MINUTES

Access to Mental Health Services
2018 Interim Study Committee

Senator Deb Soholt, Chair
Representative Herman Otten, Vice Chair

Third Meeting, 2018 Interim
Tuesday, September 11, 2018

Room 414 – State Capitol
Pierre, South Dakota

The third meeting of the Access to Mental Health Services (AMHS) 2018 Interim Study Committee was called to order by Senator Deb Soholt (Chair) at 7:35 a.m. CDT, on September 11, 2018, in Room 414 of the State Capitol, Pierre, South Dakota.

Senator Soholt requested a moment of silence in memory of those who lost their lives on September 11, 2001.

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, Steven Haugaard, Taffy Howard, Jean Hunhoff, Kevin Jensen, Tim Johns, Herman Otten (Vice Chair), Tim Reed, and Susan Wismer.

Staff members present were Emily Kerr, Legislative Attorney; Wenzel Cummings, Legislative Attorney; Tamara Darnall, Chief Fiscal and Program Analyst; and Pam Kean, Committee 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.

Approval of Minutes

A motion was made by Senator Langer, seconded by Representative Diedrich, to approve the minutes of the Access to Mental Health Services Study Committee meeting held on August 7, 2018. Motion prevailed on a voice vote.

Opening Remarks

Senator Deb Soholt, Chair, reiterated the large scope of the task force and advised members that the September meeting would conclude the assessment phase of their review. As September is Suicide Prevention Month, discussion would focus on perspective and context as to where South Dakota fits in the larger scheme of the suicide issue and prevention.

Pierre/Fort Pierre Mental Health Task Force

Dr. Mikel Holland, President/CMO, Avera St. Mary's Hospital, briefed the committee on the task force which was formed in the 1990's in response to a high teen suicide rate in the two communities (Document 1). Initially, a "crisis room" was created where a person at risk could be kept safe while

qualified mental health providers evaluated them to determine if hospitalization was needed. Use of the room generally involved an involuntary committal petition.

In the past five years, changing rules and regulations prompted the development of the Mobile Crisis Response program which brought together Capital Area Counseling, medical professionals, and local law enforcement to redefine access to mental health services with the goal to safely evaluate people in a timely fashion. Dr. Holland explained that law enforcement, clinicians, family members, or friends can call the crisis team to have a mental health professional come to the home, clinic, or hospital to evaluate the individual's needs and develop a safe in-home plan. This action allows a situation to be stabilized and can reduce the number of involuntary committals. The program has resulted in a decrease in transportations to tertiary care facilities, fewer involuntary committals, and a reduction in the use of law enforcement.

Dr. Holland said that, unfortunately, the number of persons in crisis continues to rise, and the program's challenges include timely, safe transportation; adequate staffing and financing; and expeditious access to services. The task force continues to look for ways to meet the mental health needs of the area and educate the public about what services are available.

Representative Wismer asked about voluntary versus involuntary commitment, and the cost of such services. Dr. Holland clarified voluntary commitment is when an individual realizes they are in crisis and is willing to seek help on their own while an involuntary commitment petition is signed by a third party (usually family) to get assistance for an individual who is not willing to get such help. He advised his interaction is with treating the patient, and he could not speak as to the costs involved.

At Senator Soholt's request, **Ms. Amy Iversen-Pollreisz, Deputy Secretary, Department of Social Services,** explained the financial obligations. In the case of involuntary commitment, the county pays a $600 admission fee to the Human Services Center (HSC) for a month of care for individuals who are involuntarily committed and indigent. HSC also bills insurance and other payer sources. Beyond the initial 30 days, a daily rate of about $20 is applied.

Representative Haugaard asked how the task force followed up with patients to determine if they had received satisfactory services. Dr. Holland admitted that in the past, success rates were low but with the implementation of the Mobile Crisis Response program, appointments can now be made for patients to see local counselors and access the community health center immediately following discharge to ensure they continue to receive the help they need.

Senator Kennedy inquired how long an individual would stay in the crisis room or emergency room at Avera St. Mary's Hospital before being sent on for further assistance. Dr. Holland said the stay is usually between two and four hours with occasional situations requiring a 24-hour stay.

Senator Solano asked if law enforcement is required to remain with an individual brought in by law enforcement for assistance. According to Dr. Holland, law enforcement will stay if an individual is belligerent or threatening to hospital staff but if the patient is cooperative, officers will leave. During the stay, patients are observed on a one-to-one basis.

Senator Soholt commended Dr. Holland on the efforts being made in the Pierre area and reiterated to the committee the importance of finding ways to tackle the involuntary commitment issue and develop practices to de-escalate situations involving people at risk. She noted strong programming is in place in South Dakota's larger communities and stressed the need for similar resources throughout the state, as well as ongoing education of the public to remove the stigma of mental illness.

Catholic Social Services (CSS) of the Black Hills

Mr. Jim Kinyon, Executive Director, Catholic Social Services of the Black Hills, provided background on his organization (Document 2), which offers mental health services primarily in Rapid City with outreach in Eagle Butte, Pine Ridge, and Porcupine. Among the services CSS of the Black Hills provides is outpatient counseling, mental health assessments, Indian Health Service referrals, adoption, combatting poverty and unemployment, and QPR (Question, Persuade, Refer) Suicide Prevention Training. Twenty-one QPR trainings have been conducted in the last year.

Mr. Kinyon noted the suicide rate among Native Americans in South Dakota is four times the national average. Through the CSS Lakota Circles of Hope program, Native American youth can take self-assessment surveys and learn positive beliefs and habits for mental and physical growth. The prevention curriculum is for 2nd to 8th graders. Currently, 1,000 students in 12 schools participate.

Responding to Senator Soholt's question about counseling staff, Mr. Kinyon said it is challenging to find people to fill existing positions, which has been an obstacle to extending mental health services to communities with the highest need.

Representative Howard asked for an explanation of the organization's revenues and expenses. Mr. Kinyon responded that CSS programs operate on grant funding, Medicaid assistance, and VOCA (Victims of Crime Act) dollars, and referred to the annual report provided to the committee.

Representative Haugaard inquired if relaxing licensing standards would enable CSS to find the employees it needs. Mr. Kinyon answered that being able to hire bachelor's degree level counselors to be reimbursed for mental health services could help in hiring and retaining employees.

Data Follow-Up from Previous Meetings

Mr. Terry Dosch, Executive Director, South Dakota Council of Mental Health Centers, presented statistics on the payer mix for mental health services and staffing needs for community mental health centers (Document 3). Statewide, 41.9 percent of the payer mix comes from Medicaid with 31.9 percent from DSS contracts; self-pay accounts for 4.5 percent.

In terms of staffing, Mr. Dosch shared that the biggest need over time will be for master level counselors. He also noted there is a severe national shortage of psychiatrists, particularly child psychiatrists. Recruiting and retaining licensed professionals willing to live and work in rural and frontier areas is a challenge. Currently the statewide community mental health center system has 23 open master level counselor positions.

Telehealth services are being used to support clinical services in 11 South Dakota counties. Mr. Dosch said the goal in fiscal year 2019 is to expand telehealth services to an additional 25 counties based on recent Department of Social Services guidelines.

At Senator Soholt's request, Mr. Dosch reviewed the follow-up information provided in response to committee questions regarding Lewis and Clark Behavioral Services (Document 4). He clarified that the average contact time for direct service under the day rate is 57 minutes; the day rate of $67 is a flexible way to bundle care components to provide services based on the fluctuating needs of the individual; billable contact can only be claimed once in a 24-hour period with a minimum requirement of 15 minutes of direct face to face time; and 47 percent of the 748 youth and adolescents served in fiscal year 2018 had a history of trauma. Senator Soholt commented the childhood trauma could be linked to the percentage of trauma victims who go on to have ongoing mental health disorders. In the last year, nearly 100 adverse childhood experience professionals have been trained in South Dakota to address this issue.

Lutheran Social Services of South Dakota (LSS) provided the committee with a written follow-up response (Document 5) detailing the agency's revenue sources, client fees by source, and clients served by office location. LSS provided telehealth services to clients in 93 communities in the last fiscal year. As part of their efforts to bring services to the individual level, through private funding, LSS has distributed 68 tablets and 53 hot spot devices for client use.

Suicide in South Dakota and the Nation

Ms. Kim Malsam-Rysdon, Secretary, Department of Health (DOH), related that suicide is the 9th leading cause of death in South Dakota and the 2nd leading cause of death among South Dakotans aged 15 to 34 (Document 6). DOH uses data to help target its prevention and intervention efforts, but Ms. Malsam-Rysdon said that increasing suicide rates indicate the state is moving in the wrong direction, and collectively, there is cause for concern.

According to **Dr. Joshua Clayton, State Epidemiologist, DOH,** three South Dakota counties rank in the top 1 percent for the highest suicide rate in the United States. It is important to note that in addition to the thousands of people who die by suicide every year, many more attempt suicide and live. Dr. Clayton said for every suicide death, there are approximately three hospitalizations, nine emergency department visits, and 27 attempts. The leading factors contributing to suicide are relationship problems (42 percent, which includes bullying among youth), crisis in the past or upcoming two weeks (29 percent), problematic substance abuse (28 percent), physical health problem (22 percent), job or financial problems (16 percent), criminal legal problems (9 percent), and loss of housing (4 percent).

In response to the suicide issue in South Dakota, an interagency suicide prevention work group was established that includes Lieutenant Governor Matt Michels and representatives from DOH, Department of Social Services, and Department of Tribal Relations. The guiding principles of the group are to use data to allocate resources, engage community leaders in prevention and intervention efforts, and focus on evidence-based prevention and intervention methods.

Ms. Malsam-Rysdon reported that in addition to the work group, DOH has prioritized suicide within the agency's strategic plan, making it one of five key areas for discussion and action. The agency's efforts are data-driven. Data is accessible monthly at the community and county level, and DOH is working to ensure timely and accurate reporting from its data sources and expanding to receive information regarding suicide attempts. They are also participating in the National Violent Death Reporting System, a national data set geared toward understanding the factors that contribute to suicide.

Senator Stalzer asked what caused the sharp rise in suicides among the state's Native American population in 2014. Dr. Clayton stated the increase in suicides among Native Americans during that time represented a cluster of suicides that occurred on the Pine Ridge Reservation.

Senator Solano inquired whether the number of suicide attempts has increased and if the lethality of the means used in completed suicides has changed. Dr. Clayton responded that suicide attempt data is available on DOH's suicide prevention website, and, while the means used to commit suicide have not typically changed, firearms are the number one method in South Dakota.

Senator Solano wondered if information was still being collected through the Youth Risk Behavior Survey implemented in 2015. Ms. Malsam-Rysdon confirmed the survey is submitted through schools and administered in all states through the Centers for Disease Control and Prevention (CDC). In 2017, South Dakota did not have adequate participation from schools to be able to report on the survey results. Ms. Malsam-Rysdon believes the lack of participation was due in part to time constraints during the school day and concerns by school administrators and parents as to what type of questions are being asked and if the data collected would be anonymous and confidential.

Senator Soholt commented that the Youth Risk Behavior Survey is utilized by the Center for the Prevention of Child Maltreatment in looking at child sexual abuse, and there is a statistically significant correlation between unwanted sexual touching experiences and suicide ideation and attempts. She expressed the dependency on feedback to clarify intervention.

Representative Jensen noted as a past school board member the barriers he saw to data collection including the legislature passing opt-in on all surveys, which can become cumbersome for schools, and concerns by school administrators and parents about maintaining control over the personal data being collected.

Senator Kennedy asked if the actual number of deaths by suicide in South Dakota is collected in an accurate manner. Ms. Malsam-Rysdon indicated that underreporting of suicide is a legitimate concern and that while the numbers reflect actual data, the actual number of suicides is likely higher based on death certificate reporting. Dr. Clayton added in some situations, the mindset of the person at the time they committed suicide is known so their intent is clear, but at other times there is a component of impulsivity that is difficult to quantify.

Senator Soholt asked Ms. Malsam-Rysdon where South Dakota sits in relation to the "Bullying Victimization Among U.S. Youth" report (Document 7). She responded the state has extremely high rates of bullying, and South Dakota is #1 in the country for certain populations, making it crucial that agencies and individuals who work with youth continue to address the issue and find ways to combat it.

Ms. Lynne Valenti, Secretary, and **Ms. Amy Iversen-Pollreisz, Deputy Secretary, Department of Social Services (DSS),** highlighted the work the agency has been doing in the areas of suicide prevention and intervention, state initiatives, and community engagement (Document 8, beginning at page 12).

DSS has developed population-specific suicide prevention toolkits for communities, realizing that efforts are most effective at the local level. The toolkits contain data, step by step strategies and activities, and training resources. The agency's suicide prevention website (http://sdsuicideprevention.org/) also contains extensive information for individuals, providers, first responders, and clergy.

Prevention services in South Dakota are funded with federal monies. Ms. Iversen-Pollreisz indicated the primary funding stream for prevention is a South Dakota Youth Suicide Prevention Grant, a federal grant targeting youth and young adults ages 10 to 24. The term for the five-year grant ends in September 2019. The grant covers a crisis texting program for college-age youth, awareness campaigns, community coalitions, and a follow-up program for those hospitalized for suicide attempts. Seventy percent of participants reported improvement in the severity of their depression.

Other grants utilized by the agency are the Project Aware grant which provides youth mental health first aid training (60 percent of those trained are members of school staff), and the Screening, Brief Intervention, and Referral for Treatment (SBIRT) grant which helps primary care clinics implement screening mechanisms to identify people at risk.

To meet the agency's efforts to raise public awareness about suicide and suicide prevention, DSS implemented the "BeThe1SD" prevention campaign. The program focuses on reducing the stigmas surrounding mental illness and asking for help and educating people on identifying those at risk.

Another component is the "Zero Suicide" initiative which is aimed at health care and behavioral health care systems. It consists of tools providers can use to develop suicide prevention efforts locally within their organizations. Over 100 people representing 30 organizations have attended DSS-sponsored workshops and committed to a "Zero Suicide" goal once individuals are engaged in care within their system.

Ms. Valenti discussed the state's efforts to promote September as National Suicide Prevention Month. DSS, DOH, and the Department of Tribal Relations, as well as agency partners, community coalitions, and providers, are utilizing the recognition to inform the public about suicide prevention and intervention. Governor Daugaard issued a Call to Action on August 9, 2018, in the form of a letter encouraging communities to take action. An additional letter was sent to organizations across the state linking them to the suicide prevention website and encouraging them to host events and use digital resources to foster community participation.

Representative Diedrich wondered what the most effective way is to identify suicide risk in South Dakota. Ms. Iversen-Pollreisz replied multiple strategies are needed because there is a broad array of people that can be at risk.

Representative Jensen requested information on how many federal grants the department relies on and the total amount of dollars received. Ms. Valenti said her agency would follow up with the information.

Senator Soholt commented that when the study committee gets to the solution phase, it will need to look at utilizing federal grants in a way that strategically matches the state's goals and is not dependent on the end of a grant cycle.

Ms. April Hendrickson, Western Interstate Commission for Higher Education (WICHE), provided a brief overview of national suicide trends and strategies for preventing suicide (Document 9). From 1999 to 2016, half of the states' suicide rates increased by more than 30 percent. The increase in South Dakota was 44.5 percent. The national rate of those 18 or over having serious thoughts of suicide in the past year was 4 percent. South Dakota near the national average with 3.9 percent.

Ms. Hendrickson noted several national organizations provide resources for states in the area of suicide prevention and intervention. The American Foundation for Suicide Prevention (AFSP), a national voluntary health organization, supports efforts for all 50 states to have policies related to training health care professionals, suicide prevention in K-12 schools, and suicide prevention on university and college campuses. The Suicide Prevention and Resource Center, funded by the Substance Abuse and Mental Health Services Administration, advocates a model states can use to develop comprehensive suicide prevention programs. The model is based on nine strategies: identify and assist; increase help-seeking; effective care and treatment; care transition and linkages; response to crisis; postvention; reduce access to means; life skills and resilience; and connectedness.

Several other WICHE materials were provided to committee members (Documents 10 and 11).

Representative Jensen asked if those individuals who saw their primary care providers before committing suicide were at the clinic specifically to address their mental health condition.
Ms. Hendrickson said it was likely for a routine visit.

Senator Solano wondered if there is a correlation in those states that have mandatory training in how they compare in terms of increases or decreases in suicide rates within their state. Ms. Hendrickson responded she will explore available data in that regard. Senator Soholt expanded the request to include how long the states have had the statutory change and what kind of funding supports it.

Representative Howard inquired if the correlation of policy implementation and rate information could be made available and if the major health providers in South Dakota mandate training. Senator Soholt requested follow-up information be provided on these issues.

Representative Hunhoff requested clarification on the increased incidence of suicide among Native Americans in South Dakota in 2014. Ms. Malsam-Rysdon indicated bullying played a role with the cluster of suicides impacting young adolescent females. The response at the state level involved DOH offering assistance and resources to the community. The federal Department of Health and Human Services also worked with Pine Ridge to provide funding to help address the situation.

Representative Hunhoff wondered how the state plans to determine if interventions are really changing behavior. Ms. Malsam-Rysdon said it is difficult to determine if any one thing will cause a commensurate decline in the suicide rate but believes the rate would be higher if not for the work being done in

communities across the state. Ms. Iversen-Pollreisz agreed, saying South Dakota is in line with the efforts of other states and their struggles.

Senator Stalzer asked if South Dakota participates in the federal "Drug Take-Back Day" program. Ms. Malsam-Rysdon replied in the affirmative, noting the state sees a lower number of deaths from opioid overdoses.

Representative Johns asked what the principal motivations behind suicidal ideations are and how they can be addressed. Ms. Iversen-Pollreisz responded that people at a point of despair see suicide as a way out. Educating people, helping them become more resilient, and increasing the protective factors to help them cope with the challenges of life are critical to prevention.

Representative Haugaard related that in his experience, suicide is usually based on an acute sense of hopelessness and is often a spontaneous act. He wondered how churches could be engaged to instill hope in these situations. Ms. Malsam-Rysdon stated the role of the faith community can be a large one, providing a strong sense of strength and resilience for people involved with the community. Many church bulletins contain helpline information, and there is no exclusion at the state level of any entities that want to be part of community-wide efforts.

Representative Wismer referenced information from the CDC regarding suicide prevention strategies and asked if South Dakota's plan had a ranking of those strategies, particularly in the area of childhood trauma. Senator Soholt commented the question would require additional follow-up. Ms. Malsam-Rysdon advised that some of the strategies contained in the CDC document are macro policy strategies which the state suicide plan does not tackle as the state plan is targeted more towards those strategies that are known to be effective in reducing suicide numbers.

South Dakota Veterans and Mental Health

Mr. Aaron Pollard, Deputy Secretary, Department of Veterans Affairs, shared that an estimated 25 percent of active duty service members show signs of mental health conditions and those individuals eventually reach veteran status. Veterans who live with mental health conditions are likely to have substance abuse disorders and/or diagnosed or undiagnosed traumatic brain injuries. The U.S. Department of Veterans Affairs has made significant strides in treating veterans with mental illness including the use of long-term inpatient treatment, aggressive outpatient treatment, telehealth, and regular visits with assigned mental health professionals as well as newer programs such as acupuncture, massage, and yoga.

Many veterans in South Dakota do not live near one of the state's highly populated areas, and those who live on a reservation do not have significant quality mental health treatment available near them. From January 2018 to August 2018, 15 South Dakota veterans committed suicide, with the youngest at age 18 and the oldest at age 75. Mr. Pollard stated we must continue to explore all opportunities to address veterans' mental health conditions and find treatment options that fit the individual.

Representative Hunhoff asked what was being done to help homeless veterans with mental health issues access services in South Dakota. Mr. Pollard responded the use of HUD-Veterans Affairs

Supportive Housing (HUD-VASH or VASH) vouchers to help homeless veterans find and sustain permanent housing and getting such veterans into the system to be linked with financial assistance, benefits, and other care has been effective. He said the department does not have funds devoted to outpatient services or support for mental health access other than the State Veterans Home.

Representative Haugaard commented that suicide statistics from 1950 to 2010 indicate a rise in suicides around the 1960's and 1970's. Mr. Pollard stated many Vietnam War veterans returned home wounded, mentally and physically, and few sought out the care they needed to treat those wounds. Representative Haugaard concurred and speculated that veterans from previous wars likely suffered similar conditions but were better equipped and more resilient. According to Mr. Pollard, the primary barrier to veterans seeking services is the "warrior culture" and the stigma attached to mental illness, a barrier Veterans Affairs is working to break down to help veterans access the services they need.

Representative Hunhoff and Representative Otten inquired about what type of training and partnerships are available for County Veterans Service Officers in terms of suicide and suicide prevention. Mr. Pollard responded that department employees go through the Applied Suicide Intervention Skills Training (ASIST) and an annual conference is held for the County and Tribal Veterans Service Officers at which suicide prevention and awareness training will be offered.

Representative Diedrich asked with the high percentage of Native American veterans, if the department works with Indian Health Service to deal with veteran suicides on reservations. Mr. Pollard stated the coordination is not at the level it should be. Part of the problem is that Native American veterans sometimes need to travel around 200 miles for access to quality mental health care.

Mental Health Perspective: West River Law Enforcement and Health Care System

Sheriff Kevin Thom, Pennington County Sheriff's Department, provided data regarding transports from western South Dakota to the Human Services Center (HSC) in the eastern part of the state (Document 12). Juveniles and adults are transported separately, and the bus which travels to Sioux Falls and back twice a week carries both individuals to the HSC and prisoners to the South Dakota State Penitentiary. Special runs are also conducted on short notice, based on bed availability. Such runs generally involve deputies on overtime, meaning added costs for the counties and unavailability of personnel for service calls in their respective jurisdictions.

Mr. Thom stated jails have become primary mental health providers in the absence of mental health services in the western part of the state. In 2017, Pennington County provided 13,000 hours of mental health services to jail inmates, the equivalent of six full time employees doing mental health services. In May of 2018, the daily average was 18 people on suicide watch, 250 direct inmate contacts, and 165 inmates having seen a psychiatric care provider.

Chief Karl Jegeris, Rapid City Police Department, said he is hopeful the summer study will result in better care for the most vulnerable population in communities across the state. An area of concern for his department is officer-involved shootings, related to a phenomenon called "suicide by cop." The sheriff's department and police department have collaborated on an intensive 40-hour training program to provide line level officers and staff with advanced training in mental health issues, especially

de-escalation. Approximately 50 percent of patrol officers and sworn deputies have been trained. Mr. Jegeris stressed the training is especially helpful to rural communities.

A West River Mental Health Alliance has also been formed in Rapid City which recognizes that demands for mental health services exceed resources, and it is necessary to better identify how to provide services more effectively. The current state model involving centralized services out of Yankton is not effective for western South Dakota. The Alliance has received funding through the Helmsley Foundation to conduct a comprehensive review of mental health needs with specific focus on the western part of the state.

Mr. Randy Allen, Clinical Director, Rapid City Crisis Care Center, reported the crisis center was developed in 2011 by 40 agencies in Rapid City who identified the need for a facility that could be open 24 hours a day, 365 days a year. The center has grown 10 to 15 percent annually since it opened. The center holds at risk individuals for 24 hours, attempts to stabilize the crisis, then makes referrals to services in the community. With an average of 220 to 240 admissions per year, the average length of stay is eight hours, with about seven people served daily. In its first three years, suicides in Rapid City dropped by about 33 percent. Numbers have been steadily climbing since then.

Mr. John Pierce, President, Regional Health Rapid City Hospital and Market, told committee members his facility has an inpatient Behavioral Health Center (Document 13) that serves a five-state area. It has 44 beds (18 for pediatric patients, 26 for adults) with a staff of eight which includes four psychiatrists. There were 2,000 admissions in 2017, and in August of 2018, the hospital had 59 patients on county hold and 49 voluntarily committed. Mr. Pierce advised all patients receive a medical screening in the emergency department before being admitted to the inpatient program and at times the hospital serves as a holding facility for patients that have gone through the committal process to HSC until beds become available. The average length of stay for patients on hold to HSC is 8 to 10 days. Eight additional beds will be opened at the Behavioral Health Center in the next few months. The hospital also offers outpatient behavioral health services.

Senator Solano commented at one point, children with autism and persons with dementia were being admitted to the Behavioral Health Center but those policies have changed. Mr. Pierce confirmed that about a year ago, physicians and psychiatrists reviewed the admission policies along with input from other mental health facilities to make sure they were in line in admitting the proper patients to the facility.

Representative Otten asked if the hospital was currently at capacity. Mr. Pierce responded it typically runs at capacity during the school year with lower numbers in the summer (around 26 to 28 patients). Based on needs, it is not always possible to place two people to a room so maximum capacity typically falls between 30 and 35 patients for the 44-bed facility.

Representative Reed wondered if Medicaid reimbursement from the involuntary holds is enough to cover the hospital's operating costs. Mr. Pierce replied costs run about $1,100 per day with reimbursement at about $700 per day.

Representative Howard asked how the Rapid City facility compared with the Avera Behavioral Health Center in Lincoln County. Mr. Pierce said that while he has not seen the Avera facility, he has worked closely with their medical director and has a good partnership and contracts with them. He agreed with his colleagues that more services are needed from the state to provide better care West River.

Senator Solano inquired what the discrepancy looked like annually between costs and reimbursement for patients involuntarily committed. Mr. Pierce advised he would provide follow-up fiscal information. Senator Solano stated adequate compensation is needed to sustain these services in western South Dakota. Mr. Pierce said any reimbursement that helps cover the gap are resources that can be used to provide more services.

Senator Soholt and Representative Haugaard questioned how many days patients stay at HSC and what the costs could be to provide the same level of care in the West River area. Representative Diedrich noted HSC would need to help provide that information, as once the patient is transferred, Regional Health is not necessarily notified at discharge. Representative Haugaard commented it would be beneficial to look at the costs for transitioning to outpatient care once the patient is discharged.

Senator Kennedy asked what are the estimated costs for transporting a patient from Pennington County to Yankton. Representative Johns wondered if similar statistics were also available for other West River counties like Lawrence and Meade. Mr. Thom pledged to follow-up with the information.

Senator Soholt inquired what the vision is for West River mental health services in the future. The delegation responded in an ideal world, it would include a mobile team, a crisis care center, and a quality of life unit. Senator Soholt requested follow-up data regarding numbers, average length of stay, type of diversions, and changes in the mental health population in the last decade to help the committee look at long-term policy solutions.

Senator Kennedy wanted to know how many people with mental health needs are in the jail pre-trial versus those serving a sentence and why those individuals are not being released on bond. Mr. Thom said roughly 80 to 85 percent are pre-trial and that a public safety assessment tool filled out at booking was recently implemented, resulting in the release of persons in lieu of a cash bond when appropriate.

Senator Solano requested information on the linkage of services when transitioning people from the crisis care facility back into the community. Mr. Allen explained the crisis care center has ongoing relationships with four community providers who keep mental health services slots open so an individual can usually be back into services within 24 hours or have arrangements made before they leave. As one of the symptoms of a person with a chronic mental illness is not being aware that he or she suffers from a chronic mental illness, the individual does not always take advantage of the available resources. He stated a person could be put on outpatient commitment if they do not follow through with the mental health services that have been recommended for them.

In response to a question from Representative Otten, Mr. Jeregis and Mr. Thom said the area's most immediate needs are a West River HSC type of solution, a need to de-centralize acute long-term care services, and increasing reimbursement for services provided.

Population Health as Related to Mental Health

Ms. April Hendrickson, WICHE, presented an overview of the prevalence of mental illness, access to mental health services, and changes in mental health services that have taken place nationally (Document 14). Statistics show 28.5 percent of non-institutionalized civilian adults in South Dakota report poor mental health, and 15.7 percent of adults in the state have been told they have a form of depression. South Dakota's rate of adults with a serious mental illness aligns with the national rate at 4.1 percent. A serious mental illness is defined as a diagnosable mental, behavioral, or emotional disorder other than a developmental or substance use disorder.

State mental health agency expenditures for mental health services in South Dakota are $84.13 per individual, not including jail and prison populations. Unmet need statistics indicate 54.3 percent of South Dakota adults with any mental illness (be it mild, moderate, or severe) did not receive treatment. From 1970 to 2014, the number of residents in state and county psychiatric hospitals and VA medical centers has decreased 93 percent with state hospitals decreasing services to children, persons with substance use disorders, developmentally disabled individuals, and the elderly.

Representative Hunhoff commented it was interesting to note that South Dakota's incidence of individuals with serious mental illness is on par with national statistics yet the state's length of institutionalization is longer at 24 days as compared to 11 for the national average. Ms. Hendrickson confirmed the data was from state hospitals and did not include nursing home beds. Representative Hunhoff countered that the state psychiatric facility does include nursing home beds. Ms. Hendrickson clarified South Dakota has geriatric care within the state hospital and indicated she would follow-up to ensure the data had not been skewed.

In response to requests from committee members, Ms. Hendrickson stated she would provide further clarification on whether the numbers regarding psychiatrist need reflected federal entities; if nursing home beds were factored into the calculation of the state psychiatric hospital inpatient rate; if the statistics on changes in the number of psychiatric residents reflected states that have eliminated their state hospitals; and whether changes in the use of Diagnostic and Statistical Manual of Mental Disorders (DSM) codes could impact the data presented.

South Dakota Mental Health Continuum and Policy Funding

Ms. Tamara Darnall, Chief Fiscal and Program Analyst, Legislative Research Council, provided statistics regarding expenditures by Community Mental Health Systems, the Juvenile Justice Reinvestment Initiative, the Human Services Center (HSC), and the Medicaid State Plan (Document 15).

Representative Jensen wondered why expenditures by community mental health systems increased from fiscal year 2014 to fiscal year 2015 even though fewer people were served. Ms. Iversen-Pollreisz from DSS offered to provide specific follow-up information but theorized it was likely related to a federal grant.

Representative Hunhoff asked what contributed to the decline in admissions to the HSC in fiscal year 2017. Ms. Iversen-Pollreisz advised the unit was closed for a portion of that period and there have been

some reductions in the state's ability to draw down federal Medicaid and Medicare dollars due to the patient mix at the center. She also clarified for Representative Hunhoff that the inpatient psychiatric expenditures represent private providers only.

Senator Soholt stated the data helps to show the difference in cost between providing inpatient care to a small group of people at HSC or private facilities as opposed to serving larger numbers at less cost in community facilities. Representative Kennedy interjected that HSC treats a different type of mental health patient than private inpatient systems, serving people with both acute and chronic conditions, typically keeping them in residence longer. He noted the need to differentiate between the two in comparing data. Senator Soholt concurred but noted there will always be patients with chronic long-term mental illness that need a longer-term rehabilitation environment.

Representative Hunhoff questioned what qualifies as best practices for mental health services and whether the state is using the right resources for the right services. Ms. Iversen-Pollreisz responded professionals that can provide mental health care are needed in communities and reimbursement for services for practitioners is a key element.

Senator Soholt presented two draft graph documents to committee members for discussion and feedback to summarize what the committee has learned to date and determine the best policy areas to focus on going forward. The first was an inverted triangle indicating what services are available in South Dakota including: prevention, early intervention, crisis supports, outpatient mental health services, specialized outpatient mental health services, specialized services with housing/residential, partial hospitalization, and inpatient psychiatric care. The second displayed the information in a table format, allowing the committee to expand on each area in terms of cost, return on investment, short-term versus long-term goals, and existing gaps in service.

Committee members expressed their appreciation for the information and agreed it will be beneficial as they continue to amass and analyze data and develop recommendations for further action. The documents will be discussed at later meetings and released in final form.

Public Testimony

Mr. Craig Pahl and **Mr. Douglas O'Neill**, **Brookings,** spoke on behalf of themselves as caregivers for loved ones with mental health issues and as members of the **Brookings Empowerment Project.** The project is a mental health advocacy group that focuses on education, developing and advocating for crisis management tools, and housing for re-integration into the community for individuals coming out of long-term treatment.

Dr. Steve Manlove, Rapid City, provided insight on the trends and patterns of mental illness and services in South Dakota from the perspective of a psychiatrist treating patients on a daily basis.

Final Remarks

Senator Soholt thanked the public testifiers for informing the committee on the true realities of dealing with mental illness. She reminded members of the importance of keeping their focus on this as a public

health issue for the people of South Dakota and said their task is to find ways to provide access to support and treatment for those who need it. She encouraged members to be bold in their thinking of how things need to transform for the future.

Next Meeting and Steps

The next meeting will be October 17 with the final meeting on November 19. At the October meeting, the committee will set priorities on potential statutory changes. Recommendations will be finalized in November. Both meetings will be held at the State Capitol in Pierre.

Adjourn

A motion was made by Senator Solano, seconded by Representative Howard, 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 1:59 p.m.