# MINUTES

## Access to Mental Health Services
## 2018 Interim Study Committee

**Senator Deb Soholt, Chair**
**Representative Herman Otten, Vice Chair**

SOUTH DAKOTA LEGISLATURE
LEGISLATIVE RESEARCH COUNCIL

**First Meeting, 2018 Interim**
**Thursday, June 28, 2018**

**Room 414 – State Capitol**
**Pierre, South Dakota**

The first meeting of the Access to Mental Health Services (AMHS) 2018 Interim Study Committee was called to order by Senator Deb Soholt (Chair) at 8:02 a.m. CDT, on June 28, 2018, in Room 414 of the State Capitol, Pierre, South Dakota.

A quorum was determined with the following members answering the roll call: Senators Bob Ewing, Craig Kennedy, Kris Langer, Deb Soholt (Chair), Alan Solano, and Jim Stalzer; and Representatives Michael Diedrich, Jean Hunhoff, Kevin Jensen, Tim Johns, Herman Otten (Vice Chair), Tim Reed, and Susan Wismer (who participated by telephone). Representatives Haugaard and Howard were excused.

Staff members present were Emily Kerr, Legislative Attorney; Wenzel Cummings, Legislative Attorney; Jason Simmons, Principal Fiscal and Program Analyst; and Kelly Thompson, Senior Legislative Secretary.

*NOTE: For purpose of continuity, the following minutes are not necessarily in chronological order. Also, all referenced documents distributed at the meeting are attached to the original minutes on file in the Legislative Research Council office. This meeting was webcast live. The archived webcast is available at the LRC website at sdlegislature.gov.*

### Scope of Study, Study Process and Progression

**Senator Deb Soholt, Chair,** asked each member why they were interested in serving on the committee. Responses ranged from degrees in psychology, nursing, or law, to professional experience in local government, law enforcement, and health care. Several members also mentioned personal experiences with friends or family members suffering from mental health issues or attempting or committing suicide. All agreed on the importance of finding ways to make mental health services more accessible to those who need them.

The scope of the study includes reviewing what mental health services are available in the state and the capacity of those services including treatment options, continuum care, facilities, resources, and cost to the state. Senator Soholt advised that the scope would not include autism spectrum disorder, dementia, Alzheimer's, individuals successfully managing chronic mental health diagnoses, or substance abuse disorder (on its own). The committee may identify that one of these issues be the focus of a future study in its recommendations.

Senator Soholt announced the study committee's first two meetings would be informational, focusing on definitions, systems, and resources. Funding and solutions will not be discussed until later meetings. The intention is to hold meetings in different locations around the state to gather public input in different forums. The second meeting, scheduled for August 6 and 7, will be held in Yankton and Sioux Falls and include tours of facilities in both cities.

## Interim Study Support

**Ms. Gina Brimner and Ms. April Hendrickson, Western Interstate Commission for Higher Education (WICHE),** were introduced. They will be serving as a resource for the committee, working through the Department of Social Services, and have assisted other states with similar studies.

WICHE, a nonprofit organization based in Boulder, Colorado, was created in 1953 to facilitate resource sharing among the higher education systems of its members which currently include 15 Western states, Guam, and the Northern Mariana Islands. Ms. Brimner stated WICHE maintains a team of experts that have worked in the behavioral health sector and can assist in conducting a tailored evaluation of South Dakota's mental health services and systems, comparing how the state is doing regionally and nationally to recommend improvements. Senator Soholt said the group will be an excellent resource for the committee in its efforts.

## Mental Health/Mental Illness

**Dr. Matthew Stanley, Avera Medical Group University Psychiatry Associates,** told the committee behavioral health is a broad topic encompassing a variety of conditions including mood disorders, psychotic disorders, and anxiety disorders, all of which he treats as an inpatient psychiatrist. While dementia is often cited as falling under behavioral health, it is a neurodegenerative disorder. Dr. Stanley clarified that individuals with dementia and autism spectrum disorder often end up on a "hold" (involuntary commitment) in a psychiatric facility not based solely on their confused state but because it may be combined with aggressive behavior. Depression can also be a factor in such diagnoses. Although these disorders are not a focus of the committee's study, he noted they do impact South Dakota's mental health system.

According to Dr. Stanley, several behavioral health crises exist in the state: opioid addiction, alcohol abuse, use of marijuana and methamphetamines, and suicide, which is a growing risk for females aged 10 to 14. He commented that suicide is likely beyond the scope of the study but by identifying people at risk earlier and getting them into treatment, individuals may not reach the point of committing suicide. Many South Dakota entities participate in the Zero Suicide program which offers specific tools and strategies health and behavioral health care systems can use to promote suicide prevention.

Referring to the 2015 Helmsley Trust study, Dr. Stanley noted that 17 percent of South Dakotans were identified as having depression episodes with 18 percent suffering from anxiety, making them the most common mental illnesses being treated in the state. Four percent of the state's population have chronic mental health issues while 60 to 80 percent of the inpatients being treated have co-occurring disorders.

Dr. Stanley stated that unlike other forms of illness, patients with behavioral health issues will walk into their doctor’s office, tell the provider what is wrong, and then ask for help. Evidence-based monitoring is needed to determine what is working and what is not, and good data is necessary to make effective changes in mental health services and systems. He advised members that access to treatment will continue to be a problem on both a state and national level. Over 60 percent of psychiatrists are age 55 and older, which increases the risk of retiring more practitioners than are being created. New ideas like using telemedicine to communicate with patients in rural areas and developing a system of filters to

identify people at risk and determine the appropriate level of care needed, could be endorsed to equalize care statewide.

Senator Soholt requested that the different forms of mental disorders be defined. Dr. Stanley offered the following clarifications:

- **Mood disorders.** The most common is depression for which there are 8 criteria: having depressed mood more days than not, loss of interest, loss of sleep, loss of energy, change in appetite, feelings of worthlessness or guilt, difficulty concentrating, and thoughts of suicide. To reach the level of diagnosis, the person must experience a disturbance of function, meaning they are unable to complete their duties at home or work and feel distressed.
- **Mania.** Bipolar disorder is in this category. Symptoms include decreased need for sleep, increased talkativeness, increased assertiveness, and grandiose sense of self. Manic people often do not recognize they are ill and may not follow treatment regimens because they miss getting manic.
- **Psychosis.** People with this disorder have lost touch with reality and experience hallucinations, delusions, and paranoia. It most typically occurs in the diagnosis of schizophrenia but can also be caused by the use of stimulant drugs.
- **Anxiety.** It is the most commonly diagnosed category in behavioral health with generalized anxiety being the most often treated but also includes obsessive-compulsive disorder and panic disorder. Anxiety is recognized by discomfort with activities of daily living or being around others, overwhelming fear, and feelings of being out of control. It can be a common cause of substance abuse.

Dr. Stanley described how a person would move through the mental health system. Genetic, environmental, and supportive factors can contribute to mental disorders, which are primarily diagnosed in late adolescence or early adulthood. As the illness progresses and the person matures, social supports like family and work fall away – they are unable to keep a job, friends and family burn out on coping with the person, etc. Community mental health centers step in to offer case management and community support but the patient will feel increasingly alone. In some cases, it will lead to suicide. According to Dr. Stanley, many suicidal patients never make it to the attention of mental health specialists although 77 percent of people who commit suicide have seen a primary care physician within a year of the suicide and about 44 percent within 30 days of the act. Only 17 percent will have seen a mental health specialist within 30 days of their suicide. He said consistent mental health care from early initiation to illness resolution is needed, as is the recognition that mental illness is a medical illness.

Dr. Stanley specified that mental health and mental illness can co-exist but are not interchangeable terms. Mental health is to feel connected to others and have a sense of accomplishment. Mental illness is a clear medical category that fits specific criteria. Not everyone who is not conforming to societal norms is mentally ill.

Senator Kennedy wondered if mental health and behavioral health are the same. Dr. Stanley replied to the contrary, as behavioral health includes issues like autism that are not mental illnesses.

Responding to Representative Reed as to whether better training for law enforcement could help South Dakota's mental health system, Dr. Stanley conceded that while a lot of good things have been done in that area, more training could be beneficial not only for education but to change the culture in departments, too.

Representative Hunhoff asked for a definition of comorbidity. Dr. Stanley replied that co-occurring disorders is a case in which the patient has a mental illness and a chemical dependency disorder. Sixty to 80 percent of patients admitted to mental health facilities have substance issues as well as a mental illness.

Representative Otten wondered if those individuals who committed suicide and had seen a primary care physician in the previous year suffered from co-occurring disorders. Dr. Stanley did not believe primary care providers were missing signs of suicide in their patients but stressed that co-occurring illnesses such as substance use disorders elevate the risk of suicide. He said consistent screening and the discussion of mental illness during primary care may help to identify those risks earlier.

Dr. Stanley agreed with Senator Solano that improving engagement between primary care physicians and mental health specialists could result in clearer treatment paths for those with mental illness.

Representative Johns inquired if mental illness can run in families. Dr. Stanley responded that it is difficult to interpret a genetic panel to determine risk but environmental factors can contribute to mental illness in families (depressed mother, alcoholism, physical violence, etc.).

**Access to Treatment and Services**

**Ms. Lynne Valenti, Secretary, and Amy Iversen-Pollreisz, Deputy Secretary, Department of Social Services,** spoke about the role of public mental health programs in South Dakota (Document 1). The Department of Social Services houses the Division of Behavioral Health which covers mental health services, substance abuse services, the Human Services Center in Yankton, and behavioral health services in the state's correctional facilities. Ms. Valenti thanked the committee for studying the issue of mental health, saying public awareness is critical to increased understanding of mental illness and helps reduce the stigma attached to it.

The Division of Behavioral Health has a Community Behavioral Health program which oversees prevention services (25 accredited providers), substance use disorder treatment (39 accredited providers), and mental health treatment (11 accredited community mental health centers). Ms. Iversen-Pollreisz explained the specific services offered by each category of providers and the training and public awareness campaigns associated with the programs.

**South Dakota Community Mental Health System Overview**

Ms. Iversen-Pollreisz, **Senator Alan Solano, CEO, Behavior Management Systems, Inc.,** and **Mr. Terry Dosch, Executive Director, South Dakota Council of Mental Health Centers,** provided an overview of the community mental health system in South Dakota including how it operates, who it serves, and how it is funded.

South Dakota has 11 community mental health centers with a budget of $35 million, comprised of a Federal Block Grant ($1 million), Medicaid ($10 million), and State General Funds ($24 million). The centers operate on a federally-approved state plan focusing on evidence-based practices, early intervention services, suicide prevention, and workforce development. They treat children with serious emotional disturbance (SED) and adults with serious mental illness (SMI). Ms. Iversen-Pollreisz listed the eligibility criteria for SED and SMI (Document 1 beginning with slide 9).

In FY2017, the centers served 4,589 individuals through general outpatient services and 12,290 served through specialized outpatient services. During that same time period, there was a 66 percent decrease in the number of clients who reported at least one emergency room visit for a psychiatric or emotional problem and a 62 percent drop in the number of clients who reported spending at least one night in jail.

Mr. Dosch noted all 11 centers are members of his organization (Document 2) and their purpose is to connect people with the long term outpatient care needed. Community mental health centers are private non-profit agencies that are locally governed and accredited by the Department of Social Services. They are all configured differently to meet the needs of the specific areas served but all provide 24/7 on call crisis services. Mr. Dosch stated the bulk of their services are provided at home, because that is where people want to receive them. Among the challenges centers face are increasing intensity of services and clients, declining workforce, reimbursement concerns, and services in rural and frontier areas. Contact information was provided for all of the centers (Document 3). Services are available in all 66 counties in the state, though not to the same level in each county.

Regarding his organization, Behavior Management Systems, Inc., Senator Solano advised they are moving more into telehealth to expand the reach of their services from urban to rural and frontier areas. Over 50 percent of their work is done outside of their offices. He noted the numbers of people being treated continue to grow with a 16 percent year over year increase in the number of adults with severe and persistent mental illness, an increase of 36 percent for children with mental health disorders, and a 34 percent increase in those individuals needing psychiatric services. More is being done to identify patient issues earlier but identification takes more resources, primarily staffing.

Senator Solano reiterated the core services criteria to be an accredited community mental health center:

- Outpatient assessment for early identification of patient needs
- Treatment for adults with severe or persistent mental illness
- Treatment for children with serious emotional disturbance
- Psychiatric services (including medication evaluation and follow up)
- Emergency services (24/7 crisis help)

Ms. Iversen-Pollreisz broke down the following data for services provided by community mental health services in FY2017: 4,589 served with general outpatient services; 4,989 helped with Children, Youth and Family (CYF) Services; 7,000 adults served through Comprehensive Assistance with Recovery and Empowerment (CARE) programs; 301 served through the six centers offering the highest level of adult care offered, the Individualized Mobile Programs of Assertive Community Treatment (IMPACT) program; and 724 individuals assisted through the Health Homes program offered by nine centers.

Committee members requested regionalized historical data beyond FY2017 for the areas highlighted by Ms. Iversen-Pollreisz; details on the contracts between the Department of Social Services and community mental health centers; information on the wait time for clients to get into treatment; what training programs exist for clinicians and mental health professionals in light of the shortage of such providers; information on where the state sits for telehealth usage (statistics, plans for expansion, reimbursement options); and information on the satisfaction survey process and clarification of what the percentages mean in terms of successful completions.

Representative Hunhoff asked what percentage of children with SED transition into adults with SMI. Ms. Iversen-Pollreisz replied that she had no specific numbers to offer but some youth have never gone on to have serious mental illnesses as adults.

Representative Diedrich inquired where patients are sent for care if the capacity for treatment at community mental health centers reach maximum levels. Ms. Iversen-Pollreisz said it is unlikely the individual would be sent out of state but, instead, the state psychiatric hospital could provide the higher level of care needed and work with the center to provide it.

Senator Soholt commented that more data is necessary to understand and manage workforce shortages in the mental health sector. Representative Hunhoff wondered if options exist to enhance provider competency so they could provide some services covered by psychiatrists heading toward retirement. Ms. Iversen-Pollreisz confirmed a certified nurse practitioner (CNP) or physician assistant (PA) could also provide some of those services.

Regarding the map of community mental health centers in South Dakota (Document 5), Senator Soholt asked why Brookings has its own center (East Central Behavioral Health). Mr. Dosch explained that in the past grants were provided to communities willing to start a community mental health center and organizers in Brookings took that opportunity. Community financial support to each center varies from one community to another and depends on the state contract and direct funding received locally (fundraisers, United Way, county funds). Senator Soholt requested that information on funding sources and total expenses for each center be provided at the next committee meeting.

Senator Kennedy wanted an estimate of the number of people who need mental health services that are not being reached by current services, broken down by geographic region. Ms. Iversen-Pollreisz said it may be difficult to break out the information geographically but the department will work on an estimate.

## South Dakota Investments in Mental Health

### Behavioral Health Services Work Group

Ms. Valenti spoke about the Behavioral Health Services Work Group (Document 4) established by Governor Daugaard in 2011. The group's goals are to increase access to services statewide, build the capacity of local communities to support behavioral health services, develop a strategic statewide prevention plan, and consider the role of the Human Services Center. The Work Group has four subcommittees: Commitment Laws, Prevention Services, Geriatric Services, and Essential Services.

As a result of the group's efforts, legislation was passed in 2012 and 2013 to modify outpatient commitment statutes, create an integrated commitment process for medication/treatment and co-occurring disorders, and permit involuntary treatment within jails. Other goals achieved include: implementation of an integrated assessment process; establishment of a Clinical Review Team at the Human Services Center; expansion of community nursing facility options for seniors with challenging behaviors; creation of an Evidence-Based Practice (EBP) Work Group to review and select prevention EBPs for use in South Dakota; and support for 11 suicide prevention community coalitions and the implementation of the Zero Suicide initiative across the state.

Ms. Iversen-Pollreisz highlighted several public awareness campaigns being used in prevention efforts:

- **Meth Changes Everything.** The campaign educates high school students and community members on the dangers of methamphetamine use through presentations, a website, and social media. Over 164 school presentations and 21 community meetings have been held with over 6,500 participants.
- **AvoidOpioidSD.** Aimed at all South Dakotans, with specific components geared toward Native Americans, the program uses public service announcements, website and social media content, community presentations, and Naloxone training to help prevent opioid abuse and misuse.
- **Bethe1SD.** This campaign uses school and community presentations, a website, and social media to prevent suicide and reduce the stigma surrounding mental health.

In the area of Essential Services, the work group has supported early intervention services such as screenings and risk assessments; college crisis texting programs at 5 schools, with over 200 calls received and responded to; a follow up program for youth and young adults discharged from the hospital following a suicide crisis (900 people have enrolled); Youth Mental Health First Aid trainings that have referred over 2,000 youth to mental health services; integration of screenings for depression and substance abuse in primary health care settings, with 5,900 screenings leading to treatment done among the 4 clinics participating; development of Crisis Intervention Trainings (CIT) for law enforcement and first responders that include elements of Mental Health First Aid and crisis de-escalation; supported living services for transition age youth struggling with integration back into their communities and adults with serious mental illness or co-occurring disorders; development of inpatient and outpatient specialty services; and implementation of a Family Support Program (FSP) and Systems of Care (SOC) services to identify family resources and support youth and their families regarding mental health needs.

Senator Soholt and Representative Hunhoff requested outcome data for the work group's initiatives to determine successes and the potential for improvement; Ms. Iversen-Pollreisz will work with the committee to provide the data.

Senator Kennedy questioned why the regional maps for community mental health centers provided by the Department of Social Services and the South Dakota Council of Mental Health Centers do not align with each other. Ms. Iversen-Pollreisz said the agency's map breaks the regions out to indicate hubs of health care where people in an area would logically go for services, as identified in the 2011 Governor's

Behavioral Health Work Group. Mr. Dosch clarified that community mental health centers are still responsible for the counties assigned to them, regardless of the differences in the maps.

Representative Otten asked if the 11 suicide coalitions are tied to the 11 community mental health centers and whether they could be combined to provide better services and more efficient use of funding. Ms. Iversen-Pollreisz replied the matching numbers are merely a coincidence but she could review the information regarding the entities to determine how they could work together.

In response to Representative Hunhoff, Ms. Iversen-Pollreisz clarified that when tribal members access mental health services outside of the reservation, the services may follow them back when they return home, depending on the area. There are also some tribal mental health programs in place to offer assistance to members.

**Criminal Justice Reforms**

Ms. Iversen-Pollreisz presented information on the Criminal Justice Initiative (CJI) that resulted from the 2013 South Dakota legislative session (Document 4 beginning with slide 28). CJI aims to improve rehabilitation and reduce the number of repeat offenders by determining the community-based intervention needs of the individual. A similar program to address youth offenders – the Juvenile Justice Reinvestment Initiative (JJRI) – was approved by the 2015 South Dakota Legislature. Both initiatives established oversight councils to monitor progress and outcomes.

In FY2017, JJRI served 755 clients through Functional Family Therapy (FFT) services; 75 clients through Moral Reconation Therapy (MRT) services; and 29 clients through Aggression Replacement Therapy (ART) services. Sixty-three percent or 346 youth successfully completed FFT with 97 percent of those youth having no legal violations resulting in placement in an out of home facility. Therapists reported an average of 92 percent of families who completed FFT demonstrated a positive general change. "Successfully completed" means the youth has met the milestones defined in the program.

Ms. Iversen-Pollreisz said the treatment is voluntary, and a session can only be held if the family is present. Discussions have taken place with the court system to see what options could be implemented to ensure the child attends and completes the treatment. Representative Hunhoff wondered what happens to the child if the family will not participate in the therapy. Ms. Iversen-Pollreisz assured her that they will work hard to engage the family if possible but if that proves unsuccessful, the child will not be abandoned but moved to a different program.

Representative Jensen asked if the courts are the only point of entry for the therapy services. Ms. Iversen-Pollreisz responded that it was initially but work is being done to open referrals up to other entry points like schools and child welfare workers.

Senator Soholt remarked that data from these programs will help provide an idea for cost and success rates, noting current anecdotal feedback indicates the juvenile justice system is not working, resulting in pressure from the courts, law enforcement, and schools. Other legislators will expect the interim study committee to respond to the issue, and data is needed for them to have a clearer understanding of the

situation. Representative Johns cautioned that dealing with dysfunctional families can be a difficult task and the information the committee gathers may not be helpful in addressing that overall issue.

**Oversight Council for Improving Criminal Justice Responses for Persons with Mental Illness**

The 2016 task force created by Chief Justice Gilbertson and Governor Daugaard led to legislation aiming to improve public safety and the treatment of people with mental illness in contact with the criminal justice system (Document 4 beginning with slide 33). Ms. Iversen-Pollreisz specified the individuals being referred to are those who come in contact with the criminal justice system as a direct result of their mental illness not people who have committed a crime and happen to have a mental illness.

Among the group's recommendations was requiring the use of a standardized mental health screen at jail intake and a process for mental health assessment following positive screens. House Bill 1183, passed in 2017, created a pilot program utilizing these components. Screenings are currently being conducted at seven jails across the state, linking them to mental health centers in their areas for positive screens.

As a result of the task force, the Department of Social Services has appropriated one time funds totaling $100,000 to establish a crisis services grant program. Through a request for proposal (or "RFP") process, funds were awarded to Behavior Management Services, Inc. for a crisis care center; Lewis & Clark Behavioral Health Services, Inc. for telehealth delivery of evaluations and training at the Charles Mix County Jail; and Minnehaha County for the development of a crisis response infrastructure.

Ms. Iversen-Pollreisz stated mental health training and information is now being provided to states' attorneys, court appointed attorneys, officers within jails and the state prison system, court service officers, and magistrate and circuit court judges through a collaborative effort by the Department of Social Services, Department of Corrections, and the Unified Judicial System. Public information materials have also been developed to let the general public know what services are available and how to access them. A mental health court pilot program will begin in Pennington County in January 2019, operating similarly to the drug courts already being used around the state.

Several initiatives have been implemented to expedite completion of court-ordered competency evaluations. The South Dakota Association of County Commissioners partnered with state officials to create a fund to assist counties with the costs for the evaluations. The group of professionals authorized to conduct the evaluations has also been expanded beyond psychiatrists and psychologists. After specialized training, certified social workers, licensed professional counselors with the mental health designation, and advanced practice nurses with psychiatric certification can perform the evaluations as well.

Finally, in an effort to strengthen the ability of law enforcement to identify mental illness and address crisis situations, Mental Health First Aid for Public Safety Officers Training and Crisis Intervention Training (CIT) is available for local law enforcement officials. For departments in rural areas which cannot send their only law enforcement officer to long, in-depth training sessions, a CIT coordinator will be installed as a training resource.

Ms. Iversen-Pollreisz noted the major achievements of the task force to be increased access to evidence-based prevention services, early intervention services, crisis support services and referrals to community-based treatment, and evidence-based behavioral health treatment; increased telehealth options to ensure access in rural areas; and use of community-based services over institutional services.

Representative Otten asked what level of training has occurred throughout the state with specific numbers of jails and officers participating. Ms. Iversen-Pollreisz responded that while much of the training occurred at events like annual meetings, she would compile what figures are available.

Representative Diedrich wondered if it was possible yet to gauge the impact of these efforts on the criminal justice system. Ms. Iversen-Pollreisz said while some data is available, other components have only recently been implemented or are not in place at this time. Representative Johns commented it may be too early to tell, and some statistics on how many people were diverted before they got to the justice system would not be available if the individual was not involved in the justice system previously.

## Public Testimony

**Mr. Al Scovell, self, Rapid City,** told committee members that as an attorney for over 50 years and a foster parent for over 15 years, he has witnessed firsthand the need for better mental health care services for youth and adults in South Dakota. Mr. Scovell said the state has many times missed the opportunity to investigate and resolve the issues in the state system. Wait times are too long for mentally ill people needing evaluation and treatment and computer-trained providers will not have the critical expertise needed to properly evaluate those individuals. A handout was provided to committee members (Document 6).

Senator Soholt thanked Mr. Scovell for his testimony, saying he had raised some issues that will help the committee members ask the right questions going forward.

## Final Remarks and Next Steps

Senator Soholt again thanked the committee members for committing their time to studying this important issue, adding she believes that by working together they can build on things already working and identify new pathways for improvement. Additional meetings will be scheduled. The next meeting is planned for August 6 and 7 in Yankton and Sioux Falls. Details will be forthcoming.

## Adjourn

***A motion was made by Senator Stalzer, seconded by Representative Jensen, that the Access to Mental Health Services Interim Study Committee be adjourned. The motion prevailed unanimously on a voice vote.***

Chair Soholt adjourned the meeting at 3:22 p.m.