crisis intervention services, including detoxification service to currently underserved areas. In addition, subcommittee members recommend expanding, law enforcement Crisis Intervention Training and incorporating mental health first-aid training into the law enforcement training academy.

Care coordination

Definition: Care coordination is the coordination of treatment and other services and supports on an individual and/or family basis to ensure individuals and/or families receive needed services. This includes skill development around employment and links to employment supports.

Discussion points:

- Should include more than just linking people to services- active role in coordinating care
- Not appropriate for all behavioral health clients- driven by the level of impairment and/or multiple agency involvement
- Intensity should vary depending on the needs of each individual/family

Because these services are not currently available within the substance abuse treatment area, the subcommittee prioritized defining the population within this area that should receive such services. Subcommittee members also discussed the importance of ensuring that care coordination services are individualized, and have a recovery goal.

Supported living services

Definition: Supported living services provide assistance and supportive services on an individual or congregate basis to help people with behavioral health needs live as independently as possible. Examples include:

- Supported housing –individual contacts to ensure housing stability and personal safety
- Halfway houses
- Home health and environmental and personal care supports
- Basic living supports – includes direct support services offered through CARE (Comprehensive assistance with recovery and empowerment) and IMPACT (Individualized mobile programs of assertive community treat)
- Group home supports for adults with severe mental illness
- Specialized long-term care supports –highest level of supervision (assisted living, nursing facility); psychosocial rehabilitation
- Medication management services
- Treatment foster care

Discussion points:

- Should include things such as supported housing, basic living supports, psychosocial rehabilitation, and medication management
- Should not require failure in other settings in order to qualify for these services
- Eligibility for these services should be based on both diagnostic and functional limitations
- Currently these services aren't geared for transition-age youth so this is a significant need

The recommendation in this area focuses on services to support transition-age youth, particularly those young adults moving from children's long-term placements to community services. In addition, subcommittee members recommended a review of environmental and personal care support services to ensure they are available to ensure housing and personal safety for individuals with behavioral health needs.

Inpatient specialty services

Definition: Inpatient Specialty Services are distinct, medically managed services provided on a temporary basis for an expressed diagnosis. Examples include:

- Psychiatric hospital in-patient
- Chemical dependency inpatient
- Psychiatric residential treatment facilities for youth under 21
- Medically managed detoxification services

Discussion points:

- Medically managed detoxification services should be included in this category
- Services driven by diagnosis and medical need for this level of care and individuals identified as needing inpatient services should not be able to be served in less restrictive settings
- Development of less restrictive options should be prioritized

Subcommittee members agreed that while these services are an important component of the behavioral health system of care, any new resources should be focused on less restrictive, community-based services. Therefore, the recommendation in this area is that there should be no additional investment of state funding into inpatient specialty services for increased capacity.

Outpatient specialty services

Definition: Outpatient specialty services are individualized, nonresidential therapeutic services provided on an as needed basis to treat an expressed diagnosis. Examples include:

- Day treatment services
- Group, individual and family therapy
- Psychiatry
- Psychology
- Health homes
- Assertive community treatment

Discussion points:

- Services should be driven by diagnosis but should also take into consideration other risk factors
- Data should be used to develop core outcome measures that can inform service delivery by region

Because evidence-based assertive community treatment programs have been effective in the treatment of behavioral health disorders, the subcommittee supported a recommendation of expanding these services to regions where they are currently unavailable

Family support

Definition: Family support provides flexible services and supports to families of individuals with behavioral health needs to help them meet the needs of their family member.

Discussion points:

- Currently not an available service within the behavioral health system, however, there is a model in place within the developmental disabilities system
- Must have a family member with behavioral health needs in order to qualify
- Must demonstrate that they can't meet their family member's need on their own and assistance would enable them to help their family member
- Should include flexible funds but should not have strict criteria for what can be supported with such funding

As a starting point in this area, the subcommittee recommended a work group be created to look at the development of family support coordinator services as part of children's behavioral health services. The subcommittee discussed that these types of supports are also needed for adults and consideration of expansion to adult services should be considered.

Behavioral Health Services Work Group

Final Recommendations: Essential Services

1. **Primary prevention**
   - Prioritize the expansion of primary prevention services to those evidence-based programs/promising practices that are effective in SD and ensure community coalitions, schools, etc. are aware of these resources.
   - Support the development of community coalitions by aligning existing staff and budgetary resources towards this effort.

2. **Early intervention**
   - Encourage community partnerships between schools, early childhood providers, and substance use and mental health providers to begin creating the framework for school-based screening, risk assessment, and early intervention with an emphasis on effective programs and practices already occurring.

3. **Recovery supports**
   - Develop mechanisms to assist people in identifying the recovery supports currently available, for example using current resources such as Aging and Disability Resource Connections and Prevention Resource Centers.

4. **Assessment & Referral**
   - Support the creation of an integrated assessment process for state-funded services at Certified Mental Health Centers and accredited substance abuse providers. Ensure behavioral health assessments across all providers are criteria based.

5. **Community Crisis Intervention**
   - Support the development of state-county partnerships to sustain existing services and provide additional detox and crisis intervention services.
     - Expand detox services in Region 2 and behavioral health crisis intervention in Region 4.
     - Expand Crisis Intervention Training for law enforcement in Regions 2, 3, and 4.
     - Provide mental health first-aid training to attendees of the state law enforcement training academy.
     - Consider additional services needed in regions to ensure effective use of community crisis intervention services.

6. **Care Coordination**
   - Define the population that should receive care coordination services and develop such services within substance abuse treatment.
   - Ensure care coordination services are based on individualized outcomes and have recovery as the goal.
   - Determine if and how care coordination can be expanded to additional populations.

7. **Supported Living Services**
   - Develop supervised supported housing services for transition-age youth.
   - Review current environmental and personal care support services.
   - Determine how to expand these services to ensure housing stability and personal safety.

8. **Inpatient Specialty Services**
   - No additional investment of state funding into inpatient specialty services for increased capacity.
   - Continue analysis of current beds and modify their use in response to needs.

9. **Outpatient Specialty Services**
   - Ensure existing assertive community treatment services are effective and meet fidelity measures.
   - Develop assertive community treatment in region 2 and region 3 and develop specific tribal/IHS assertive community treatment.
   - Increase access to outpatient substance use services in uncovered areas (may include transportation services).
   - Increase accountability by using existing data sets to develop core outcome measures that can inform service delivery by region.

10. **Family Support**
    - Establish a work group to look at the development of family support coordinator services as part of children's behavioral health services.
    - Ensure the assessment process includes the identification of resources within the family.

Behavioral Health Services Work Group

Subcommittee: Geriatric Services

Name	Affiliation
Judy Carroll	Department of Social Services, Human Services Center
Mark Deak	SD Healthcare Association
Anita Dunham	Rapid City Regional Hospital
Melissa Gale	Avera St. Benedict Health Center
Rep. Bernie Hunhoff	South Dakota House of Representatives
Sen. Jean Hunhoff	South Dakota Senate
Amy Iversen-Pollreisz	Department of Social Services
Jeremy Johnson	Department of Social Services, Human Services Center
Marilyn Kinsman	Department of Social Services, Division of Adult Services & Aging
Steve Lindquist	Avera Behavioral Health Services
Rep. Nick Moser	South Dakota House of Representatives
Shawn Nills	Community Counseling Services
Ken Senger	SD Association of Healthcare Organizations
Dr. Ramesh Somepalli	Department of Social Services, Human Services Center
Bob Stahl	Department of Health
Tom Stanage	Lewis & Clark Behavioral Health
Steve VandeKop	Prairie Homes Assisted Living
Pam VanMeeteren	Department of Social Services, Human Services Center
Dr. Vickie Walker	Department of Social Services, Human Services Center
Ginger Wells	Good Samaritan Society

Geriatric Services subcommittee members received input from numerous stakeholders that pointed to a growing trend of dementia-related healthcare needs among the state's senior population. This trend is leading to an increased need for behavioral health training among healthcare staff and additional capacity for patients with dementia and short-term behavioral health needs.

Subcommittee members examined a number of complications and mitigation tactics relative to this growing need. They included:

- Increasing demand for behavioral health services among geriatric population
- Inappropriate long-term placement of people with short-term psychiatric treatment needs
- Overuse of the Human Services Center for short-term geriatric psychiatric treatment needs
- Inability of Human Services Center to discharge geriatric patients to less-restrictive environments
- Nursing care capacity
- Psychiatric consultation and behavioral support for nursing facilities
- Behavioral health focused programs within nursing facilities
- Medicaid add-on pay options for behavioral health services and staffing
- Hospital admissions processes
- Nursing home occupancy rates
- State hospital/nursing home admittance regulations
- Geropsychiatric services throughout the Midwest

Behavioral Health Services Work Group

Final Recommendations: Geriatric Services

1. Reduce inappropriate admissions by developing the capacity for the Human Services Center (HSC) to provide psychiatric review/consultation to nursing facilities to assist them with challenging behaviors/behavioral health issues.

2. Modify the intake process at HSC and develop the capacity to allow senior individuals to be admitted directly to a geriatric unit, possibly having a designated geriatric admission unit.

3. Similar to the state's adolescent placement review, develop a referral process/application for long-term placements at HSC, and ensure the purpose of HSC is acute/emergency care. Ensure consistency between HSC, Avera, and Rapid City Regional.

4. Coordinate with the Department of Health (DOH) and others to provide education/training for nursing facilities. Training should be comprehensive and include:
    - Appropriate responses to challenging behaviors/behavioral health issues
    - Provide re-education on basic nursing facility requirements
    - Provide information on the Center for Medicare and Medicaid (CMS) initiative regarding decreasing the use of psychotropic Medication for dementia
    - Explain changes regarding the moratorium on nursing home beds

5. Develop the capacity to better serve individuals with dementia and challenging behaviors in community nursing homes. Consider utilizing the Canistota mental illness program model.

6. Recognize assessment as an essential service.

7. Consider statute change allowing HSC to establish capacity limits to avoid geriatric overflow into the general admission units and eliminate HSC's financial responsibility if capacity is not available at HSC.

Behavioral Health Services Work Group

Subcommittee: Prevention Services

Name	Affiliation
Linda Ahrendt	Department of Health , Office of Health Promotion
Lee Axdahl	Department of Public Safety, Office of Highway Safety
Erika Batcheller	Face It TOGETHER Sioux Falls
Donna Brown	Southern Plains Behavioral Health Services
Sen. Joni Cutler	South Dakota Senate
Sandy Diegel	John T. Vucurevich Foundation
Terry Dosch	South Dakota Council of Substance Abuse Directors, Inc. & South Dakota Council of Mental Health Centers, Inc.
Shawna Fullerton	Department of Social Services, Division of Community Behavioral Health
Dodi Haug	Human Service Agency NE Prevention Resource Center
Amy Iversen-Pollreisz	Department of Social Services
Timothy R. Johns	Johns & Kosel, Prof. LLC Attorneys at Law
Janet Kittams-Lalley	Helpline Center
Sara McGregor-Okroi	Aliive-Roberts County
Dr. Timothy M. Mitchell	Rapid City School District
Kristi “Cricket” Palmer	SD National Guard Drug Demand Reduction Program
Stephanie Schweitzer-Dixon	Front Porch Coalition, Inc.
Kari Senger	Department of Education Office of Coordinated School Health
Cecelia Spotted Tail	Rosebud Sioux Tribe
Gib Sudbeck	Department of Social Services Prevention Program
Gary Tuschen	Carroll Institute

The Prevention Subcommittee began their work with an overview of current prevention initiatives within behavioral health. South Dakota has targeted substance abuse prevention activities under a federal grant that focuses on underage drinking and binge drinking.

Several community coalitions have been created as part of this project, and primary prevention activities and school-based curriculums are in place. While significant work has occurred within primary prevention, it has not focused on mental health aspects often referred to as mental health promotion. The only prevention activity on the mental health side has been through a federal suicide prevention grant. This grant also supported the development of community coalitions, as well as significant training efforts around suicide prevention. As part of information sharing, the subcommittee also learned about the current data sources within prevention.

As a result of those discussions, Subcommittee members crafted a strategic plan which includes the following vision statement, mission statements, and goals. To see the strategic plan in its entirety, visit dss.sd.gov/behavioralhealthservices/index.asp.

Vision
South Dakota communities working together to promote behavioral health and wellness across the lifespan

Mission
Create and sustain a statewide prevention system promoting behavioral health and preventing mental and substance use disorders through evidence-based programs/promising practices.

Goals

- **Ensure access to a prevention system to support behavioral health and wellness and reduce substance use disorders**
  Goal 1 focuses on developing, implementing, and sustaining primary prevention services, early intervention strategies, and recovery supports. While previous prevention activities were tied to federal funding that only supported primary prevention, the subcommittee determined it is critical to have a full continuum of prevention services, including early intervention, connections to treatment services, and recovery support services as they will assist individuals in sustaining long-term recovery.

- **Improve behavioral health through evidence-based programs/promising practices as determined by community needs**
  Goal 2 stresses the importance of utilizing evidence-based practices and includes strategies that will identify those evidence-based programs/promising practices that are effective in rural states like South Dakota. The programs/practices should also align with needs of each community. Once such programs and practices are identified, efforts to assist communities in implementation will be conducted.

- **Foster alignment of prevention strategies at a state level and systems integration at the regional and local levels**
  Goal 3 identifies coordination and enhancement of prevention policies, programs, and practices at the state level as a needed component. Because prevention activities are supported and funded across multiple state government agencies, it will be important to align those efforts to eliminate duplication and integrate programming. A well-coordinated state system will help communities develop a well-coordinated system at the local level.

- **Measure behavioral health outcomes of evidence-based programs/promising practices**
  To determine if prevention programs are effective, Goal 4 requires the development of an evaluation framework and expanded data and evaluation capacity.

Behavioral Health Services Work Group

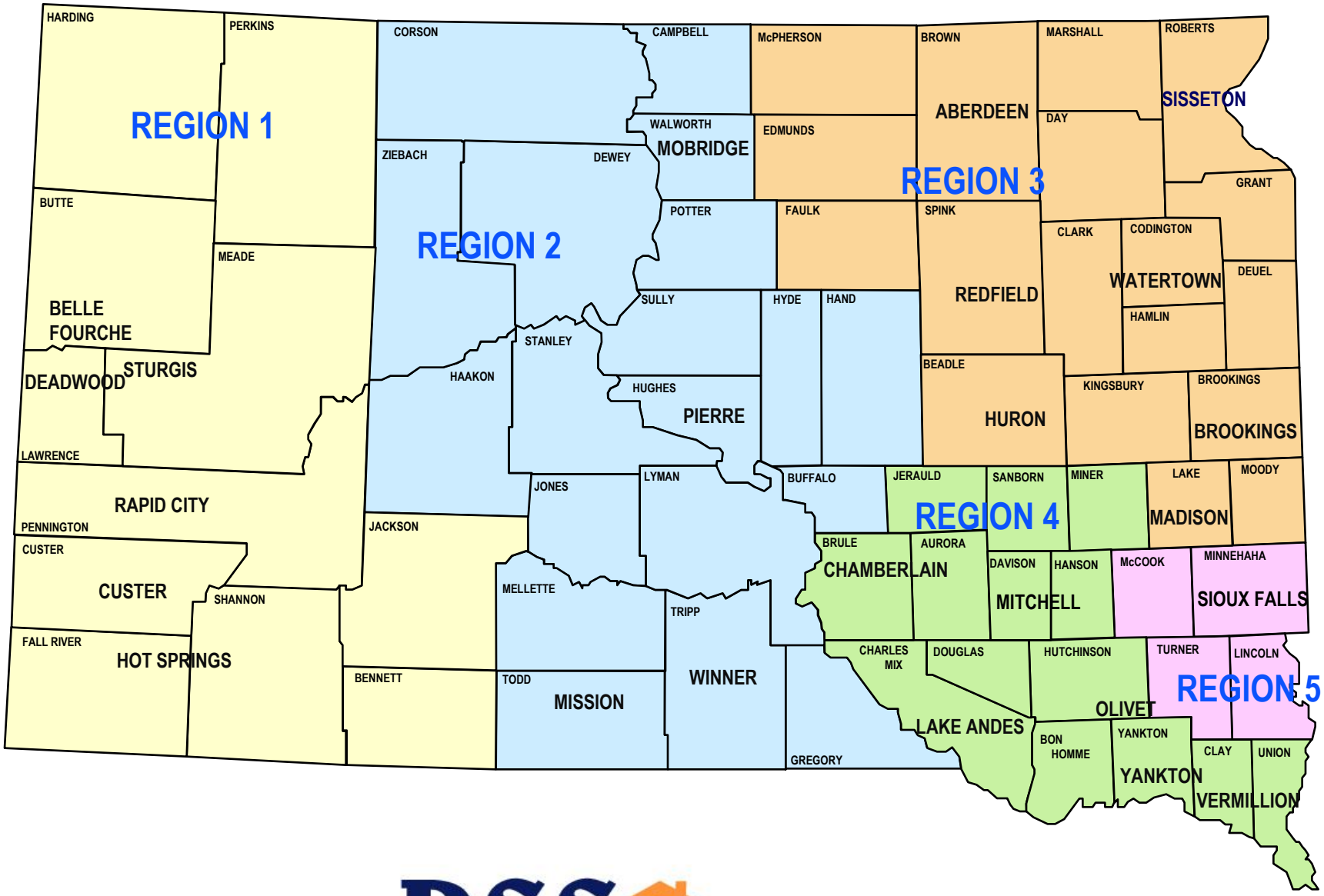
Final Recommendations: Prevention Strategic Plan

1. Ensure access to a prevention system to support behavioral health and wellness and reduce substance use disorders.
    - Develop, implement, and sustain primary prevention services by identifying essential prevention services and the population to be served.
    - Develop, implement, and sustain early intervention strategies and the process to link to appropriate services by identifying essential early intervention services and the population to be served, and by developing a process to foster lineage of early intervention services to treatment.
    - Develop, implement and sustain recovery supports by identifying essential recovery supports and the population to be served.

2. Improve behavioral health through evidence-based programs/promising practices as determined by community needs.
    - Identify evidence-based programs/promising practices to match community needs.
    - Implement evidence-based programs/promising practices to align with community priorities.

3. Foster alignment of prevention strategies at a state level and systems integration at the regional and local levels.
    - Coordinate and enhance prevention policies, programs and practices to align at the state level.
    - Facilitate community development for a comprehensive integrated prevention system.

4. Measure behavioral health outcomes of evidence-based programs/ promising practices.
    - Assess state and community needs and identify prevention priorities.
    - Strengthen data and evaluation capacity to measure outcomes.



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