Board Training Manual for Community Mental Health Center Boards
May 10, 2010

Dear Colleague:

As board member of a community mental health center, you play a vital role in the public mental health system. Your efforts, in concert with the executive director, staff and clients, form a corner-stone for our goal of providing a community-based system of care for people with mental illnesses in South Carolina.

Many of you have asked for more training and information about the state's public mental health system. In response to your requests, the South Carolina Department of Mental Health has developed this community mental health center board manual.

I know how important it is for board members to have adequate information in order to make informed policy decisions. I hope this manual will help you understand our complex system.

The South Carolina Mental Health Commission, community mental health center boards, and the Department must work together to address the pressing issues facing public mental health in South Carolina. In this way we can achieve our goal of providing community-based mental health services.

I thank you for your work as a member of the SCDMH family.

Sincerely,

John H. Magill
State Director
May 10, 2009

Dear Board Member:

The close relationship that the Department of Mental Health has developed with community mental health center boards has evolved because it is our joint priority to realize a true community-based system of care for people with mental illnesses in South Carolina. We value the time, energy, and expertise which you devote to this mission and are eager to assist you in any way to become more effective contributors to the CMHC programs.

The purpose of this manual is to provide you with general principles for the operation of community boards, basic information about the Department of Mental Health, the laws and statutes that govern our agency, and the state-wide structure of our system.

We welcome your comments and feedback on this manual and encourage you to suggest board training topics that go beyond this basic training.

Our goal is to work with you to improve mental health services. Toward this end, please know that we appreciate your involvement.

Sincerely,

Geoffrey J. Mason
Deputy Director
Community Mental Health Services
# Board Training Manual

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Introduction

Welcome to service to your community through your local mental health center. You are a key participant in local and state efforts to improve care and treatment for people with mental illness. Your role as a board member is crucial in this effort.

In addition to your services to people with mental illness and to the mental well-being of your community, you are a part of a long-standing volunteer movement in our state and our nation. Our country--even prior to the Revolutionary War--has embraced a spirit of volunteerism, as noted by Alexis de Tocqueville in *A Brief History of Voluntarism in America*. This tradition encourages increased participation by all citizens in community and public service programs. With our society rooted firmly in its democratic beliefs of individual rights, freedom, dignity and its sense of humanitarianism, the volunteer movement has flourished. Most predictions for the future indicate that people in America will spend even more of their valuable leisure time in some form of volunteer work. Your service on the board of your local mental health center will enable you to become a part of this movement and offer an opportunity to make a difference in the lives of your neighbors!

The purpose of this board manual is to assist you in your efforts to understand the entire mental health system and your invaluable role within this system. The Manual is divided into three primary components: the state-level mental health system, roles and responsibilities of center boards, and specific information on your local center. The section on the state-level mental health system focuses on the statutory information pertaining to all center boards, general information about the South Carolina Department of Mental Health, and general services provided by mental health centers. The section on the roles and responsibilities of board members includes specific information on functions, job descriptions, and committee roles. Finally, the third section includes information deemed important for you by your board chair and by your director of your local center.

The South Carolina Department of Mental Health wishes to take this opportunity to thank you for your willingness to share your time, ideas and talents in providing mental health services in your community. Your participation will be crucial in meeting this goal of a community-based system of care for the mentally ill. We look forward to working with you to reach this dream.
The board of directors links the mental health center to the overall state mental health system of care. The primary responsibility of the center board is to ensure that quality care and treatment is provided by the center. There are four primary local components: the board, the executive director, the staff, and the clients. Integration of mission and roles is crucial in the success of this system. So you can offer high quality leadership on the board, it is important to understand your role and the role of the other components of the local system of mental health care.

**Role of the Board**

The traditional description of the relationship between the four components is that the board of directors establishes policy while the executive director implements it through the staff of the community mental health center. However, this description indicates that the roles are clear-cut and simple which, in fact, they are not. The board, executive director and staff form a partnership with each partner having certain primary responsibilities while offering input or monitoring other responsibilities. The role of the board can be summarized in the following eleven areas:

- **Focus on the mission:** The most fundamental of the responsibilities of the board is to ensure that the mission of the mental health center is the focus of all goals and objectives and that all parts of the center work together to accomplish this aim.

- **Develop long-range plans:** In order for a center to know its direction and its "road map" for accomplishing its mission, the board should develop, approve and periodically evaluate its long-range plans within the context of the DMH State Plan. The development of these plans should include representation from the community and the constituents of the center, but the final decision rests with the board.

- **Establish policies:** Policies are basic statements which guide the directions, decisions, and plans of the center. There are three stages in establishing a policy: development, determination, and implementation. During the development stage, all who are involved in the center may have input, for example: the board, executive director, staff, and advocacy groups. The actual determination or decision on what the policy will be is the responsibility of the board within the policy framework established by the DMH Commission. On the other hand, the implementation process is the role of the executive director with the board monitoring the progress and outcomes.

- **Recruit local financial support:** For the center to accomplish its mission to people with mental illness, local support must be developed. The board, as the primary link to these potential resources, has the responsibility for soliciting funds through the community and through local governments. A representative of the board may meet with local elected
officials to garner public financial support or meet with local foundations to seek grants for special programs.

- **Assist in hiring the executive director:** During the selection of an executive director, the board plays a major role in making the decision. In coordination with the state office of the Department of Mental Health, the board is crucial in making this determination. During the process, the board may appoint several members to participate in a search committee and outline the criteria for potential candidates. The board will select candidates to interview and then forward several finalists to the Deputy Director, CMHS and the State Director for final selection.

- **Establishing committees:** The board may utilize a committee structure to achieve its goals and objectives. Often the board chair has the responsibility to appoint committees, but it enhances the process if board approval is sought. Standing committees are specified in the by-laws, but temporary, special purpose committees may be established to meet particular needs such as to develop linkages on other social service issues or to secure additional facilities for the center.

- **Holding property:** The board is the legal entity to hold any property purchased by the center utilizing local funds. Generally, it is the responsibility of the executive director to maintain it, but the board is considered the owner. For example, the board may take a lead role in selecting and acquiring space for the center programs, but the executive director is responsible for the ongoing maintenance.

- **Recruitment of future members:** Although board members are normally appointed by the local legislative delegation, members are often contacted for suggestions for new members. Members need to keep "their eyes-open" for people who may add to the strength of the board.

- **Integration with the community:** Mental Health centers are a key part of a much larger social system network in the community. A major function of the board is to ensure that the center is a participant in that system and that its mission is understood by the community at large. Also, members represent the broad spectrum of needs of the citizens to the local mental health center. Board members may participate in community coalitions or serve as a speaker for civil organizations to explain the needs of the mentally ill and the role of the center in meeting these needs.

- **Evaluation of programs:** A key function of the center and the board is to routinely evaluate the effectiveness of the center programs and their continued need. Board members should also have a basic knowledge of trends in care of the mentally ill and an awareness of their respective mental health center. The board is the link to the community to ensure that the center provides high quality and effective programs. This evaluation should be a routine function, preferably conducted annually.

- **Self-evaluation:** The board must periodically examine its effectiveness. While a key standard in determining effectiveness is achieving the mission, the board also should analyze and evaluate its processes. This evaluation should include, at a minimum, the problem-solving method used by the board, fulfillment of the roles and responsibilities of
the board, respect for the role of the executive director and the staff, and evaluation of the board's committee structure.

Orientation and Training: Understanding the system of providing services to the mentally ill and the role of the board is essential to quality service on the board. An annual orientation session should be held to share information to the new members. Also, on-going training of all board members will enable them to remain current on new trends in care of the mentally ill and new initiatives within the mental health system. Board members are encouraged to become familiar with all DMH facilities--particularly those which serve their catchment area.

Legal Responsibilities of Board Members

Community mental health center board members have responsibilities established by South Carolina statutes, by the mental health center board by-laws, and by general law applying to all public officers. Public officers are required to exercise the duties of the office with intelligence, diligence, conscientiousness, discretion and, above all, by displaying good faith, honesty and integrity.

Each community mental health board must exercise its responsibilities in compliance with the provisions of the South Carolina Code of Laws and the rules and regulations of the Department of Mental Health. The legal responsibilities, as established by statute, include managing center property, evaluating the center's services and reporting the results of the evaluation to the Department and the center director, soliciting financial support, promoting inter-agency cooperation, stimulating effective community relations, and reviewing the center's annual plan and budget.

The State Ethics Act and Department of Mental Health directives provide the ethical guidelines which Board members must follow. The primary goals of these guidelines are to avoid a public officer's acting in cases where the officer has a conflict of interests, to avoid the appearance of impropriety and to ensure the public's business is conducted without the influence of personal interests.

South Carolina law provides important limitations on the legal liability of public officers and employees. The Tort Claims Act covers actions brought against mental health center board members and employees because of an alleged negligent act committed in the course of center employment or official duties that result in injury or death. These actions cannot name individual employees or officers and have a maximum amount of potential collection established by the law. As officers of the Department of Mental Health, board members are insured by the coverage purchased by the Department. In addition to tort liability insurance, the Department carries professional liability coverage and automobile liability coverage. If a board member has knowledge of an incident or accident that may result in a claim, the member should report the matter to the Department of Mental Health directly or through their center director.

Any questions regarding legal liability, insurance coverage, or any legal issue should be directed to the Department's General Counsel who represents all Department officers and employees in their official capacities.
Relationship between the Board and the Executive Director

As noted earlier, the board, executive director and staff form a partnership to accomplish the mission of the center. Often it is difficult to determine the delineation of the different responsibilities of the three components of the local system. One "rule of thumb" is that the board addresses issues that affect the center as whole, policy concerns, items mandated by law, or requests by the executive director. Meanwhile, the executive director administers the policies and puts the programs into action. The board works best when it makes a decision as a group.

Role of the Board Chair
The board chair provides leadership to the board in ensuring that the board meets all of its responsibilities, serves as the chief spokesperson in agency matters, and promotes agency programs. Specific responsibilities of the chair are outlined in the community mental health center by-laws which may include the following:

- **Presiding officer:** The chair presides in all regular and special meetings of the board.

- **Committee appointment:** The chair appoints chairs and members of all standing and ad hoc committees with the ratification of the Board.

- **Supervision of the executive director:** The chair works with the central office to evaluate the executive director. This process ensures that the internal operations of the agency are conducted effectively and efficiency.

- **Planning:** The chair oversees the planning, goal-setting, and evaluation process for the center and ensures that all components of the center work effectively together and as a part of the SCDMH.

- **Finances:** The chair appoints the finance committee and monitors the development of the budget and the management of the agency.

- **Community relations:** As the official spokesperson for the community mental health center, the chair is the leader in ensuring that the center is a part of the social service network and the center's mission is understood by the community.

- **Evaluation of the board:** The chair assumes the leadership role in determining that the board functions effectively and monitors the legal accountability for the board and the center.

Board Committees
Committees provide a structure and a process for a board of directors to accomplish many
different tasks and to carry out the mission of the mental health center and the SCDMH in an orderly, economical way. They let work be divided so that much more can be accomplished that if the entire board acted on every item of business. Committees also provide an opportunity for individual board members to use specific skills and talents, such as planning, public relations, or fund raising.

Committees work most effectively when they have a specific area of responsibility (such as community relations), members who are knowledgeable (or ready to learn) about that area, and staff support as needed.

Most boards have three types of committees: executive, standing, and ad hoc. The functions of the executive committee and any standing committees are often described in the organization's by-laws. The executive committee usually plans the overall task for the board. If the board does not meet monthly, the executive committee commonly has the authority to act on behalf of the board between meetings. Standing committees usually focus on a specific area of agency operations, such as finance, planning, or evaluation. Ad hoc committees (sometimes called task forces) usually focus on a specific issue or task, make recommendations about it to the full board, and then disband. Some common standing committees include finance (or budget), fundraising, community relations (or public relations), program (or planning), and nominating.

- **Finance**: Within the financial policies established by the SCDMH, this committee often oversees the agency's financial operations. It frequently reviews and makes recommendations about the agency's operating budget, as well as engaging in financial planning for the agency's future.

- **Fundraising**: This committee often sets targets for and assists the agency with supplemental fund raising. It may sponsor special events or activities, such as a walk-a-thon or a barbecue. Members of the fund-raising committee may also assist in presentations to foundations, businesses, or other potential funding sources for the agency. This committee may work very closely with both the finance and the community relations committees.

- **Community relations**: This committee assists the agency by making sure that the community (and potential clients) is aware of the agency's services, as well as the agency's needs. It tells the story of the organization to the community. It may work closely with local media to publicize the agency's programs and services, and to address the community needs, which the agency serves. This committee often works closely with the SCDMH Office of Public Affairs, which provides current information about the mission of and services provided by the Department.

- **Program: (or planning)**: Within the context of the overall State Mental Health Plan and the programs established by SCDMH, this committee oversees ongoing agency program activities and operations. It often evaluates the effectiveness of those activities, and may recommend a change in focus or priorities, depending upon the needs of the local community. This committee is also often involved in setting or recommending short (one or two year) and long (three to five year) range plans for the agency.

- **Nominating**: Often considered the single most important board committee, the Nominating Committee is responsible for identifying and recruiting potential board members. As such, this committee needs to know what types of people and what types of skills are most
Illustrative Job Descriptions

Center Board Member
Purpose:
To be legally and morally responsible for all activities of the mental health center and to ensure that the center focuses on its stated mission within the framework of SCDMH's mission. In general, board members determine center policy.

Specific Responsibilities:
- Plan for the organization's future through long-range and short-range plans, monitor their implementation, and evaluate them on a regular basis.
- Assist in establishing qualifications and criteria and in the selection process in hiring the executive director.
- Recruit local financial support for the center and ensure the center is financially accountable.
- Hold the properties of the center.
- Represent the center in the community through cooperative action and ongoing public relations.
- Represent the varied needs of the community to the mental health center and to the state office.
- Assess the community and evaluate center programs to ensure that community and client needs are addressed.
- Ensure that the center and the board operate efficiently.

Requirements:
Board members should be committed to the mission of the SCDMH and the center's mission within that framework and have a specific experience or knowledge needed by the board or represent a segment of the population served by the center. Board members should be willing to devote the required time to board service and to represent the center to the community.

Center Board Chair
Purpose:
Provides leadership to the center board in ensuring that the board meets all of its responsibilities and serves as the chief spokesperson in agency matters and promotes agency programs.

**Specific Responsibilities:**
- Preside over all regular and special meetings of the board.

- Appoint, with board approval, committees and committee chairs ensuring that the potential of each board member is actualized.

- Ensure that the committee structure operates smoothly and that the purpose of committees is routinely evaluated.

- Serve as the local representative in the evaluation process of the executive director.

- Oversee the planning and goal-setting process of the center and ensure that it is in the context of the SCDMH State Plan.

- Appoint the finance committee and monitor the financial management of the center through this committee.

- Serve as the official spokesperson to the local community for the center.

**Requirements:**
Center chairs should be committed to the goals and objectives of the center as demonstrated by board service and leadership in a key board function. The chair should be respected in the general community, be willing to expand his/her knowledge of the board and the center, and willing to commit the time necessary to this role.

**Committee Chair**

**Purpose:**
Provides leadership to the committee to ensure that the committee focuses on its assigned function.

**Responsibilities:**
- Call and preside over all committee meetings.

- Regularly report to the full board the activities of the committee and seek approval for the direction of the committee.

- Evaluate the function of the committee to ensure that the stated purpose is addressed, and that the committee continues to serve a needed role for the board.

**Requirements:**
Specific knowledge of the subject area of the committee and a willingness to dedicate the needed time to accomplish the task of the committee.
Board Bylaws
[Name of Mental Health Center]

Article I - Name

The name of this board shall be the [name of Mental Health Center] Board (Board).

Article II - Purpose

Section 1. The purpose of this Board is to administer the [name of Mental Health Center] (Center), an outpatient facility of the South Carolina Department of Mental Health (SCDMH) pursuant to Chapter 15, Title 44, Code of Laws of South Carolina (Chapter 15).

Section 2. Pursuant to Chapter 15 and SCDMH rules and regulations, this Board shall:

(a) Be the administrative agency for the center.

(b) Review and evaluate center services and report its findings and recommendations to SCDMH, the center director, and as needed, the public.

(c) Recruit and promote financial support for the center from local private sources such as business and private foundations and promote public support for local appropriations.

(d) Develop and implement agreements with health, social service, educational and judicial agencies.

(e) Advise the center director on the adoption and implementation of Center policies to further effective community relations.

(f) Review the annual center plan and budget and make recommendations to the center and SCDMH.

Article III - Membership Of Board

Section 1. In accordance with Chapter 15:
(a) This board shall consist of [the statute requires “not less than seven nor more than fifteen members”, insert the exact total number of Board members] members representing each county in the center service area in proportion to each county's population.

(b) Members shall be appointed by the governor upon recommendation of a majority of the members of the legislative delegations of the counties participating. A county delegation may by resolution, delegate to their county governing body the authority to recommend board members to the governor.

(c) At least one member shall be a medical doctor licensed to practice medicine in South Carolina. Board membership shall as far as practicable, include representatives of local health, medical and social service agencies, boards and organizations; lay associations concerned with mental health; as well as labor, business and civic groups and the general public. Client and family representation, including parents of emotionally disturbed children and adolescents, shall also be considered when making recommendations for board membership.

Section 2. The term of each board member shall be four (4) years and until a successor is appointed. A board member may serve consecutive terms.

Section 3. Vacancies must be filled for the unexpired term in the same manner as original appointments. Upon request by the applicable county or on its own initiative, the board may suggest candidates for board membership.

Section 4. Board members are expected to attend at least [insert number or percentage, e.g. “eight”, “seventy-five (75) percent” etc.] of the regularly scheduled board meetings during each twelve (12) month term of service. Members should notify the board chairperson at least 24 hours before a board meeting to request an excuse for absence.

Section 5. The governor may remove a board member pursuant to §1-3-240, Code of Laws of South Carolina, or as otherwise provided for by law.

Article IV - Officers

Section 1. The officers of the board shall be a chairperson, a vice-chairperson, and a secretary/treasurer.

Section 2. Officers shall be elected from the board membership at the last regular meeting of each calendar year by majority vote. Officers shall serve for a period of [e.g. “two (2) years”] and until their successors are installed, subject to their membership on the board.

Section 3. The chairperson shall preside at all meetings and shall have general responsibility for planning the work of the board.

Section 4. The vice-chairperson, in the absence of the chairperson, shall act as presiding
Section 5. The secretary/treasurer shall be responsible for recording and preserving the minutes of board meetings and executive committee meetings. With the assistance of the director and the administrative staff, the secretary/treasurer shall assure that the following are done: keep lists of members, notify the membership of meetings, take care of records and correspondence.

Section 6. Officers may be removed by two-thirds vote of the board.

Article V - Executive Committee

Section 1. The officers of the board shall serve as members of the executive committee.

Section 2. The Executive Committee shall have general supervision over the affairs of the Board between meetings of the Board. The Executive Committee shall carry out the functions of the Board and shall not act in conflict with any action of the Board. Minutes of each meeting of the Executive Committee shall be given to the Board at the next scheduled Board meeting.

Article VI – Standing Committees

Section 1. The Chairperson shall appoint as standing committees:

[Examples: Policy Committee scope: review Board Bylaws and Center policies for presentation to the Board for consideration/approval, correspondence to Board not pertaining to other committees and other Board issues not pertaining/referred to other Board committees.

Finance Committee scope: review Center fiscal matters, especially if requiring Board participation, e.g. Center budget.

Programs/Services Committee scope: advisory and public relations capacity with Center Executive Director to identify community needs, concerns and issues related to Center programs and services.]

Section 2. The board may create such committees as are required, in addition to those listed in Section 1, for the adequate functioning of the board.

Section 3. Committee members shall serve only while the chairperson appointing them shall be in office, but shall be eligible for reappointment.

Section 4. All committees and sub-committees shall keep minutes of meetings and forward copies of the minutes to the board. At the board meeting following the receipt of committee or sub-committees minutes, the board shall review the minutes. The board may approve the minutes and thereby approve and ratify the actions taken by committee or sub-committee. The board may disapprove any item in the minutes and thereby disapprove the itemized action of the committee or sub-committee.
Article VII - Meetings of the Board, Committees and Subcommittees

Section 1. For every meeting of the board or board committee or sub-committee, a simple majority of the members of the board, committee or sub-committee shall constitute a quorum. Members shall notify the respective chairperson in advance of their inability to attend a meeting so that a quorum may be assured in order to convene the meeting.

Section 2. Notice of all board, committee and sub-committee meetings shall be posted and meeting minutes recorded in accord with the South Carolina Freedom of Information Act, Chapter 4 of Title 30, Code of Laws of South Carolina (FOIA).

Section 3. All board, committee and sub-committee meetings shall be open to the public unless an executive session has been called in accordance with the FOIA. They shall conduct all meetings in accordance with Robert's Rules of Order.

Section 4. Minutes of all board, committee and sub-committee meetings shall be recorded and preserved in accordance with the FOIA.

Section 5. A member who is present at a board, committee or sub-committee meeting at which action on any matter is taken shall be presumed to have assented to the action unless his or her dissent is noted in the minutes.

Section 6. Regular meetings of the board shall be held [e.g. “the second Tuesday of each month at 6:30 p.m.”, also note specific FOIA notice requirements]. Special meetings may be called by the chairperson or upon petition of executive committee or a majority of the members of the board not serving as officers.

Section 7. One of the regularly scheduled board meetings shall be an annual meeting for review of the preceding year's activities, review of the bylaws, the installation of new officers (as needed), and recognition of retiring board members.

Article VIII - Voting Of the Board

Section 1. A simple majority of the members present shall determine all questions when a quorum is present.

Article IX - Amendments

Subject to Chapter 15, the Bylaws may be amended by a majority vote of the Board at any time, if the proposed amendments shall have been read at a previous meeting of the Board, or if it has been mailed to each member at least thirty (30) days before action is taken.

REVISED AND ADOPTED ________________, 20______________.

______________________________________________________________, CHAIRPERSON,
BOARD
Emergency Admission and Commitment Laws and Procedures

(For additional information, refer to SCDMH Intranet, Office of General Counsel, and SCDMH training materials including the Emergency Department Training DVD series.)

The Emergency Admission and commitment processes (as noted below) are required legal procedures for the involuntary inpatient and/or outpatient treatment of a person because of mental illness, or chemical dependency, or a child in need of treatment.

Under Title 44 of the Code of Laws of South Carolina, the legal procedures for Emergency Admission and commitment of a person with a mental illness (Chapter 17), or for a person with a chemical dependency (Chapter 52), or for a child in need of treatment (Chapter 24), are similar yet separate procedures. For instance, if a person is admitted by Emergency Admission for mental illness, and after inpatient examination the hospital determines that the person is in need of Emergency Admission for chemical dependency instead, the person cannot continue to be held and involuntarily treated without starting a separate legal procedure for chemical dependency Emergency Admission.

The following summary uses the adult psychiatric model.

Voluntary Admission (adult inpatient psychiatric hospitalization model)

A person who realizes that he or she needs treatment may agree to be admitted and treated by a mental health facility. In a voluntary admission, a person must have the capacity to volunteer, need applicable treatment and sign a statement consenting to treatment, including requirements and conditions for requesting discharge.

A voluntarily admitted patient in a SCDMH inpatient facility may later request discharge. However, if the hospital believes that the patient needs further involuntary treatment and denies that request, the hospital then must petition the probate court for a judicial commitment. The patient may then be held involuntarily pending a commitment hearing.

Involuntary Treatment (adult inpatient psychiatric hospitalization model)

Before the State can take a person's liberty, our Constitution normally requires notice to the person followed by a full court hearing. A Judicial Admission/Commitment follows this full "due process" requirement. However, in an emergency, in order to protect the person or others
from immediate harm, it may be necessary to involuntarily treat and detain an individual first, closely followed by a commitment hearing. The commitment hearing process is substantially the same either following an Emergency Admission or as a Judicial Admission/Commitment.

Once a person is detained and involuntarily treated in an inpatient facility (and even after committed following a hearing by the probate court), there is a continued burden to show that the person requires involuntary inpatient treatment. Regardless of the type of involuntarily admission, the person must be released when they no longer require involuntary inpatient treatment. Inpatient and/or outpatient commitments may be appealed to the circuit court and otherwise are subject to periodic review.

_Judicial Admission/commitment (adult psychiatric model)_

If a person needs involuntary treatment (inpatient/outpatient) because of a mental illness, but there is NOT an immediate serious risk because of that mental illness, a Petition for a Judicial Commitment of that person may be filed with the probate court. The Petitioner must state his or her belief that the person needs involuntary treatment for mental illness. The Petition is accompanied by an examining physician certificate that involuntary treatment is needed. After accepting the Petition, the court appoints an attorney for the person (if the person has not already retained an attorney) and appoints two Designated Examiners (at least one must be a physician licensed to practice medicine in South Carolina) (DEs) to examine the person and report their findings to the court. The person is then examined on an outpatient basis by the DEs. If the DEs report that involuntary treatment for mentally illness is needed, the court then schedules a commitment hearing. During the hearing, testimony from the DEs and others is taken and may be questioned by the person’s attorney. At the end of the hearing, the judge then decides if there is “clear and convincing evidence” to order involuntary inpatient and/or outpatient treatment. If not, the process ends. Inpatient and/or outpatient commitments may be appealed to circuit court and otherwise are subject to periodic review.

_Emergency Admission (adult inpatient psychiatric hospitalization model)_

In an emergency caused by a person's mental illness, any individual can begin the process of Emergency Admission by completing an Application for Emergency Admission. The application is a sworn statement of the applicant’s belief (and specific facts supporting that belief) that because of a person’s mentally illness there is the likelihood of serious harm to self or others if the person is not immediately hospitalized. The applicant is often a family member, friend or others (e.g. law enforcement, medical provider, etc.) recently observing the person's condition to explain the emergency and provide the sworn statements.

After the application is completed, the person must be examined by a physician licensed to practice in South Carolina for possible Certification for Emergency Admission. If the person can not or will not be examined by physician, the probate judge MAY issue a Detention Order authorizing law enforcement to take the person into protective custody for up to 24 hours to be examined (i.e., a Detention Order is NOT an order for admission or commitment).

If the examining physician finds that the person is NOT in need of immediate involuntary psychiatric hospitalization, then the process ends (and any Detention Order expires). Even though there is then not a need for Emergency Admission, if the person needs involuntary treatment, the participants should consider a Petition for Judicial Commitment.
If the physician “Certifies” that the person needs psychiatric Emergency Admission, the completed Application and Certification (Emergency Admission Papers) authorize and require law enforcement to take the person to the hospital named on the Certification. Under special circumstances, family members may take the person to the hospital.

If no bed is available for immediate admission, until the Emergency Admission papers expire, the person often stays in the county emergency department for attempted stabilization in accord with applicable state and federal law. Otherwise, by state law, the county is responsible for the person’s treatment and care pending a SC DMH admission.

Within 48 hours of Emergency Admission (except for Saturdays, Sundays and holidays) to the hospital named on the physician’s Certification, the Emergency Admission Papers are sent to the probate court where the person lives or where the acts occurred. The court then has up to 48 hours to consider the Emergency Admission papers and other evidence to determine if there is Probable Cause for further emergency detention.

If the court finds that there is NO Probable Cause for further emergency detention, it orders discharge of the person and the process ends. If the court finds that there IS Probable Cause for further emergency detention, it appoints two Designated Examiners (at least one must be a South Carolina licensed physician) (DEs) to examine the person. The DEs must send their reports to the court within seven days of the Emergency Admission.

If the DEs report that the person is NOT mentally ill to the extent that involuntary treatment is required, the court must dismiss the case and the person is discharged. If the DEs report that the person IS mentally ill and involuntary treatment is required, the court MAY order that the person be detained. If so, the court orders that the person be detained, appoints an attorney for the person (if one has not been retained) and schedules a commitment hearing within 15 days of the Emergency Admission. If a supplemental DEs’ report is provided to the court at least 48 hours before the hearing indicating that the person then no longer needs involuntary psychiatric treatment, the process ends and the person is discharged.

During a commitment hearing, the DEs and others testify and may be questioned by the person’s attorney. At the end of the hearing, the judge decides if there is “clear and convincing evidence” to order (commit) the person to involuntary inpatient and/or outpatient treatment. Without such finding, the process ends and the person is discharged. Inpatient and/or outpatient commitments may be appealed to the circuit court and are otherwise subject to periodic review.

If the person is ordered to continued inpatient treatment, the person stays until the hospital determines that involuntary hospitalization is not needed.

If the person is ordered to outpatient treatment (following or instead of additional inpatient), the court maintains jurisdiction over the person, and if the person fails to adhere to the outpatient treatment prescribed, and as reported by, the Center, the court may conduct a Supplemental Hearing. Following the hearing and findings, the court may order the person to inpatient or other needed treatment, or otherwise take any action within the court’s authority.
Center Boards
Gray Areas

• Clearly ‘OK’:

Center Budget
  o Program Effectiveness
  o Outcome data
• Clearly ‘day to day’
  o Personnel Issues
    ▪ Within purview of management
    ▪ Time and Expertise
    ▪ Risk of litigation

Complaints
  o From clients or families
  o From community/referral sources
  o From employees

• Don’t ignore complaints, problems and concerns, but…
  o Do not investigate them yourself
  o Refer to management/other available process
  o Ensure there is a process for addressing complaints and that it is operational

Advocacy/Lobbying for Center
  o Within DMH
  o With State’s elected officials
  o Within the community

• Be an advocate for Center, but…
  o Collaborate with management
  o Act as a Board, not as individuals

Concerns about management

• Discuss as a Board

• If others share the concern
  o Address with management first
  o If concerns persist, address with DMH
• Requests for information by members
  o What is legitimate
  o What is excessive

• Interests of individual Board members
  o What is appropriate
  o What is burdensome or divisive

Community Mental Health Programs

Emergency Services Program
An array of screening, referral, and treatment services to persons living in the state, as well as their families, who are experiencing acute psychiatric/substance abuse crises. This program operates 24 hours a day, seven days a week and provides a range of emergency intervention alternatives aimed at stabilizing the immediate crisis.

Specialized emergency services are necessary for children and adolescents and are defined as emergency services, crisis residential services, and home-based services (those considered clinically appropriate when a child's controls are too limited and he/she lacks the ability to appropriately handle changes in the environment without significant dysfunction.)

Essential Service Delivery
1. Crisis telephone intervention: Direct telephone access to a trained mental health center employee available 24 hours a day, seven days a week for residents of any county who are in, or dealing with, a psychiatric or substance abuse crisis.

2. Face-to-face crisis intervention: Professionally trained mental health and medical staff available to persons in or dealing with a psychiatric or substance abuse crisis 24 hours a day, seven days a week for the purpose of unscheduled face-to-face emergency evaluation and treatment at "safe sites" such as local emergency rooms.

An alternative component to "face-to-face crisis intervention" that should be used when considerations dictate is mobile crisis or home-based component (family preservation component for children.) This is a 24 hours a day, seven day a week outreach emergency team which responds to the client and family in crisis at the client's location rather than at a safe site designated by the mental health center.

This component offers the unique advantages of being able to assess the client in the natural environment as opposed to the traditional clinical settings. It also mobilizes a natural support network of family and friends that may avoid unnecessary hospitalization and make future crises less severe or less likely to occur.

Optimal Service Delivery
3. Crisis stabilization unit: A mental health center crisis residential component that provides the maximum level of treatment and supervision available in a non-hospital community setting. The program is appropriately staffed seven days a week. Crisis intervention can be used with this placement.
4. Crisis residential: One or all of the following services to enable clients to avoid unnecessary hospital admission:

**Therapeutic foster homes:** Program places a client experiencing a crisis in a family residential setting for up to 30 days. The family is well trained, and one member is available to the client on a one-to-one basis at all hours when the client is not engaged in a treatment program through the mental health center.

**Crisis placement within a local community residential facility:** Provides a designated number of designated beds for crisis placement through a mental health center contract with a local, private non-hospital facility. Supervision by trained staff is available on a one-to-one basis when the client is in the facility. Length of stay is generally brief, not expected to exceed 30 days.

**Day treatment:** intensive treatment by professional staff up to 12 hours per day for persons experiencing a psychiatric crisis. Services include comprehensive assessment, psychotherapy (individual and group), family counseling and education, skills training, vocational assessment, psychiatric evaluation and medications, and activity therapy.

**Outpatient Mental Health Services**
A program designed to provide an array of assessment and counseling services to persons of all ages and their families who are experiencing a wide variety of mental health problems other than those treated in the inpatient psychiatric facilities. In this community setting, the array of services provided is responsive to a wide range of individual needs with the flexibility for continuum of interventions that can address mild to severe dysfunction in brief to longer term periods of treatment.

Local needs are identified by local mental health center boards but normally are aimed at providing only necessary, limited assessment and counseling services to persons of all ages who because of mental health problems are: 1) at risk; 2) temporarily, psychiatrically disabled which causes a major disruption in level of functioning; and/or 3) in need of mental health enhancement and growth.

Outpatient program components normally consist of the traditional therapies developed in office settings. Nontraditional methods are encouraged to address accessibility and availability of services such as decentralization with outreach offices, or cooperative ventures with other resources for space, transportation, or other services.

Staffing patterns are representative of the area being served, addressing elements of race, sex, community interest, values, and conditions. Variability of hours are used to address special needs of the population served or needing to be served, i.e., special population groupings as children/adolescents or persons in rural areas.

The components of this program are provided on three levels of treatment duration: intensive, short-term intervention that rarely exceeds six sessions; time-limited outpatient treatment of less than six months; and open-end treatment for problems that may require lengthier intervention. Emphasis is placed on limiting the duration of treatment to the minimum essential based upon client need. By limiting the duration of treatment for persons who can be effectively treated more rapidly, the center and the Department intend to treat more individuals.
and focus resources upon the neediest, most disabled populations.

Outpatient community mental health services are community based activities designed to support community tenure at the highest possible levels of personal autonomy and functioning for adults/elderly persons with serious and sustaining mental illness, and for children and adolescents who are exhibiting behavior warranting services for emotional disturbance by providing whatever services are needed, whenever they are needed, for as long as they are needed.

For the adult/elderly clients, the community support programs foster choices, independence, and opportunity. The adult/elderly community support components include residential support and services including outreach to the homeless; vocational and vocational services; case management services; clinical management services including medication maintenance and supportive counseling; programs to build skills and strengths for independent living; strategies to persons refusing organized program participation; services to families; and natural support network development.

For the child/adolescent client and families, the community support programs address physical, emotional, social, and educational needs. Child/adolescent community support components include day treatment services; therapeutic foster care; therapeutic group care; therapeutic camp services; independent living; and residential treatment services.

**Essential Service Delivery (Adult/Elderly)**

There are four major categories of essential service delivery: assessment, treatment, rehabilitation and residential support.

(a) **Assessment:** This component is provided by a non-physician professional and/or a physician.

- Non-physician assessment: contacts with individual clients, and/or their families or significant others on a face-to-face basis to screen and assess the client's presenting problems, assets, and deficits; develops or determines a diagnostic impression; performs an evaluation; and develops or reviews a service plan.

- Psychiatric/medical assessment: physician contacts with clients that provide specialized medical and/or psychiatric assessment of physiological phenomena; psychiatric diagnostic evaluation; medical or psychiatric therapeutic services in order to assess the appropriateness of initiating or continuing the use of psychotropic medication, as well as providing psychiatric expertise to other staff or family involved with the client.

(b) **Treatment:** Treatment services are as specified by quality management.

Treatment services include the following functions:
- psychiatric/medical assessment
- medication monitoring
- medication administration
- assessment
- individual and family therapy
- group psychotherapy
- medication maintenance.
• **Case management:** This component of treatment is a key clinical intervention and core clinical function and as such is a major building block of the community support program. The importance of the supportive counseling relationship should not be under stressed. In case management, the staff person provides outreach to those in need of service; assesses the needs of the individual and suggests possible interventions; plans to provide or arrange for needed services; works to keep the client involved with life experiences and motivated to achieve; helps clients organize themselves in order to achieve their goals; provides reality-based and supportive feedback; is available when and where and for how long needed; and works with families and significant others.

• **Case management is provided in essentially three ways:** individual case management, intensive case management, and team case management. Individual case management is the assignment of an individual case manager to an individual client for services. Intensive case management is when services are provided by an individual case manager with a caseload capped at 20 clients in order to ensure the availability of staff and the needed intensity of services for clients at lower functional levels. A case management team is a group of staff specifically responsible for providing or arranging all needed services for a group of clients, usually those most disabled clients within a service setting. Staffs share responsibility for client care in all settings 24 hours, seven days a week.

(c) **Rehabilitation:**

• **Day treatment:** this component provides assessment, treatment planning and interventions to foster reality orientation, symptom reduction, and skills development through the provision of task-oriented groups and individually designed activities. Day treatment components provide a predictable, safe, and highly structured environment for clients requiring this degree of structure because of episodic or continuing functional limitations.

• **Group psychosocial rehabilitation:** a psychosocial component designed for seriously mentally ill persons and aimed primarily at fostering skills necessary for independent functioning in the community.

Functions are provided at a central location in a group setting and include:

a) **Living skills:** an activity which emphasizes skill acquisition such as riding the bus, budgeting, personal hygiene, cooking. Staff works with clients to develop skills needed for independent living.

b) **Activity therapy:** this social therapy breaks the cycle of social isolation common in people with a psychiatric disability. Services help clients improve their social skills, learn new skills, and develop vocational interests.

c) **Employment:**

1. **Hospital pre-employment** provides pre-vocational training to patients while in the hospital. This component assists some patients in being "job ready" upon discharge from the hospital.

2. **Transitional employment** is temporary employment with the goal of placement competitive employment or more permanence for those who
require on-going support to maintain the worker role. Transitional employment placements are for up to six months.

3. **Supported employment** is defined in federal regulations as “competitive employment in integrated work settings…consistent with the strengths, resources, priorities, concerns, capabilities, interest, and informed choice of individuals, for individuals with the most significant disabilities for whom competitive employment has been interrupted or intermitted as a result of a significant disability (Rehabilitation Act Amendment of 1998; Title IV of Workforce Investment Act of 1998, Pub Law 105-220, 112 State 936).

- **Individual Placement and Support (IPS) model** is an evidenced-based best practice approach designed to assist an individual with a serious mental illness obtain competitive employment in an integrated work environment that provide compensation to individuals of at least minimum wages or wages commensurate to the job.

- **Enclave or work station modes** is a group of up to eight disabled individuals who are trained and supervised among non-disabled workers in a business or industry. The group can be employees of the business or industry and can be trained and supervised by staff from a non-profit agency. On-site support and training are provided through the ongoing presence of a job coach who serves as a supervisor.

- **Mobile work crews** consist of less than eight supported employees who provide specialized contract services throughout a community. This is usually janitorial or grounds maintenance work. A job coach provides on-site supervision and training.

- **Benchwork model** provides work in electronic assembly work in a service agency that also functions as a business enterprise.

4. **Competitive employment** is part-time or full-time employment in the general labor market in positions that pay at least minimum wages, that are open and available to any qualified individual in the labor pool and not set aside or reserved for individuals with disabilities.

5. **Client-run businesses** are incorporated businesses that employ, are run by, and/or function under the direction of a board of directors that is client-run. While mental health agency staff may advise on services, the basic program is managed by self-identified people living with a mental health disability.

6. **Volunteerism or non-paid employment** is non-paid opportunities within a non-profit setting for clients who do not have the necessary skills to engage in paid employment but may be able to do volunteer work to enhance their self-esteem, improve their vocational abilities and increase their probability of job readiness.

- **Individual living skills**: a rehabilitation component in which all the needed services included in a group psychosocial rehabilitative program are provided on an individual basis, primarily in home and community based settings. A client can maintain community tenure, obtain all necessary treatment and services and improve his or her capacity for independent living.
(d) Residential Support:

Traditional treatment programs are focused around a site where people live and receive treatment services. When a person gets better or worse, he or she moves to a site where more appropriate treatment can be offered. This model works well in situations involving treatment for severe ailments that require constant supervision from on site staff, often with specialized training and skills.

However, the mental health movement across the country has found that many people with many conditions can be treated successfully in a different way. A person can live in a normal, permanent home with services brought to that home (as well as in other locations) on a varying frequency depending on the person's needs at the time. In this model, the person does not move every time he or she functions better or worse. The services are varied according to need. This approach is defined as Supported Independent Living.

Supported Independent Living Facilities:

- **Nursing homes:** licensed facilities designed to meet the needs of people who must meet community long term care eligibility for intermediate or skilled care needs. These facilities have daily licensed nursing services and provide direct care services to assist with basic daily living needs and functional limitations but do not need an acute care hospital.

- **Community Residential Care Facilities (CRCF):** licensed by the South Carolina Department of Health and Environmental Control and designed to meet the needs of people who need 24 hour staff supervision, but do not need nursing home care. These facilities vary in size, staffing, and in their capacity to work with people with various problems. These facilities may be operated by mental health centers, contracted with mental health centers, or independently operated for profit or not for profit.

Many community residential care facilities in South Carolina have memorandums of agreement (MOA) with local mental health centers to provide for the needs of the centers’ clients who live there. While client preference is pursued concerning CRCF placement, DMH Directives encourage staff to make every effort to recommend and/or assist clients and their family members with CRCF placements that are licensed and have a MOA with the mental health center.

**Supported Independent Living Housing**

This is affordable, scattered, or clustered housing where the tenant/landlord relationship is the same as any rental housing development and where the tenant would have a standard lease agreement and only moves when he or she chose to do so or when he or she would be evicted under normal circumstances. This does not mean that there is no assistance available. The full array of services can and should be provided, but on a flexible basis on or off site without requiring the tenant to move when his or her needs change.

**Housing and Homeless Program**

Because of SCDMH’s acknowledgement of the relationship between residential supports and mental health, the SCDMH Housing and Homeless Program were created. This program provides technical assistance and funding through vendor contracts to private non-profit organizations to provide housing with coordinated supportive services to persons with serious mental illnesses. The program mission is to provide people with mental illnesses the opportunity to live independently in the community of their choice with dignity and respect.
The housing program works in partnership with local mental health centers and non-profit housing organizations to fund the development of safe, quality, and affordable housing with coordinated supportive services targeting clients as tenants. Clients typically have incomes of less than $650 per month; therefore, rent subsidies must also be accessed for clients to be able to afford the housing.

SCDMH contracts directly with non-profit organizations to fund a portion of the project's total development cost. Non-profit organizations access other state and federal affordable housing resources for the remaining funds needed to complete the project. These other funding sources may include the HUD Section 811 program, HUD Continuum of Care Supportive Housing Programs for the Homeless, the State Housing Trust Fund, and/or the State HOME Program. SCDMH has a strong network of over 40 non-profit groups statewide that are actively involved in housing development and/or the management of existing developments. SCDMH funds no more than 50 percent of the project's total development cost, but in recent years, the program has been able to leverage approximately $4 in other (non-DMH) funds for every $1 in DMH funds invested in client housing.

The SCDMH Housing and Homeless Program also are involved with development and management of the following initiatives:

**Shelter Plus Care Programs**

Since 1999, the SCDMH Housing and Homeless Program have administered HUD Shelter Plus Care grants that provide rental assistance to persons with serious mental illnesses who are homeless. SCDMH now manages ten Shelter Plus Care programs located in 14 counties. These programs are partnerships with non-profit sponsors that provide the housing they may own or through lease arrangements with private landlords. The units are provided to persons with mental illnesses who are homeless through occupancy agreements that outline the program requirements. These units may be occupied by individuals or families with children with mental illnesses. All clients served by the program pay rent to the nonprofit sponsors based on their income.

Shelter Plus Care program locations and corresponding non-profit sponsors are: Columbia, Lexington County/MIRCI (Home Base I, II, III, and IV); Rock Hill/Pilgrims' Inn; Myrtle Beach area/Waccamaw Housing, Inc.; Spartanburg/Upstate Homeless Coalition; Greenville/Upstate Homeless Coalition; Aiken, Barnwell, Bamberg, Orangeburg, Allendale Counties/MHA of SC; and Florence/Palmetto Housing Corporation.

**PATH Program**

The SCDMH PATH (Projects for Assistance in Transition from Homelessness) program is administered by the Housing and Homeless Program. An annual allocation from the U.S. Department of Health and Human Services (currently $464,000) provides funding for six providers: Greenville Mental Health Center, Waccamaw Center for Mental Health, Spartanburg Area Mental Health Center, Pee Dee Mental Health Center, Columbia Area Mental Health Center, and Crisis Ministries in Charleston. The funds are used to provide outreach and clinical services for persons with mental illnesses who are homeless in Greenville, Myrtle Beach, Spartanburg, Florence, Columbia, and Charleston.
Other Support Components:

These are community activities, events, and advocacy services in which other necessary services are provided or arranged for to ensure the client maintains community tenure. The following services or groups are desirable:

- **Transportation services:** transportation to clinical program sites, rehabilitation program locations and to needed supports and services.

- **Self-help groups:** support and mutual aid groups and organizations that encourage participants' growth through the sharing of common experiences and mutual problem solving community and belonging.

- **Client groups:** an organization of persons who have received mental health services, either in a hospital or community setting, who come together for advocacy, support services, friendship and socialization through the sharing of experiences, solutions, alternatives, resources, ideas, needs, goals, talents and skills (e.g., SC SHARE). A primary goal of this group is to stimulate new interests, and expand member's awareness of what the community has to offer.

- **Drop-in center:** where clients of mental health services can come to socialize and relax in a comfortable setting. Drop-in centers are often client-run.

- **Advocacy groups:** national and state groups that support the recovery of individuals experiencing symptoms of mental illness, such as the following:

  a. **Legal aid:** professional rights protection services that may include legal representation. Advocacy services include support to clients in the defense of constitutional and civil rights issues, right to treatment, right to refuse treatment, right to choice, right to grieve agency or department policies and rights to be free from abuse and neglect.

  b. **Mental Health America in South Carolina:** a voluntary non-government citizens' organization dedicated to the promotion of mental health, the prevention of mental illness, and the improved care and treatment of persons suffering from mental illnesses.

  c. **National Alliance on Mental Illness in SC:** NAMI SC, an organization of families and concerned citizens that provides support, information sharing, and advocacy on behalf of its individuals.

  d. **Federation of Families in South Carolina:** a parent-run organization supporting family-run programs to meet the needs of children and youth with emotional, behavioral, or mental disorders.

**Essential Service Delivery (Children and Youth)**

The community support components for moderate to severely emotionally disturbed children and youth include case management, day treatment, and residential.
(a) **Case management**: this component mirrors case management for adult/elderly except for the obvious focus on needs of children and youth. Efforts must be directed toward family preservation whenever possible.

(b) **Day treatment**: non-residential therapeutic activities provided in a structured setting by professionally trained staff to provide an integrated set of educational, counseling and family interventions which involve a youngster for at least five hours a day. Day treatment works with education agencies and provides:

- special education, generally in small classes and with a strong emphasis on individualized instruction;
- individual and group counseling;
- family services including family counseling, parent training, brief individual counseling with parents, and assistance with transportation, housing or medical attention;
- vocational training, particularly for adolescents;
- crisis intervention to assist students through difficult situations and help them improve their problem solving skills;
- skill building with emphasis on interpersonal and problem solving skills and the practical skills needed in daily living;
- behavior modification with emphasis on success through the use of positive reinforcements procedures; and
- recreational therapy, art therapy and music therapy, to further aid in the social and emotional development of the youngsters.

While day treatment attempts to avert the need for residential placement, it is also well-suited as a transitional program to help youngsters move out of residential treatment. In addition, day treatment can be used with a community-based residential component, such as therapeutic foster care for therapeutic group care, to maximize the impact of both programs.

(c) **Residential**: this component includes therapeutic foster care, therapeutic group care, therapeutic camp services, residential treatment centers, and independent living services.

- Therapeutic foster care: a residential component in which one child is normally placed in the home of foster parents who have been specifically recruited to work with an emotionally disturbed child. This activity also requires special training to the foster parents; low staff-to-client ratio in the mental health center to enable clinical staff to work very closely with each child, the foster parents, and the biological parents if they are available; creation of a support system among the foster parents; and payment of a special stipend to the foster parents.

- Therapeutic group care: a residential component in which a therapeutic environment and services treat from five to ten emotionally disturbed children. The approaches employed within the homes vary. Some programs, such as the teaching family programs, emphasize structured behavioral interventions, with a major focus on strengthening positive behaviors. Other frequently used interventions are group interaction and treatment and individual psychotherapy. In many cases, these interventions are used in combination.
- **Therapeutic camp**: a service component in which youngsters and staff live together in a wilderness situation. The very nature of the living situation presumably requires more responsible and independent behavior from the youngsters than a more traditional residential setting requires. Each youngster is encouraged to contribute to the group in order to help to take care of the basic necessities of living including food and shelter. Group meetings are held at regularly scheduled intervals and as special problems develop that require attention. The treatment deals with immediate situations of both a social and non-social nature, and the group helps individuals experiencing special problems.

- **Residential treatment center (RTC)**: A residential component in which a therapeutic environment and services treat larger numbers (more than 10) of emotionally disturbed children. Campus types of programs with multiple living units serve a wider variety of youngsters. Frequently, there are units for younger children, and other units for older children. There may be specialized units to help older adolescents prepare for independent living. Treatment components include medical, individual, group and family therapy, behavior modification, special education, and recreational therapy. Although the philosophy and models that guide RTCs vary, two models have influenced many of these programs. One is the philosophy of milieu therapy, and the other is Re-Education (or Re-Ed) model.

- **Independent living component**: specific services provided with other services to help adolescents make the transition to independent living, including independent living skills, vocational training, and work experience. Independent living skills are developed through individual and group training and through apartment living supervised by center staff. It is graduated to less and less supervision, based upon the youngster's demonstrated skill.
Associated Outpatient Community Programs

Local Inpatient Hospital Program:
A local or regional inpatient facility (private or county supported) for clients who require hospitalization. Mental health centers use their own mental health professional staff to assess the client during the crisis evaluation in an emergency room setting or inpatient stay whenever possible and consult with local medical staff.

Consultation, Education and Prevention (CE&P) Program
The CE&P program provides a wide range of mental health center services that are not direct services to clients. This program assists with the de-stigmatization of mental illness by informing and enabling people to reassess their thinking which assists with coping and acting on their environment, and seeking to create environments that are more supportive of human life. This program is applicable to a wide variety of purposes and target groups and has potential for preventing emotional disability and for promoting growth in people and community groups. Activities include but are not limited to the following:

- Consultation to medical, health and social service providers, clergy, school personnel, law enforcement and other public service personnel;
- Education for the general public, medical representatives, and government officials as well as those named above; and
- Prevention services through coordination with the above persons/agencies and presentations provided through advocacy and client groups, civic organizations, and churches.

Consultation: a component in which coordination is effected with service providers, clergy, law enforcement personnel and others regarding a specific client or a program for clients. These consultations are focused on assisting these other professionals to become more skilled and knowledgeable in dealing with mentally ill persons, becoming better allies in the therapeutic process, and ensuring a coordinated interagency total human service delivery system.

Education: a component in which services are provided that educate the general public about mental health problems and resources in order to 1) create a better informed public more likely to use mental health services appropriately and to accept others who need mental health services. Services to the general public should also be designed to promote positive mental health and facilitate personal growth and awareness; 2) educate non-client populations which are at risk in order to assist such populations in coping with predictable transitional crises,
living under stressful conditions and managing stress more successfully; 3) educate clients and their significant others so that these persons can become more skilled and knowledgeable clients of mental health services, better users and allies in the therapeutic process and more effective "mainstream" residents of the larger community; 4) educate those in the community who are in key positions to affect the lives of others. These services are directed to the so-called "front line care givers" such as agency personnel, law enforcement officers, clergy, attorneys, physicians, and others; and 5) educate those who are in a position to influence and affect public policy. These services are directed to such people as elected officials, governmental authorities, and other key policymakers.

**Prevention**: a component which works to reduce the effect or incidence of emotional problems. It refers to interventions directed at individuals and/or families who have not yet been identified as having emotional problems, especially those who, by virtue of genetic, family or situational factors, are at the highest risk of becoming severely emotionally disturbed. There are basically three main approaches in mental health prevention programming.

- The first approach involves the promotion of positive mental health and competencies. Many program and curricula have been developed to strengthen an individual's sense of identity and self-esteem and to teach specific skills, particularly in the area of problem solving. The area of problem solving competency is emphasized because of research that has shown a linkage between skill in this area and adjustment. These efforts are based on the premise that the promotion of positive mental health and competencies can enhance coping abilities and, thus, reduce the incidence of further emotional problems.

- The second basic approach to prevention is increasing self-help groups and support systems. This approach is based on the finding that individuals with strong and intimate relationships are better able to handle crises and stresses than individuals without such relationships. This is a particularly relevant approach with the large increases in the number of children living in single parent household.

- A third approach to prevention can be considered systems change. This involves making modifications in systems to increase the likelihood that individuals will encounter favorable outcomes within the system.
Administration

This program provides a wide variety of functions necessary to accomplish the primary recovery mission of service delivery. It includes supervision, planning and evaluation, personnel, supply/procurement, budgeting and accounting, pharmacology oversight, and operating a management information system. All of entities foster the advancement of SCDMH’s recovery-oriented system approach.

SCDMH Table of Organization

State Director - John H. Magill
- Has ultimate responsibility for the direction and operation of the SCDMH’s statewide network of hospitals and community mental health centers;
- Serves as principal liaison with external entities such as the South Carolina General Assembly, other state agencies, advocacy and consumer groups, and numerous private and not-for-profit organizations;
- Recommends policies and procedures to the SCDMH’s top governing body, the Mental Health Commission and implements such.

Mental Health Commission Liaison – Connie Mancari
- Prepares the agenda for commission meetings, communicates with commissioners, and provides information relating to policies and procedures and other areas of concern.

General Counsel - Mark Binkley
The Office of General Counsel provides legal representation and advice to all organizational components of the SCDMH including the Mental Health Commission, the state director, the SCDMH Governing Council, community mental health center boards, center and facility directors, and their staff. In general, the subjects covered include:
- Confidentiality and privacy of health information;
- Involuntary admission;
- Informed consent to care;
- Threatened or actual claims for malpractice or other alleged negligence;
- Contracts and Procurement;
- Legal issues related to child and adolescent services, particularly questions related to orders for evaluations from Family Courts;
- Employee relations and employment law;
- Compliance with laws and regulations, including Medicaid and Medicare reimbursement
standards;
• Collection of SCDMH charges for inpatient services; and
• Real Estate issues.

Laws and Regulations
• Reviews or drafts proposed legislation as needed;
• Advises and informs appropriate staff of new laws and regulations applicable to their job duties;
• Helps SCDMH prepare policies and initiate practices to comply with applicable laws and regulations;
• Educates and informs the public and public officials about mental health laws.

Client Advocacy Program – Rochelle Canton
• Administers a statewide rights and advocacy program to ensure the rights of individuals receiving services;
• Advocates for the provision of quality care in a humane environment;
• Provides a process for the effective review and resolution of rights and advocacy complaints/issues.

Risk Management – Ann Marie Dwyer
• Informs the state director and other senior managers with a need to know of adverse incidents or events which pose a legal risk to SCDMH;
• Reviews aggregate adverse incident data for possible trends requiring further review, in conjunction with the Division of Public Safety and the Office of Performance Improvement;
• Provides training and information to SCDMH staff on measures to reduce exposure to claims of negligence and prevail in the event of such claims;
• Coordinates the investigation of adverse clinical incidents to identify mechanisms for improvement in our service, including trend analysis of incidents to identify opportunities for system-wide initiatives to improve care.

Office of Public Safety - Elizabeth Hall
The Division of Public Safety is the law enforcement entity for the SCDMH. As such, it has specific responsibilities for coordinating all law enforcement, safety, and disaster preparedness programs within the SCDMH. Generally, Public Safety performs the following functions:
• Enforces SCDMH rules, regulations, policies, and procedures;
• Protects SCDMH Clients, employees, visitors, and property;
• Investigates incidents of alleged consumer abuse and other violations;
• Enforces all traffic rules and regulations;
• Serves as a liaison with local law enforcement agencies including the Department of Juvenile Justice, S. C. Department of Public Safety, Richland County Sheriff’s Department, and the S. C. Law Enforcement Division (SLED).

Office of Quality Management - Ligia Latiff Bolet, Ph.D.
Quality Assurance
• Establishes methods and procedures to assure that services provided are of the highest quality;
• Systematically monitors performance against established standards for practice and implements actions for improvements as needed to assure that service delivery is appropriate and meets the needs of the Clients.

Corporate Compliance
• Monitors the compliance of the SCDMH in meeting the requirements of third party payers (federal, state, and private) for the proper provision and documentation of clinical services.

Utilization Review
• Monitors the use of or evaluates the clinical necessity, appropriateness, efficacy or efficiency of services, procedures, providers, or facilities.

Community Residential Care Facilities (CRCFs and PASARR) – Vicki McGahee
• Coordinates a comprehensive statewide program to improve the care provided to Clients who live in CRCFs;
• Implements and coordinates a statewide program to administer Pre-Admission Screening and Annual Resident Reviews (PASARR)

Division of Administrative Services - Brenda Estridge-Hart
Deputy Director
• Provides technical and administrative functions to SCDMH, keeping it fiscally responsible, technologically efficient, and environmentally supportive for the work of the agency’s employees.

Community Centers and Facilities Administrator – Stewart Cooner
• Provides technical assistance to the state’s CMHCs and inpatient facilities
• Administers special projects that assist Centers/Facilities in reaching the overall goals of the agency

Information Technology Services – Herb Drucker
• Provides automation/technology services, resources, and support to the SCDMH in an effective and cost-efficient manner.

Financial Services – David Schaefer
• Establishes policies and administers the financial operations of the SCDMH;
• Ensures the practice of sound business methodologies, financial accountability, and adherence to the laws and regulations of state and federal governments;
• Monitors and regulates the financial operations of the SCDMH divisions to achieve cost effective results from their activities so that the stated mission of the SCDMH will be accomplished with accountability.

Nutritional Services – Carol Petersen, Interim Director
• Directs clinical nutritional services, food production, food delivery and food service.

Public Affairs – Alyce C. McEachern
• Develops and manages the SCDMH internal and external communications including press relations;
• Coordinates agency’s volunteer program;
• Monitors legislation and provides electronic updates to key people;
• Assists with meeting planning.

Physical Plant Services – James “Jim” Berry
• Directs professional engineering, special and preventive maintenance, construction and renovation, building codes and licensing standards, energy use and conservation;
• Directs vehicle management, transportation services, and grounds maintenance.
• Provides strategic planning, building use, and future land use plans of the inpatient facilities operated by the SCDMH;
• Develops a five-year facilities plan to determine effective and cost-efficient use of buildings.

Human Resource Services – Eleanor Odom
• Supports the SCDMH’s efforts for a qualified and productive workforce to accomplish the Department’s mission to respect the dignity of all individuals; to protect people’s rights to fair and equitable treatment in all aspects of employment without regard to race, sex, religion, age, national origin, disability or any other non-job related factor; and to promote affirmative action.

Medicaid Services – Keith Randolph
• Coordinates the Medicaid efforts of the department with all Medicaid levels, federal and state, while maximizing the revenue available for necessary services;
• Directs statewide HIPAA strategic planning and implementation.

Grants and Planning – Tammy Orr
• Develops, writes, and consults on grants for the SCDMH and its partner agencies;
• Supports the State Planning Council;
• Disseminates best practices, including sustainability planning and implementation;

Office of the Medical Director - Robert L. Bank, M.D.

Medical Director
• Identifies and implements psychiatric best practices and evidence-based models of mental health care;
• Coordinates and monitors implementation of the desired models of behavior health care;
• Is responsible for quality review and assurance.

Program and Planning – William Wells
• Provides planning, implementation, and monitoring of the SCDMH Strategic Plan;
• Develops the SCDMH annual Accountability Report
• Provides guidance and project management to develop and improve quality systems in the Department;
• Monitors and communicates performance improvement activities throughout the SCDMH

Disaster Response Management Services – William Wells
• Maintains the SCDMH’s “All Hazards” Disaster Response Plan;
• Coordinates training and drills with SCDMH mental health centers’ and hospitals’ disaster coordinators with a focus on local, state, and national disaster issues;
• Serves as liaison to the South Carolina Emergency Management Division, health and medical functions.

Evaluation, Training, and Research- Sandy Hyre, RN Office of the Director
• Serves as liaison with the University of South Carolina School of Medicine;
• Manages activities within the division, including training programs, grants, outcome indicators, continuing education programs, and overall administration;
• Chairs the Continuing Medical Education committee;
• Serves as liaison between the SCDMH and Palmetto Health Alliance Education Programs.

Residency Training Program
• Provides oversight of the Palmetto Health Alliance residents in the general, child and adolescent, and forensic psychiatry programs while they rotate through SCDMH hospitals and centers.

Data Outcomes, Evaluation – Maria Butkus
• Designs and develops the SCDMH system performance indicators (dashboard indicators);
• Develops, writes, and consults on grants for the SCDMH and its partner agencies;
• Provides data infrastructure support and serves as liaison to state Data Warehouse;
• Develops the SCDMH dashboard indicators.

Office of Best Practices – Ellen Sparks
• Disseminates best practices, including sustainability planning and implementation;
• Develops and coordinates Centers for Excellence

Staff Development and On-Line Training - Sandy Hyre, RN
• Provides workforce development and training;
• Manages Distance Education (both web-based and satellite);
• Maintains the CME, NCEU, and CEU database for the SCDMH;
• Develops an annual needs assessment survey for physicians, nurses, and other clinicians in the SCDMH;
• Develops Computerized Learning Modules;
• Administers the Pathlore training database;
• Manages the Continuing Medical Education, the Nursing Continuing Education, and the Continuing Education accrediting processes.

Division of Community Mental Health Systems

Operations Director - Geoff Mason, Deputy State Director
Responsible for the daily operations of the comprehensive community mental health centers (17) and in addition to the following:
• Develops and administers operational policies and procedures;
• Manages budget allocations, development of new services and revenue streams in collaboration with the Department of Health and Human Services;
• Responds to the needs of Clients, families, elected officials, advocates and other agencies and stakeholders;
• Articulates the SCDMH vision and mission to community mental health center boards;
• Assures appropriate care in the least restrictive environment and implements innovative service initiatives for the Department.

Community Mental Health Centers and Recovery – Jeffery Ham, Program Manager
This division coordinates the state wide system of Community Mental Health Centers providing comprehensive outpatient services: developing associated policy and procedures; implementing state wide initiatives; ensuring access to the most appropriate care within the state and meeting the state office needs of the seventeen Community mental health centers; as well as:

- Designs and develops community based partnerships, alliances, and collaborations to provide community based services;
- Develops priorities, plans, and operational agreements for joint ventures to develop local community capabilities;
- Meets regularly with managerial staff to assess regional needs, priorities, strengths and opportunities to build systems of community care;
- Articulates the vision, mission, strategic plans, priorities, policies, procedures, regulatory and legal requirements of the SCDMH at monthly meetings of the governor-appointed community mental health center boards;
- Assures system continuity of care: assuring the patient’s service linkage throughout the community and hospital operational continuum;
- Develops and administers the SCDMH’s Youth in Transition service program;
- Provides state level interagency coordination with the South Carolina Department of Disabilities and Special Needs, Department of Social Services, DJJ, DHEC, the South Carolina Primary Healthcare Association, SC SHARE, NAMI and others to develop and integrate services for those with needs for coordinated services from multiple agencies and to promote development of local service partnerships.
- Responsible for the implementation of the initiative for Recovery; mental health care as partners on the road to Recovery from serious and persistent mental illness.

Toward Local Care (TLC)/Continuity of Care – Mallory Miller, Program Coordinator

- Coordinates and consults on implementation and ongoing maintenance of identified TLC long-term and crisis stabilization/diversion programs to ensure program integrity and accountability through monthly meetings, site visits, program evaluation and outcome measurement, training, and consultations;
- Collaborates with SCDMH psychiatric facilities to identify patient needs, coordinate hospital liaison activities, develop resources, and assist with linkage to available community resources to aid in clients’ return to the community in agreement with the Olmstead ruling;

Continuity of Care oversees the management of operations between inpatient facilities to community and between communities to ensure that service delivery is provided in a timely and appropriate manner. Client information is entered daily into a data system that is monitored by SCDMH state office. The daily monitoring allows for corrective needs to be identified and action to ensue so that the preparation of reports and dissemination provides accurate information that will guide clinical care and treatment.

Forensic Services – Shirley Furtick, MSW
• Serves as liaison with other human services and law enforcement entities to promote continuity of best practice services for persons with mental illness in the criminal justice system;
• Provides training and consultation for law enforcement and coordinates a Biennial Forensic Forum which promotes opportunities for interagency cross training and networking.

Office of Multicultural Services - Shirley Furtick, MSW.
• Provides consultation, coordination and education on multicultural affairs.
• Promotes department-wide awareness of cultural issues that respond to improving treatment of Clients. Responsible for the implementation of the initiative for Family Inclusion, maximizing the involvement of the family in the healthcare decisions of those we serve.

Housing and Homeless Program – Michele Murff, Director of Housing/Homeless
• Provides technical and financial assistance to eligible organizations for the development of safe, decent, and affordable housing options with supportive services for persons with serious and persistent mental illnesses;
• Provides lead state agency coordination to address the needs of homeless South Carolinians and administers HUD Shelter Care and Health and Human Services Path Programs, providing housing and/or supportive services for homeless people with mental illness, as appointed by the governor.

Employment Program – Demetrius Henderson, MSW
• Provides consultation, training, and fidelity monitoring to CMHS for the establishment and growth of consumer employment programming, with a focus on evidence-based practices that result in gainful employment of seriously mentally ill Clients.

Co-occurring Services – Shelley McGeorge, Ph.D.
• Provides technical assistance to community mental health centers in the development of best practices for Clients with co-occurring disorders;
• Leads in the collaboration with other organizations and agencies regarding addictions services;
• Liaises with the Medical University of South Carolina’s Clinical Trials Network with the National Institute of Drug Abuse.

Institutional Review Board – Katherine Roberts, MPH
• Provides administrative coordination for the Institutional Review Board, charged with protecting the rights and welfare of human subjects involved in research activities;
• Secures/maintains federal authorization/accreditation for the Institutional Review Board.

Office of Consumer and Family Affairs - Katherine Roberts, MPH
• Assists in empowering Clients to be actively involved in the planning, delivery, and evaluation of mental health services.

Crisis Stabilization Services - Raymond Benasutti, MA
The Director of Crisis Stabilization Services oversees annual funding allocations to community mental health centers statewide for the purpose of implementing enhanced crisis stabilization
These programs are designed primarily with the goal of providing timely and intensive community intervention and support to those who may be experiencing a mental health and/or a substance abuse related crisis in an effort to prevent a lengthy hospital ER visit.

In an effort to monitor the overall effectiveness of each center’s funded crisis stabilization initiatives, the Director of Crisis Stabilization also formally tracks the number of persons and the relevant length of time they have spent in hospital ER’s statewide awaiting placement in a state treatment facility bed on a weekly basis. On a quarterly basis, that information is collectively presented along with the overall total number of persons served by each center’s crisis stabilization programs in a formal report as required legislatively. That report also provides a description of each center’s crisis initiatives and relevant expenditures.

Additionally, the overall standard of effectiveness for each program is reported by the number of people who experienced direct program intervention and were either successfully prevented from unnecessarily being admitted to a hospital ER or were able to be quickly diverted from a hospital ER setting to a more appropriate clinical setting.

Office of Deaf Services – Roger Williams L.M.S.W., C.T.
- Directs the planning, oversight, and evaluation of a continuum of outpatient and inpatient best practice behavioral health services to persons in South Carolina who are deaf or hard of hearing;
- Administers the recruitment, hiring, and ongoing support of a staff of direct service providers and assures their fluency in American Sign Language;
- Assures that all SCDMH programs are accessible to persons who do not hear well;
- Develops innovative technological and human service program initiatives to be certain that all services are delivered in a cost-effective and timely manner throughout the state.

Children, Adolescents and their Families (CAF) - Director, Louise K. Johnson, M.S.
Program Manager Renaye S. Long, L.M.S.W., MPA
- Responsible for the development and implementation of the department's state-wide system of care for the children, adolescents and families of South Carolina. This includes keeping abreast of "Best Practices" trends in Child Mental Health and ensuring the implementation of these programs in South Carolina when appropriate. The Division of CAF serves as the central hub of communication for local CAF Directors, providing consultation services, technical assistance as well as a monthly forum for the discussion of issues relative to Children's Services.

Programs in CAF Services
OASIS Project / "No Wrong Door"- Kennard DuBose, LMSW, CAC II
- Offering Assistance, Stability and Intensive Support is dedicated to strengthening children, families and communities, by promoting the concept of prevention, empowerment and collaboration in a statewide effort to build the infrastructure for a family support system.
- OASIS actively provides assistance to families who have children with severe emotional disturbances and substance abuse problems by being a family focused, child centered culturally competent, and community based initiative.

School Based Services- Melissa Craft, MSW, LMSW
- The school-based team provides a continuum of services at school sites to address the needs of youth and their families. All clinical services are voluntary and require parental
permission. Services include: primary prevention e.g., helping to increase parental involvement in school, helping to coordinate activities related to a violence prevention initiative early intervention and services to youth dealing with transitions and milestones e.g., social skills training, school transition programs individual and family services e.g., individual, family and group counseling, crisis intervention, mentoring, tutoring

**YouthNet - Vacant**
- YouthNet involves everyone working together on behalf of a child who may have extra needs. This initiative seeks to capture and address the needs of seriously emotionally disturbed children, age 21 and younger, and their families. Our main goal is to strengthen families in becoming more effective citizens who will thrive in their communities.
- YouthNet serves York, Chester and Lancaster counties, and the Catawba Indian Nation. We offer trainings to include peer-to-peer groups; after-school programs; summer camps; respite; sibling support groups and much more.

**Public Information Coordinator Antoine X. Knox**

**Community Pharmacy Services – JoAnn Daniels, R.Ph.**
- Develops and administers policies affecting the appropriate use and storage of medications across the system;
- Devises methods to provide medications through collaboration with local community pharmacies, pharmaceutical companies, and non-profit organizations;
- Provides consultation and quality assurance to the South Carolina Implementation of the Medication Algorithm Project (SCIMAP).

**Internal Audit Division - Valarie Perkins**
- Serves an independent auditing function to examine and evaluate SCDMH activities as a service to SCDMH management and the S.C. Mental Health Commission;
- Provides analyses, recommendations, counsel, and information about the activities or processes reviewed.

**DIVISION OF INPATIENT SERVICES (DIS)**

The SCDMH Division of Inpatient Services provides inpatient and related specialty services to support the recovery of persons with mental illness, behavioral disorders, and/or addictions.

**Programs/Hospitals Operated By the DIS:**
- Bryan Psychiatric Hospital: Adult Psychiatric Services; Adult Forensic Services
- Patrick B. Harris Psychiatric Hospital: Adult Psychiatric Services
- William S. Hall Psychiatric Institute: Child & Adolescent Psychiatric Services
- Morris Village: Alcohol & Drug Addiction Treatment Services
- Campbell Veteran’s Home, Victory House Veteran’s Home: Contract Veteran’s Nursing Home Services
- Sexually Violent Predator Treatment Program: Adult Treatment Services for Persons Adjudicated as Sexually Violent Predators.

**Deputy Director for Inpatient Services - Versie J. Bellamy, MN, RN**
Has overall authority and responsibility for the operations and administration of the Division of Inpatient Services.

Provides for information and support systems, recruitment and retention of staff, physical and financial assets for the Division of Inpatient Services.

Responsible for the development and execution of strategic planning for the Division of Inpatient Services.

Directs and collaborates with hospital/program directors and directors of centralized services to ensure overall operations of the multi-hospital system are conducted in accordance with the strategic plan, applicable laws, regulations, and standards of regulatory, licensing, and accrediting bodies.

**INPATIENT MEDICAL/NURSING SERVICES**

A Medical Director and Chief Nursing Officer for Inpatient Services provide oversight of 24/7 treatment services to include Nursing, Psychiatry, and Non-Psychiatric medical service needs. To ensure professional practice standards are met, Nurse Program Managers and Medical Directors assigned to each hospital/program dually report to the hospital/program director as well as to the DIS Chief Nursing Officer or Medical Director.

**Medical Director – Tanya Dillihay, M.D.**

- Plans and directs medical staff and clinical programs for the Division of Inpatient Services, collaborating with Division Leadership to maintain compliance with policy, and standards for quality medical services within a comprehensive hospital system.
- Formulates and implements medical policies.
- Maintains effective relationships with referral sources.
- Provides supervision to all program Medical Directors, medical staff and clinical programs for a broad range of clinical services.

**Chief Nursing Officer – Algie Bryant, MSN, RN (Interim)**

- Has the authority and oversight responsibility for the organization and administration of nursing services for the Division of Inpatient Services.
- Develops and implements Recruitment and Retention Plans to ensure adequate staffing for the delivery of 24/7 nursing care.
- Represents nursing at the senior leadership and Governing Body organizational level.

**ADMINISTRATIVE AND CLINICAL SUPPORT LEADERSHIP FOR INPATIENT SERVICES**

Central administrative services support all or portions of the Division of Inpatient Services and Columbia-Area Hospitals/Programs to include: Finance, Performance Improvement, Planning, Human Resources, Information Technologies, Medical Clinics, Materials Management, Timekeeping, and Community Resource Services.

**Administrator/Controller – Doug Glover**
• Maintains the overall financial performance of the Division of Inpatient Services to ensure sound business methodologies, accountability and compliance with State and Federal laws and regulations.
• Provides guidance for information technology, contract administration, medical/infirmary administration, materials management, community development operations, and facilities management, central timekeeping and medical records to ensure standards are being met.

**Director of Performance Improvement – Algie Bryant, MSN, RN**
• Responsible for the functioning and work of the Division of Inpatient Services Standards, Performance Improvement, Utilization Management, Infection Control, Safety, and Risk Management Departments within the Division of Inpatient Services. Participates as a member of DIS Leadership in decision-making processes for development and implementation of compliance with accreditation/regulatory standards impacting on provision of patient care, treatment, services and safety of patients and staff.

**Director of Organizational Planning and Human Resources – Irene T. Thornley**
• Develops strategies to support the development and implementation of Division of Inpatient Services’ plans relative to; change management, organizational trends, productivity, communications, staffing, human resource/staffing standards and practices, and the table of organization.
• Oversees staffing budgets and staffing standards to advise Inpatient Leadership on position movement, changes in organizational structure, and hiring.
• Provides guidance for the development and operations of Inpatient Services Human Resources.

**DIS Compliance/Privacy Officer/ Registrar Manager – Delores C. Monteith, RHIA, CCS**
• DIS Compliance/Privacy Officer ensuring Compliance program is maintained throughout DIS facilities.
• Directs/coordinates all Medical Records and Insurance including scanning activities, of five campuses: Morris Village, Bryan Adult Psychiatric, Hall Institute, CM Tucker, and Bryan Forensics.
• Establishes procedures ensuring an effective Judicial Processing System for five campuses.
• Serves as Chair of Information Management Committee, DIS Compliance Committee, HIS Directors Committee and Coding Roundtable.

**Director of Information Technology – Mesa Foard**
• Aligns IT operations and objectives to Division of Inpatient Services business needs and SCDMH policies and procedures.
• Plans, coordinates, directs, and designs all operational activities of the DIS IT department, as well as provides direction and support for IT solutions that enhance mission-critical business operations.
• Identifies, recommends, develops, implements, and supports cost-effective technology solutions for all aspects of DIS.
• Manages IT department operational and strategic planning, including business requirements, project planning, and organizing and negotiating the allocation of resources.
• Analyzes, researches, organizes and supervises technology related projects as assigned by the Deputy Director.
Long Term Care Advisor/Compliance Officer – Jaclynn S. Lane, MN, RN
- Functions as contract monitor for Campbell and Victory House Veteran’s Homes.
- Advises the Deputy Director on long term care matters to include review and auditing of current long term care practice.
- Responsible for compliance with applicable standards, laws and regulations relevant to long term care nursing home facilities.

HOSPITALS/PROGRAMS LEADERSHIP

Bryan Psychiatric Hospital – Harvey Miller, Executive Director
- Responsible for the overall operation of the two components of Bryan Psychiatric Hospital - Adult Psychiatric and Adult Forensics services.
- Oversees Central Admissions for the DIS hospitals in the Columbia area.
- Oversees Entitlement Services, which is responsible for securing entitlements for the DIS hospitals in the Columbia Area.

Bryan Psychiatric Hospital Adult Services – Ralph H. Randolph, LMSW, Program Director
- Bryan Hospital is licensed by DHEC as a Specialized Hospital and is accredited by The Joint Commission.
- Provides inpatient acute, intermediate, extended, and geriatric psychiatric services.
- Patients are admitted primarily from 33 counties of the state on referral from community mental health centers. The majority of patients are civil involuntary admissions.

Bryan psychiatric Hospital Forensic Services – Holly Scaturo, MSN, RN, Program Director
- Bryan Hospital operates the forensics component within the confines of Geo-Care, a privately owned prison hospital located on the Crafts-Farrow campus. This secured prison hospital is licensed by DHEC as a Specialized Hospital. An additional 25 beds are operational in a free standing building on the campus.
- The Forensic Service provides in-patient psychiatric services to adults. Patients are admitted from throughout the state through the criminal or probate court system. The legal status of patients includes: not guilty by reason of insanity, incompetent to stand trial, or pretrial status with charges pending.
- Outpatient services include a Forensic Evaluation Service and the Not Guilty by reason of Insanity (NGRI) Outreach Clinic.

Sexually Violent Predator Treatment Program (SVPTP) – Holly Scaturo, MSN, RN, Program Director
- This program was established by legislation to provide treatment for adult persons adjudicated as sexually violent predators.
- The program is physically located within the confines of facilities maintained by the South Carolina Department of Corrections.

Patrick B. Harris Psychiatric Hospital – John Fletcher, MHA, Hospital Director
- Harris Hospital is licensed by DHEC as a Specialized Hospital and is accredited by The Joint Commission.
- Provides inpatient psychiatric services to adults.
• Serves as the regional in-patient facility for the following mental health centers: Anderson-Oconee-Pickens (AOP), The Beckman Center for Mental Health, Greenville Mental Health Center, Piedmont Mental Health Center, and the Spartanburg Mental Health Center.
• The majority of patients are civil involuntary admissions.

**William S. Hall Psychiatric Institute – Angela Q. Forand, Ph.D., Program Director**
• Hall Institute is licensed by DHEC as a Specialized Hospital with a separately licensed 37 bed Residential Treatment Facility for Children and Adolescents.
• Provides in-patient psychiatric services, treatment for alcoholism and drug abuse or addiction, and residential treatment for children and adolescents ages 4 to 21.
• Patients are admitted from throughout the state with referral from community mental health centers, juvenile parole boards, Department of Social Services, the family court system and the Department of Juvenile Justice.
• The majority of patients are civil, criminal or juvenile justice involuntary admissions.

• The Program Director provides clinical, administrative and fiscal oversight for the Assessment and Resource Center, an outpatient program for children suspected of being abused.

**Morris Village – George McConnell, M.Div., Program Director**
• Morris Village is licensed by DHEC as a Specialized Hospital and is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).
• Provides in-patient treatment for adults with alcoholism and drug abuse or addiction and when indicated, addiction accompanied by psychiatric illness.
• Patients are admitted from throughout the state with referral from community mental health centers and community drug and alcohol commissions. The majority of patients are civil involuntary admissions.

**C.M. Tucker Nursing Care Center – Norma Jean Mobley, R.Ph., NHA, Administrator, Roddey; Frances Corley, RN, BHS, NHA, Administrator, Stone Pavilion (Veterans)**
• Tucker Center is licensed by the state of South Carolina as a long term care facility.
• Is the long term nursing care facility of the DMH, providing intermediate and skilled care.
• Tucker Center is certified by the Centers for Medicare/Medicaid and the Veterans Administration, and is accredited by The Joint Commission.
• Patients are admitted from throughout the state.
Glossary of Terms, Abbreviations, Acronyms - Commonly Used In SCDMH

ACT/PACT/RBHS  Assertive Community Treatment, a set of case management programs delivered outside of the CMHC offices, in the natural living environment of the consumer, urban or rural.
A & D  Alcohol and Drug
ADL  Activities of Daily Living
AFDC  Aid to Families with Dependent Children
B & C Board  Budget and Control Board
BMC  Brynes Medical Center (No longer an organizational entity.)
BPH  Bryan Psychiatric Hospital, an acute care inpatient facility in the Columbia area
C & A  Child and Adolescent
CAF  Division of Children and Families
CAFAS  Child and Adolescent Functional Assessment Scale, used by the clinician to evaluate the level of functioning and degree of symptoms in children and adolescents.
CARF  Commission on Accreditation of Rehabilitation Facilities, one on the bodies which accredit DMH facilities.
CBHS  Columbia Behavioral Healthcare System (BPH, WSHPI, MV, Just Care, and Behavioral Disorders Treatment Program
CCET  Consumer-to-Consumer Evaluation Team, a consumer satisfaction measurement system run by fellow Clients
CFSH  Crafts-Farrow State Hospital (No longer an organizational entity.)
CGO  Comptroller General’s Office
Chapter 22  Medicaid policies and procedures for mental health providers of community mental health services.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>CIS</td>
<td>Client Information System, database containing consumer information.</td>
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<td>CMHC</td>
<td>Community Mental Health Center</td>
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<td>CMHS</td>
<td>Community Mental Health Services</td>
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<td>CMI</td>
<td>Chronically Mentally Ill</td>
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<td>CMTHRC</td>
<td>C. M. Tucker, Jr. Human Resources Center (Now, Tucker Center Nursing Care Center)</td>
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<td>Commission</td>
<td>A seven-member body designated by the state to govern the DMH.</td>
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<td>Client</td>
<td>Person with mental illness served by the DMH.</td>
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<td>Continuity of Care</td>
<td>A set of standards governing the provision of treatment to ensure seamless care is provided through hospital and community based care.</td>
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<td>Corporate Compliance</td>
<td>Process by which third party payers are assured that reimbursed clinical services are delivered as described.</td>
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<td>DAODAS</td>
<td>Department of Alcohol and Other Drug Addiction Services (Formerly, South Carolina Commission on Alcohol and Drug Abuse)</td>
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<td>DD</td>
<td>Dual Diagnosis, usually meaning substance abuse and mental illness. Sometimes meaning mental retardation and mental illnesses. Initials also used when talking about Developmentally Disabled.</td>
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<td>DDSN</td>
<td>Department of Disabilities and Special Needs (Formerly, Department of Mental Retardation)</td>
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<td>DGNCC</td>
<td>Dowdy-Gardner Nursing Care Center (Now, combined with Tucker Center Nursing Care Center)</td>
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<td>DHEC</td>
<td>Department of Health and Environmental Control</td>
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<td>DJJ</td>
<td>Department of Juvenile Justice (formerly Department of Youth Services)</td>
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<td>DMH</td>
<td>Department of Mental Health</td>
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<td>DOAS</td>
<td>Division of Administrative Services, SCDMH</td>
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<td>DOFS</td>
<td>Division of Financial Services, SCDMH</td>
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<td>DoIT</td>
<td>Division of Information Technology</td>
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<td>DRG</td>
<td>Diagnosis Related Group</td>
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<tr>
<td>DSM-IV</td>
<td>Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition</td>
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<tr>
<td>DSS</td>
<td>Department of Social Services</td>
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<tr>
<td>EPMS</td>
<td>Employee Performance Management System</td>
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<tr>
<td>FY</td>
<td>Fiscal Year</td>
</tr>
<tr>
<td>GAF</td>
<td>Global Assessment of Functioning, a clinical evaluation instrument used by the clinician to assess consumer level of functioning and symptoms.</td>
</tr>
<tr>
<td>HCFA</td>
<td>Health Care Financing Administration</td>
</tr>
<tr>
<td>HHS</td>
<td>Health and Human Services</td>
</tr>
<tr>
<td>HHSFC</td>
<td>Health and Human Services Finance Commission</td>
</tr>
<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
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</tr>
<tr>
<td>HPH</td>
<td>Harris Psychiatric Hospital</td>
</tr>
<tr>
<td>ICD-9-CM</td>
<td>International Classification of Diseases, Ninth Version, Clinical Modification</td>
</tr>
<tr>
<td>IPS</td>
<td>Individual Planning and Service, evidence-based employment model</td>
</tr>
<tr>
<td>ISP</td>
<td>Individual Service Plan</td>
</tr>
<tr>
<td>IT</td>
<td>Information Technology</td>
</tr>
<tr>
<td>JCAHO</td>
<td>Joint Commission on Accreditation of Healthcare Organizations, one of the bodies which accredit DMH facilities</td>
</tr>
<tr>
<td>LAC</td>
<td>Legislative Audit Council</td>
</tr>
<tr>
<td>Medication Algorithm</td>
<td>Evidence-based approach to pharmaceutical treatment.</td>
</tr>
<tr>
<td>MHA</td>
<td>Mental Health America</td>
</tr>
<tr>
<td>MHSIP</td>
<td>Mental Health Statistical Improvement Project, a multi-state project to design consumer satisfaction surveys for mental health clients</td>
</tr>
<tr>
<td>MIS</td>
<td>Management Information System</td>
</tr>
<tr>
<td>MOA</td>
<td>Memorandum of Agreement</td>
</tr>
<tr>
<td>MST</td>
<td>Multi-Systemic Therapy, an in-home, intensive service to children and their families.</td>
</tr>
<tr>
<td>MV</td>
<td>Earle E. Morris, Jr. Alcohol and Drug Treatment Center</td>
</tr>
<tr>
<td>NAMI</td>
<td>National Alliance on Mental Illness</td>
</tr>
<tr>
<td>NASMHPD</td>
<td>National Association of State Mental Health Program Directors</td>
</tr>
<tr>
<td>MHP</td>
<td>Mental Health Professional</td>
</tr>
<tr>
<td>MST</td>
<td>Multi-Systemic Therapy, an evidence-based practice providing wrap-around services to children and family/</td>
</tr>
<tr>
<td>NIMH</td>
<td>National Institute of Mental Health</td>
</tr>
<tr>
<td>P &amp; A</td>
<td>S. C. Protection and Advocacy System for the Handicapped, Inc.</td>
</tr>
<tr>
<td>PACT</td>
<td>Programs for Assertive Community Treatment, see ACT</td>
</tr>
<tr>
<td>PAMI</td>
<td>Protection and Advocacy for the Mentally Ill (part of SCP &amp; A)</td>
</tr>
<tr>
<td>Pathlore</td>
<td>a computerized employee training registration and documentation system.</td>
</tr>
<tr>
<td>PSRO</td>
<td>Professional Standards Review Organization</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
</tr>
<tr>
<td>QA</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>QCRB</td>
<td>Quality of Care Review Board, a convened group of experts charged with analyzing the events leading up to and through an outcome deemed adverse and making recommendations to the Department to prevent the event from recurring</td>
</tr>
</tbody>
</table>
Recovery  
Recovery is an ongoing process by which a person overcomes the challenges presented by a mental illness to live a life of meaning and purpose.

REGION 4  
Designation of southern states catchment area by federal government (HCFA, SS, etc.): Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee. Now called the Atlanta Region.

Risk Management  
The process by which potential clinical adverse outcomes are minimized in frequency or severity, or actual adverse outcomes are appropriately responded to opportunities to improve services (root cause analysis, QCRBs, etc.).

SAP  
Computerized financial management system.

SCAMI  
South Carolina Alliance on the Mental Illness (S. C. Chapter of NAMI)

School-Based  
Services delivered by mental health professionals within the walls of the school system.

SCSH  
South Carolina State Hospital (Combined with CFSH to form the Division of Rehabilitative Services.)

SHARE  
Self-Help Association Regarding Emotions (Consumer self-help group)

SSA  
Social Security Administration

SSBG  
Social Services Block Grant

SSDI  
Social Security Disability Income

SSI  
Supplemental Security Income

State Plan  
Document required annually by federal government that specifies specific goals for expenditure of Block Grant monies.

State Planning Council  
Stakeholder group who plans expenditures of federal Block Grant funds. The council is required to have at least 50% of its membership be non-DMH stakeholders

SVP  
Sexually Violent Predator

TCM  
Targeted Case Management

TITLE II  
Regular Social Security

TITLE IV  
Aid to Families with Dependent Children

TITLE IV-B  
Child Welfare Services

TITLE IV-D  
Child Support

TITLE VIII  
Medicare

TITLE VIX  
Medicaid

TITLE XX  
Social Services

TLC  
Toward Local Care, a program to return long term psychiatric inpatient clients to life in the community with intensive support from CMHCs.

Trauma  
Treatment and assessment, directed toward children and adults, to reduce the traumatic effects of psychiatric hospitalizations and previous life traumas.
Utilization Review  Process by which clinical services or documentation are monitored to assure delivery of clinically appropriate treatment (a.k.a., clinical pertinence).

VA  Veterans Administration

VR  Vocational Rehabilitation

WSHPI  William S. Hall Psychiatric Institute

Wrap  Intensive services, primarily for children, that “wrap” the individual in a full range of services to meet the psychiatric, emotional, social, and academic need

WRAP  Wellness Recovery Action Plan, an adult treatment model involving intensive, recovery-oriented services, developed by Mary Ellen Copeland.

SCDMH Commonly Used (Mainly Forensic) Legal Terms

Acquittal - not guilty verdict in a criminal case.

Adjudication - judgment/court decision. frequently refers to family court judgment in juvenile delinquency proceedings.

Beyond A Reasonable Doubt - Highest Burden Of Proof needed for guilty verdict in a criminal case. no real doubt after careful, impartial consideration of the evidence.

Burden Of Proof - Obligation to prove allegations made by that party.

Capacity/Competency To Stand Trial - “CST” Present ability for defendant to understand the charges, legal process and assist his attorney in his defense.

Capacity To Conform - “CC,” “Guilty But Mentally Ill/GBMI” defendant knew right from wrong but was unable to conform conduct (“irresistible urge”).

Clear and Convincing - Burden of proof greater than preponderance of the evidence but less than beyond a reasonable doubt. highly probable.

Commitment – Ordered (usually by probate court) for involuntary treatment after a full hearing (may or may not follow an emergency admission) and the court finding that there is “clear and convincing evidence” that the person before the court needs involuntary inpatient and/or outpatient treatment.

Conviction - Guilty verdict in a criminal case.

Criminal Responsibility - “CR” If defendant afflicted with mental disorder or defect at time of act, then may assert insanity defense. South Carolina version of m’naghten rule: because of a mental disease or mental defect at the time of the criminal act, defendant did not understand legal or moral right from wrong and could not conform conduct to the law.

Deposition - Sworn, out of court (no judge present) testimony of a witness taken before trial; part of
pre-trial “discovery” fact-finding process among parties.

**Due Process** - Constitutional right of party affected by government action to have prior notice and an opportunity to be heard.

**Emergency Admission** – Process for short term hospitalization of a person with a psychiatric or chemical dependency emergency requiring immediate, involuntary hospitalization. Because of the emergency, the normal process for a commitment is temporarily suspended. If the person is held beyond the emergency, there must be a commitment hearing and possible commitment.

**Ex Parte** - ’For One Party’ Only one party appears before and/or otherwise communicates with a judge on a matter before the court involving the parties. Usually prohibited.

**Foreseeability** - A key element in liability. If defendant could not reasonably foresee damage/injury caused by his/her action or inaction, then usually there is no liability.

**Freedom of Information Act** -provides public access to certain limited information which is routinely found in the personnel tiles. Information such as the employee's name, sex, race, paygrade, classification and dates of employment are required by the Act to be made available to the public upon request.

**General Sessions** - South Carolina State Criminal Court.

**Grand Jury** - Considers solicitor’s evidence to decide if there is probable cause to try defendant for a felony, a serious crime.

**Gross Negligence** - Failure to use the slightest amount of care. extreme negligence.

**Guardian** - Person appointed by court to care for and make decisions on behalf of minor children or adjudicated incompetent/incapacitated adults.

**Guardian Ad Litem** - Person appointed by court to determine best interests of a child or other incompetent/incapacitated person during legal proceedings.

**Habeas Corpus** - "You Have The Body" petition to the court asking that the prisoner/detainee be brought to court to determine if the person is imprisoned/detained unlawfully and should be released.

**Hearsay** - Secondhand information that witness heard from another. usually excluded as evidence.

**Indictment** - Sworn accusation of a crime.

**In Re** - “Pertaining To” issue to be decided, normally without adversarial parties.

**Insanity** - As a defense in a criminal case, any mental abnormality, disorder or defect, not limited to a clinical psychiatric condition or diagnosis.

**M’naghten Rule** - Legal test of insanity named after 19th century case involving assassination attempt on British prime minister resulting in his secretary’s death.

**Negligence** -Failure to use ordinary, reasonable care.
Nolle Prosequi - “Nol Pros” solicitor decides not to prosecute. Unless accompanied by dismissal with prejudice, solicitor may later “restore” charges and prosecute.

Non Compos Mentis - “Not of sound mind”

Party/Parties - In a civil action, plaintiff sues defendant. In a criminal action, the state brings action because offense is against the public.

Plea Bargain - Defendant usually pleads guilty to a lesser charge in exchange for a promise from the solicitor of a lower sentence.

Pleadings - Parties’ allegations in documents filed as part of the court record of the case.

Preponderance of Evidence - More likely than not burden of proof in most civil cases.

Probable Cause - Facts supporting reasonable grounds for a belief.

Pro Se - "On one's own behalf” A person who represents himself in a court case without an attorney.

Proximate Cause - A major element in the cause of injury or damage.

Subpoena - A formal command to appear (“duces tecum” commands production of documents).

Summary Judgement - No dispute among the parties as to the facts in the case as presented in the court record. One party is then entitled to judgment as a matter of law; often granted before trial.

Solicitor - Prosecuting attorney in criminal cases in South Carolina state courts.

Tort - Negligent or intentional wrong causing damage or injury to a private party.

Waive - Give up a right.
Definitions of Services and Client Populations

General Terms

1. Mental health and mental illness: These terms may be defined in a very general or global fashion. A more concise definition may be gleaned from the Global Assessment of Functioning Scale (GAF) in the Diagnostic and Statistical Manual (DSM- IV) or its latest version and herein referenced as DSM.

The GAF scale "considers psychological, social and occupational functioning on a hypothetical continuum of mental health-illness" (DSM p.32). Therefore, at the high end of the scale, mental health may be defined as "absent" or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns. If symptoms are present, they are transient and expected reactions to psychosocial stressors. At the midpoint of the scale, it is possible to begin defining mental illness: "moderate symptoms (e.g., flat affect, occasional panic attack) or some difficulty in social, occupational or school functioning e.g., few friends, conflicts with co-workers)." Descending the scale, a person presents a danger of hurting self or others.

A textbook definition of mental health is positive striving and includes such terms as growth, development, maturity, responsibility, self-fulfillment, adaptation to stress, and successfully coping with life. Mental illness can be described in terms of the absence of mental health. Problems arise in developing an explicit set of criteria because of subjectivity and culture-bounds in our values i.e. what is appropriate or acceptable behavior in one place may not be in another.

2. Mission: An overall philosophy that defines an agency’s purpose for carrying out activities and is the basis for formulating program plans and direction. The SCDMH’s mission is to support the recovery of people with mental illness.

3. Goal: An aim that one strives to attain that is in keeping with the stated mission.

4. Objective: A specific activity by which a goal may be attained.

5. Target: One component of an objective, usually completed by a date certain.

6. Client: An individual who experiences symptoms of mental illness and who uses the services of the Department of Mental Health and who, with the family, has a voice in determining program and service needs and goals.

7. Target population: A particular group of clients in need of specialized services. The group has unique identifying characteristic that define the special services that are needed (e.g., deaf mentally ill, who would require the same services as other mentally ill persons, but those services must be delivered either through sign language, speech reading, or home-made signs).

8. Program: A logical grouping of clinical or non-clinical functions required to be performed within a community mental health center. This grouping is designed as a basis for supervision, planning, budgeting, evaluation, and statistical reporting.

9. Services: Specific discreet activities provided to or with a client as specified by quality
assurance standards and contained currently in SCDMH Directive 782-96 (6-100). These services are provided to specified target populations within programs and components based upon client needs. Services are not necessarily limited to one or more target population, program, or component.

**Primary Target Populations**

**Adult/Elderly**

1. **Severe mental illness:** A category in which a person suffers from a serious, persistent mental illness as classified in the DSM that impairs his/her ability to carry out the normal activities of daily living. This person requires ongoing treatment and support. This category includes psychiatrically disabled people over age 17 (with no upper limit) who are considered psychiatrically disabled when they have:
   - a clinically verifiable psychiatric diagnosis of schizophrenia or major affective disorder or other psychosis or severe personality disorder; or
   - require ongoing and frequent mental health agency intervention in order to maintain community tenure; or
   - have functional limitations as evidenced by requiring assistance to meet the basic needs of food, clothing, and shelter; or
   - work in competitive, non-sheltered settings; or
   - engage in social, recreational and vocational activities; or
   - carry out daily living skills; or
   - develop and sustain meaningful interpersonal relationships or participate in services.

2. **Chemically dependent/mentally ill:** A population category in which the client is diagnosed per the DSM as suffering from both mental illness and psychoactive substance abuse/dependence.

3. **Chemically dependent:** A population category in which the client is diagnosed per the DSM as suffering from psychoactive substance abuse/dependence.

4. **Dementia/MI:** Those persons over age 17 who have been previously diagnosed with mental illness whose current diagnosis is primary dementia.

5. **Others:** Persons over age 17 (with no upper limit) and their families who are experiencing a disruption in their normal level of functioning and who can reasonably be expected to have the capability of resuming their normal level of functioning through appropriate psychotherapeutic interventions, or who have the potential for growth above their normal level of functioning, and:
   - there are generally an identifiable developmental, familial, or environmental stresses(s) precipitating the onset of dysfunctional behavior or an identifiable pattern of maladaptive behaviors that can be modified through cognitive learning, environmental manipulation, and/or other medical/psychiatric interventions, such as medications;
   - the disruption in level of functioning is generally a temporary disabling condition that can develop into a chronic problem if untreated or ineffectively treated; or
Priority concerns and efforts are directed toward people experiencing severe and persistent symptoms of mental illness and disruptive emotional distress associated with such issues as poverty, housing, employment, physical or sexual abuse, or other problems.

**Children/Adolescents/Families**

1. **Moderate to severe emotionally disturbed/mentally ill child/adolescent:** A person between the age of birth through 17 years who manifests a substantial disorder of cognitive or emotional processes that lessens or impairs to a marked degree that child's capacity either to develop or to exercise age-appropriate or aged-adequate behavior or both.

Such behavior includes, but is not limited to, marked disorders of mood or thought processes, severe difficulties with self-control and judgment including behavior dangerous to self or others, and serious disturbances in the ability to care for and relate to others.

The presence of epilepsy, mental retardation, organic brain syndrome, physical or sensory handicaps, or brief periods of intoxication caused by alcohol or other substances is not sufficient to meet the criteria for a child to be served as emotionally disturbed/mentally ill, but does not exclude a child with these problems who is otherwise determined to fulfill the criteria.

2. **Others:** The same as "others" in the adult/elderly population except that this category includes persons between the age of birth through 17 years.

**Special Populations**

Categories of mental health clients that have special needs that either do not match primary target populations or include clients from multiple primary target populations. This category includes but not limited to the following:

1. **Developmentally disabled/mentally retarded:** These are individuals with significant, sub-average intellectual functioning and deficits in adaptive behavior who also have an additional discrete mental disorder(s).

2. **Deaf/hard of hearing:** Adults and children who have serious psychiatric disorders or emotional disturbances and have a significant hearing loss. This includes the following sub-populations:

   a) **Clients who are deaf:** Those individuals who identify themselves as culturally deaf and have a significant hearing loss. These individuals may communicate by American Sign Language, by the use of speech reading and residual hearing, by idiosyncratic sign/gesture systems, or by some other manual communication system such as Cued Speech or Signed English.
b) **Clients who are hard of hearing:** Those individuals with a significant hearing loss that impairs their ability to hear and understand speech but do not identify themselves as deaf. These individuals may communicate in a variety of ways but are most likely to use residual hearing and speech reading.

c) **Clients who are deaf/blind:** Those individuals who have a both a significant hearing loss and a significant vision loss.

3. **Homeless:** Persons who suffer from mental illness, are in need of mental health services, have no permanent residence, and lack resources or a support system.

4. **Elderly:** Persons over the age of sixty-five who have complex problems and needs and who have mental disorders that require treatment, perhaps including long-term care.

5. **Minority outreach:** A special project or effort to increase participation and/or tailor programs or services to selected groups such as African/American, Hispanic, rural, etc.

6. **Others:** Categories of projects or clients selected by SCDMH or mental health centers for special, discrete identification for programmatic or accounting purposes (e.g. grants, temporary special emphasis).

7. **Offenders with mental illness etc:** adult persons who have an identified mental illness and/or mental illness and alcohol and abuse and are incarcerated in a local jail, supervised probation, and returning to local communities from prison.
The role and mission of the South Carolina Department of Mental Health (SCDMH) and the community mental health centers are defined by the Code of Laws of South Carolina. The role of a mental health center board member is also defined in part by state law. The most pertinent laws are summarized below. Full text of applicable laws is available from the Internet and through your mental health center executive director. Questions concerning those laws and other legal issues may be directed to the SCDMH Office of General Counsel.

Chapter 9 of Title 44 of the Code of Laws of South Carolina creates the State Department of Mental Health, and gives it jurisdiction over the state's psychiatric hospitals, alcohol and drug facilities, and community mental health centers. It also establishes the South Carolina Mental Health Commission as the governing board of directors for SCDMH statewide.

Chapter 15 of Title 44 of the Code of Laws of South Carolina covers local mental health programs, boards and centers. It specifies how community mental health center(s) are to be established, what geographic areas they will cover, and how they shall be governed and administered.

Center board(s) must consist of at least seven and not more than fifteen members representing the counties in the center service area in proportion to each county's population. At least one board member must be a medical doctor licensed to practice medicine in South Carolina. To the extent feasible, other board members are to include representation from county health departments and welfare boards, hospital boards, medical societies, lay groups, and business, labor and civic associations, as well as the general public. Client and family representation, including parents of emotionally disturbed children and adolescents, must be considered when making recommendations for board membership. Board members are appointed by the governor upon the recommendation of a majority of the county legislative delegation.

Subject to state statutes and SCDMH rules and regulations, boards are authorized to:

- be the administrative agency for center programs (e.g., guiding, advising, and assisting the center executive director on the internal policies necessary to implement statewide and local priorities);
- employ the center executive director and through him or her the personnel necessary to carry out the center programs;
- promote statewide priorities and establish local priorities;
- review and evaluate center services, the annual plan and budget, and make recommendations about them to the center executive director and SCDMH;
- seek local public and private financial support for the center;
- promote, arrange, and implement working agreements with local agencies;
- advise the center executive director on the adoption and implementation of center policies to further effective community relations.

Updated 5/6/2010