SOUTH CAROLINA GENERAL ASSEMBLY

Legislative Audit Council

October 2015

Response to Oversight Committee

A Limited Review of Issues at the S.C. Department of Mental Health

LEGISLATIVE AUDIT COUNCIL

1331 Elmwood Ave., Suite 315
Columbia, SC 29201
(803) 253-7612 VOICE
(803) 253-7639 FAX

The Legislative Audit Council performs audits of state agencies and programs, in which we identify ways to reduce the cost and improve the performance of state agencies, and provide information to the General Assembly and the public. We help ensure that operations are efficient and that agencies follow the law to achieve the desired results. We provide information, analysis, and recommendations to help the General Assembly improve state agencies and to help the citizens of South Carolina oversee state government. The LAC is part of the legislative branch of state government and, therefore, it is organizationally independent of the executive branch agencies it audits. Our audits must be requested by the General Assembly, either by statute or on an as-needed basis, Senate Oversight Committee, or House Oversight Committee.

The Legislative Audit Council is composed of five public members, one of whom must be a practicing certified or licensed public accountant and one of whom must be an attorney. In addition, four members of the General Assembly serve ex officio.

Audits by the Legislative Audit Council are conducted in accordance with generally accepted government auditing standards as set forth by the Comptroller General of the United States.

Copies of all LAC audits are available at no charge. We encourage you to visit our website to view and print copies of LAC reports.

LAC.SC.GOV

Legislative Audit Council

A LIMITED REVIEW OF ISSUES AT THE S.C. DEPARTMENT OF MENTAL HEALTH

Contents

Contents

Introduction and Background

In January 2015, state law was amended to declare that, in the General Assembly's efforts to provide for appropriate agencies to function in the areas of health, welfare, and safety and to determine the activities, powers, and duties of these agencies and departments, periodic reviews should be conducted of the programs, agencies, and departments and their responsiveness to the needs of the state's citizens by the standing committees of the Senate or House of Representatives.

The Senate determined that it would rely on its current standing committees to identify agencies and programs to be reviewed while the House of Representatives established a Legislative Oversight Committee as a separate standing committee. These entities would act as investigating committees. S.C. Code of Laws §2-2-60(D) states, in part, that the chairman of the investigating committee may direct the Legislative Audit Council to perform its own audit of a program or operation being studied or investigated by the investigating committee.

On March 30, 2015, the Medical Affairs Committee of the Senate directed the Legislative Audit Council to perform an audit of the following issues related to the Senate's oversight of the S.C. Department of Mental Health and report on the results by October 2015:

- Review the sale of the DMH Bull Street campus to determine and evaluate the terms of the sale and DMH's plans for the use of the proceeds from the sale.
- Determine whether the responsibilities of DMH, as established by the Sexually Violent Predator Act (S.C. Code §44-48-10 et seq.), are appropriate for this agency or should be assigned to another entity and review the adequacy of the funding and resources for the program.
- Evaluate whether the Department of Mental Health and the Department of Alcohol and Other Drug Abuse Services could be combined into one department.
- Review the efficiency and effectiveness of the requirements of the forensics program operated by DMH.

After discussions with Senate Oversight staff and staff of the Medical Affairs Committee, the scope of these issues was more clearly defined.

Introduction and Background

Bull Street Campus Sale and Use of Proceeds

After discussing the issue with oversight staff to determine what the main concerns of the committee were, we focused primarily on the use of the proceeds from the sale. However, we also discuss how the sale was handled and the amount of the proceeds.

Terms of Sale

In FY 04-05, the State Budget and Control Board was directed to identify state properties which were no longer needed and should be sold. The Bull Street Complex of the S.C. Department of Mental Health (DMH) was included in the property identified for sale. The proceeds from these properties were to go to the state's general fund.

In December 2005, the S.C. Attorney General (AG) issued an opinion stating that the Bull Street property is impressed with a "charitable trust" in favor of the mentally ill, that no sale of the property could take place without court approval, and that the proceeds from any court-approved sale would have to go to DMH to further the purposes of the trust. The opinion also recommended that DMH bring an action to settle the question.

DMH filed an action with the S.C. Supreme Court in February 2006. One year later, the Supreme Court issued a declaratory judgment holding that the Bull Street property is subject to a charitable trust and the proceeds from any sale of the property must go to DMH in trust for the care and treatment of the mentally ill.

From June 2007 through December 2010, environmental concerns about the property were identified and demolition/abatement plans were drawn and completed. With the exception of Hall Institute, which DMH decided to retain at that time, the following relocation tasks were completed between March 2007 and June 2009:

- Created a separate energy plant for the Tucker Center.
- Patients moved back to Bryan Psychiatric Hospital from the Byrnes building on the Bull Street property after Bryan's roof was renovated.

In June 2007, a Request for Proposals (RFP) was issued for an appraiser and a selection was made in October 2007. The appraisal, dated December 2010, valued the property at $12 million. In January 2008, an RFP for a real estate broker/marketing firm was issued by state procurement and a contract was awarded in June 2008. The formal marketing of the property began in January 2009.

In December 2010, the DMH Commission authorized the state director to sign a contract with Hughes Development Corporation (HDC). The sale agreement with HDC for the purchase of approximately 165 acres of the Bull Street campus, excluding Hall Institute, was for approximately $15 million to be paid as each parcel was sold over the next 7 years. Beginning in the fourth year of the agreement, DMH will also receive 35% of the net profits from the sale of each parcel above the assigned parcel price and a 15% developer's fee will go to HDC.

In June 2011, a Circuit Court judge signed an order approving the sale and concluding that the purchase price and other terms of the agreement were fair and reasonable and that the sale of the property was in the best interest of DMH and the beneficiaries of the charitable trust. The State Budget and Control Board approved the sale and purchase agreement between DMH and HDC in its June 2011 meeting.

On March 30, 2015, an amendment to the original agreement between DMH and HDC was entered into to add approximately 16 acres for the Hall Institute site, with a modified payment schedule.

Table 1: Modified Payment Schedule Including Hall Institute

CUMULATIVE AMOUNT	DUE BY SEPT. 30 OF:
$1,500,000	2014
$3,800,000	2015
$6,562,543	2016
$10,125,086	2017
$13,687,629	2018
$16,250,172	2019
$17,812,715	2020
$18,612,715	2021

Source: DMH

As of September 16, 2015, DMH was in discussions with the AG's office regarding the sale of the Hall Institute parcel. According to DMH, it is the AG's opinion that DMH will need court approval for this parcel to be added. DMH had not obtained court approval for that sale but planned to initiate a lawsuit by the end of September 2015.

DMH Commission minutes dating back to at least 2008 show that the DMH Commission was apprised of the ongoing progress regarding the sale of the Bull Street property at each Commission meeting.

Use of Proceeds

In June 2015, DMH staff asked the DMH Commission for guidance on how to utilize the proceeds from the sale of the Bull Street property. According to a DMH official, in addition to the suggestion that these funds be used for community housing, staff also initially suggested other uses for these one-time funds, such as using the funds for capital, maintenance, or equipment needs. However, according to DMH, the Commission members expressed their interest almost immediately in using the funds for additional community housing. DMH staff sent a memorandum to the commissioners prior to the June 2015 meeting outlining a recommendation to use the proceeds for additional affordable housing for patients in the community and some contractual means by which DMH's funds could be blended with others to create additional housing for patients.

At the July 2015 Commission meeting, staff gave a presentation about the agency's past activities to create additional affordable housing options statewide. The Commission was notified that a housing task force, convened in April 2013, had quantified the amount of unmet need for additional permanent supportive housing units for persons with mental illnesses and their families in integrated settings to be 1,745. It has long been recognized that having safe, affordable housing is a basic prerequisite for patients to successfully recover. Staff provided the Commission with a handout showing examples of the types of apartments the agency could secure for patients by partnering with a private developer to obtain guaranteed access for apartments for patients referred by the agency.

The DMH Commission approved an Issue Action Paper in August 2015 regarding the use of proceeds from the sale of the Bull Street property. It recommended that the agency use the current proceeds as one-time matching funds for the development of new affordable housing for patients.

Under this proposal, the proceeds would primarily be used to partner with private developers applying for State Housing Authority programs, such as the Low Income Housing Tax Credit and HOME programs. Under this proposal, the proceeds would be used to develop new apartments for low and moderate income individuals with a mental illness. The apartments would be "integrated," meaning that no more than 25% of the total units in each development would be designated for persons with serious mental illnesses. Also, rental assistance would be available for patients in need through DMH community housing funds, HUD Housing Choice/Section 8 vouchers, or other available rent subsidy programs. Staff stated that routine progress reports will be made to the Commission regarding the use of the proceeds.

According to DMH management, all proceeds from the sale of the Bull Street campus will be used for additional community housing. As of September 23, 2015, $4,419,183 had been paid to DMH.

Sexually Violent Predator Treatment Program

The S.C. Department of Mental Health (DMH) administers the sexually violent predator (SVP) treatment program, which was established in 1998. After individuals convicted of certain sex crimes complete their prison sentences, they may be involuntarily civilly committed to the SVP treatment program if they are adjudicated to be "sexually violent predators" pursuant to the South Carolina Sexually Violent Predator Act.

The SVP treatment program is designed to be therapeutic and not punitive in nature. Individuals committed to the SVP treatment program are housed in a facility located at the Broad River Correctional Institution in Columbia (BRCI). BRCI is owned by the S.C. Department of Corrections (SCDC) and DMH is allowed to use a part of the facility for the SVP treatment program. The SVP treatment program staff and the security officers who work in the SVP treatment program are employees of DMH. SVP treatment program residents do not interact with the inmates of BRCI.

We reviewed the SVP treatment program and used a variety of sources of evidence, including:

- State laws, including the Sexually Violent Predator Act, regulations, and agency policies.
- Interviews with DMH officials and employees of other state agencies.
- State and federal case law.
- Information from other states.

We found that the SVP treatment program currently houses 179 residents and that the cost of the program has increased substantially in the last five years. The program is predicted to continue to increase its number of residents. We found that the Office of the Attorney General (AG) currently tracks the status of the 93 living individuals who have been discharged from the program.

Commitment Process

In order to be committed to the SVP treatment program, an individual must be convicted of a qualifying sexual offense, as defined in S.C. Code of Laws §44-48-30(2). An individual convicted of one of the specified offenses will go through a multi-step process to determine whether he should be civilly committed.

At the end of the prison sentence, an individual convicted of a qualifying offense will have his case examined by a multidisciplinary team. The multidisciplinary team consists of officials representing SCDC, the S.C. Department of Probation, Parole and Pardon Services, and DMH, as well as a retired judge and a criminal defense attorney. The team may either dismiss the case or refer it to the prosecutor's review committee.

The prosecutor's review committee is a three-member board that decides whether probable cause exists to determine whether the individual is a sexually violent predator. The prosecutor's review committee may either dismiss the case or refer it to the AG. If the case is referred to the AG, the AG will file a petition in the county of the last qualifying sexual offense conviction and a judge will rule on whether probable cause exists.

If the judge determines that probable cause exists, he will order an evaluation by a DMH evaluator. If the evaluator determines that the individual meets the criteria of being a sexually violent predator, the individual can consent to his involuntary commitment to the SVP treatment program, request an independent evaluation, or ask for a trial. If the evaluator determines that the individual does not meet the criteria, the AG can agree to dismiss the case, request an independent expert, or ask for a trial.

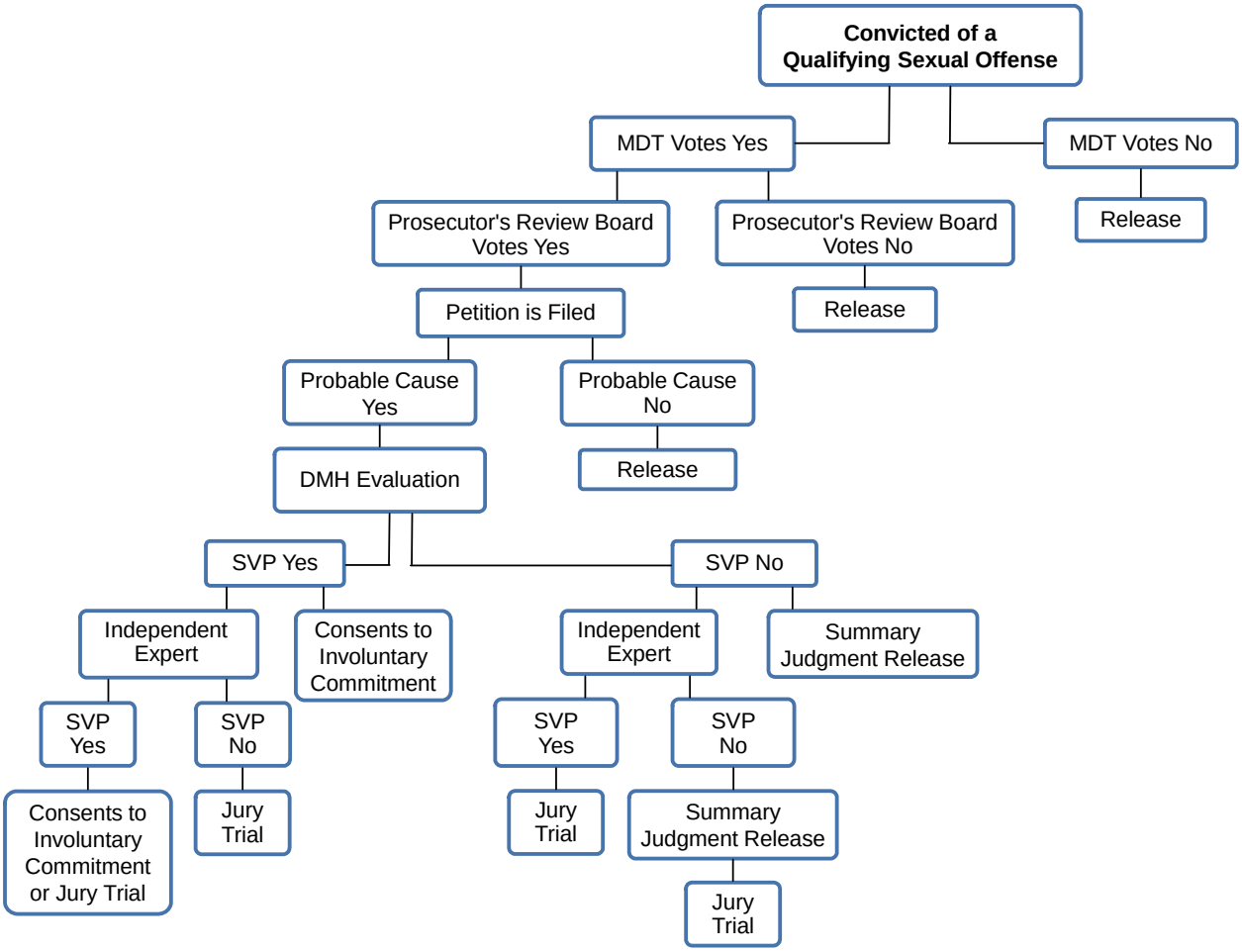
The trial can be either a jury trial or a trial solely before a judge. The state must prove beyond a reasonable doubt that the individual is a sexually violent predator. If an individual is adjudicated as being a sexually violent predator, that individual will be civilly committed to the SVP treatment program for treatment in a secure setting.

Once an individual becomes a resident of the SVP treatment program, he will remain committed until it is determined that he is no longer a sexually violent predator. It is possible for an individual to spend the rest of his life in the SVP treatment program after being committed. S.C. Code §44-48-110 requires a court to conduct an annual hearing to review the status of the resident, at which time the resident can petition for release.

If the court determines that probable cause exists to believe that the individual is safe to be at large and is not likely to commit acts of sexual violence, a new trial on this issue must be scheduled.

As of July 16, 2015, a total of 7,660 offenders had been screened since the SVP treatment program's inception by the multidisciplinary team. Of that number, 1,379 were referred to the prosecutor's review committee and a total of 281 sex offenders had been court committed to the SVP treatment program.

Chart 2: Commitment Process



Source: DMH

Treatment Program

SVP treatment program residents have the opportunity to undergo treatment programs designed to reduce their risk to society. Due to constitutional concerns, program residents are not required to participate in treatment programs. Residents who participate in treatment are eligible for extra privileges during their periods of commitment. According to DMH, 97% of the residents participate in the treatment program.

The SVP treatment program employs psychologists, therapists, and social workers to treat residents with therapies such as cognitive behavioral and group therapy. Additionally, residents may be prescribed medication by a psychiatrist. Unlike some other state sexually violent predator programs, South Carolina's SVP treatment program does not provide for the conditional release of residents in which residents can be supervised and treated in the community instead of in a mental health institution.

According to DMH officials, the BRCI facility presents some challenges as a treatment facility. A lack of office space in the facility requires certain SVP treatment program employees to work at a remote location. DMH officials state that the prison environment, though separate from the general population, is not ideal for the delivery of treatment services. A lack of space for medical service delivery at BRCI requires residents to be frequently transported to off-site medical providers. Additionally, security at BRCI presents logistical challenges.

Employees of the SVP treatment program must go through general prison security procedures, such as identity checks and passing through metal detectors. Any supplies that are brought into the SVP treatment program must also be checked by general prison security. An official for SCDC stated that housing the SVP treatment program at BRCI was originally supposed to be a temporary arrangement and that SCDC believes that the current location is not ideal.

The SVP treatment program currently has several unfilled positions, including security positions and positions for therapists and psychologists. According to SVP treatment program officials, it is difficult to fill the positions due to the nature of the job, the security procedures at BRCI, and salaries. In order to attract more qualified employees, DMH offers bonus pay to individuals willing to work in the SVP treatment program.

SVP Treatment Programs Nationwide

Twenty states, as well as the federal government and the District of Columbia, have some form of a sexually violent predator treatment program. The constitutionality of sexually violent predator treatment programs was upheld in the 1997 U.S. Supreme Court decision *Kansas v. Hendricks*. The court held that the Kansas program was not punitive in nature.

Of the states that have sexually violent predator treatment programs, three, including South Carolina's, are housed in a correctional institution. Only one program, Massachusetts, is operated by a department of corrections. Other state programs, including South Carolina's, are operated by health and mental health agencies.

SVP Treatment Program Costs and Privatization Plans

The SVP treatment program has grown significantly in size and cost since its inception. Since FY 08-09, expenditures by DMH on the SVP treatment program have increased from $6,896,233 to $12,875,689 in FY 14-15.

Table 3: DMH SVP Expenditures

Fiscal Year	Expenditures
08-09	$6,896,234
09-10	$7,579,824
10-11	$7,873,290
11-12	$9,668,529
12-13	$12,399,606
13-14	$12,465,593
14-15	$12,875,689

Source: DMH

Most of the spending increases for the program have been a result of increases in salaries and employee benefits and additional staff. Other areas in which spending increased include case services and other personal services.

Table 4: SVP Spending Increases

CATEGORY	FY 08-09	FY 14-15	SPENDING INCREASE
Permanent Position Salaries	$3,457,499	$5,530,350	$2,072,851
Case Services	241,243	1,434,411	1,193,168
Employee Benefits	1,263,738	2,435,164	1,171,426
Other Personal Services	304,941	976,023	671,082
Supplies	633,316	993,709	360,393
Contract Personnel	97,217	382,426	285,209
Other Spending	898,280	1,123,606	225,326
TOTAL	**$6,896,234**	**$12,875,689**	**$5,979,455**

Source: DMH

The per-resident cost of the program has also increased. On July 1, 2010, the program had 113 residents at a cost of approximately $67,078 per resident. In 2015, the program had 179 residents at a cost of approximately $71,931 per resident. According to DMH, the program population is predicted to increase to 239 residents by FY 19-20. According to a DMH official, financial circumstances do not impact the intake of individuals into the SVP treatment program.

In part due to rising costs and pursuant to a proviso in the FY 12-13 appropriations act, DMH issued a request for proposal (RFP) in October 2013 for a private company to operate the SVP treatment program. The private company would be required to have a facility and operate the SVP treatment program. DMH would monitor the adherence to the contract and still make the recommendations to the AG regarding the potential discharge of residents. Currently, Florida is the only state that is operated privately, and Virginia has also examined the possibility of using a private operator. Several factors should be considered regarding potential privatization of the SVP treatment program.

South Carolina's RFP seeks to contract with a vendor that offers treatment programs "….that are at least the equal to those which SCDMH presently provides" while also providing a cost advantage. The contractor will be required to use the model guidelines of the Association for Treatment of Sexual Abusers and have a no refusal/no eject policy. The RFP stipulates staff qualifications, reporting requirements to DMH, and DMH's ability to monitor quality of care.

Although private firms have an incentive to be efficient and minimize costs, it is critical that the quality of care and treatment of SVP treatment program residents and the safety of the general public remain a key priority and not be compromised by the profit motive. Additionally, concerns have been raised regarding the working relationship between a potential private administrator and the numerous agencies that participate in the SVP treatment program commitment process. Careful consideration must be given to any potential privatization arrangement and thorough monitoring of any potential arrangement must take place.

Monitoring Discharged Residents

Since the inception of the SVP treatment program, 93 residents have been discharged. The AG currently monitors the status of individuals discharged from the SVP treatment program. A report is periodically produced by the AG which details the status of individuals who have exited the SVP treatment program. This report includes information on the recidivism of the individuals released from the program and is shared with different agencies, including DMH. According to the AG report, five individuals have committed sexually-based offenses since leaving the SVP treatment program. Table 5 outlines the status of discharged residents.

Table 5: Status of Residents Discharged from SVP

Status	Number of Discharged Residents
No Incidents	71
Incarcerated Due to Sexually Based Offense	5
Incarcerated for Failing to Register as a Sex Offender	2
Non-Compliant With Sex Offender Registration	2
Incarcerated for Other Offenses	5
Died Following Discharge	8

Source: Office of the Attorney General

According to an official at the AG's office, the office is not required to produce the status report and it is not required to monitor the residents following their discharge from the SVP treatment program. Also, the AG does not have a written procedure for maintaining the report. This status report is a helpful tool for protecting public safety and measuring the effectiveness of the SVP treatment program. The AG's office should continue to monitor the status of residents who have been discharged from the program.

Discharged residents are required to register as sexually violent predators every 90 days. If a discharged resident is on probation, the S.C. Department of Probation, Parole and Pardon Services monitors his case. DMH does not monitor residents discharged into the community.

Recommendation

1. The S.C. Department of Mental Health should, at least annually, request the status of individuals who have been discharged from the sexually violent predator treatment program from the Office of the Attorney General.

SVP Treatment Program Governance

Since its inception, the SVP treatment program has been administered by DMH. Most other states' SVP treatment programs are also administered by health departments. We examined whether DMH or SCDC should administer the SVP treatment program. Due to constitutional concerns and standard practices nationwide, we conclude that the SVP treatment program should continue to be administered by DMH.

In determining the constitutionality of Kansas' SVP program, the Supreme Court determined that the Kansas program was civil and not punitive. One of the factors that the Supreme Court took into account in determining that the Kansas program was civil was that it was administered by the Kansas Department of Health and Social and Rehabilitative Services and not by the Kansas Department of Corrections. The opinion of the court stated:

> What is significant, however, is that Hendricks was placed under the supervision of the Kansas Department of Health and Social and Rehabilitative Services, housed in a unit segregated from the general prison population and operated not by employees of the Department of Corrections, but by other trained individuals.

The Supreme Court's emphasis on the Kansas program being run by the Kansas Department of Health and Social and Rehabilitative Services and not the Department of Corrections suggests that having a health department administer the program is a relevant factor in ensuring an SVP program's constitutionality.

Most other state SVP programs are administered by health departments. Only one state's program, Massachusetts, is administered by a department of corrections. In a 2013 report prepared jointly by SCDC and DMH, the agencies agreed that either agency could potentially administer the SVP treatment program. DMH's director stated that either agency could operate the program. Although the agencies both agreed that either could potentially administer the SVP treatment program, neither provided a policy reason for an agency other than DMH to administer the program.

Given constitutional concerns and the practice of most states in having a mental health department administer SVP programs, we found no compelling reason for an agency other than DMH to administer South Carolina's SVP treatment program.

DMH and DAODAS Consolidation Considerations

We evaluated whether the S.C. Department of Mental Health (DMH) and the S.C. Department of Alcohol and Other Drug Abuse Services (DAODAS) could be consolidated. We interviewed DMH and DAODAS staff and a cross-section of local alcohol and other drug services providers in the state. We also reviewed current literature and financial data to identify considerations for consolidating the agencies. Finally, we reviewed the organizational structure and service delivery models of mental health and substance abuse programs in other Southeastern states.

In our report, we present the issues to consider associated with consolidating these two agencies. We found the following:

- The varying governance and service delivery models of DMH and DAODAS would need to be addressed if the two agencies consolidated.
- The DMH and the DAODAS substance abuse providers often maintained some degree of collaboration; however, these relationships could be strengthened for the benefit of the patient.
- The cost benefits have already been realized with the administrative colocation of DMH and DAODAS in 2011; additional savings are questionable.
- From our review of Southeastern states, there does not appear to be a leading organizational form that is the most beneficial for the treatment of mental health and substance abuse patients.

While there are pros and cons to the models employed by both agencies, consolidating DMH and DAODAS would likely require a significant departure in governance and service delivery for one or both agencies. Both agencies have operated independently of each other, although with some degree of collaboration, for nearly 60 years.

It should be noted that the overarching concern for both DMH and DAODAS is patient care. When considering the pros and cons to consolidation, focusing on government efficiencies can distract from how to best care for the patient. Rather than focusing solely on what is most cost effective and efficient, consideration should center on these themes within the larger context of patient care.

Background

DMH

DMH's mission is to support the recovery of people with mental illnesses. S.C. Code of Laws §44-9-30 establishes a commission of seven members to govern the department. DMH primarily provides direct inpatient and outpatient treatment services through a community-based system which includes 4 hospitals, 17 community mental health centers and clinics serving each of the 46 counties, and 4 nursing homes. DMH also operates several other programs, including a tele-psychiatry program (psychiatric consultations via a televised connection), the state's sexually violent predator program, and a forensics program.

In FY 15-16, the agency's general fund allocation was $203,582,260 and total fund allocation was $435,803,832. Its funding sources include state funds, federal grants, and Medicaid reimbursement, among others. As of September 2015, DMH employed approximately 4,000 full-time employees (FTEs), of which 175 provide substance abuse services and an additional 4 are substance abuse contractors. In FY 14-15, DMH provided clinical services to approximately 87,000 patients.

DAODAS

The mission of DAODAS is to support healthy individuals, healthy families, and healthy communities. DAODAS is a cabinet agency for which the Governor, with the advice and consent of the Senate, appoints the agency director. It is responsible for informing the Governor and state agencies on the state's alcohol and drug use issues. The agency also contracts with 33 local drug and alcohol abuse providers, covering all 46 counties, to provide prevention, intervention, and treatment for persons with alcohol and drug use issues.

In FY 15-16, the agency was allocated $6,643,669 in general funds and $43,274,207 in total funds. DAODAS' primary funding source is the federal substance abuse prevention and treatment block grant, which is primarily passed along to the local providers. Other funding sources include state funds and other federal grants. As of September 2015, DAODAS employed 23 FTEs. In FY 14-15, DAODAS, through its providers, admitted approximately 37,000 patients.

301 Providers

DAODAS contracts with 33 local entities to provide alcohol and drug abuse services. Act 301 in 1973 authorizes county councils to designate a single county agency, either public or private, for planning alcohol and drug abuse programs. In reference to the act number, these local entities became known as 301 providers. The majority of these entities are private, nonprofit organizations with established boards, budgets, and programs. These organizations directly provide alcohol and drug abuse prevention, intervention, and treatment services. DAODAS tracks the 301 providers through outputs and outcomes in annual reports; however, it does not manage the providers.

301 providers receive funds from several sources. These organizations receive pass-through funds from DAODAS, including the federal substance abuse prevention and treatment block grant and state funds. Also, all 301 providers receive a percentage of revenue derived from the liquor excise tax; these funds are directly allocated to the providers. Other sources of funds vary from county to county, but may include funding from county governments, client fees, and Medicaid reimbursement.

Consolidation Overview

Consolidation of South Carolina's mental health and substance abuse agencies has long been a consideration. Since the FY 09-10 legislative session, seven bills have been introduced to consolidate the mental health and substance abuse agencies into a single agency or to merge with other health services agencies including the S.C. Department of Disabilities and Special Needs (DDSN) and the public health portion of the S.C. Department of Health and Environmental Control (DHEC). The Governor's office has also argued for consolidation, specifically in FY 04-05 with a call to merge the S.C. Department of Health and Human Services (DHHS), DMH, and DDSN.

South Carolina is one of three states in the nation in which the substance abuse services are housed in an agency separate from the mental health services. Other states have agencies that offer any combination of mental health, substance abuse, disability, and/or Medicaid services. The federal government also offers mental health and substance abuse services from a single agency called the Substance Abuse and Mental Health Services Administration (SAMHSA). When mental health and substance abuse services are combined, they are often referred to as behavioral health, which federal statute defines as the blending of substance abuse and mental health disorders prevention and treatment for the purpose of providing comprehensive services.

When mental health and substance abuse conditions occur simultaneously, patients are diagnosed with co-occurring disorders. According to a 2014 SAMHSA survey, 63.8 million adult Americans had either a mental health or substance abuse disorder. Of these, 7.9 million (12%) had a co-occurring mental health and substance abuse disorder. In South Carolina, the Revenue and Fiscal Affairs Office estimated that 14% of behavioral health patients were diagnosed with a co-occurring disorder in calendar years 2013 and 2014.

Furthermore, trends in healthcare lean towards “one-stop-shop” models or patient-centered health homes in which the care of the whole patient, including physical and behavioral health conditions, is coordinated through a centralized setting. South Carolina DHHS’s Health Outcomes Plan (HOP) embraces this model. The HOP, created in 2013, was designed to reduce hospital costs by encouraging routine care for the chronically-ill uninsured, frequent users of hospital emergency rooms through the use of patient centered health homes.

Despite national consolidation trends and leading research, thorough consideration should be given to the idea of consolidating the mental health and substance abuse agencies in South Carolina. Consolidating DMH and DAODAS would likely require a significant departure in governance and service delivery for one or both agencies, both of which have operated independently of each other, although with some degree of collaboration, for nearly 60 years.

Governance Considerations

DMH and DAODAS operate under two different governance models; DMH is governed by a gubernatorial-appointed commission, whereas DAODAS is managed by a gubernatorial-appointed director.

DMH

DMH is governed by a seven-member commission which is responsible for overseeing the operation, administration, and organization of the department. The Governor appoints the members, with the advice and consent of the Senate, and each of the members represents a congressional district of the state. Statute requires the Governor to consider consumer and family representation when appointing members. The term of the commission members is five years or until their successors are appointed and qualify.

According to S.C. Code of Laws §44-9-40, commission members are tasked with appointing a state director of mental health according to proven executive and administrative ability, appropriate education, and substantial experience in the field of mental illness; this individual serves at the pleasure of the commission.

Characteristics of a commission-governed agency generally include the requirement that there is a majority to act. Also, all members must be accorded the opportunity to speak on the subject matter which allows varying perspectives to emerge and be debated. In addition, this design increases greater transparency as the DMH Commission is required to publicly announce and hold open meetings and publicly disclose its minutes.

Another aspect to consider is that there is no educational or professional requirement for the agency's commission members to have a strong background in mental health issues. However, most current DMH commission members have a behavioral health background. Also, commission members are appointed by an elected official; however, they are not elected, which may confuse the public in terms of accountability. Tenure could also be an issue as commission members may remain in place until their successors are appointed. As such, members may serve longer than five years, limiting fresh ideas and debate.

DAODAS

Conversely, DAODAS is a cabinet-level agency, meaning the director is appointed by the Governor, with the advice and consent of the Senate, and serves at his/her pleasure. While the DAODAS statute does not prescribe any specific qualifications related to alcohol or drug services for the position, S.C. Code of Laws §1-30-10(B)(2) requires the Governor to appoint individuals who have demonstrated exemplary managerial skills in either the public or private sector.

As a gubernatorial appointee, the DAODAS director is directly accountable to a single elected official, the Governor. For citizens, this relationship presents a clear line of accountability. The relationship also provides a direct line of communication between DAODAS and the Governor for the agency director to advocate on behalf of the agency's clients. Furthermore, with a single leader, as opposed to a governing body, decisions may be made more efficiently.

However, statute does not require the director to have a background in substance abuse. Also, as part of the Governor's cabinet, DAODAS is subject to the policy and management direction of the Governor, which may supersede the director's advocacy role for the agency's clients. Furthermore, the turnover rate in the current South Carolina's Governor's first cabinet was 50%, although the current DAODAS director has served continually since his appointment in 2011.

Southeastern States

We reviewed the governance model of mental health and substance abuse services in other Southeastern states including North Carolina, Tennessee, Georgia, and Florida. All of these states are structured differently than South Carolina and differently than each other. Table 6 summarizes these differences. In all of these states, the Governor has authority to appoint the agency head, with the exception of Georgia in which the Governor approves the agency head.

Table 6: Southeastern States' Governance Models

	Agency	Organizational Structure	Agency Director	Cabinet Agency
South Carolina	Dept. of Mental Health	Separate agencies	Hired	No
	Dept. of Alcohol and Other Drug Abuse Services		Gubernatorial appointee	Yes
North Carolina	Dept. of Health and Human Services (Division of Mental Health, Developmental Disabilities, and Substance Abuse)	Under umbrella agency	Gubernatorial appointee	Yes
Georgia	Dept. of Behavioral Health & Developmental Disabilities	Same agency	Hired with consent of the Governor	No
Tennessee	Dept. of Mental Health & Substance Abuse	Same agency	Gubernatorial appointee	Yes
Florida	Dept. of Children & Families (Office of Mental Health & Substance Abuse)	Under umbrella agency	Gubernatorial appointee	No

Source: South Carolina, North Carolina, Georgia, Tennessee, and Florida statutes.

Service Delivery Considerations

In addition to governance considerations, another factor to consider is the varying service delivery methods of the two agencies. Primarily, DMH directly provides services through a community-based system whereas DAODAS contracts with local providers to administer services.

DMH

With the centralized DMH model, the agency has a greater degree of oversight over its programs. An agency with direct oversight of its programs is liable to demonstrate better performance and less likely to result in fraud or waste. For example, a DMH official indicated that the success of the agency's tele-psychiatry program is linked to the agency's direct oversight of the program; a fragmented system would make such a program more difficult to operate as there would be less control over the providers of the services. Furthermore, centralized models tend to offer greater uniformity. The tele-psychiatry program operates the same in each of the participating emergency departments.

However, the layers of bureaucracy in centralized models may inhibit decision-making abilities. For example, a 301 provider noted how difficult it was to collaborate with a state government's county office due to the county office's limited authority and communication breakdown with the state office.

DAODAS

With the decentralized approach of outsourcing for services, such as the DAODAS model, there are other factors to consider. For one, there is greater flexibility and creativity in service provision. While DAODAS requires providers to offer a base set of services, these providers may tailor these services and offer additional services around the needs identified in their respective communities. Also, contracting for services often creates greater efficiencies. For example, the private 301 providers are not bound by a formal procurement process and can therefore make purchases more efficiently. Compared to a centralized model, the 301 providers are more autonomous and therefore have greater flexibility for making decisions.

Conversely, fragmented service delivery models can present uniformity issues from provider to provider. Several providers interviewed identified consistency concerns associated with the current system. With the flexibility afforded to the 301 provider network, there is a lack of uniformity between the number, type, and quality of services offered among providers.

However, it should be noted that all of the 301 providers are members of the Behavioral Health Services Association of South Carolina (BHSA), which is a South Carolina nonprofit that, in part, serves to improve coordination between the providers. Through this organization, the providers have reduced inconsistencies. For example, the BHSA recently purchased a standardized electronic health record for all of its providers. This new software ensures providers are capturing the same information from clients.

Some providers also questioned the capacity capabilities of the current design. Several of the larger providers assist the smaller providers in areas such as billing so the smaller entities can focus on providing core services. Another capacity concern is the few detoxification clinics operating in the state. There are a total of four programs located in Charleston, Greenville, Richland, and York counties. According to a DAODAS official, agency budget cuts between 2008 and 2012 resulted in the closure of detoxification clinics operated by smaller 301 providers leaving larger 301 providers to provide these services for the entire state.

Southeastern States

We reviewed neighboring states' service delivery models and found that the models vary widely. Table 7 outlines the various service delivery models and methods of provision. Tennessee, Georgia, Florida, and North Carolina operate some facilities, typically state hospitals, and contract for others. In North Carolina, Florida, and Georgia, the states' mental health and substance abuse agencies use regional offices to manage service delivery. In North Carolina and Florida, these regional offices are contracted management entities, which in turn, contract with service providers. Georgia's regional offices are state-run while services are provided through contract. Tennessee's mental health and substance abuse department directly contracts for services.

Table 7: Southeastern States' Service Delivery Models

	Agency	Operated or Contracted		
		State Hospitals	Regional Mgmt. Entities*	Local Providers
South Carolina	Dept. of Mental Health	Operated	N/A	N/A**
	Dept. of Alcohol & Other Drug Abuse Services	N/A	N/A	Contracted
North Carolina	Dept. of Health & Human Services (Office of Mental Health, Developmental Disabilities, & Substance Abuse)	Operated	Contracted	Contracted
Georgia	Dept. of Behavioral Health & Developmental Disabilities	Operated & contracted	Operated	Contracted
Tennessee	Dept. of Mental Health & Substance Abuse	Operated	N/A	Contracted
Florida	Dept. of Children & Families (Office of Mental Health & Substance Abuse)	Operated & contracted	Contracted	Contracted

* Entities on the regional level, in addition to a state agency, that oversee providers of services.
** DMH contracts out the operation of two of its four nursing homes.

Source: South Carolina, North Carolina, Georgia, Tennessee, and Florida agency websites & interviews.

Other Considerations

Clinicians and Treatment

We found that the clinical perspective is something to consider in the consolidation of DMH and DAODAS. According to our research, there is a belief that substance abuse issues are symptoms of deeper psychological distress and, for this reason, are perceived as less legitimate and therefore less deserving of attention and resources. Several of our interviewees echoed these concerns stating that if DMH and DAODAS consolidated, the more widespread mental health issues would likely consume substance abuse issues, treatment, and funding. While it is unclear how a consolidated mental health and substance abuse agency will allocate funding to each area, other Southeastern states indicated that funding streams and billing for each area was not an issue with proper coding of treatment.

Furthermore, research also suggests that combining mental health and substance abuse services can threaten quality of treatment. If these services were integrated, patients with severe co-occurring disorders are likely to receive the most attention whereas patients with less severe disorders or single disorders are more likely to be excluded from treatment.

Also, mental health and substance abuse clinicians often employ different treatment practices. Substance abuse providers typically adhere to the public health model, which incorporates prevention and early intervention whereas the mental health camp falls under the medical model which relies more heavily on treatment. Also, substance abuse services often employ more confrontational approaches, through 12-step models, and avoid drug treatment whereas mental health services often employ more supportive approaches and medication is commonplace.

Salary

Salary discrepancies are another factor to consider in consolidation. As private, nonprofit entities, the 301 providers are often able to compensate its directors at higher rates than commensurate roles at the state mental health agency. DMH staff stated that they can only compete with the substance abuse salaries for positions that require a medical degree. If consolidation were to occur under the current state salary structure, it would likely be difficult to co-opt the staff of the 301 providers at a decreased salary rate.

Sharing Protected Health Information

Legal restrictions on sharing patient health information present yet another obstacle in consolidation. The Health Insurance Portability and Accountability Act (HIPAA) permits the disclosure of protected health information by covered entities for treatment, payment, and health care operations under specific circumstances. However, 42 CFR Part 2 is a federal regulation that limits the disclosure of substance abuse patient records more strictly than patients with physical or mental health conditions. This information is required to remain confidential with few exceptions. As a result, substance abuse providers are not permitted to share courses of treatment and prescriptions with the patient's other healthcare providers.

Conversely, physical and mental health clinicians may share a patient's health record with other clinicians, improving patient care through increased coordination and reducing costs by minimizing duplication of effort.

These legal restrictions affect substance abuse providers in all states. In the event these legal restrictions on substance abuse patient records are lifted, South Carolina's Health Information Exchange can provide a secure medium for providers to share protected health information.

Consolidation Options

Administrative Consolidation

With the varying governance and service delivery models in place at DMH and DAODAS, consolidation can take several organizational forms. The agencies could consolidate administratively while maintaining separate service delivery models. This may reduce administrative costs including office space and shared personnel. It is important to note that since 2011, DMH and DAODAS have co-located administratively at DMH's main office in Columbia, so office space savings have already been realized.

Transitioning from co-location to consolidation may further reduce costs by eliminating duplicate positions such as staff in human resources, budget, and information technology. After service delivery funding is funneled through to its providers, DAODAS's administration operates with approximately $600,000 in state funds, some of which could result in savings if DMH and DAODAS consolidated.

However, while consolidation may eliminate duplicate administrative positions, it may also create additional layers of bureaucracy. Other states mentioned that their consolidated mental health and substance abuse agencies had several top-management positions including an agency director, division directors for both mental health and substance abuse and, in some instances, additional management.

Also, in North Carolina, Georgia, and Florida, consolidated mental health and substance abuse agencies relied on regional management entities to oversee the service providers, creating an additional layer of government.

Administrative and Service Delivery Consolidation

Another option would be to consolidate both agencies' administrative and service delivery components. With this type of consolidation, the administrative role of the agencies could remain as a public function and service delivery could either be primarily publicly-managed, as in the S.C. Department of Social Services; contracted out for private delivery, as practiced by the S.C. Department of Disabilities and Special Needs; or offered through a hybrid model of public and private service delivery as was found in North Carolina, Georgia, Tennessee, and Florida.

At the service-delivery level, consolidation would not likely reduce personnel or office space costs. Staff from both agencies believed that consolidation would not eliminate service delivery staff positions, as both agencies report they are understaffed. Furthermore, DMH and 301 providers typically own their facilities. If consolidation required co-location of mental health and substance abuse facilities, the costs incurred to sell, buy, and move would likely be substantial and may cause a disruption in service delivery.

Alternatives

Status Quo With Improved Collaboration

While we were asked to review whether DMH and DAODAS could be consolidated, we found alternatives to consolidation. DMH and DAODAS could remain as separate state agencies, but improve collaboration. Mental health and substance abuse officials stated that communication and referrals between DMH and DAODAS's 301 providers was generally good; however, they also stated that collaboration could be improved. We found that formal collaboration exists between some of the DMH community mental health centers and 301 providers in memorandums of agreement; however, we did not find evidence that these agreements were common between all mental health and substance abuse providers. Allowing these agencies to remain discrete, but requiring stronger collaboration, may have better success than consolidation.

When asked about their preference, officials from DMH, DAODAS, and the 301 provider system were generally resistant to consolidation favoring rather increased collaboration between mental health and substance abuse. A DMH official stated that because DMH and DAODAS have a history of separation, as opposed to other states in which substance abuse programs developed from within an already established mental health agency, consolidation is unlikely to be successful. A DAODAS official stated that the community connection drives the success of the 301 provider system. Given the importance of these local connections, the DAODAS official stated that there are 46 solutions, one for each county, with a patient-centered focus. The 301 providers share a belief that the flexibility and autonomy of the 301 provider system is the platform for their success. Without these characteristics, which they believe would be lost in consolidation, substance abuse services would not be provided with the same efficiency and quality.

Co-location of Mental Health and Substance Abuse Services

Co-location is another option to full consolidation. Research suggests that patient navigation of healthcare systems is a barrier to seeking and obtaining treatment. If mental health and substance abuse providers were to co-locate in the same facility, while remaining separate entities, patients would have easier access to both mental health and substance abuse treatment services. As previously mentioned, the drawbacks to this option include the financial cost of co-locating and the opportunity cost of co-locating rather than providing services. It is important to note that many of the substance abuse providers also employ personnel capable of providing mild mental health treatment, essentially co-locating treatment options without co-locating physically with DMH.

Consolidate Similar Services Under Single Agency

Another consolidation option includes combining similar services under a single agency. According to the DMH statute, DMH is required to operate an alcohol and drug addiction division, despite the substance abuse charge of DAODAS and the 301 providers. A 2003 LAC audit recommended consolidating all addiction treatment programs including those located at DMH, DAODAS/301 providers, and the S.C. Department of Vocational Rehabilitation, and suggested that if this were to occur, patients would encounter less complexity in obtaining help, interagency referrals could be reduced, and planning and budgeting could be done more comprehensively.

Merge Similar Service Delivery Models

Another alternative would include the consolidation of mental health and physical health services. Both community mental health centers and federally-qualified health centers offer outpatient mental health care and physical health care, respectively, throughout the state. With the link between physical health and mental health conditions, this model could address common co-occurring conditions in a single setting.

Conclusion

Regardless of what is the most cost effective or logical organization of behavioral health agencies in the state, the primary focus of this discussion should be those in need of mental health and substance abuse services. Research suggests that when a potential client is motivated to seek treatment but must coordinate his own care, he is unlikely to follow through with the treatment. Officials from both DMH and DAODAS agree that the focus, therefore, should be patient centered.

Forensics — Timeframes

In this section, we discuss the S.C. Department of Mental Health's (DMH) forensics program as it relates to initial evaluations and the restoration of individuals to competency in order to stand trial. S.C. Code of Laws §44-23-410 allows DMH 45 days to complete initial evaluations and §44-23-430 allows 60 days for DMH to restore defendants to competency. If given a longer timeframe for restoration, it is likely that more individuals would be competent to stand trial.

Determination of Competency to Stand Trial Process

When a person is accused of a crime and a concern is raised that the defendant is not competent to stand trial, he is sent to either DMH or the S.C. Department of Disabilities and Special Needs (DDSN) for an initial evaluation. This evaluation is used to determine if the defendant is incompetent to stand trial and whether the defendant is able to be restored to competency (this is called a Blair hearing). Defendants can only be referred from General Sessions Court, which handles criminal cases. DMH handles defendants who may have mental health issues, while DDSN handles defendants who have developmental disabilities. In some cases, DMH and DDSN work together to determine defendants' competency.

DMH has 30 days to perform an initial competency evaluation on the defendant. DMH can also request an additional 15 days from the court to complete the evaluation (for a total of 45 days). Once DMH has completed its initial evaluation, the court is notified. The Medical University of South Carolina (MUSC) has a contract with DMH to perform the initial competency evaluations on defendants in the ten counties on the coast of South Carolina. DMH handles the other 36 counties.

In comparison, North Carolina has 60 days to complete its initial competency examination and the court may grant up to 60 days of extensions. Georgia has no time limit, while Florida has up to six months to perform the initial competency evaluation on defendants charged with a felony. Tennessee reported that it has no time limit to complete an outpatient initial competency evaluation, but has 30 days for inpatient competency evaluations.

DMH can find that the defendant is competent, is incompetent but restorable, is incompetent and not restorable, or that he is not criminally responsible for his crime. If the court finds that the defendant is competent, the case moves forward in the courts. If the court finds that the defendant is incompetent and not restorable or not criminally responsible for his crime, civil commitment proceedings are initiated against the defendant to place him in DMH's custody. If the defendant is declared incompetent, but restorable, that is when the 60 days to restore begins.

Incompetent, But Restorable

If a defendant is declared incompetent, but restorable, it means that DMH staff feel that the defendant is not currently competent to stand trial but, through DMH's restoration program, he can be restored to competency and the defendant's case can move forward.

DMH staff performing the restoration and interacting with the patient include psychiatrists, psychologists, social workers, activity therapists, nurses, guards, etc. The patient is sent to Columbia for treatment at DMH's forensic facility, when a bed is available.

The restoration process is different for each patient but generally consists of such things as medication, individual and group counseling, activity therapy, and making sure the patient understands the court process (who the solicitor is, what the judge's role is, etc.). DMH holds mock trials and role playing to make sure the defendants understand the court process. For example, according to DMH staff, some defendants believe the solicitor is their friend and is on their side.

S.C. Code §44-23-430 states that DMH currently has 60 days from the date of the Blair hearing to complete its restoration process. By law, the defendant can remain hospitalized for an additional 14 days while the solicitor initiates civil commitment proceedings. However, DMH officials stated that, in most cases, after the 60 days, the defendant is released from DMH custody and sent back to the local detention center where the case is based (unless he was on bond). The court then has a second competency hearing. If the defendant is still found to be incompetent, civil commitment proceedings are started to place the defendant into DMH custody. In this case, the charges are often dismissed but can be restored if the defendant later becomes competent. DMH sends the solicitor a letter prior to releasing a patient, in case the solicitor wants to bring charges again.

Program Statistics

For FY 15-16, DMH's forensic services budget is approximately $28 million. Also, the average cost per day per forensic patient in FY 13-14 was approximately $383.

DMH's forensics program has two units: the Acute/Pre-Trial Unit and the Psychosocial Rehabilitation Program (PRP). The Pre-Trial Unit patients consist of defendants who are not competent but may be restored to competency, patients needing inpatient evaluation, and emergency admissions.

The PRP patients are those who have been found Not Guilty by Reason of Insanity (NGRI) and incompetent, not restorable. Table 8 shows the average number of patients housed in DMH's forensic facility for the past three years.

Table 8: Average Number of Forensics Patients

FY 12-13	FY 13-14	FY 14-15
162*	178*	198*

* NGRI residents are a significant percentage of patients and will not be released from DMH custody quickly, if at all. For example, on July 13, 2015, NGRI patients constituted 18% of the forensics population.

Source: DMH and LAC calculations

Best Practices and Other States

Research shows that rates of competence restoration are generally high with 75% to 90% of individuals typically restored in approximately 6 months of inpatient restoration efforts. For example, one study we reviewed found that 81.3% of the patients reviewed were restored to competence during 6 months of restoration efforts. It further found that 64.2% of the patients, who were not restored to competency within 6 months, were restored to competency in 1.58 years.

We also contacted other Southeastern states to determine maximum timelines allowed for restoration and found that South Carolina's maximum restoration time limit is not adequate.

Table 9: Southeastern States' Maximum Restoration Times Allowed

State	Maximum Restoration Time Allowed*
South Carolina	60 days.
North Carolina	Up to 5 years for a misdemeanor or 10 years for a felony.
Georgia	One year for a misdemeanor. For a felony, it is up to a maximum of the sentence time if the defendant was found guilty.
Florida	Generally, up to five years.
Tennessee	Up to one year for a misdemeanor. Felonies have no maximum time specified in state law.

* We determined these times by talking with officials in these states and reviewing their state laws.

Source: LAC

Effect on Other Agencies

We contacted our state's Commission on Prosecution Coordination, the Commission on Indigent Defense, Court Administration, and the S.C. Department of Corrections (SCDC) to determine how extending DMH's restoration period to six months may affect these agencies. Only Court Administration and SCDC raised any concerns.

Court Administration is concerned that DMH does not have the staff or resources to deal with the increase in restoration patients that will occur if the restoration time limit is increased to six months. DMH would still have the same number of PRP patients it currently has, but would also see an increase in pre-trial patients because those patients would be staying with DMH longer.

SCDC is concerned with an increase in its costs since it would be receiving more prisoners. For example, if more defendants are restored then more defendants' trials would move forward and a certain percentage of those defendants would be found guilty and be sent to prison. SCDC stated it would provide a fiscal impact study, but the agency did not provide one. We originally contacted SCDC about this issue on July 24, 2015.

Conclusion

Over the last three state fiscal years, DMH's data indicates that 41% of the patients who have been referred to the agency for restoration have been restored within 60 days. Research suggests that this percentage would increase if DMH had longer to perform the restoration.

According to a DMH official, the agency has the space to house the additional patients; however, it would take time and funds to open additional beds. Also, forensics will be a high-priority hiring area for the agency and the agency will use incentives to attract new employees. DMH also has other employees throughout the agency who can be reassigned to the forensics unit. Finally, DMH will use technology (such as tele-psychiatry) to deal with the increase in forensics patients.

Although Court Administration's and SCDC's concerns are valid, national research on forensics programs suggests that at least six months is needed to restore defendants. Of the other Southeastern states reviewed, one year was the minimum restoration period.

Recommendation

2. The General Assembly should amend S.C. Code of Laws §44-23-430 to increase the maximum time limit the S.C. Department of Mental Health has to restore defendants to competency to stand trial to six months.

This report was published for a
total cost of $22;
44 bound copies were printed
at a cost of 51¢ per unit.