South Carolina

UNIFORM APPLICATION
FY 2026/2027 Only ApplicationBehavioral Health Assessment and Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 08/12/2025 4.06.02 PM)

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

State Unique Entity Identification

Unique Entity ID	KGLNFGPQMFB4

I. State Agency to be the Grantee for the Block Grant

Agency Name	SC Department of Behavioral Health and Developmental Disabilities, Office of Mental Health
Organizational Unit	Office of the Director
Mailing Address	P.O. Box 485
City	Columbia
Zip Code	29202

II. Contact Person for the Grantee of the Block Grant

First Name	Robert
Last Name	Bank
Agency Name	SC Department of Behavioral Health and Developmental Disabilities, Office of Mental Health
Mailing Address	P.O. Box 485
City	Columbia
Zip Code	29202
Telephone	803-898-8319
Fax	803-898-1383
Email Address	robert.bank@scdmh.org

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

V. Date Submitted

Submission Date	
Revision Date	

VI. Contact Person Responsible for Application Submission

First Name	Mahri
Last Name	Irvine

Telephone	803-898-8184
Fax	
Email Address	mahri.irvine@scdmh.org

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2026

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**

Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State

management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Robert L. Bank, MD

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

BHDD SOUTH CAROLINA
DEPARTMENT of BEHAVIORAL HEALTH
AND DEVELOPMENTAL DISABILITIES
OFFICE of MENTAL HEALTH

Henry Dargan McMaster, *Governor*

OFFICE of MENTAL HEALTH
Robert L. Bank, M.D., *Office Director*

September 1, 2025

Arthur Kleinschmidt, Ph.D., MBA
Principal Deputy Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Kleinschmidt:

Please find attached with this letter the following documents as required by the FFY26 Community Mental Health Services Block Grant (MHGB) application, which is due September 1, 2025. These documents conform to the requirements discussed in the *FFY 2026 Community Mental Health Services Block Grant* letter dated June 24, 2025.

- Funding Agreements, Assurances – Non-Construction Programs, and Certifications to sign in one document
- MHBG Assessment and Plan
- State Behavioral Health Advisory Council Members and Behavioral Health Advisory Council composition by member type (narrative and form)
- Funding plan for the fourth allotment of the Bipartisan Safer Communities Act (BSCA)

Please note that while the Disclosure of Lobbying Activities is not applicable to the SC Department of Behavioral Health and Developmental Disabilities, Office of Mental Health (BHDD OMH), it is being submitted in its blank form to remain consistent with prior years' block grant applications.

BHDD OMH appreciates the opportunities afforded by the MHGB to help individuals, families, and communities in South Carolina who are affected by mental illnesses.

Sincerely,

Robert L. Bank, MD
Director

HENRY DARGAN MCMASTER
GOVERNOR

June 25, 2025

Arthur Kleinschmidt, Ph.D., MBA
Principal Deputy Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
5600 Fisher Lane
Rockville, Maryland 20857

Dear Dr. Kleinschmidt,

As the Governor of the State of South Carolina, I hereby delegate authority to Robert Bank, MD, the Interim Director of the Office of Mental Health, Department of Behavioral Health and Developmental Disabilities, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG) and the Projects for Assistance in Transition from Homelessness (PATH) grant.

Please do not hesitate to contact me if you have any questions or if I may be of further assistance.

Yours very truly,

Henry Dargan McMaster

HDM/jsg

STATE HOUSE • 1100 GERVAIS STREET • COLUMBIA, SOUTH CAROLINA 29201 • TELEPHONE: 803-734-2100

South Carolina Department of Behavioral Health and Developmental Disabilities, Office of Mental Health

The Bipartisan Safer Communities Act (BSCA)

Fourth Allotment

Funding Plan

Submitted: September 1, 2025

Table of Contents

Introduction

Thank you for reviewing this proposal for South Carolina's use of the fourth allotment of the Bipartisan Safer Communities Act (BSCA) funds.

Previously, the South Carolina Department of Behavioral Health and Developmental Disabilities, Office of Mental Health (BHDD OMH) received three allotments of BSCA funds, and developed a plan to use the funds for NAVIGATE programs at Community Mental Health Centers (CMHCs), to support the SC Mobile Crisis Call Center, to support Mobile Crisis Teams, and provide trainings for staff members.

This proposal provides information about how SCDMH plans to spend its fourth allotment of BSCA funds, for the period of September 30, 2025 – September 29, 2027, in the amount of $776,272.

Overview of SC Department of Behavioral Health and Developmental Disabilities, Office of Mental Health

The mission of BHDD OMH is to support the recovery of people with mental illnesses. BHDD OMH is one of the largest hospital- and community-based systems of care in South Carolina. Since opening its first hospital in 1828, BHDD OMH has served approximately four million South Carolinians, including three million patients in outpatient community mental health centers and clinics and one million patients in inpatient facilities (hospitals and nursing homes).

BHDD OMH operates 16 community-based, outpatient mental health centers and dozens of associated clinics and satellite offices. These agencies serve people throughout all 46 counties in the state. Approximately 70,000 adults and 30,000 children are served by BHDD OMH each year. Community Mental Health Centers (CMHCs) provide comprehensive mental health services, offering outpatient, home-based, school, and community-based programs to children, adolescents, adults, and families throughout South Carolina. Each CMHC covers a geographic catchment area; together, they provide services to all 46 SC counties. All 16 CMHCs have advisory boards and are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

South Carolina is one of the only states in the nation with a state-operated, comprehensive mental health system, resulting in numerous benefits for South Carolinians in need of services. For example, this structure means that BHDD OMH centers, clinics, and hospitals provide an inclusive, uniform array of core mental health services; provide and coordinate the necessary supports for successful recovery; provide transition services to and from inpatient care to support long-term recovery; and provide services to anyone in need following a natural disaster. BHDD OMH has created a trauma-informed system of care; this system includes policies, procedures, and practices that do not create, or recreate, traumatizing events for patients. The agency ensures all patients are offered evidence-based trauma assessments, and it offers evidence-based treatment options to patients experiencing trauma-related symptoms.

Budget Overview

Bipartisan Safer Communities Act (BSCA) Funding Plan Fourth Allotment South Carolina Mental Health Block Grant Proposed Expenditures for Sep. 30, 2025 - Sep. 29, 2027	
ESMI/FEP Set-Aside (10% of Total Award)	
NAVIGATE	$77,628
Subtotal	***$77,628***
Crisis Set-Aside (90% of Total Award)	
Crisis Receiving and Stabilization Facility	$698,644
Subtotal	***$698,644***
Community Mental Health Services (0% of Total Award)	
n/a	$0
Subtotal	***$0***
Total	**$776,272**
Award	$776,272
Difference	$0

Scope of Services and Budget Narrative

BHDD OMH proposes the use of the fourth round of BSCA funding to support two current initiatives: NAVIGATE programs at several Community Mental Health Centers (CMHCs), and a new Crisis Receiving and Stabilization Facility operated by the Columbia Area Mental Health Center (CAMHC).

Ten Percent Set-Aside for ESMI/FEP

BHDD OMH proposes using ten percent of the fourth round of BSCA funding to support or start a NAVIGATE program at a CMHC. This amount of funding will be $77,628.

Funding for NAVIGATE Program

NAVIGATE – Program Description

The NAVIGATE program is a nationally recognized Coordinated Specialty Care (CSC) treatment model. Patients between the ages of 15 and 40 years of age who have been diagnosed in the schizophrenia spectrum, and are new to treatments in the past two years, are eligible to participate in NAVIGATE. This program is designed for patients to graduate within two years; the majority of patients successfully graduate.

The NAVIGATE treatment team is comprised of a wide variety of professionals, including a psychiatrist, program director, mental health clinician (referred to as the Individual Resiliency Trainer), employment and education specialist, care coordinator, entitlements specialist, nurse, and peer support specialist. Patients who participate in NAVIGATE may meet with their Individual Resiliency Trainer (IRT) as often as weekly, or even more than once a week, depending on their needs. The IRT visits with patients not just in clinical settings, but also in their homes or in communities; sessions can be conducted in-person or through telehealth. The NAVIGATE Individual Resiliency Training Manual is used in every session to help patients learn and practice skills. This training manual includes modules on a wide range of topics, including education about psychosis and how to cope with hallucinations, skills to cope with stress and anxiety, gaining awareness of strengths, focusing on health and wellness, and relapse prevention skills.

The psychiatrist can meet with patients as often as monthly, and uses the NAVIGATE prescriber's manual to follow the NAVIGATE model for medication adherence. Patients can meet as often as weekly with their Employment and Education Specialists, Peer Support Specialists, and Care Coordinators. Each week, the entire care team meets to discuss every patient. The IRT and program director also meet on a weekly basis; they review the NAVIGATE model and address any potential problems that have arisen.

Support and education for family members and other loved ones is also provided through NAVIGATE. The NAVIGATE Family Education Manual is provided to patients' families and friends to help them learn how to support their loved ones and help them reach their goals.

NAVIGATE – Statement of Need

Over the past few years, BHDD OMH's Community Mental Health Centers (CMHCs) have significantly increased the number of programs that provide specialized services to individuals experiencing Early Serious Mental Illness (ESMI) and First Episode Psychosis (FEP). Currently, five CMHCs offer three different Coordinated Specialty Care (CSC) programs, including NAVIGATE. In the past few years, BHDD OMH has expanded the number of CMHCs offering NAVIGATE. Currently, five CMHCs implement NAVIGATE: Aiken Barnwell MHC, Charleston Dorchester MHC, Coastal Empire CMHC, Columbia Area MHC, and Lexington County CMHC.

Because NAVIGATE is evidence-based and is one of the most rigorous and highest quality FEP programs in the nation, BHDD OMH leadership wants to ensure that all individuals experiencing FEP will benefit from the rigorous, comprehensive set of services that NAVIGATE provides.

BHDD OMH plans to use the full ten percent set-aside to support CMHCs as they develop or continue their NAVIGATE programs.

Five Percent Set-Aside for Crisis Services

After the ESMI/FEP set-aside has been accounted for, $698,644 of the third allotment of BSCA funds will remain. BHDD OMH proposes using all of the remaining funds to strengthen and expand the state's newest Crisis Receiving and Stabilization Facility (CRSF).

Funding for Crisis Receiving and Stabilization Facility

BHDD OMH plans to provide $698,9644 to support the implementation of SC's newest Crisis Receiving and Stabilization Facility (CRSF). This facility is the second CRSF launched in the state; it just started serving patients in July 2025.

CRSF – Program Description

CRSFs reduce hospitalization by helping people receive services in their communities. CRSFs are generally viewed as a more appropriate and less expensive alternative to hospital emergency departments or inpatient psychiatric hospital units. A second CRSF is now operational at the Columbia Area Mental Health Center (CAMHC). CAMHC opened the CRSF doors to patients in July 2025.

Established in 2025, the Midlands Crisis Stabilization Unit (MCSU) is a 9-bed, voluntary, short-term facility for adults, with the primary focus of stabilizing psychiatric symptoms. The target population is people who are experiencing symptoms significant enough that they need more than outpatient services can provide, but not quite to the level of inpatient treatment. Many of these individuals have historically ended up in the local EDs, and this program is designed to route them to a more appropriate level of care, when possible. For someone to be admitted to the unit, they must be experiencing psychiatric symptoms, willing for admission and participation in treatment, medically stable, and able to perform ADLs. Patients can have co-occurring substance use disorders, but cannot currently be under the influence of substances or in need of medical detox. The staff

consists of masters prepared clinicians, bachelors level clinicians, a nurse on each shift, and a psychiatrist who makes rounds in the facility each morning and is available by phone 24/7. The treatment services consist of group therapy, individual therapy, nursing services, assessment for medications by a psychiatrist, and psychosocial rehabilitation services. Since the average length of stay is 3-5 days, the clinical programming is intensive and requires patient participation throughout the day. MCSU staff members focus on what led to the patients' current crises, how to stabilize their symptoms, and how to set up skills and support systems to prevent these types of crises in the future. A part of this support system includes linking the patients to follow-up services with appropriate outpatient treatments when they are discharged.

CRSF – Statement of Need

Because of the intensive, comprehensive nature of services provided by the CRSF and the need for 24/7 staffing, implementation of this program requires a significant amount of money. Patients served in this program require ongoing monitoring to ensure that their mental health and physical health continue to improve in the program. Staff members operate as a cohesive team, which requires additional time for case reviews and meetings to discuss patient progress and discharge plans. The CRSF is a new program for CAMHC, and no other programs have been discontinued. This means that CAMHC cannot simply absorb the costs of the staff members or shift job duties; instead, funding is needed to recruit and retain high-quality employees. The on-call nature of the work creates a significant expense, because many staff members, including a psychiatrist, may need to respond after hours. After-hours services result in increased staff expenses. It is also likely that many patients will be uninsured or underinsured and will not be able to afford to pay for services. The CRSF will provide services to people regardless of their ability to pay. This means that the program will undoubtedly "lose" money, since staff expenses will not be balanced out by payments for services.

Funding for this program will include personnel expenses, training/professional development for the grant-funded staff members, and/or program supplies for the grant-funded staff members.

Community Mental Health Services Funding

As discussed in the above two sections, BHDD OMH plans to spend all of its BSCA funding on services in the ESMI/FEP category and the Crisis Services category. Therefore, general community services will not be funded by BSCA 4.

Plans to Develop/Enhance Mental Health Emergency Preparedness and Response Plan

BHDD OMH does not plan to use its fourth allotment of BSCA funding to develop or enhance its mental health emergency preparedness and response plan. This decision is due, in part, because BHDD OMH's plan is already robust and was prepared in careful collaboration with numerous other state government agencies.

In 2017, South Carolina's governor signed Executive Order 2017-11, requiring each state agency to be capable of carrying out its responsibilities as listed in the SC Emergency Operations Plan. The South Carolina Emergency Operations Plan (SCEOP) was established by the South Carolina Emergency Management Department (SCEMD) to ensure that state responses to disasters would

be well-coordinated and effective. In 2018, BHDD OMH developed the South Carolina Behavioral Health Plan. The plan provides for comprehensive planning, mitigation, response and recovery activities that address the immediate and long-term individual and community behavioral health needs to any State declared or federal Presidential Declared Disaster (PDD). The plan provides a matrix of behavioral health response protocols for any human induced incident or accident, natural disaster, or terrorist event involving weapons of mass destruction (WMD). The plan also provides for support of local emergencies which do not qualify as a state or federal disaster but which may require additional behavioral health response beyond the capacity of a local CMHC or DIS facility.

Plans to Develop/Enhance State Behavioral Health Team

BHDD OMH does not plan to use its fourth allotment of BSCA funding to develop or enhance a state behavioral health team that coordinates, provides guidance, and gives direction in collaboration with state emergency management planners during a crisis. This decision is due, in part, because BHDD OMH's mobile crisis call center and mobile crisis teams are already robust and provide services throughout the state. Please see the section directly following for a description of Mobile Crisis teams.

Plans to Develop/Enhance Mobile Crisis Team

BHDD OMH does not plan to use its fourth allotment of BSCA funding to develop or enhance Mobile Crisis teams. This decision is due, in part, because BHDD OMH's mobile crisis c teams are already robust and provide services throughout the state.

SC Mobile Crisis (MC) is a program created by BHDD OMH, in partnership with SC Department of Health and Human Services, to enhance the agency's crisis services array through the provision of statewide on-site emergency psychiatric screenings and assessments.

MC provides services 24/7/365 in all 46 counties of South Carolina. Services are available for children, adolescents, and adults. The program's goals are: increase access to the appropriate level of care for people experiencing psychiatric crises; reduce hospitalizations; and reduce unnecessary emergency department visits and incarcerations. The success of MC is built on the foundation of partnerships with partnerships with local law enforcement, hospitals, judges, community providers, and other mental health providers. This program provides an extension of BHDD OMH community mental health center services; during business hours, BHDD OMH mental health centers serve patients by appointment, during walk-in hours, and via phone. MC provides mobile response to patients in the community who cannot, or are unable to, access services. This program has the capability to provide a mobile response in the community for individuals in crisis who are in need of crisis intervention services when local mental health centers are closed. The MC teams are also able to provide assessment, intervention, and referral for people who are at imminent risk but refuse to seek voluntary services.

When local Community Mental Health Centers are closed, including after-hours, on weekends, and during holidays, MC teams of two professionals respond in person, via telehealth, or by phone to people experiencing psychiatric emergencies. These two-person MC teams are comprised of a master's level (or higher) clinician and local law enforcement personnel. The team may also

include a bachelor's level staff member or a peer with lived expertise. The MC teams are dispatched by the Mobile Crisis Call Center, which is operated by the BHDD OMH Charleston Dorchester Mental Health Center. Referrals are received from individuals in crisis, law enforcement and other first responders, as well as third-party callers. Third-party callers include family members and friends, community providers, and the 988 Suicide and Crisis Lifeline Network. MC teams, working collaboratively with the detention centers, may provide assessment and crisis intervention services in jails and prisons.

Plans to Develop/Enhance Services for Young Adults, Youth and Children, or their Families

It is reasonable to assume that a small portion of the fourth allotment of BSCA funding will help BHDD OMH enhance services provided to young adults and their families by funding NAVIGATE programs.

Please refer to the descriptions provided previously in this application for detailed information about NAVIGATE.

Plans to Develop/Enhance Services Provided to Communities

It is reasonable to assume that a small portion of the fourth allotment of BSCA funding may help BHDD OMH enhance services provided to communities in the Midlands part of the state that have been affected by trauma, mass shootings, and school violence, through the newly established CRSF. The CRSF is available to provide services to people in crisis; some of these people may be trauma survivors.

Please refer to the description provided previously in this application for detailed information about the CRSF.

Plans to Develop/Enhance Culturally and Linguistically Tailored Messaging

BHDD OMH does not plan to use its fourth allotment of BSCA funding to develop or enhance culturally and linguistically tailored messaging. Previously, BHDD OMH used American Rescue Plan Act of 2021 (ARPA) grant funding available to provide culturally and linguistically tailored messaging to improve SMI/SED patient services. In the future, BHDD OMH will use state funds and other funding sources to provide these types of messages.

Plans to Develop/Enhance Other Mental Health Emergency/Crisis Behavioral Health Practices

BHDD OMH does not plan to use its fourth allotment of BSCA funding to develop or enhance other mental health emergency or crisis behavioral health practices; other funding sources are available to support various other crisis services.

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).

Standard Form LLL (click here)

Name

Robert L. Bank, MD

Title

Director

Organization

SC BHDD, Office of Mental Health

Signature: Robert L Bank MD Date: 7/15/25

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2026

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**

Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State

management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Robert L. Bank, MD

Signature of CEO or Designee[1]: 

Title: Director

Date Signed: 7/15/2025

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Disclosure of Lobbying Activities

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Name

Robert L. Bank, MD

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Director

Organization

SC BHDD, Office of Mental Health

Signature: Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations

Narrative Question

Provide an overview of the state's prevention system (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

Prior to April 2025, two different state government agencies were responsible for providing services related to mental healthcare and substance use healthcare. In April 2025, Bill S.2 was signed into law by Governor McMaster. This law formed a new state agency named the SC Department of Behavioral Health and Developmental Disabilities (BHDD). Three offices are housed within the new agency: the Office of Mental Health (BHDD OMH), the Office of Substance Use Services (BHDD OSUS), and the Office of Intellectual and Developmental Disabilities (BHDD OIDD). The restructuring was designed as a system to promote more collaborative care for patients with diverse healthcare needs who might receive services from one, two, or all three of these offices.

Through this restructuring process, the State Mental Health Authority of South Carolina was officially transformed from the South Carolina Department of Mental Health (SCDMH), which had been an independent state agency overseen by a commission, into the Office of Mental Health (BHDD OMH), which is an office housed within a state agency overseen by a state cabinet.

BHDD OMH is responsible for oversight and management of direct patient services in numerous facilities throughout South Carolina: 16 community mental health centers (CMHCs); three psychiatric hospitals, one of which treats substance use disorders; one community nursing home; and a Sexually Violent Predator Treatment Program. Each CMHC operates clinics and satellite offices. The locations of the CMHC main offices, clinics, and satellite offices are strategically placed throughout each county, ensuring that all South Carolina residents will be able to access services within a 45-minute car ride from their homes.

BHDD OMH ensures that both adults and children receive a wide variety of mental health services. Both outpatient and inpatient services, along with services to help patients transition from inpatient settings back into their communities, are available for children, adolescents, and adults. BHDD OMH has a dedicated Children and Family Services Department; this department focuses on ensuring that children of all ages, from infancy through their teenage years, will receive evidence-based, high quality mental health services.

In April 2025, the Single State Authority of South Carolina was officially transformed from the South Carolina Department of Alcohol and Other Drug Abuse Services (SCDAODAS), which had been an independent state agency, into the Office of Substance User Services (BHDD OSUS), which is an office housed within a state agency overseen by a state cabinet.

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

BHDD OMH serves not only as the SMHA, but it is also the largest provider of mental healthcare services in South Carolina. The mission of BHDD OMH is "to support the recovery of people with mental illnesses." Since opening its first hospital in 1828, BHDD OMH has served approximately 4 million South Carolinians. Approximately 3 million patients have been served in BHDD OMH outpatient community mental health centers and clinics, while approximately 1 million patients have been served in BHDD OMH inpatient facilities.

BHDD OMH is comprised of 16 Community Mental Health Centers (CMHCs) and dozens of associated clinics and satellite offices, serving all 46 counties in the state. The office also operates three licensed hospitals (including a hospital for treatment of substance use disorders) and a nursing home that is not limited to psychiatric patients. BHDD OMH also operates a large forensics program for defendants referred from the state's criminal courts is mandated to operate the state's Sexually Violent Predator Treatment Program. The office provides services to approximately 100,000 patients per year, approximately 30,000 of whom are children.

The programs, services, and divisions provided by BHDD OMH are designed to ensure that South Carolinians receive the right

treatment, at the right place, at the right time. They work together to ensure that South Carolina's public mental health system is a robust, interconnected, evidence-based system of care that supports the recovery of people with mental illnesses. BHDD OMH designs its services and programs based on the understanding that patients treated in community settings fare better clinically, that people with SMI/SED need family and community support, and that patients recover faster and stay well longer when receiving services in their communities.

BHDD OSUS contracts with 31 of the state's county alcohol and drug abuse authorities to provide most of the core substance use services in all 46 counties. These services include traditional group, individual, and family outpatient counseling for adults; post-discharge services; Alcohol and Drug Safety Action Program (ADSAP), the state's DUI program; youth and adolescent services; and primary prevention/education programs. Service delivery emphasizes evidence-based practices and is supported by BHDD OSUS quality assurance efforts. BHDD OSUS engages in close relationships with the county authorities and other contracted providers and supports systematic and continuous actions for quality improvement in service delivery.

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

The SMHA and the SSA were recently merged into a single larger agency, as described in Question 1 above. However, the two newly created offices will continue to be responsible for management of mental health services and substance use services, until notified to do otherwise by BHDD leadership.

BHDD OMH's 16 Community Mental Health Centers (CMHCs) covers a geographic catchment area; together, they provide services to all 46 SC counties. The CMHCs are all accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). Each CMHC has an advisory board comprised of seven to 15 members, including at least one medical doctor. The advisory boards meet monthly.

The BHDD OMH Division of Long-Term Care engages in oversight of several facilities and programs. CM Tucker Roddey is a nursing home providing intermediate or skilled nursing care. Roddey offers residents a complete living environment, including medical care, rehabilitative therapy, pharmacy services, recreational and therapeutic activities, social services, pastoral care, and dietary services. Roddey is not considered a psychiatric nursing home, but full-time psychiatrists are available to provide services to patients. Admission to Roddey is available to the general community for those who meet skilled or intermediate nursing care needs. This nursing home is licensed by the SC Department of Public Health (SCDPH) and is certified by the Centers for Medicare & Medicaid Services. Previously, BHDD OMH managed several veterans' nursing homes. In SFY24, the SC legislature transferred administration of the state's nursing homes from BHDD OMH to the SC Department of Veterans Affairs (SCDVA). Since the transfer took place, BHDD OMH has continued to support these nursing homes through contract management for SCDVA.

The BHDD OMH Division of Medical Affairs engages in oversight of several programs and facilities. Patrick B. Harris Hospital, located in Anderson, provides inpatient treatment for adults. It is licensed by the State of South Carolina as a Specialized Hospital and is accredited by The Joint Commission. Patients are admitted from the 13 Upstate counties of South Carolina, and the majority are civil involuntary admissions. The hospital director provides oversight for Professional Services, Nursing, Quality Management and Compliance, and the Chief Operations Officer. G. Werber Bryan Psychiatric Hospital, located in Columbia, provides inpatient psychiatric treatment to adults and children. It is licensed by the State of South Carolina as a Specialized Hospital and is accredited by The Joint Commission. The majority of patients admitted to Bryan Hospital are civil involuntary admissions. Bryan Hospital's Forensics Division provides inpatient evaluation and treatment, rehabilitation, and outpatient services. Admissions are court-ordered from across SC through the state's criminal justice system. This division includes implementation of a Sexually Violent Predator Treatment Program, which is mandated by the state. The William S. Hall Psychiatric Institute at Bryan Hospital provides inpatient treatment for children and adolescents aged 4-17. It has three inpatient programs: Adolescent Acute, Child Acute, and a program for adolescents with both substance use and psychiatric disorders.

The BHDD OMH Division of Alcohol and Drug Addiction operates Morris Village Alcohol and Drug Addiction Treatment Center in Columbia. Morris Village provides inpatient treatment for adults with alcohol and drug use disorders, and, when indicated, addiction accompanied by psychiatric illness, often referred to as "dual diagnosis." It is licensed by the South Carolina Department of Public Health (SCDPH) and is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), an independent, nonprofit accreditor of health and human services. Patients are admitted to Morris Village from throughout the state, with referrals from community mental health centers, county alcohol and drug commissions, community hospitals, and the judicial system. The patient population includes both individuals who are voluntarily admitted and individuals who are civil involuntary admissions.

BHDD OMH's outpatient and inpatient facilities and programs provide services for patients who SMI/SED, as well as patients who have co-occurring SUD and/or IDD health challenges. Outpatient and inpatient facilities and programs also provide services for people who are in crisis.

As described in Question 2, BHDD OSUS contracts with 31 of the state's county alcohol and drug abuse authorities to provide most of the core substance use services in all 46 counties. Each county authority is licensed by the SC Department of Public Health and accredited by CARF International or the Joint Commission. Licensing and credentialing of substance use disorder counselors

is regulated by state statute. This includes the requirement for certification of treatment counselors by Addiction Professionals of South Carolina and of prevention professionals by the S.C. Association of Prevention Professionals and Advocates. There are no financial intermediaries between BHDD OSUS and the county authorities, nor are there separate child and adult systems. BHDD OSUS and the county authorities' leaders have a strong relationship and work closely to optimize the efficiency and effectiveness of services.

BHDD OSUS reviews and approves the county authorities' yearly priorities through county plan submissions, which aid in the collection of information able to describe county-level needs and local provider efforts. These plans are structured according to the Strategic Prevention Framework (SPF) and focus on communicating county-level initiatives that influence priorities included in the state's SUBG application. The county authorities identify their priorities with multiple data sources and with input from local surveys, focus groups, advisory councils, and/or political entities that oversee them (either county governments or specially appointed commissions). All county authorities are required to address each of the six CSAP-established primary prevention strategy areas or to submit a waiver letter stating that a specified CSAP prevention strategy is being implemented by another entity in the county authority's service Substance Use Prevention Treatment and Recovery Services Block Grant Application 2024-2025 catchment area. A state team reviews the plans for identification of statewide priorities. Approval is granted by the BHDD OSUS Director.

BHDD OSUS has a statewide program that is designed to identify issues and implement mandatory "technical assistance" through a County Assistance Plan (CAP) before any problems worsen. The CAP can apply to subgrantee compliance with federal and state requirements regarding the special populations listed above. If a county authority does not participate in its assigned CAP or fails to make progress, a Managed Improvement Plan (MIP) is imposed. If the MIP is unsuccessful, BHDD OSUS may take a number of measures, ranging from withholding reimbursements to assigning the agency's catchment area to another county authority.

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Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

To date, BHDD OMH has not conducted a statewide needs assessment.

Each BHDD OMH Community Mental Health Center (CMHC) regularly conducts community needs assessments, asking for feedback from current and former patients, Patient Advisory Boards, and community stakeholders. The CMHC Executive Directors work with their staff members and Patient Advisory Boards to design the questions on their needs assessments. BHDD OMH inpatient facilities and Central Administration programs also solicit feedback from current and former patients and community stakeholders through surveys and other tools. Additionally, BHDD OMH management and other staff members routinely communicate with employees of other state government agencies, as well as service providers and nonprofits, to help identify the state's current gaps and challenges in the delivery of services.

However, BHDD OMH does not use a standardized survey instrument or needs assessment tool throughout the state, and does not use statewide standardized strategies to solicit feedback from different types of constituents.

If SAMHSA has a recommended statewide needs assessment tool and recommended standardized strategies to reach a diverse group of constituents throughout the state, BHDD OMH would welcome technical assistance about this topic.

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified

under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

Three major needs and gaps in SC's current mental healthcare system are workforce challenges, serving patients who are involved in the criminal justice system, and a lack of permanent affordable housing for people with SMI/SED.

Workforce Challenges:

Throughout the United States, the COVID-19 pandemic created previously unimagined workforce challenges. Over the past several years, numerous healthcare providers, including mental health professionals, have suffered from burnout related to the pandemic; many have decided to leave the healthcare system entirely, and engage in career transitions. This mass exodus of healthcare professionals caused ongoing challenges for providers throughout the country, and continues to affect South Carolina, even a few years after the pandemic ended.

BHDD OMH experienced a decline in full-time equivalent (FTE) employees during the past few years. During the pandemic, BHDD OMH lost a significant number of employees, both clinical and support staff, through a combination of resignations and retirements. Since the pandemic, BHDD OMH has struggled to maintain enough FTEs. Constant turnover creates ongoing challenges for staff members. According to a 2025 report produced by the SC Office of the State Inspector General (SIG), from SFY20 through SFY24, 5,859 employees separated from BHDD OMH, while only 5,305 new employees were hired. The SIG report was based on a Climate and Employee Satisfaction Survey. This survey "identified slow hiring processes, uncompetitive salaries, and recruitment challenges as key barriers" for BHDD OMH.

According to the SIG report, the amount of state funding provided by the legislature has not matched the number of vacancies that need to be filled; the amount of state funding for vacant FTEs grew 67% since SFY20, but the number of vacancies grew by 80%. State funds were used to pay for the expenses of contracted providers, which were needed to cover services that typically would be provided by FTEs. The contracted providers tend to cost significantly more than FTEs.

Some of the many challenges caused by high turnover rates include lowered employee morale due to increased workloads, a steady loss of institutional knowledge, and chaotic internal processes as the remaining employees struggle to fill new gaps of knowledge and job responsibilities. Turnover rates for the Community Mental Health Centers are tracked monthly; many CMHCs report challenges with recruiting enough FTEs. Hiring mental health professionals for specialty programs, like Mobile Crisis teams, ACT teams, and NAVIGATE programs can be especially challenging. The 2025 SIG report identified employees' concerns about perceived unfair human resources practices related to disciplinary action and the use of FMLA. The employee survey and SIG report also found that many employees were not satisfied with how BHDD OMH management communicated details about the executive leadership reorganization that occurred during the past few years.

Criminal Justice Services and Collaborations:

BHDD OMH continues to identify opportunities to improve mental health services within the criminal justice system. In the last full block grant application (submitted in September 2023), BHDD OMH discussed challenges related to criminal justice services and collaborations. The needs and gaps related to these services and collaborations continue to be a major focus for the office.

BHDD OMH developed a Criminal Justice System Intercept Map using the SAMHSA GAINS Center's Sequential Intercept Model (SIM). This map illustrates six service areas for people with mental illnesses who become involved in the criminal justice system. Intercept 0 refers to community services, including resources like the statewide crisis lines, statewide mobile crisis team, school mental health providers, Intensive Community Services, and homeless outreach initiatives. Intercept 1 focuses on working with local law enforcement, and includes services such as embedded mental health professionals in the Alliance program, the First Responder Support Teams (FRST), providing telehealth services through collaborative partnerships with EMS, and participating in Criminal Justice Coordinating Councils (CJCCs). Intercept 2 refers to initial hearings and detentions; in these settings, BHDD OMH collaborates to provide services like forensic evaluations, forensic inpatient services, MHPs embedded in detention centers, and a liaison with the Department of Juvenile Justice (DJJ). Intercept 3 focuses on working with jails, prisons, and courts, including collaborations with other state agencies to engage in mental health courts, drug courts, veterans' courts, and homeless courts. In Intercepts 0 – 3, BHDD OMH is already providing many services, and has developed positive and strong relationships with a variety of community and law enforcement partners. Intercept 4 focuses on reentry, and Intercept 5 refers to community corrections. Services in Intercept 4 include sharing records with the South Carolina Department of Corrections, the SOAR project, and the SVP program. Intercept 5 provides services such as providing released offenders with immediate appointments at their local Community Mental Health Centers, engaging care coordination, and ensuring that recently released offenders are given warm handoffs to a variety of community resources.

BHDD OMH is actively providing robust services in Intercepts 0 – 3. However, the office has had only limited success in providing adequate and comprehensive services in Intercepts 4 and 5. Over the next few years, BHDD OMH will continue to focus on improving its services in the areas of reentry and community corrections.

Lack of Affordable Housing:

Throughout the United States, affordable housing has continued to be a growing concern, as rental rates have increased and home ownership remains out of reach for many people. According to the National Low Income Housing Coalition, South Carolina has almost 150,000 "extremely low income renter households" but there are fewer than 71,000 affordable and available rental homes for these people in need. Therefore, approximately 79,000 renters cannot find affordable homes. The US Chamber of Commerce reports that the median listing price for a home in South Carolina is $350,000. This price is far out of reach for low-income people aspiring to home ownership. The BHDD OMH Housing and Homeless Services Program works continuously with mental health providers throughout the state, engaging in outreach and education to help connect unhoused people with housing resources.

Many BHDD OMH patients who live in Community Residential Care Facilities (CRCFs) hope to return to independent living at some point in time. Unfortunately, the lack of affordable housing throughout the state has made it very difficult for many patients to find places to live. Because SSDI, SSI, or other forms of financial assistance often do not provide large amounts of monthly income, it is challenging for many patients to find affordable homes or apartments to rent.

On July 6, 2023, the US Department of Justice (DOJ) issued a report that found reasonable cause to believe South Carolina had violated Title II of the ADA by unnecessarily housing patients in Community Residential Care Facilities (CRCFs). On December 9, 2024, the DOJ sued the state of South Carolina, stating that SC "violated Title II of the ADA, 42 U.S.C. §§ 12131–34, by failing to administer its services, programs, and activities for adults with SMI in the most integrated setting appropriate to their needs." The DOJ urged SC to stop discriminating against adults with SMI and provide them with community-based services "in the most integrated setting appropriate, consistent with their individual needs."

BHDD OMH continues to work diligently to move patients to independence in the community, as appropriate. The office looks forward to working with DOJ and the SC Department of Health and Human Services to reach the shared goal of improving services for individuals with SMI who reside in CRCFs. This shared goal of improving services will be carried out in ways that are consistent with professional standards, resource availability, and individual choice.

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

As discussed in Question 1 of this document, the CMHCs use a variety of strategies, including community needs assessments, patient satisfaction surveys, and feedback from Patient Advisory Boards, to identify their communities' biggest challenges and service gaps. The CMHCs, along with several Central Administration programs, strategically implement a variety of evidence-based practices (EBPs), along with other services, to support adults with SMI and children with SED, as well as adults and children with co-occurring conditions.

Just a few of the EBPs that the CMHCs and other BHDD OMH programs/departments plan to implement during the next few years include, but are not limited to: Cognitive Behavioral Therapy (CBT), Cognitive Behavioral Therapy for Psychosis (CBTp), Dialectical Behavioral Therapy (DBT), Mental Health/Primary Health Integration, Multi-Dimensional Family Therapy (MDFT), Parent Child Interaction Therapy (PCIT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Eye Movement Desensitization and Reprocessing Therapy (EMDR), and Infant and Early Childhood Mental Health Consultation (IECMHC).

It is likely that block grant funding will be used to support clinicians who implement the EBPs listed above, as well as the following special programs:

Assertive Community Treatment Teams:

The purpose of the Assertive Community Treatment (ACT) Program is to serve patients in need who are not accessing traditional programs offered by Community Mental Health Centers (CMHCs). The ACT Program provides a comprehensive approach to the delivery of services; ACT services are provided in 12 of the 16 CMHCs across South Carolina, and a 13th CMHC is in the process of establishing an ACT Team. ACT involves a team of professionals whose job duties focus solely on providing service to patients with serious mental illness. Because of their mental illness, many individuals have difficulty functioning in the community. Patients in the ACT Program have histories of long and frequent hospitalizations and limited success with independent living and finding and maintaining employment. They also over utilize hospital emergency rooms to treat their psychiatric illness. A host of supportive individually designed interventions are required to maintain these individuals in the community, which is what the ACT Team is designed to do. ACT is an evidence-based practice and is adopted nationally as a best practice for individuals who meet admission criteria. Admission criteria include: adults with serious, long term mental illness; high users of inpatient and emergency room services; persons who have not responded to traditional case management services; persons who fail to keep scheduled appointments; persons at risk for homelessness; and persons at risk for incarceration. ACT services are provided by a multidisciplinary team that must include the following: a psychiatric care provider, a team leader (qualified mental health professional), a registered nurse, a co-occurring disorder professional, a certified peer support specialist, a vocational success specialist, and a mental health professional.

Alliance Program:

Alliance provides opportunities for first responders to collaborate with BHDD OMH and better serve community members who are experiencing mental health or behavioral health issues, including crises. Through Alliance, Mental Health Professionals (MHPs) are embedded in law enforcement agencies, fire and rescue departments, 911 dispatch centers, and hospital emergency departments. The MHPs work collaboratively with first responders to identify and support children, adolescents, and families experiencing mental health issues. The MHPs also collaborate with other community agencies to provide information and resources to people in need. They provide mental health screenings, assessments, and crisis interventions, determine the need for inpatient admissions, and make appropriate referrals. MHPs working in hospital emergency departments support the mental health needs of patients, including referrals to community treatment and determining the need for inpatient admission. MHPs who are embedded in law enforcement agencies serve victims of crime, and respond alongside uniformed officers to calls that involve mental health situations; they help provide crisis response and de-escalation. Some Alliance staff are embedded or work closely in detention centers, which are a type of law enforcement agency. MHPs who are embedded at 911 dispatch centers respond to calls that are mental health related; they support dispatchers in determining the appropriate response to calls that may involve mental health crises.

Certified Community Behavioral Health Clinics:

There are nine program requirements to meet criteria for the Certified Community Behavioral Health Clinic (CCBHC) Model: Crisis Services; Screening, Assessment, and Diagnosis; Person-Centered and Family Centers Treatment Planning; Outpatient Mental Health and Substance Abuse Use Services; Primary Care Component; Targeted Case Management; Psychiatric Rehabilitation Services; Peer Supports, Peer Counseling, and Family/Caregiver Supports; and Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans. BHDD OMH currently operates two Community Mental Health Centers (CMHCs) that are implementing all of the clinical components of a Certified Community Behavioral Health Clinic (CCBHC). The two CMHCs providing these services are the Spartanburg Area Mental Health Center (SAMHC) and the Beckman Center for Mental Health Services (BCMHS). Ten counties are served by these two centers. These programs have not yet been certified as CCBHCs by the SC Department of Health and Human Services (SCDHHS), due to logistical issues related to certification. However, BHDD OMH is pursuing certification for both of these CMHCs, with the goal of certification as soon as possible. Despite the fact that these CMHCs are not yet certified, they are implementing all of the program requirements to meet criteria for the national CCBHC Model. At both the Spartanburg and Beckman locations, most of the programming is already provided in-house. BHDD OMH has contracted with its local Substance Use Disorder (SUD) providers and its local Federally Qualified Health Centers (FQHCs) to place Certified Addictions Counselors and primary care healthcare providers in each location.

First Responder Support Team:

The First Responder Support Team (FRST) provides behavioral health services to all branches of first responders and their families, including firefighters, law enforcement personnel, and paramedics. The FRST Program's mission is to provide behavioral health services in ways that are confidential, accessible, effective, safe and comfortable for all first responders and their families. FRST clinicians provide an array of services designed to meet the needs of first responder personnel and their families including assessment, referrals, short term counseling, trauma-focused therapy, substance abuse treatment, medical consultation, couples counseling and family treatment. Clinicians work with law enforcement agencies, EMS agencies, dispatch centers, and fire houses to teach, train, educate and connect with peers. This clinical team understands the public nature of first responder positions and offers services in a highly confidential environment; FRST services are offered in locations separate from BHDD OMH facilities. In addition to providing behavioral health services to the first responders, FRST clinicians are also trained to assist with Critical Incident Stress Debriefings. Critical Incident Stress Management (CISM) is a comprehensive, phase-sensitive, and integrated multi-component approach to crisis/disaster intervention. Through CISM trainings, mental health professionals and first responders learn how to facilitate Critical Incident Stress Debriefings (CISDs), which can be provided one-on-one, in small groups, or in large group formats. In the first responder community, having a team comprised of both MHPs and peer support staff increases the effectiveness of the interventions. CISM's format provides those who have been through a critical incident with opportunities to process traumatic events, as well as receive psychoeducation regarding stress and trauma reactions. CISM has been proven to help participants process traumatic events and prevent stress reactions from developing into PTSD or other serious mental illnesses or disorders. Although CISM is used most often within the first responder community, this practice can also be applied to a community setting after a tragedy, and BHDD OMH also uses CISM to support communities who have experienced workplace violence, traumatic deaths, and prolonged exposure to traumatic stress, etc. FRST clinicians assist with these debriefings as well.

Forensic Outpatient Services:

BHDD OMH provides forensic services to justice-involved adults and juveniles, including pretrial competency and criminal responsibility evaluations, and competency restoration treatment for defendants found not competent to stand trial, but restorable. Individuals found not competent to stand trial and ordered for competency restoration treatment are by and large suffering from SMI. Treatments are provided in detention centers by BHDD OMH staff members or contracted mental health professionals. These services support psychiatric stability for incarcerated individuals; the Forensic Outpatient Services Program coordinates and improves continuity of care in jail settings while people with serious mental illnesses await resolutions of their cases. Forensic Outpatient Services treatment curriculum requires the use of CBT for psychosis (CBTp), which SAMHSA has identified as the standard of care for individuals with psychotic disorders. Currently, not all CMHCs have the capacity to provide CBTp, but all of the BHDD OMH forensic pilot programs have been trained by Forensic Outpatient Services to use CBTp. This

program supports the ongoing provision of CBTp as a core component of the pilot programs.

Individual Placement and Support Employment Services:

BHDD OMH uses Individual Placement and Support (IPS) as its supported employment model. This evidence-based program is located in 14 out of 16 BHDD OMH community mental health centers. Each center partners with local SC Vocational Rehabilitation Department offices to provide opportunities for people with serious mental illnesses to become gainfully employed in the community.

Intensive Community Treatment Teams:

Some BHDD OMH patients need a higher level of care to prevent hospitalization. These patients can be referred to the CMHCs' Intensive Community Treatment (ICT) Teams. ICT Teams deliver services from multidisciplinary teams made up of mental health professionals, nurses, psychiatrists, care coordinators, nurse practitioners, and peer support specialists. The teams provide a wide range of therapeutic services. Patients are offered appointments at least weekly, and can receive multiple services each week, depending on their unique needs. Each ICT mental health professional works with no more than 35 patients at a time. ICT services can be delivered in patients' homes or other community locations at times that work best for patients.

Mobile Crisis Call Center and Teams:

Mobile Crisis provides services 24/7/365 in all 46 counties of South Carolina to children, adolescents, and adults. The program's goals are to increase access through linkage to the appropriate level of care for those experiencing psychiatric crises, reduce hospitalizations, and reduce unnecessary emergency department visits and incarcerations. The success of the Mobile Crisis program is built on the foundation of partnerships with local law enforcement, hospitals, judges, community providers, and other mental health providers. The Mobile Crisis program provides an extension of BHDD OMH community mental health center services; during business hours, BHDD OMH mental health centers serve patients by appointment, during walk-in hours, and via phone. Mobile Crisis provides mobile response to patients in the community who cannot, or are unable to, access services; the program is able to provide a mobile response in the community for individuals in crisis who are in need of crisis intervention services when mental health centers are closed. Mobile Crisis teams are able to provide assessment, intervention, and referral for people who are at imminent risk and need to be involuntarily committed to protect themselves or other people. After hours, weekends, and on holidays, teams of two respond in person, remotely via telehealth, or by phone to those experiencing psychiatric emergencies. Mobile Crisis teams, working collaboratively with the detention centers, may provide assessment and crisis intervention services in the jails. For an on-site response, two-person teams comprised of at least one master's level clinician co-respond with local law enforcement. The team of two may also include a bachelor's level staff person or a peer with lived expertise. Mobile Crisis teams are dispatched by the BHDD OMH Mobile Crisis Call Center, which is operated by the Charleston Dorchester Mental Health Center (CDMHC). Referral calls are received from individuals in crisis, law enforcement and other first responders, and third-party callers including family or community providers and the 988 Suicide and Crisis Lifeline Network.

NAVIGATE:

The NAVIGATE program is a nationally recognized Coordinated Specialty Care (CSC) treatment model. Patients between the ages of 15 and 40 years of age who have been diagnosed in the schizophrenia spectrum, and are new to treatments in the past two years, are eligible to participate in NAVIGATE. This program is designed for patients to graduate within two years; the majority of patients successfully graduate. The NAVIGATE treatment team is comprised of a wide variety of professionals, including a psychiatrist, program director, mental health clinician (referred to as the Individual Resiliency Trainer), employment and education specialist, care coordinator, entitlements specialist, nurse, and peer support specialist. Patients who participate in NAVIGATE may meet with their Individual Resiliency Trainer (IRT) as often as weekly, or even more than once a week, depending on their needs. The IRT visits with patients not just in clinical settings, but also in their homes or in communities; sessions can be conducted in-person or through telehealth. The NAVIGATE Individual Resiliency Training Manual is used in every session to help patients learn and practice skills. This training manual includes modules on a wide range of topics, including education about psychosis and how to cope with hallucinations, skills to cope with stress and anxiety, gaining awareness of strengths, focusing on health and wellness, and relapse prevention skills. The psychiatrist can meet with patients as often as monthly, and uses the NAVIGATE prescriber's manual to follow the NAVIGATE model for medication adherence. Patients can meet as often as weekly with their Employment and Education Specialists, Peer Support Specialists, and Care Coordinators. Each week, the entire care team meets to discuss every patient. The IRT and program director also meet on a weekly basis; they review the NAVIGATE model and address any potential problems that have arisen. Support and education for family members and other loved ones is also provided through NAVIGATE. The NAVIGATE Family Education Manual is provided to patients' families and friends to help them learn how to support their loved ones and help them reach their goals.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Office of the State Inspector General

Brian D. Lamkin

Review of Organizational Restructuring and Human Resource Practices at the South Carolina Department of Mental Health

Case #: 2025-0003-I

June 2025

I. Introduction

The South Carolina Office of the State Inspector General (SIG) was established by the South Carolina General Assembly in 2012 (Act No. 105) for the purpose of investigating and addressing allegations of fraud, waste, abuse, mismanagement, and misconduct in agencies, specifically the executive branch of state government. The SIG's authorities are found in S.C. Code of Laws § 1-6-50(C).

By letter dated 7/15/24, the South Carolina House of Representatives Ways and Means Subcommittee requested that the SIG conduct a review of the South Carolina Department of Mental Health (SCDMH) regarding the organizational restructuring and allegations of discriminatory human resource practices, and that the SIG take appropriate action regarding any other matters that the SIG deemed appropriate identified through the review.

The purpose of this report is to provide a road map for the SCDMH leadership to improve in its delivery of mental health services to the people of South Carolina. This investigation focused on the allegations of racial injustices in the leadership structure and discriminatory human resource practices. The SIG's report is not intended to address every individual complaint or issue conveyed to the SIG.

The SIG determined that there was no factual basis to substantiate the allegations of discrimination within the reorganization of senior leadership responsibilities. However, the Climate and Employee Satisfaction Survey conducted by the SIG showed that 34.30% the SCDMH employees felt the organizational structural changes were not fair or in the agency's best interest, and 37.96% felt the organization's future direction was not clearly communicated. Further, the survey revealed that only 33.19% of the employees viewed the SCDMH human resource practices as fair. It is crucial that the SCDMH leadership improve the morale within the work environment as it relates to unfair human resource practices.

The SIG extends its appreciation to the SCDMH acting state director, Dr. Robert Bank, and the SCDMH employees for their cooperation and intentionality of seeking solutions to the issues identified by the SIG. In addition, the SIG is appreciative of the collaboration with the South Carolina Human Affairs Commission, the South Carolina Executive Budget Office, and the South Carolina Department of Administration Division of State Human Resources throughout the review process.

Table of Contents

II. Background

A. Predicate

By letter dated 7/15/24, members of the South Carolina House of Representatives Ways and Means Subcommittee requested that the SIG conduct a review of the South Carolina Department of Mental Health (SCDMH) regarding the organizational restructuring in executive leadership and allegations of discriminatory human resource practices. The letter also requested that the SIG take appropriate action regarding any other matters that the SIG deemed appropriate identified through the review.

B. Scope and Objectives

The scope of the review concerned the organizational restructuring of the executive leadership team responsibilities and allegations of discriminatory human resource practices. The SIG period of review covered the timeframe of 7/1/19 through 6/30/24.

C. Methodology

The SIG reviewed applicable state and federal laws, regulations, and policies, as well as relevant documentation comprised of human resource records, financial records, contracts, and other documentation provided by the SCDMH and the South Carolina Human Affairs Commission, the South Carolina Department of Administration – Division of State Human Resources (DSHR), and the South Carolina Executive Budget Office (EBO).

The SIG conducted interviews of current and former SCDMH employees, members of the public, subject matter experts, and persons who initiated confidential contact with the SIG. In addition, the SIG conducted a climate and employee satisfaction survey.

Reviews and investigations by the SIG are conducted in accordance with professional standards set forth by the Association of Inspectors General's *Principles and Standards for Offices of Inspector General*, often referred to as the "*Green Book.*" This investigation used the preponderance of evidence standard.

D. South Carolina Department of Mental Health

The SCDMH serves the state of South Carolina through 16 community-based outpatient mental health centers, clinics which serve all 46 counties in South Carolina, three licensed hospitals with one for substance abuse treatment, a network of state veteran nursing homes, a forensics program, and telepsychiatry (as indicated on its public website). As South Carolina's public mental health system, the SCDMH's mission is to support the recovery of people with mental illnesses.

Services and programs offered include Assertive Community Treatment, Child/Adolescent and Family Services, School Mental Health Services, Continuity of Care, Crisis Stabilization Services, Deaf Services, and Mobile Crisis. The SCDMH also offers many grant programs such as the Metropolitan Children's Advocacy Center, First Responder Support Team, Housing and Homeless Services, Jail and Correctional Services, Suicide Prevention, Telepsychiatry, Toward Local Care, and Trauma Services.

Dr. Robert Bank was appointed acting state director by the SCDMH Board of Commissioners in September 2022. For FY2024, the SCDMH was allocated $318,934,865 in state appropriations.[1]

[1] The SCDMH also received authorization for the use of earmarked/earned funds ($266,356,451) and federal funding ($34,145,662).

The SCDMH's organizational structure as of 11/21/24 was comprised of six different divisions, as depicted in Table 1 below. Other SCDMH leadership included the office of general counsel, internal audit and governmental affairs.

Table 1

SCDMH Divisions	
1	Division of Administrative Services
2	Division of Alcohol & Drug Addiction
3	Division of Community Mental Health Services
4	Division of Long-Term Care
5	Division of Medical Affairs & Psychiatric Inpatient Services
6	Division of Quality Management & Compliance

The SCDMH employs psychiatrists, mental health counselors, nurses, case managers, and administrative and support employees. For purposes of this report, the SIG reviewed the demographics of the total population of employees at the SCDMH. As of 4/10/25, the SCDMH advised the total population of employees was 3,808, of which 2,068 (54%) were Black/African American, 1,581 (42%) were White, and 159 (4%) were Other Races.[2]

E. Board of Commissioners

The SCDMH was governed by a Board of Commissioners (Board) comprised of seven members, one from each congressional district, appointed by the governor with advice and consent of the Senate to five-year terms. At the time of this review, four positions were filled from the 1st, 4th, 5th, and 6th congressional districts while the other three remained vacant. As set forth in the S.C. Code of Laws, Title 44, Chapter 9, the Board *"shall determine policies and promulgate regulations governing the operation of the department and the employment of professional and staff personnel."* The Board was constituted as follows:

Table 2

Board of Commissioners	Congressional District	Current Term
Dr. Elliot Levy (Chair)	1st	2021-2026
Dr. Carl Edison Jones (Vice Chair)	6th	2022-2027
Bobby H. Mann, Jr.	4th	2021-2026
Dr. Crystal A. Maxwell	5th	2021-2026
VACANT	2nd	N/A
VACANT	3rd	N/A
VACANT	7th	N/A

On 4/24/25, the SCDMH was consolidated with the Department of Disabilities and Special Needs and the Department of Alcohol and Other Drug Abuse Services in an effort to streamline healthcare resources through Act 003 of 2025. On 4/28/25, Act 003 of 2025 was signed into law by Governor McMaster at which point in time the Board was dissolved.

[2] Other Races included: Hispanic/Latino, Native American, Hawaiian/Other Pacific Islander, two or more races.

F. External Reports

During the SIG review period, the following reports were issued to the SCDMH with recommendations applicable to this review:

- A study conducted by the SC House of Representatives Legislative Oversight Committee (HLOC) regarding the SCDMH was released in March 2020. Among other things, this study reflected a need for each division within the SCDMH to be organized in a way which optimizes patient care and the use of agency resources. The HLOC members recommended a review of the Division of Inpatient Services'(DIS) organizational structures to confirm it was appropriate. The HLOC members also recommended the SCDMH seek funding to maintain mean salaries at or above the midpoint for each classification, as well as review mental health salaries of bordering states to maintain a competitive market for the recruitment and retention of mental health professionals.

- The SCDMH's former state director requested a review of the DIS in 2021 by an executive consultant. Due to the complexity and size of the DIS, recommendations included relocating several of the services within this division to other areas at the SCDMH and changing the organizational structure. The notated intention for organizational restructuring was to assist in enhancing the ability of the DIS to fulfill its mission to care for a vulnerable population.

- The South Carolina Department of Administration (DOA) issued a report in May 2023, regarding the SCDMH human resources and budgeting functions with relevant findings and recommendations. The EBO recommended that management review the SCDMH's internal agency structure and make the necessary organizational and operational changes to better align its resources to accomplish its mission. The EBO commented that the SCDMH has a very complex accounting structure that limits its ability to make both immediate and strategic financial decisions. The EBO further recommended that the SCDMH modify/simplify its accounting structure to enable the agency to properly manage and utilize its available resources and utilize excess cash balances to fund agency operations.

III. Organizational Restructuring

A. SIG Analysis of Executive Leadership Reorganization

The SCDMH executive leadership organizational structure was amended 37 times between 5/19/20 – 11/21/24. Eleven of the organizational charts were changed under the former state director's administration, and 26 were under the current administration.

The SIG categorized the changes in the organizational structure into three categories: span of control, major changes in the organizational structure, and minor changes. The change in span of control addressed realignment of responsibilities and duties in the organizational structure. Major changes in the organizational structure represented additional or new organizational levels, or reduction of existing organizational levels. Minor changes in the organizational chart primarily included the addition of names to existing vacant positions and section name changes.

A breakdown of the organizational chart changes is depicted in Table 3 below:

Table 3

Changes in Org. Charts 5/2020 - 11/2024	
Span of Control Changes	12
Major Changes	13
Minor Changes	12
Total	**37**

In March 2023, an agency-wide newsletter notification was sent from the acting state director informing employees of future organizational changes taking place in executive leadership. The newsletter presented two of the goals that executive leadership considered when looking at the current structure:

- *"ensuring clear and timely communication between Agency leadership and the Department's multiple centers and facilities; and*
- *ensuring accountability on the part of center and facility leadership for the delivery of services to patients and residents."*

Although, the agency-wide newsletter was circulated detailing the pending organizational changes and shift in executive leadership responsibilities, senior officials still advised the SIG of poor communication surrounding the changes. Senior officials also advised the SIG that employees affected did not initially receive any written notice of how the changes would affect them including uncertainties regarding the employee reporting structures following the reorganization.

Prior to the 3/26/24 change to the organizational chart, the deputy director for the DIS managed the hospitals, the Veteran's Nursing Homes, other ancillary programs, and directly supervised employees whose positions were redirected within the new reporting structure. The deputy director of the DIS was changed to the deputy director for the Division of Long-Term Care.

The SCDMH senior officials advised the SIG that when the organizational changes occurred, the DIS deputy director lost leadership responsibilities as it pertained to the hospitals. The hospital directors who previously reported to the DIS deputy director now reported directly to the acting state director. Senior officials advised the SIG that these changes within the organization's structure and executive leadership responsibilities were made to aid in communications regarding the hospitals' budgets and needs.

The SIG assessed that the DIS, over a five-year period, lost approximately $8 million annually prior to the executive leadership restructuring. Senior leadership expressed that the actual operating cost of the individual hospitals could not be accessed for review due to the maladministration of the DIS leadership prior to the reorganization. A breakdown of the DIS deficit is depicted in Table 4 below:

Table 4

			**Enhanced Medicaid Era		
DIS Deficit Areas	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
Hospitals*	$ (8,397,489)	$ (382,002)	$ 1,382,875	$ (7,513,723)	$ (20,885,025)
CM Tucker-Roddey	$ (1,318,615)	$ (1,835,281)	$ (27,908)	$ (2,342,198)	$ 2,231,128
Nutritional Services	$ (60,300)	$ 470,942	$ (1,236,007)	$ 789,950	$ 326,690
Total	**$ (9,776,404)**	**$ (1,746,341)**	**$ 118,960**	**$ (9,065,971)**	**$ (18,327,207)**
***G. Werber Bryan Psychiatric Hospital & Patrick B. Harris Psychiatric Hospital**			**Census FTE[3] drop	**Census & Contract Staff Increased	

[3] Full Time Equivalent (FTE) positions.

As depicted in Table 4, the DIS operated at a deficit for several years. For FY2022 and FY2023, the DIS received additional funding, referred to as "*Enhanced Medicaid Era,*" during the COVID-19 pandemic when federal funding for Medicaid programs saw a substantial boost. A SCDMH senior official indicated that the key elements to the deficits were revenue decreases in Medicaid, payroll, contract personnel, case services expenses, and decrease in patient census at the hospitals. Case services expenses were primarily driven by the increased census at the contracted Veterans' Nursing Homes and was offset by the increased Veterans Administration revenue and state allocations.

From FY2020 - FY2024, the DIS deficits were supplemented by $3,430,692 in surplus revenue generated by the contracted Veteran's Nursing Homes ($2,430,212), and other ancillary areas ($1,000,480) to offset some of the deficit.

The DOA 2023 report stated that the DIS "*appeared to operate at a level above its resource allocation… with shortfalls having to be cleared by revenue from other areas of the agency*."

Various senior officials at the SCDMH also relayed to the SIG that this was an accurate observation, along with multiple employees alleging poor communication and lack of information on financial data from the DIS regarding the day-to-day operations, and fiscal deficiencies.

Subsequently, based on the findings and recommendations referenced in the external reports, the consistent deficits, and apparent communication breakdowns were factors that attributed to the DIS restructuring and reorganization in executive leadership responsibilities according to the SCDMH senior officials.

Even though the reorganization was deemed necessary due to the complexity of the division and budget oversight deficiencies, some employees may have perceived this reorganization in executive leadership responsibilities as racially motivated due to the deputy director of the DIS being the only Black/African American in senior leadership at that time. When the restructuring of the DIS occurred, the deputy director of the DIS lost leadership responsibilities in this division. However, the deputy director did not lose executive leadership status, and compensation was unaffected. Of the six division director positions within the SCDMH, currently two are Black/African Americans.

B. Statewide Healthcare Agency Merger and Future Plans

In an effort to streamline healthcare resources, the South Carolina Legislature ratified Act 003 of 2025 on 4/24/25, and the Governor signed it into law on 4/28/25. The Act established the South Carolina Department of Behavioral Health and Developmental Disabilities, consolidating the former the SCDMH, the South Carolina Department of Disabilities and Special Needs, and the South Carolina Department of Alcohol and Other Drug Abuse Services into a single entity. The Act amended various sections of the S.C. Code of Laws to reflect this restructuring, including repealing outdated sections related to the SCDMH, renaming and reassigning duties, eliminating the commissions of the former departments, and integrating their functions under the new department.

In addition, on 7/1/25, the Veteran's Nursing Homes will be transferred to the South Carolina Department of Veterans Affairs.

C. Findings and Recommendations – Organizational Restructuring

Finding Sec. III – 1: The SIG determined that numerous employees felt the SCDMH leadership did not thoroughly communicate the details surrounding the reorganization in executive leadership responsibilities and reporting structure changes.

Recommendation Sec. III – 1: The SIG recommends the SCDMH leadership ensure proper and thorough communication occurs regarding the anticipated impacts of reorganizations.

Finding Sec. III – 2: The SIG determined the DIS hospitals operated at a $7.5 million deficit in FY2023 before the reorganization in senior leadership and operated at a $20.8 million deficit for FY2024.

Recommendation Sec. III – 2: The SIG recommends the SCDMH continue to work with stakeholders and funding sources to more accurately determine its budget and avoid fiscal deficits.

Finding Sec. III – 3: The SIG determined employees had reservations regarding the upcoming new office location changes and have confidentiality concerns working within cubicles.

Recommendation Sec. III – 3: The SIG recommends that the SCDMH plan accordingly to ensure employees have a secure place for confidential conversations and communicate openly with employees regarding the Statewide Health Care Agency merger enacted 4/28/25, and how it may affect their jobs.

IV. SCDMH Climate and Employee Satisfaction Survey

The SIG developed and administered a climate and employee satisfaction survey to gauge leadership, morale, communication, and policy issues. The survey included 33 questions, while not all-encompassing, covered various topics such as leadership, supervision, work environment, job satisfaction, and areas for improvement. The survey was constructed by the SIG to provide anonymity to the SCDMH employees.

The survey included 28 questions known as "agree/disagree" questions where a statement is made with five possible responses: strongly disagree; disagree; neither agree nor disagree; agree; strongly agree; and three employment status questions, one on training opportunities, and one open-ended question, which was included to provide survey participants the opportunity to offer suggestions for improving the work environment.

The survey was distributed to all SCDMH employees via a SurveyMonkey link on 3/28/25. Of the 3,935 employee email addresses provided by the SCDMH, 70 (1.78%) were undeliverable. Reminder emails were sent to all SCDMH employees on April 14th, 17th, 21st, and the 25th. The survey deadline was extended given the number of email addresses that were undeliverable upon distribution of the initial email, and concerns shared about confidentiality or inadvertent deletion of the email assuming it was spam.

A. SCDMH Climate and Employee Satisfaction Survey Analysis

The SCDMH Climate and Employee Satisfaction Survey statement questions yielded 1,592 responses, 41.19% of 3,865 SCDMH employees evaluated employee tenure, leadership perceptions, supervisor effectiveness, workplace morale, and job satisfaction across 28 statement questions. Response rates ranged from 1,446 to 1,587 per question. Below is a summary of the key issues and strengths derived from the survey responses.

Workforce Tenure and Professional License Status

- **Tenure at the SCDMH**: 51.61% of the respondents had 3–15 years of service, 26.91% had 2 years or less, and 21.68% had 15+ years.
- **Current Position Tenure**: 52.72% of the respondents held their current role for 3–15 years, 37.04% for 2 years or less, and 10.37% for 15+ years.
- **Professional Licensing**: 37.72% of the respondents were professionally licensed by South Carolina, 62.28% were not.

Agency Leadership

The survey included the following five statements that assessed the perception of agency leadership, communication and organizational direction:

- I am satisfied with the SCDMH leadership and the status of the agency.
- I have trust and confidence in my agency leadership.
- Senior level management has clearly communicated the future direction of this organization.
- Changes by the SCDMH in organizational structure are made fairly and with the agency's best interest in mind.
- Employee morale is important to the SCDMH's senior executives (i.e., director, division directors, etc.).

Leadership and Organizational Direction

- **Leadership Satisfaction:** 40.48% of the respondents agreed or strongly agreed that they were satisfied with the SCDMH leadership, and only 41.40% of the respondents had trust in agency leadership.

- **Communication:** 36.27% of the respondents agreed senior management communicated the organization’s future direction clearly.

- **Organizational Changes:** 29.84% of the respondent felt structural changes were fair, and in the agency’s best interest.

- **Morale Priority:** 35.66% of the respondents agreed or strongly agreed that senior executives valued employee morale and 43.14% disagreed or strongly disagreed.

- **Overall Assessment:** 35–43% of the respondents expressed distrust or dissatisfaction with leadership, signaling a need for improved transparency, communication, and engagement.

Supervisory Leadership

The survey included the following seven statements that assessed supervisory leadership effectiveness:

- Division leadership empowers and supports supervisors to perform their jobs.
- My supervisor treats people fairly.
- My supervisor awards promotions based on merit.
- My supervisor takes actions to hold employees accountable, and deal with poor performance/behavior.
- I feel supported and valued by my supervisor.
- I have trust and confidence in my supervisor as a leader.
- My supervisor engages employees and solicits ideas for making work more efficient and/or to meet the public's needs more effectively.

Supervisory Effectiveness

- **Fairness**: 71.90% of the respondents agreed or strongly agreed that supervisors treated people fairly.

- **Support**: 68.82% of the respondents felt supported and valued by supervisors, and 66.09% of the respondents had trust in their supervisor’s leadership.

- **Accountability**: 60.43% of the respondents agreed or strongly agreed supervisors addressed poor performance.

- **Engagement**: 64.65% of the respondents agreed or strongly agreed that supervisors solicited ideas for efficiency and public needs.

- **Communication:** 54.80% of the respondents expressed supervisors communicated the reasons for important decisions affecting the department.

- **Overall Effectiveness**: Supervisors received strong approval (60–72% of the respondents), which is a key asset for employee morale and performance.

Work Environment

The survey included the following twelve statements that assessed the work environment:

- I am offered the proper training to successfully perform my job.
- Select the type(s) of training you received when you began working at the SCDMH: question and answer sessions.
- Morale at work is good at the SCDMH.
- The workload is fairly distributed.
- The work hours are satisfactory.
- My supervisor communicates the reasons for important decisions to my work group before they are made.
- The agency promotes equality and fairness in the workplace.
- The agency fosters an environment that is inclusive and values its diverse workforce.
- The agency minimizes the perception of pay disparity based on race and/or gender.
- Human resources' policies (e.g., performance appraisal, promotion, rewards) are applied fairly and consistently.
- The agency's human resource practices are not discriminatory.
- Vacancies are filled in a timely manner.

Work Environment and Morale

- **Training Access**: 61.95% of the respondents agreed or strongly agreed they received adequate training. Common training included manuals (76.39%), hands-on (69.20%), supervisor meetings (58.25%) and questions and answer sessions (44.42%). However, 5.07% (193) of the respondents indicated they received no training, indicating gaps in training consistency.

- **Morale**: 30.77% of the respondents agreed or strongly agreed that morale was good, and 47.71% of the respondents disagreed.

- **Workload**: 8.49% of the respondents agreed or strongly agreed workload was fairly distributed, and 38.62% of the respondents disagreed.

- **Work Hours**: 76.75% of the respondents were satisfied with work hours.

- **Fairness and Inclusion**: 42.74% of the respondents agreed or strongly agreed the agency promoted equality, and 52.67% of the respondents agreed or strongly agreed the agency fostered inclusivity.

- **Pay Equity**: 37.35% of the respondents believe pay disparity based on race/gender was minimized.

- **Human Resource (HR) Practices**: 33.19% of the respondents viewed HR policies as fair, and 54.05% of the respondents perceived HR practices as non-discriminatory.

- **Vacancies:** 18.62% of the respondents agreed or strongly agreed that vacancies were filled timely, with 55.03% of the respondents disagreeing. Slow hiring exacerbates workload and morale issues.

- **Overall Operational Efficiency and Work Environment**: Low morale and uneven workload distribution were critical issues identified by the SIG.

Job Satisfaction and Retention

The survey included the following five statements that assessed employee job satisfaction:

- I am satisfied with my total compensation (e.g., salary, bonus, benefits, etc.).
- I feel my job performance is recognized and appreciated by leadership.
- Overall, I am satisfied with my job.
- I am proud to work for the SCDMH.
- I would like to continue my career with the SCDMH.

Employees' Perception of Job Satisfaction

- **Compensation**: 25.62% of the respondents were satisfied with their compensation, with 57.09% of the respondents dissatisfied. Compensation dissatisfaction drives low morale and retention risks.

- **Recognition**: 46.42% of the respondents felt their performance was recognized and appreciated by leadership, and 36.57% of the respondents disagreed.

- **Job Satisfaction**: 56.32% of the respondents were satisfied with their job.

- **Pride and Retention**: 63.28% of the respondents were proud to work for the SCDMH, and 69.84% of the respondents wanted to continue their career with the SCDMH.

- **Overall Assessment of Employees Job Satisfaction**: Respondents expressed high ranking of job satisfaction, strong pride in the agency, and that its mission reflects commitment to the agency.

B. <u>SCDMH Climate and Employee Satisfaction Survey - SIG Analysis of Comments</u>

The SCDMH employees provided 1,065 responses to the question, "What would you change about the agency to improve the work environment?"

Below is a high-level summary of key themes derived from the survey comments on areas for improvement and actionable insights for consideration by executive leadership.

Leadership and Management Issues

- Employees reported a disconnect between senior leadership and frontline employees, with decisions perceived as out-of-touch or prioritizing metrics and billings over quality care.

- Employees expressed concerns about favoritism, nepotism, and unfair promotions, particularly among senior management which undermines trust.

- Employees cited allegations of toxic behavior, retaliation, bullying, and unethical practices.

Compensation and Retention

- Employees requested merit-based raises, cost-of-living adjustments, and bonuses to reflect performance and economic realities.
- Employees noted inequities in pay distribution (e.g., administrative vs. clinical employees, long-term vs. new hires) which fueled morale issues.
- Competitive salaries for new and existing employees. Low salaries compared to industry standards and private sector roles contribute to high turnover and difficulty recruiting/retaining qualified employees.

Work Environment and Morale

- Employees desired a more positive and inclusive culture with recognition, team building, and morale-boosting initiatives.
- Employees voiced their concerns about poor facility conditions (e.g., outdated infrastructure, lack of privacy) and inadequate resources (e.g., office supplies, information technology (IT) support) all of which lower employee morale and hinder performance.
- Employees requested more flexible work arrangements (e.g., telecommuting, 4-day workweeks) to improve work-life balance.
- Employees expressed there was an excessive focus on billable and patient care hours which created not only unrealistic expectations but also the potential for unethical practices.

Training and Professional Development

- Employees expressed there was a lack of standardized training, especially for new hires and school-based employees, which leads to inefficiencies and stress.
- Employees requested support for licensure, continuing education, and career advancement opportunities to enhance skills and retention.

Operational and Policy Inefficiencies

- Employees conveyed that there was a heavy administrative workload to maintain documentation due to redundant processes, which reduced the time for patient care and contribute to burnout.
- Employees suggested there should be caseload caps, process and necessary documentation streamlining, and more time dedicated for patient charting.
- Employees conveyed the agency operated with inconsistent policies (e.g., medical records release, remote work approvals, bonuses, annual performance reviews, and dual employment) which created confusion and potential legal risks.
- Employees commented that due to the slow hiring processes and unfilled vacancies, workloads for existing employees increased.
- Employees expressed issues concerning communications with HR and IT being unresponsive and delaying problem resolutions.

C. SIG Analysis of SCDMH Climate and Employee Satisfaction Survey

The survey results revealed significant challenges in leadership trust, compensation, workload, and morale that threaten the SCDMH's ability to deliver high-quality care and retain talent. Employees expressed a need for improved accountability, transparency, and communication from leadership. Immediate action on leadership accountability, salary adjustments, and an assessment of workload distribution is critical to improving the work environment and ensuring the agency's mission to serve South Carolina's mental health needs is met effectively.

The SCDMH benefits from a dedicated workforce and strong supervisor support, but faces challenges with low morale, leadership distrust, and compensation dissatisfaction. Strategic interventions in communication, hiring, and fairness can enhance employee engagement and organizational success.

The SIG was made aware that the SCDMH initiated an Employee Engagement and Satisfaction Survey to all employees which concluded in 2021. The results of that survey to 4,441 employees (1,863 responses) conveyed prominent areas needing improvements including effective communication between senior leadership and the rest of the agency, and opportunities for professional growth and development. Employees also voiced concerns in the following areas:

- Facilities and technologies
- Labor concerns (pay and benefits, staffing and hiring, safety, and professional development)
- Organizational leadership and culture (clear communication, management/supervisory concerns, and cultural/social environment).

The SIG determined most of the concerns voiced in both the SCDMH's 2021 survey as well as the DOA's 2023 report still existed. The failure to implement effective strategies to improve employee satisfaction led to a decrease in employee morale and an unsatisfactory work environment – which could also be a contributing factor of employee turnover. As noted previously throughout this SIG report, employee retention is critically necessary to ensure the SCDMH fulfills its mission. The SCDMH missed an opportunity to improve the agency and yield better outcomes by failing to act on the results of the 2021 survey.

D. Findings and Recommendations – SCDMH Climate and Employee Satisfaction Survey

Finding Sec. IV – 1: The SIG determined there were employee concerns with leadership as it related to accountability and trust.

> **Recommendation Sec. IV – 1:** The SIG recommends the SCDMH conduct an independent review of leadership practices to address allegations of favoritism, retaliation, and unethical behavior. In addition, the SIG recommends management enhance leadership training on communication, empathy, and accountability to rebuild trust and increase senior leadership visibility through regular in-person engagement with the SCDMH employees.

Finding Sec. IV – 2: The SIG determined numerous employees advised they did not receive their annual Employee Performance Management System (EPMS) despite being employed for multiple years.

> **Recommendation Sec. IV – 2:** The SIG recommends the SCDMH conduct EPMS reviews in accordance with State Human Resource Regulations.

Finding Sec. IV – 3: The SIG determined employees were unsatisfied with their compensation, and that this unfavorable compensation correlated with high turnover and staffing difficulties of recruiting and retention.

Recommendation Sec. IV – 3: The SIG recommends the SCDMH review and adjust salary structures to align with industry standards, implement merit-based raises and performance bonuses tied to EPMS evaluations, develop strategies to support competitive wages and staffing needs. The DOA issued a report on Mental Health Professional Compensation Review February 2023 on positions in the mental health professional classification series and other positions.

Finding Sec. IV – 4: The SIG determined employees felt workloads were not consistent or fair, with many clinical employees mentioning aversion to patient care hours compensation.

Recommendation Sec. IV – 4: The SIG recommends the SCDMH streamline required documentation and processes and eliminate redundancy to reduce administrative burdens, establish caseload caps, and provide dedicated patient charting time to prevent burnout.

Finding Sec. IV – 5: The SIG determined there were areas that needed significant improvement regarding employee morale and culture.

Recommendation Sec. IV – 5: The SIG recommends the SCDMH launch agency-wide recognition programs, team-building events, and employee wellness day to boost morale. The SCDMH could also standardize policies for remote work and flexible schedules to enhance work-life balance. Further, the SIG recommends the SCDMH invest in facility upgrades to improve employee working conditions and patient care environments.

Finding Sec. IV – 6: The SIG determined operations within the SCDMH needed improvements regarding policies and procedures, hiring processes, and IT services.

Recommendation Sec. IV – 6: The SIG recommends the SCDMH standardize policies and procedures to ensure consistency and compliance, expedite hiring processes, and fill vacancies to alleviate staffing shortages, as well as improve responsiveness of centralized IT and HR services through dedicated support channels.

Finding Sec. IV – 7: The SIG determined training and development initiatives could be improved upon to show appreciation for employees, build confidence and competence, as well as supporting employees' professional licensure, continuing education, and increasing career advancement opportunities.

Recommendation Sec. IV – 7: The SIG recommends the SCDMH develop a comprehensive training curriculum for long-term employees and new hires that includes billing and documentation guidance. Further, management could subsidize licensure fees and provide paid professional development opportunities and foster career advancement pathways to retain talent. Professional licensure support ties clinicians to the SCDMH, as they gain credentials while maintaining employment at the SCDMH, which also benefits the agency.

Finding Sec. IV – 8: The SIG determined the SCDMH failed to act on its own Employee Engagement and Satisfaction Survey report from 2021, and the DOA 2023 report.

Recommendation Sec. IV – 8: The SIG recommends the SCDMH review and implement the applicable recommendations outlined in both reports which still existed.

Finding Sec. IV – 9: The SIG determined the SCDMH employees participated in improper medical documentation that increased billable hours that resulted in annual reimbursements for "erroneous claims" in the amounts of $868,745 and $858,197 for FY2023-2024 respectively.

Recommendation Sec. IV – 9: The SIG recommends the SCDMH develop procedures to comply with all state and federal regulations to continue to reduce the amount of reimbursement for "erroneous claims" in order to mitigate any potential fraud and legal risk.

V. Human Resource Practices

A. SIG Analysis of South Carolina Human Affairs Commission Complaints Referred

The SIG analyzed the complaints received by the South Carolina Human Affairs Commission (SCHAC) regarding discrimination and nepotism at the SCDMH. During the five-year period, the SCHAC received 72 complaints of discrimination. The SCHAC investigations determined there was insufficient evidence for 21 of the charges, 28 complaints were converted to formal charges of discrimination, eight complaints were charges of discrimination dual-filed with the Equal Employment Opportunity Commission (EEOC) and deferred to SCHAC, settlement negotiation/mediation for six cases, five inquiries were submitted/cases ongoing, three of the charges were withdrawn with benefits, and one was waived/transferred to the EEOC for investigation.[4]

The SCHAC's investigation results of complaints received from 7/1/19 to 6/30/24, are detailed below:

- FY2020 – The SCHAC received a total of 16 complaints/inquiries against the SCDMH. Of the 16 complaints: four complaints were closed at the inquiry stage, and no formal charge of discrimination was filed; eight complaints were converted to formal charges of discrimination to be processed; and four complaints were charges of discrimination dual-filed with the EEOC and deferred to the SCHAC for processing.

- FY2021 – The SCHAC received a total of 12 complaints/inquiries against the SCDMH. Of the 12 complaints: ten complaints converted to formal charges of discrimination to be processed; and two complaints were charges of discrimination dual-filed with the EEOC and deferred to the SCHAC for processing.

- FY2022 – The SCHAC received a total of 12 complaints/inquiries against the SCDMH. Of the 12 complaints: six complaints were closed at the inquiry stage, and no formal charge of discrimination was filed; four complaints converted to formal charges of discrimination to be processed; and two complaints were charges of discrimination dual-filed with the EEOC and deferred to the SCHAC for processing.
- FY2023 – The SCHAC received a total of 13 complaints/inquiries against the SCDMH. Of the 13 complaints: three complaints were closed at the inquiry stage, and no formal charge of discrimination was filed; one charge was formerly filed and SCHAC was reviewing the claim; three complaints were withdrawn with benefits; and six were closed through mediation, settlement, or SCHAC determined no reasonable cause for a charge.

- FY2024 – The SCHAC received a total of 19 complaints/inquiries against the SCDMH. Of the 19 complaints: eight complaints were closed at the inquiry stage, and no formal charge of discrimination was filed; four charges were formerly filed and SCHAC was reviewing the claim; and

[4] *"The SCHAC closed some case files without making a recommendation. These closures were due to settlement by the parties (reflected as "negotiated settlement" or "withdrawal with benefits"), withdrawal of the charge without benefits, waiver to the EEOC or transferred to the EEOC. Waiver to the EEOC, where a charge is filed more than 180 days, but fewer than 300 days after the alleged discriminatory action occurred."*

six complaints were converted to formal charges (prepared/filed) of discrimination to be processed and one was waived/transferred to the EEOC for investigation.

B. SIG Analysis of Hiring and Separations

SCDMH New Hires

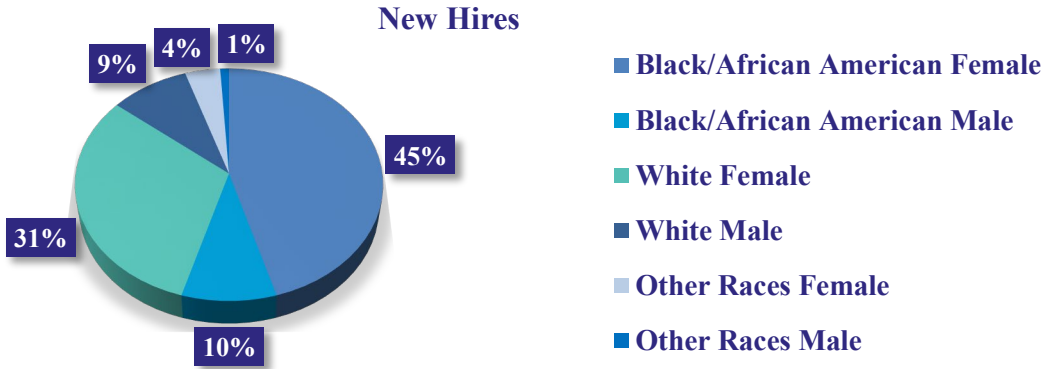
The SIG assessed that the SCDMH had a total of 5,305 new hires in FY2020 - 2024. The SIG analyzed new hire trends by gender and race of new hires over the past five fiscal years. A breakdown of the 5,305 new hire postions by gender and race is depicted in Table 5 below:

Table 5

New Hires						
Race & Gender	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**Total**
Black/African American Female	584	341	429	543	501	2,398
White Female	337	285	338	362	325	1,647
Other Races Female	43	34	47	52	49	225
Black/African American Male	119	75	91	96	108	489
White Male	106	86	102	103	96	493
Other Races Male	15	5	11	10	12	53
Total	**1,204**	**826**	**1,018**	**1,166**	**1,091**	**5,305**

The total (female and male) hiring of the Black/African Americans represented 2,887 employees, while 2,140 were White, and 278 employees were Other races. The SIG assessed that 55% of new hires from FY2020 - FY2024 were Black/African American, while 40% of new hires were White, and 5% of new hires were of Other races. A breakdown of the percentage of new hires by gender and race is depicted in Chart 1 below:

Chart 1



The SIG determined that the number of new hires by race remained relatively stable and in line with the SCDMH's demographic population across the previous five fiscal years.

SCDMH Separations

The SIG assessed that the SCDMH had a total of 5,859 personnel who separated from the SCDMH in FY2020 - FY2024. The SIG analyzed separation trends by gender and race over the past five fiscal years.

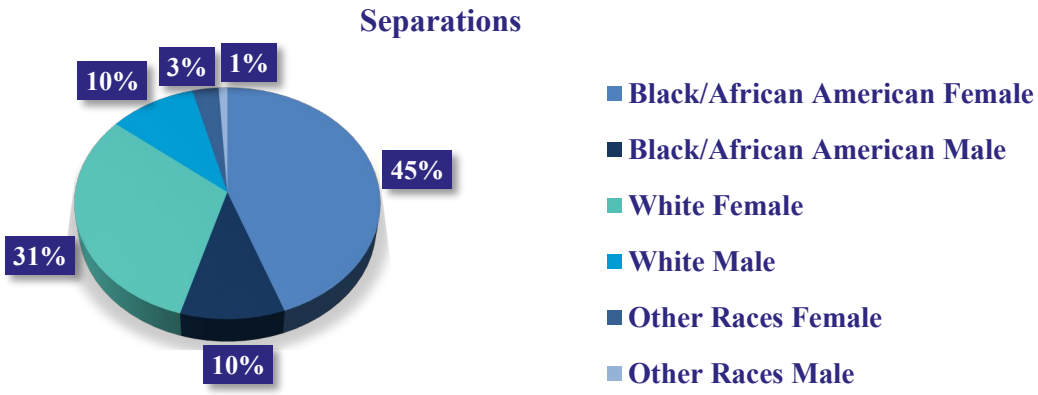
The total number of separations are depicted in Table 6 below:

Table 6

Separations						
Race & Gender	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**	**Total**
Black/African American Female	545	558	534	519	451	**2,607**
White Female	334	399	488	316	305	**1,842**
Other Races Female	28	40	38	49	48	**203**
Black/African American Male	138	129	111	123	81	**582**
White Male	118	120	131	122	83	**574**
Other Races Male	11	13	9	10	8	**51**
Total	**1,174**	**1,259**	**1,311**	**1,139**	**976**	**5,859**

The total (female and male) separations of the Black/African Americans represented 3,189 employees, while 2,416 were White, and 254 employees were Other races. A breakdown of the 5,859 separations by gender and race is depicted in the Chart 2 below:

Chart 2



The SIG determined that the number of separations by gender and race remained relatively stable and in line with the SCDMH's demographic population across the previous five fiscal years.

The contributing cause for most of the separations over the five years were classified as "*personal*." Out of 5,859 separations, 3,117 (53%) were classified as separations for "*personal reasons*."

Employee retention at the SCDMH is important because fewer personnel mean fewer patients were served with quality mental health services. Senior officials advised the SIG that recruiting and retaining employees is difficult at the SCDMH due to salaries being too low to support employees. More than one senior official advised the SIG that other employers in their areas can offer more competitive salaries which affects recruitment and retention.

C. SIG Analysis of FTE Promotions

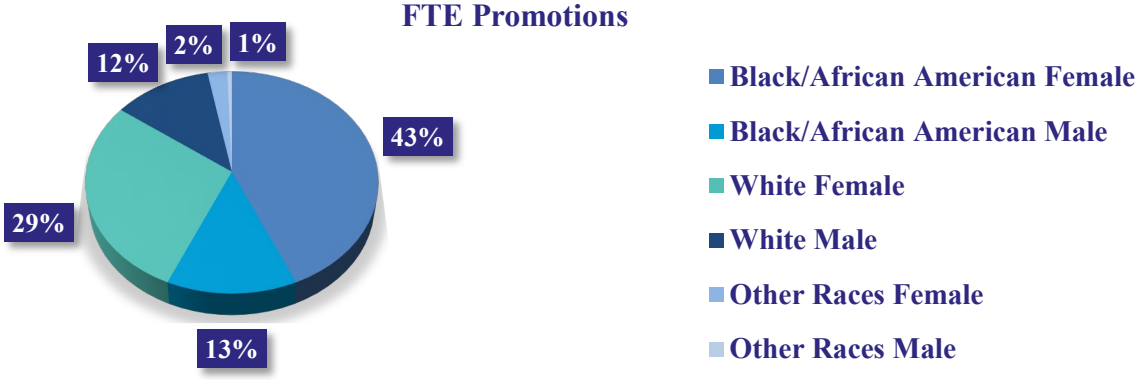
The SIG analyzed promotion trends by gender and race over the past five fiscal years to determine if there was any disparity negatively impacting protected classes. The SIG determined a promotion to be when an employee received a salary increase for an FTE promotion or an upward reclassification of the employee's position.

The SIG determined that the distribution of promotions by gender and race remained relatively stable across the SIG's scope of five fiscal years.

A breakdown of the promotions awarded by gender and race is depicted in Chart 3 below:

Chart 3

FTE Promotions



The SIG further determined that the SCDMH awarded promotions as expected when comparing them with the overall demographics of the SCDMH employees. However, per the SIG initiated survey, many employees perceived that individuals selected for promotions did not meet qualifications. Additionally, employees commented that even though they desired to acquire additional qualifications, they were informed by leadership that additional qualifications would not contribute to career progression within the SCDMH.

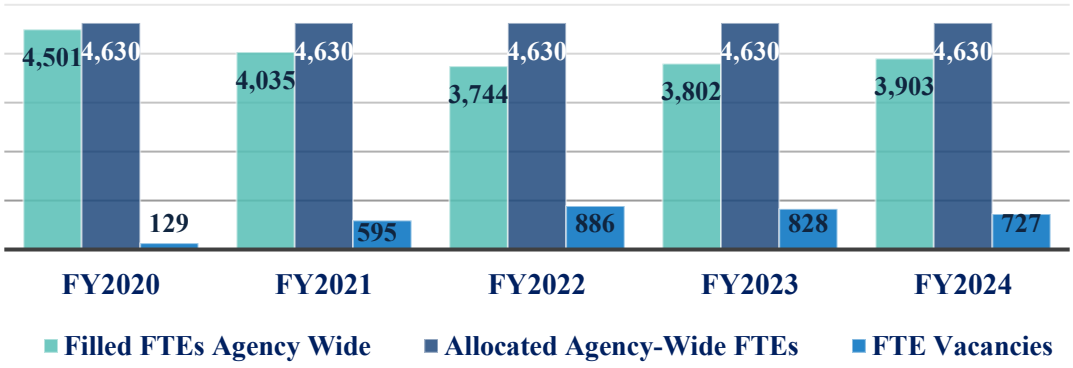
D. SIG Analysis of FTE Vacancies and Turnover

SCDMH FTE Vacancies

For FY2024, the SCDMH was allocated 4,630 agency-wide FTE positions. Of those 4,630 positions, 3,903 were filled, and the remaining 727 positions were vacant. A breakdown of the SCDMH's filled, vacant, and allocated positions for FY2020 – FY2024 are depicted in Table 7 below:

Table 7

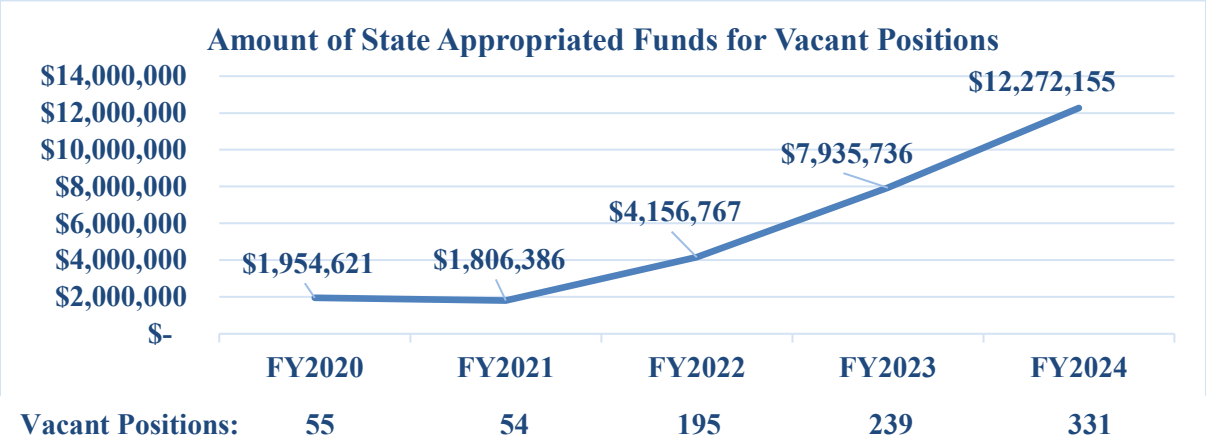
SCDMH FTE Positions



The SIG further conducted an analysis on FTE vacancies provided by DSHR during the years of FY2020 – FY2024. The data was filtered by one "whole" classified position, funded with state appropriation funds, open for 12 months or more.

The state appropriated amounts that the SCDMH received for these open positions are depicted in Table 8 as follows:

Table 8



The amount of state funding received for vacant FTEs at the SCDMH has grown 67% since FY2020, while the number of vacancies has grown by 80%. The SCDMH maintained and utilized these state appropriated funds for other functions and expenses of the agency rather than filling these positions. These vacancies put vulnerable patients at risk of not receiving adequate treatment.

A senior SCDMH official advised the SIG that a large contributing factor to the vacancies was budget constraints. The SCDMH utilized contract staffing to support clinical needs and the cost of these contracts is significantly higher than the actual cost to employ internally. While these contracts were necessary to fill essential positions and aid in a temporary solution for staffing needs, they create a long-term undesirable effect on the agency's financial ability to fill vacant FTEs.

SCDMH FTE Turnover

During the period of the SIG review, based on the data provided by the SCDMH for FY2020 - FY2024, the agency lost on average 914.8 FTEs annually. The SIG analyzed turnover rates compared to the statewide turnover rate of employees in FTE positions over the past five years as depicted in Table 9 below:

Table 9

Turnover Data	FY2020	FY2021	FY2022	FY2023	FY2024
FTE Average	4,227	4,027	3,637	3,552.80	3,701.80
FTE Terminations	837	1,020	1,074	878	765
FTE Turnover Rate	19.80%	25.33%	29.53%	24.71%	20.67%
Statewide Rate[5]	16.43%	20.67%	22.57%	18.48%	16.25%

The SCDMH turnover rates were significantly higher than the statewide rate for each of the five fiscal years.

The SIG assessed that per the SCDMH's publicly available website, it is a healthcare organization committed to providing quality mental health services to residents of South Carolina, and excessive turnover negatively affects patient care and operational stability.

[5] This is the statewide turnover of employees in FTE positions, excluding institutions of higher education. The SIG source of this information was DOA/DHSR (data obtained from SCEIS and based on data entered in SCEIS by the state agencies).

E. SIG Analysis of Bonus Payments

The Critical Employee Recruitment and Retention Proviso 117.62 stipulates that the DOA/DSHR must approve the designation of critical needs positions applicable to this provision.

The SIG analyzed a sample of 40 bonus payments classified as Critical Employee Recruitment and Retention. A senior DSHR official advised the SIG that the SCDMH reported bonus payments were approved under the Critical Employee Recruitment and Retention Proviso as required. However, the SIG determined that 25 of the 40 (63%) bonus payments were incorrectly reported to DSHR (e.g. incorrect job class code, reported bonus amount, employees not included on the report).

The SIG further analyzed an additional 20,575 regular bonus payments made by the SCDMH during the period reviewed to determine whether the bonus payments were compliant with state policies, and if any involved pay disparity negatively impacting protected classes.

Per the SCDMH records, the total amount of bonus payments disbursed for FY2020 through FY2024 was $17,951,137. The SIG further determined that the bonus payments significantly increased from FY2022 to FY2023. The increase was driven by a one-time employee bonus allocation paid through Proviso 118.19 [6] of the 2022-2023 Appropriations Act from the General Assembly.

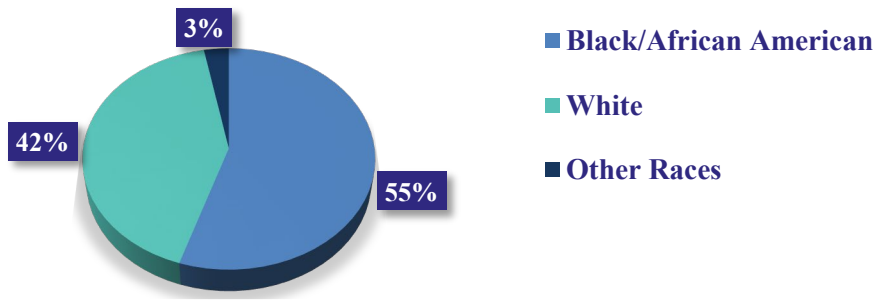
A breakdown of the bonus payments by race is presented in Table 10 below:

Table 10

SCDMH Bonus Payments		
Black/African Americans	$9,914,361	55%
White	$7,443,379	42%
Other Races	$593,397	3%
Total	**$17,951,137**	**100%**

A breakdown of the bonus payments percentages by race is presented in Chart 4 below:

Chart 4



The SIG determined there was no significant pay disparity in the SCDMH's distribution of bonus payments and the payments were in line with the SCDMH's demographic population. However, the SIG determined the SCDMH should ensure it is appropriately reporting bonuses to DSHR to prevent future mishaps regarding

[6] Each permanent state employee, in an FTE position, with continuous state service for at least six months prior to July 1, 2022, received an $1,500 one-time lump sum payment. The earnings limitation on bonuses in Proviso 117.52 did not apply to this bonus.

potentially incorrect job class codes, discrepancies in reported bonus amount, and/or all employees not conveyed on the report.

F. Other Observations – Human Resource Practices

Intra-Agency Dual Employment

The South Carolina State Human Resource Regulations allows state employees in FTE positions to accept additional temporary, part-time employment with the same or another agency. As stated in Regulation 19-713.01, *"In accordance with this Regulation, agencies may develop internal dual employment policies. Dual Employment within the same agency must be approved by the Division of State Human Resources prior to implementation. Dual employment within the same agency should only exist when extraordinary circumstances exist based on the agency's business needs and must be approved by the Division of State Human Resources. Dual employment shall be limited in duration to the specific time frame approved which cannot exceed 12 months."*

State HR Regulation 19-713.01 was revised 9/1/24 regarding dual employment requirements and required state agencies to submit dual employment agreements to DOA for approval. DOA advised the SIG that existing agreements were allowed a one-year grace period.

The SCDMH's dual employment total payments for FY2020 – FY2024[7] are depicted in Table 11 below:

Table 11

FY2020	FY2021	FY2022	FY2023	FY2024
$2,483,004	$2,868,903	$2,560,751	$2,401,434	$2,205,948

The SIG analyzed the SCDMH's dual employment payments for FY2020 – FY2024. The SIG determined that the awarded dual employment pay was in line with the SCDMH's demographic population. However, the SIG determined that the SCDMH relied heavily on the use of dual employment to fulfill *"on call"* positions. The DOA report issued in May 2023 recommended the SCDMH to limit the use of *"on call"* positions. The DOA report stated: "*the appropriate use of dual employment will ensure compliance with not just the letter but the spirit of regulations regarding employee pay, improve the consistency in the payment of employees, improve predictability in payroll costs and improve accuracy of payroll data*."

The SCDMH advised that they utilized dual employment pay to make it easier for them to pay employees from different pools of funding. The SCDMH justified the ongoing use of internal dual employment at the SCDMH due to certain programs being operated 24/7 such as its hotlines and Mobile Crisis Unit. A senior official at the SCDMH advised the SIG that these programs would be shut down if they did not offer dual employment because some facilities have difficulty staffing the positions. Further, this senior official advised that DSHR knows the SCDMH offers dual employment and "*doesn't love it but knows they need it."*

As stipulated in the State HR Regulation 19-713.01 (D.3.), *"the maximum compensation that an employee will be authorized to receive for dual employment in a fiscal year shall not exceed 30% of the employee's annualized salary with the employing agency for that fiscal year."* However, the SCDMH received approval from DSHR in 2013 to increase the percentage of earnings for physician staff from thirty (30) percent to seventy-five (75)

[7] SC Dual Employment Reports prepared by the Office of the Comptroller General.

percent due to staffing shortages in physicians. The affected classifications, in the 2013 waiver, were expressly limited to: Physician I, Physician II, Unclassified Psychiatrist, and Unclassified Clinical Instructor.

During the SIG review of publicly available dual employment information, the SIG identified multiple instances of employees earning the equivalent of an additional FTE's full salary under the dual employment program. An example of four employees[8] from FY2023 is shown in Table 12 below, which illustrates the dual employment (DE) paid to SCDMH's employees exceeded the 30% maximum allowed:

Table 12

FY2023	Total Compensation	Employee Salary	Dual Employment	Maximum Allowed DE	% of DE to Salary
Employee A	$249,272	$120,591	$128,681	$36,177	106.71%
Employee B	$186,703	$123,928	$62,775	$37,178	50.65%
Employee C	$218,377	$133,758	$84,619	$40,127	63.26%
Employee D	$86,562	$55,539	$ 31,023	$16,662	55.86%
Average					**70.79%**

The SIG reviewed the dual employment payment for the same four employees from FY2024 to evaluate changes SCDMH made to its policies after the DOA 2023 report recommendation. As shown in Table 13 below, the dual employment paid to SCDMH's employees decreased, but the payments exceeded the 30% maximum allowed for two of the four employees.

Table 13

FY2024	Total Compensation	Employee Salary	Dual Employment	Maximum Allowed DE	% of DE to Salary
Employee A	$194,132	$132,951	$61,181	$39,885	46.02%
Employee B	$164,661	$147,467	$17,194	$44,240	11.66%
Employee C	$177,411	$136,630	$40,781	$40,989	29.85%
Employee D	$92,046	$64,801	$27,245	$19,440	42.04%
Average					**30.38%**

Human Resource Management

Various senior officials from the SCDMH advised the SIG of discriminatory practices regarding the use of the Family and Medical Leave Act (FMLA). One senior official alleged that "*there are different standards for different people based off of race…*" Another senior official further elaborated that the use of the FMLA within the SCDMH is excessive which leads to a shortage of employees. The SIG was further advised that the use of discipline is also applied differently, suggesting favoritism and discrimination.

Multiple senior officials from the SCDMH also advised the SIG of poor working conditions. The SIG confirmed that one community mental health center had been without heating and air conditioning since November 2024, which included the winter months and the summer months.

While patients were provided the option to have telehealth visits to avoid coming into the cold/hot environment, employees were still expected to report to work daily in difficult working conditions. The SIG was advised by

[8] This sample excluded employees under the umbrella of the 2013 waiver.

employees they were instructed to find immediate solutions on their own until the deficiencies were corrected appropriately. In the meantime, employees were offered limited space available only for meetings, on a reservation basis, at a site across the street.

The SCDMH advised the SIG that employees of this center were updated regarding the status of the situation on 11/20/24, 11/27/24, 12/02/24, 1/16/25, 3/28/25, 5/19/25, and 6/05/25. Further, the SCDMH provided dated actions detailing the extended period without heating and air conditioning.

A senior official advised the SIG that the SCDMH's Medicaid Cash match account could be used for maintenance and repairs for the centers. As of FY2024, the SCDMH's Medicaid Cash match account was $17,582,922.

G. Findings and Recommendations – Human Resource Practices

Finding Sec. V – 1: The SIG determined that of the sample of 40 bonus payments to employees under the Critical Employees Recruitment and Retention Proviso, for 25 of the 40 (63%), the annual reports were not submitted correctly to DSHR (i.e., incorrect job class code, reported bonus amount, employees not reported on the report).

> **Recommendation Sec. V – 1:** The SIG recommends the SCDMH ensure accurate submission of its Critical Needs Recruitment and Retention annual report to DSHR.

Finding Sec. V – 2: The SIG determined the SCDMH relied on the use of dual employment pay.

> **Recommendation Sec. V – 2:** The SIG recommends the SCDMH work towards decreasing the use of dual employment pay as referenced in the DOA 2023 report. Additionally, the SCDMH should update any policy or procedure to comply with the new State HR Regulations revised 9/1/24.

Finding Sec. V – 3: The SIG determined that 3,117 (53%) out of 5,859 separations were classified as separations for personal reasons. Further, the number of separations negatively affects the SCDMH's ability to fulfill its mission of serving patients.

> **Recommendation Sec. V – 3:** The SIG recommends the SCDMH develop strategies to maximize employee retention.

Finding Sec. V – 4: The SIG determined through direct interviews and analysis of comments from the SCDMH Climate and Employee Satisfaction Survey, a potential risk of discrimination can occur within human resource practices as it relates to the use of disciplinary action and FMLA authorization.

> **Recommendation Sec. V – 4:** The SIG recommends the SCDMH apply best practices regarding human resource practices in accordance with applicable state and federal laws and regulations.

Finding Sec. V – 5: The SIG determined filling vacancies at the SCDMH is critical to addressing shortages, reducing workloads, and improving employee retention and patient care, as highlighted in the SCDMH Climate and Employee Satisfaction Survey. The survey identified slow hiring processes, uncompetitive salaries, and recruitment challenges as key barriers.

> **Recommendation Sec. V – 5:** The SIG recommends the SCDMH streamline and accelerate the hiring process.

Finding Sec. V – 6: The SIG determined that at least one mental health facility did not have a suitable environment to see patients, and for employees to work, since November 2024 due to poor maintenance despite dedicated funds available for facility maintenance. The SIG determined that as of FY2024, the SCDMH's Medicaid Cash match account that could be used for maintenance and repairs for the centers was $17,582,922.

> **Recommendation Sec. V – 6:** The SIG recommends the SCDMH work with appropriate entities to facilitate and expedite resolution of the confirmed mechanical and structural deficiencies to ensure acceptable conditions for the health and safety of the employees and patients. In addition, the SIG also recommends the SCDMH analyze the needs for regular maintenance and repairs and use the state taxpayer's resources effectively and efficiently in providing a suitable environment for patients' care and employees to work comfortably.

VI. Other Observations

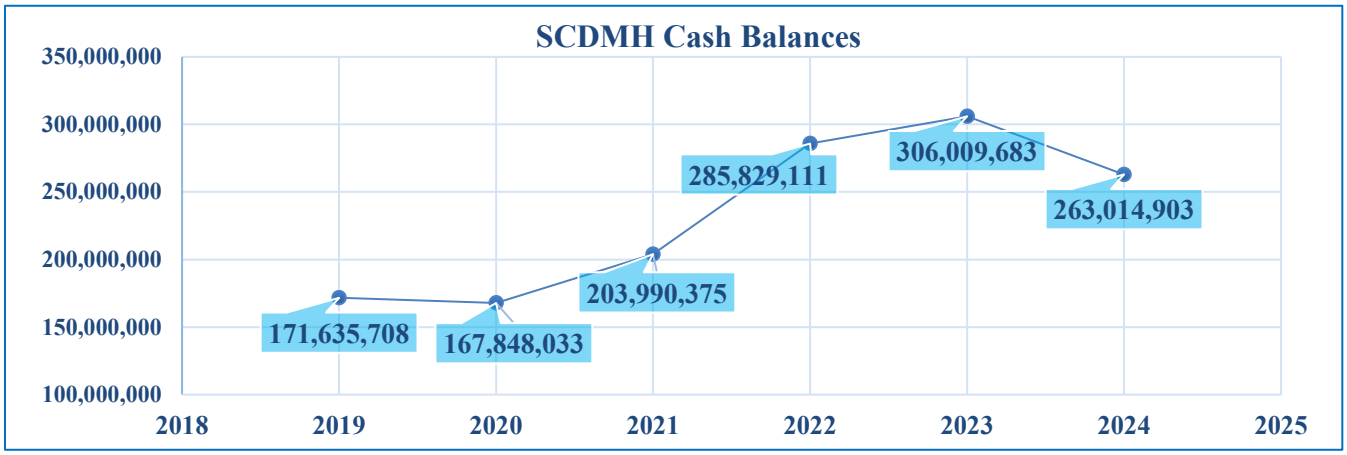
A. Growing Carryforward Balance

In accordance with carry forward Proviso 117.23 of each annual state appropriation act during the review period: *"Each agency is authorized to carry forward unspent general fund appropriations from the prior fiscal year into the current fiscal year, up to a maximum of ten percent of its original general fund appropriations less any appropriation reductions for the current fiscal year."*

In addition to the stated proviso, funds which are restricted or earmarked for specific functions can be carried forward as a separate line item from the "*ten percent*." Further, each agency can also request, through the General Assembly, an exception to carryforward more than the stipulated "*ten percent*."

The SCDMH cash balances for FY2019 – FY2024 are depicted in Table 14 below:

Table 14



The SIG analyzed the Year-End Cash Report (Appendix III) from the DOA 2023 report (covering FY2022) and did not identify any component of the $285,829,111 that consisted of general funds improperly carried forward by SCDMH in excess of the 10% carryforward limit(s). Further analysis of the carryforward cash balance for FY2023 and FY2024 provided by SCDMH [9] did not identify any component of the $306,009,683 or $263,014,903, respectively, that did not exceed the 10% carryforward limit.

[9] SCDMH FY2019 – FY2022 cash balances were obtained from the DOA 2023 report.

The SIG was provided SCEIS financial data by the EBO, regarding SCDMH general fund balances.[10] A comparison of the financial information provided by EBO and internal financial tracking provided by SCDMH identified timing issues in updating SCDMH financial data into SCEIS. This was previously identified by the EBO in the DOA 2023 report. The SIG recommends that SCDMH continue to regularly update SCEIS. (See the SCDMH Response to the DOA 2023 Report)

B. Inpatient Census Rates

The SIG determined that the SCDMH has several licensed beds within their facilities which are not being utilized or deemed as functional due to budget and staffing constraints. Table 15 depicts how many licensed beds and current functional beds maintained by each of these hospitals.

Table 15

Hospital	Licensed Beds Capacity	Current Functional Beds
G. Werber Bryan Psychiatric Hospital – Civil	200	124
G. Werber Bryan Psychiatric Hospital – Forensics	279	200
G. Werber Bryan Psychiatric Hospital – Child & Adolescent	51	30
Patrick B. Harris Psychiatric Hospital	200	110
Morris Village – Alcohol & Drug Addiction Treatment Center	150	42

In addition to the above hospitals, the SCDMH also has a Sexually Violent Predator Program which is not an inpatient facility but has functional capacity for 268 residents. This Sexually Violent Predator Program also has a small infirmary with 14 licensed beds.

Various senior officials at the SCDMH advised the SIG that they had active waiting/referral lists comprised of patients needing services who were waiting for a bed to become available. Per the SCDMH 1/3/2025 Commission Meeting minutes: "*[a]s of 12/13/24, there were 134 patients on the forensic ready for admission waitlist.*" The waiting/referral lists could be minimized if the SCDMH utilized all of its licensed beds. The five inpatient hospitals are currently operating on average at 57.5% of their licensed bed capacity. As referenced in the DOA 2023 report, the SCDMH should develop "a *plan to increase each facility's patient census to a level more aligned with their licensed capacities*."

A SCDMH senior official advised the SIG there were sections of hospitals being shut down and used for storage even though there were patients actively on waiting lists for care. Given the state appropriations determination is based on census data for functioning beds, the SIG determined the SCDMH having licensed beds that were not utilized for patient care constitutes waste.

According to senior officials, the solution to this shortcoming would be additional funding and staffing to care for the patients. As part of the SCDMH budget process, state appropriations are requested based on census rates, as well as other factors such as the cost of personnel and the Consumer Price Index.

Therefore, the SIG determined it is vital for the SCDMH to ensure its state appropriation requests are fully encompassing of the agency's needs as this limitation with budgeting and staffing restricts the SCDMH from

[10] South Carolina Enterprise Information System (SCEIS) was implemented to "*standardize and streamline business processes within the government of South Carolina, using best business practices to achieve cost-effective and efficient delivery of services.*"

fulfilling its mission. Per the DOA 2023 report, "*In developing its FY 2023 – 2024 budget request, EBO recommended DMH seek additional funding from the General Assembly to 'right-size' the inpatient facilities."*

C. Concerns With Validity of Data

During the review period, the SIG identified multiple inconsistencies regarding the accuracy of the SCDMH's record keeping. As noted in the DOA 2023 report, the SCDMH's "*reliance of data stored outside of SCEIS, and the lack of DMH Central Human Resources control over human resources related data, has resulted in incorrect information reported by DMH to outside entities*." The SIG determined that there was a lack of accurate tracking of available staffing needs and financial data across various reporting agencies for the SCDMH.

After the previously discussed human resources deficiencies, the SIG conducted further reviews of employee turnover, historical financial data, and internal and external funding factors. The SIG was provided data from multiple state agencies and reviewed publicly available information from state websites. The SIG determined that providing an accurately detailed review would not be feasible. This was because the information provided by the SCDMH, other state agencies, and publicly available information could not be corroborated. Despite information from multiple sources, with each source independently confirming accuracy, not even two of the multiple agencies could agree upon the number of current employees nor current number of open vacancies during any given period. The only data point every information source did agree on was the total number of FTEs allocated for the SCDMH.

D. Findings and Recommendations – Other Observations

Finding Sec. VI – 1: The SIG determined the SCDMH was not utilizing all licensed beds due to budget and staffing constraints and has no identifiable plan as referenced in the DOA 2023 report, SCDMH should develop "a *plan to increase each facility's patient census to a level more aligned with their licensed capacities*."

> **Recommendation Sec. VI – 1:** The SIG recommends the SCDMH work with stakeholders and funding sources to utilize all available licensed beds in its inpatient hospitals and develop a comprehensive plan as identified in the DOA 2023 report.

Finding Sec. VI – 2: The SIG determined the SCDMH's fiscal responsibility and accountability of state taxpayer funds continues to improve since restructuring of the senior leadership took place.

> **Recommendation Sec. VI – 2:** The SIG recommends the SCDMH continue its current fiscal course correction towards financial sustainability while continuing to adhere to applicable state and federal laws and regulations.

VII. Conclusion

The scope of this SIG review was to evaluate the senior leadership reorganization, to identify any discriminatory practices within human resource matters, and any other matters that the SIG deemed appropriate during the review.

The SIG initiated Climate and Employee Satisfaction survey results and comments along with witness testimony revealed that a lot of employees felt disconcertment with the SCDMH human resource practices. The Climate and Employee Satisfaction Survey conducted by the SIG revealed that only 33.19% of the employees viewed the SCDMH human resource practices were fair. It is crucial for the SCDMH leadership to improve the morale within the work environment as it relates to unfair human resource practices.

After a thorough review of external reports, analysis of financial statements, and following testimony from several senior officials within the SCDMH, the SIG determined the reorganization of senior leadership responsibilities was necessary to improve division efficiency and to streamline budgeting efforts. The survey also revealed that 34.30% the SCDMH employees felt the organizational structural changes were not fair or in the agency's best interest, and 37.96% felt the organization's future direction was not clearly communicated.

This review was conducted on the former SCDMH which merged on 4/28/25 with the South Carolina Department of Alcohol and Other Drug Abuse Services and the South Carolina Department of Disabilities and Special Needs to become one agency, the South Carolina Department of Behavioral Health and Developmental Disabilities (DBHDD). These findings still apply insofar as the mission of the former SCDMH will now be carried out by the DBHDD.

The SIG acknowledges the efforts of the SCDMH and their talented team of psychiatrists, mental health counselors, nurses, case managers, and administrative and support employees who work to provide quality mental health services to the residents of South Carolina. As outlined within the employee survey, the dedicated employees of the SCDMH truly believe in their work and service to the people of South Carolina.

The SIG extends its appreciation to the SCDMH acting state director, Dr. Robert Bank, and the SCDMH employees for their cooperation and intentionality of seeking solutions to the issues identified by the SIG. In addition, the SIG is appreciative of the collaboration with the South Carolina Human Affairs Commission, the South Carolina Executive Budget Office, and the South Carolina Department of Administration throughout the review process.

Compilation of Findings and Recommendations

Section III – Findings and Recommendations – Organizational Restructuring

Finding Sec. III – 1: The SIG determined that numerous employees felt the SCDMH leadership did not thoroughly communicate the details surrounding the reorganization in executive leadership responsibilities and reporting structure changes.

> **Recommendation Sec. III – 1:** The SIG recommends the SCDMH leadership ensure proper and thorough communication occurs regarding the anticipated impacts of reorganizations.

Finding Sec. III – 2: The SIG determined the DIS hospitals operated at a $7.5 million deficit in FY2023 before the reorganization in senior leadership and operated at a $20.8 million deficit for FY2024.

> **Recommendation Sec. III – 2:** The SIG recommends the SCDMH continue to work with stakeholders and funding sources to more accurately determine its budget and avoid fiscal deficits.

Finding Sec. III – 3: The SIG determined employees have reservations regarding the upcoming new office location changes and have confidentiality concerns working within cubicles.

> **Recommendation Sec. III – 3:** The SIG recommends that the SCDMH plan accordingly to ensure employees have a secure place for confidential conversations and communicate openly with employees regarding the Statewide Health Care Agency merger enacted 4/28/25, and how it may affect their jobs.

Section IV – Findings and Recommendations – SCDMH Climate and Employee Satisfaction Survey

Finding Sec. IV – 1: The SIG determined there were employee concerns with leadership as it related to accountability and trust.

> **Recommendation Sec. IV – 1:** The SIG recommends the SCDMH conduct an independent review of leadership practices to address allegations of favoritism, retaliation, and unethical behavior. In addition, the SIG recommends management enhance leadership training on communication, empathy, and accountability to rebuild trust and increase senior leadership visibility through regular in-person engagement with the SCDMH employees.

Finding Sec. IV – 2: The SIG determined numerous employees advised they did not receive their annual Employee Performance Management System (EPMS) despite being employed for multiple years.

> **Recommendation Sec. IV – 2:** The SIG recommends the SCDMH conduct EPMS reviews in accordance with State Human Resource Regulations.

Finding Sec. IV – 3: The SIG determined employees were unsatisfied with their compensation, and that this unfavorable compensation correlated with high turnover and staffing difficulties of recruiting and retention.

> **Recommendation Sec. IV – 3:** The SIG recommends the SCDMH review and adjust salary structures to align with industry standards, implement merit-based raises and performance bonuses tied to EPMS evaluations, develop strategies to support competitive wages and staffing needs. The DOA issued a report on Mental Health Professional Compensation Review February 2023 on positions in the mental health professional classification series and other positions.

Finding Sec. IV – 4: The SIG determined employees felt workloads were not consistent or fair, with many clinical employees mentioning aversion to patient care hours compensation.

> **Recommendation Sec. IV – 4:** The SIG recommends the SCDMH streamline required documentation and processes and eliminate redundancy to reduce administrative burdens, establish caseload caps, and provide dedicated patient charting time to prevent burnout.

Finding Sec. IV – 5: The SIG determined there were areas that needed significant improvement regarding employee morale and culture.

> **Recommendation Sec. IV – 5:** The SIG recommends the SCDMH launch agency-wide recognition programs, team-building events, and employee wellness day to boost morale. The SCDMH could also standardize policies for remote work and flexible schedules to enhance work-life balance. Further, the SIG recommends the SCDMH invest in facility upgrades to improve employee working conditions and patient care environments.

Finding Sec. IV – 6: The SIG determined operations within the SCDMH needed improvements regarding policies and procedures, hiring processes, and IT services.

> **Recommendation Sec. IV – 6:** The SIG recommends the SCDMH standardize policies and procedures to ensure consistency and compliance, expedite hiring processes, and fill vacancies to alleviate staffing shortages, as well as improve responsiveness of centralized IT and HR services through dedicated support channels.

Finding Sec. IV – 7: The SIG determined training and development initiatives could be improved upon to show appreciation for employees, build confidence and competence, as well as supporting employees' professional licensure, continuing education, and increasing career advancement opportunities.

> **Recommendation Sec. IV – 7:** The SIG recommends the SCDMH develop a comprehensive training curriculum for long-term employees and new hires that includes billing and documentation guidance. Further, management could subsidize licensure fees and provide paid professional development opportunities and foster career advancement pathways to retain talent. Professional licensure support ties clinicians to the SCDMH, as they gain credentials while maintaining employment at the SCDMH, which also benefits the agency.

Finding Sec. IV – 8: The SIG determined the SCDMH failed to act on its own Employee Engagement and Satisfaction Survey report from 2021, and the DOA 2023 report.

> **Recommendation Sec. IV – 8:** The SIG recommends the SCDMH review and implement the applicable recommendations outlined in both reports which still existed.

Finding Sec. IV – 9: The SIG determined the SCDMH employees participated in improper medical documentation that increased billable hours that resulted in annual reimbursements for "erroneous claims" in the amounts of $868,745 and $858,197 for FY2023-2024 respectively.

> **Recommendation Sec. IV – 9:** The SIG recommends the SCDMH develop procedures to comply with all state and federal regulations to continue to reduce the amount of reimbursement for "erroneous claims" in order to mitigate any potential fraud and legal risk.

Section V – Findings and Recommendations – Human Resource Practices

Finding Sec. V – 1: The SIG determined that of the sample of 40 bonus payments to employees under the Critical Employees Recruitment and Retention Proviso, for 25 of the 40 (63%), the annual reports were not submitted correctly to DSHR (i.e., incorrect job class code, reported bonus amount, employees not reported on the report).

> **Recommendation Sec. V – 1:** The SIG recommends the SCDMH ensure accurate submission of its Critical Needs Recruitment and Retention annual report to DSHR.

Finding Sec. V – 2: The SIG determined the SCDMH relied on the use of dual employment pay.

> **Recommendation Sec. V – 2:** The SIG recommends the SCDMH work towards decreasing the use of dual employment pay as referenced in the DOA 2023 report. Additionally, the SCDMH should update any policy or procedure to comply with the new State HR Regulations revised 9/1/24.

Finding Sec. V – 3: The SIG determined that 3,117 (53%) out of 5,859 separations were classified as separations for personal reasons. Further, the number of separations negatively affects the SCDMH's ability to fulfill its mission of serving patients.

> **Recommendation Sec. V – 3:** The SIG recommends the SCDMH develop strategies to maximize employee retention.

Finding Sec. V – 4: The SIG determined through direct interviews and analysis of comments from the SCDMH Climate and Employee Satisfaction Survey, a potential risk of discrimination can occur within human resource practices as it relates to the use of disciplinary action and FMLA authorization.

> **Recommendation Sec. V – 4:** The SIG recommends the SCDMH apply best practices regarding human resource practices in accordance with applicable state and federal laws and regulations.

Finding Sec. V – 5: The SIG determined filling vacancies at the SCDMH is critical to addressing shortages, reducing workloads, and improving employee retention and patient care, as highlighted in the SCDMH Climate and Employee Satisfaction Survey. The survey identified slow hiring processes, uncompetitive salaries, and recruitment challenges as key barriers.

> **Recommendation Sec. V – 5:** The SIG recommends the SCDMH streamline and accelerate the hiring process.

Finding Sec. V – 6: The SIG determined that at least one mental health facility did not have a suitable environment to see patients, and for employees to work, since November 2024 due to poor maintenance despite dedicated funds available for facility maintenance. The SIG determined that as of FY2024, the SCDMH's Medicaid Cash match account that could be used for maintenance and repairs for the centers was $17,582,922.

> **Recommendation Sec. V – 6:** The SIG recommends the SCDMH work with appropriate entities to facilitate and expedite resolution of the confirmed mechanical and structural deficiencies to ensure acceptable conditions for the health and safety of the employees and patients. In addition, the SIG also recommends the SCDMH analyze the needs for regular maintenance and repairs and use the state taxpayer's resources effectively and efficiently in providing a suitable environment for patients' care and employees to work comfortably.

Section VI – Findings and Recommendations – Other Observations

Finding Sec. VI – 1: The SIG determined the SCDMH was not utilizing all licensed beds due to budget and staffing constraints and has no identifiable plan as referenced in the DOA 2023 report, SCDMH should develop "a *plan to increase each facility's patient census to a level more aligned with their licensed capacities*."

> **Recommendation Sec. VI – 1:** The SIG recommends the SCDMH work with stakeholders and funding sources to utilize all available licensed beds in its inpatient hospitals and develop a comprehensive plan as identified in the DOA 2023 report.

Finding Sec. VI – 2: The SIG determined the SCDMH's fiscal responsibility and accountability of state taxpayer funds continues to improve since restructuring of the senior leadership took place.

> **Recommendation Sec. VI – 2:** The SIG recommends the SCDMH continue its current fiscal course correction towards financial sustainability while continuing to adhere to applicable state and federal laws and regulations.

IN THE DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
COLUMBIA DIVISION

UNITED STATES OF AMERICA,	)	
	)	
Plaintiff	)	
	)	
vs.	)	Case No. _____
	)	
STATE OF SOUTH CAROLINA,	)	
	)	
Defendant.	)	
	)	
	)	
	)	

COMPLAINT

1. The United States brings this action to enforce the rights of adults with serious mental illness ("SMI") to receive services in the most integrated setting appropriate to their needs. The State of South Carolina ("State" or "South Carolina") administers and funds its programs and services for adults with SMI in a manner that results in their unnecessary institutionalization in Community Residential Care Facilities ("CRCFs") in violation of Title II of the Americans with Disabilities Act of 1990 (the "ADA"), 42 U.S.C. §§ 12132–34.

2. Over 1,000 South Carolinians with SMI are unnecessarily segregated in CRCFs due to the State's failure to make community-based services available to them, and more are regularly admitted to these settings.

3. People with SMI can typically live in integrated settings in the community, but they may need help managing their mental health conditions. For example, some people with mental health conditions, like bipolar disorder or schizophrenia, may need support taking their medications

consistently. Others may need help finding and maintaining housing or securing and sustaining employment.

4. More integrated and appropriate alternatives to CRCFs exist that offer support for these needs in the community. These alternatives include supportive housing—integrated, community-based housing that provides tenants with all the rights of tenancy combined with supportive services to help individuals with SMI secure and maintain stable housing—and mental health services to support people with SMI living in the community.

5. South Carolina funds and administers services for low-income residents who have SMI through Medicaid and other public funding.

6. Although these services could support people with SMI in living successfully in the community, South Carolina does not provide adequate community-based services to avoid unnecessary institutionalization in CRCFs.

7. Instead, it relies on segregated CRCFs to serve individuals with SMI. These facilities, also known as "adult care homes", are congregate settings where people with disabilities have limited choice and independence and rarely engage with the broader community.

8. South Carolinians with SMI move into CRCFs after experiencing mental health crises, psychiatric hospital stays, or the inability to access the community-based services they need. Many others remain in CRCFs unnecessarily.

9. Most South Carolinians with SMI who have moved to CRCFs could live at home, either alone or with family or friends, if they could access community-based services.

10. The vast majority of South Carolinians with SMI would not oppose transitioning to a more integrated setting if provided an opportunity to do so.

11. Moving into a CRCF not only separates people from their communities, but also deprives them of the ability to make basic choices about their daily lives. For example, most CRCF residents cannot choose who they live with, what they eat, or how they spend their days.

12. The State could prevent discrimination against South Carolinians with SMI by changing its policies and practices to ensure that people have the information they need to make a meaningful choice about moving into a CRCF; making services in the community more reliably available; and actively supporting people to move back to the community.

13. Under Title II of the ADA, 42 U.S.C. § 12132, the United States brings this lawsuit, seeking a judicial order compelling the State to make reasonable modifications to its services for low-income South Carolinians with SMI. Changes to the State's policies and practices would enable many more South Carolinians with SMI to live in their own homes, contribute to their communities, and develop and maintain bonds with their friends and loved ones.

JURISDICTION

14. This Court has jurisdiction over this action under 28 U.S.C. §§ 1331, 1345, because it involves claims arising under federal law. *See* 42 U.S.C. § 12133. The Court may grant the relief sought in this action pursuant to 28 U.S.C. §§ 2201–02.

15. Venue is proper in this district pursuant to 28 U.S.C. § 1391 because a substantial part of the acts and omissions giving rise to this action occurred in the District of South Carolina. 28 U.S.C. § 1391(b).

PARTIES

16. Plaintiff is the United States of America.

17. Defendant, the State of South Carolina, is a "public entity" within the meaning of the ADA, 42 U.S.C. § 12131(1), and is therefore subject to Title II of the ADA, 42 U.S.C. §§ 12131–34, and its implementing regulation, 28 C.F.R. Part 35.

STATUTORY AND REGULATORY BACKGROUND

18. Congress enacted the ADA in 1990 "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1). It found that "historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem." *Id*. § 12101(a)(2).

19. For those reasons, Congress prohibited discrimination against individuals with disabilities by public entities: "[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." *Id*. § 12132.

20. Title II of the ADA prohibits discrimination on the basis of disability by public entities. A "public entity" includes any state or local government, as well as any department, agency, or other instrumentality of a state or local government, and it applies to all services, programs, and activities provided or made available by public entities, such as through contractual, licensing, or other arrangements. *Id*. § 12131(1); 28 C.F.R. § 35.130(b)(3)(i).

21. Congress directed the Attorney General to issue regulations implementing Title II of the ADA. 42 U.S.C. § 12134. The Title II regulations include an "integration mandate," which requires public entities to "administer services, programs, and activities in the most integrated

setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). The most integrated setting is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible . . . ." *Id.*, App. B, at 711 (2020).

22. In *Olmstead v. L.C.*, the Supreme Court held that Title II prohibits the unjustified segregation of individuals with disabilities. 527 U.S. 581, 597 (1999). The Court explained that its holding "reflects two evident judgments." *Id.* at 600. "First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id.* "Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Id.* at 601.

23. Under Title II, as interpreted by the United States Supreme Court in the *Olmstead* decision, public entities are required to provide community-based services when (a) such services are appropriate, (b) the affected individuals do not oppose community-based treatment, and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other people with disabilities. *Id.* at 607.

24. All conditions precedent to the filing of this Complaint have been satisfied. Fed. R. Civ. P. 9(c); 28 C.F.R. Part 35, Subpart F. The United States received a complaint of discrimination about South Carolina's overuse of CRCFs to provide services to people with serious mental illness. Following an investigation under Title II of the ADA, the United States notified the State of its conclusion that South Carolina fails to provide services to adults with mental illness in the most integrated setting appropriate to their needs as required by the ADA. The letter provided the

State notice of its failure to comply with the ADA and identified the steps necessary for the State to meet its obligations pursuant to federal law. The United States determined that South Carolina's compliance with the ADA cannot be secured by voluntary means.

OVER A THOUSAND ADULTS WITH SMI RESIDE IN SEGREGATED CRCFS IN SOUTH CAROLINA WITH MORE SEEKING ADMISSION EACH MONTH.

A. *The State pays for, licensees, and operates CRCFs, which are segregated settings.*

25. South Carolina made CRCFs a significant part of its mental health service system. The State funds and oversees approximately 362 State-run or State-licensed CRCFs licensed for ten or more beds; additionally, there are smaller separately licensed facilities clustered together and administered as one facility. Over 1,000 individuals with SMI receive state subsidies to live in these South Carolina CRCFs with ten or more beds, and many seek admission to these CRCFs each year to access the services they need.

26. The South Carolina Department of Public Health licenses, inspects, and monitors CRCFs.

27. The South Carolina Department of Health and Human Services ("DHHS") administers the Optional State Supplementation ("OSS") program, and its companion, the Optional Supplemental Care for Assisted Living Participants ("OSCAP"). These two programs pay for room, board, and services provided by CRCFs to individuals with disabilities.

28. OSS and OSCAP payments are state-funded and may only be used toward the cost of residing in a segregated CRCF, rather than in the community. Thus, the State subsidizes a significant portion of the cost of providing care to many CRCF residents with SMI.

29. The South Carolina Department of Mental Health ("DMH") directly operates eight CRCFs for individuals with SMI. The State serves approximately 80 individuals at any one time in these facilities.

30. At the eight DMH-run CRCFs, all residents have SMI. Even at private CRCFs that are licensed by the State, people exclusively live alongside others with SMI and other disabilities.

31. CRCFs vary in size, with some licensed for over 100 beds. Of the adults with SMI in these CRCFs, nearly half reside in facilities licensed for 25 beds or more.

32. Residents have little to no control over their daily activities. Many facilities monitor residents' movement within and near the facility itself using security cameras in the common areas and on the exterior of the building. Staff determine when and what residents eat. Residents typically live in shared rooms with little privacy or choice of roommate.

33. CRCFs also limit independence and autonomy in other ways. For instance, medication is distributed to all residents, and residents may not store their own medication. Residents thus lack experience in knowing when and how to take their medications. And individuals living in CRCFs typically do not cook their own meals because regulations require a medical professional's permission for a CRCF resident to cook.

34. CRCFs isolate individuals from the broader community. These facilities are often located in areas where residents cannot safely walk or take mass transit to destinations in the local community. Some CRCFs are even fenced in. For example, at least one has a padlocked front gate, and another has a gate with an alarm that sounds upon exit.

35. CRCF residents have limited to no interaction with individuals without disabilities other than facility staff. They rarely leave CRCFs to attend social, recreational, vocational, or religious activities of their choosing outside of the facility, in part because CRCF staff make meals and medications available only at specific times on site. CRCF staff take residents on occasional trips to stores like Walmart or Dollar General. Residents generally do not visit other locations in the

community for more substantive engagement or contact with people without disabilities. Instead, they often spend their days watching television in common areas or smoking on outdoor patios. Many residents do not leave the facility at all except for medical appointments. Some residents even receive medical services on-site.

36. The State has long been on notice that CRCFs are segregated settings. Public filings from a lawsuit brought by Disability Rights South Carolina include a 2016 report noting that the State's "ongoing reliance on CRCFs and other congregate settings, calls into question South Carolina's ability to ensure that individuals with disabilities are living in the most integrated settings." The report also noted that the State's continued use of OSS in CRCFs "may make South Carolina vulnerable for Olmstead activity." *AW et al. v. McGill et al.*, No. 2:17-cv-01346-RMG, Doc. 26-12 at 5, 11 (D.S.C. Apr. 3, 2018).

B. *The State's policies and practices result in individuals entering or remaining in CRCFs.*

37. Many South Carolinians with SMI move to CRCFs to access the services they need. Changes in personal circumstances, like a mental health crisis or psychiatric hospital stay, can create a need for additional community-based services that goes unmet, driving unnecessary institutionalization in CRCFs.

38. In addition to the need for community-based services, people remain in CRCFs because DMH Community Mental Health Centers ("CMHCs"), which each provide services for a given set of counties, set unnecessary requirements for transition to the community. Requiring people to be symptom-free or medication-compliant contributes to unnecessarily long CRCF stays. This approach ignores the community-based services that support individuals in the community. Rather than identifying community-based services, like Assertive Community Treatment

("ACT"), to meet people's needs, the State often confines its assessment to whether the person can transition to independent housing without services.

39. CRCF stays may also be extended because State staff expect a resident to demonstrate specific independent living skills before transitioning. For someone who wants to transition to the community and live independently, DMH CRCF staff sometimes assign the person tasks to prove they have the ability to perform skills before discharge. Instead, the State could assist people in transitioning, with the support of services to help them develop skills once in the community.

40. The State does not focus on transitioning people out of CRCFs. As noted in the State's Continuity of Care policy, South Carolina views CRCFs as having an "important role . . . in providing residential care for persons with mental illnesses." The policy further states that DMH intends to "provide needed treatment in local communities whenever possible" but relies on CRCFs as discharge destinations from State-run psychiatric hospitals.

41. On paper, DMH notes that the goal is for everyone with mental illness to "live as independently as possible," which "may include obtaining employment and moving from the CRCF to more independent living where they assume responsibilities for the activities of daily living such as cooking, laundry, etc." Despite this stated goal, DMH relies on CRCFs to serve many people with SMI and fails to provide the support necessary to help CRCF residents move to an integrated setting.

42. DMH employees who engage in transition planning for people who leave the two State-run psychiatric hospitals often send people directly to CRCFs. For example, in February 2024,

the DMH Office of Transition Programs assisted with the discharge of 25 individuals from a State psychiatric hospital. This included 8 individuals that the State placed in a CRCF.

43. South Carolina has further incentivized placement in CRCFs above and beyond its OSS and OSCAP payment. South Carolina also created an enhanced CRCF rate meant to encourage CRCFs to accept people who are discharging from the State psychiatric hospitals and have a history of repeated readmissions to these hospitals. The State pays an additional $30 to $40 per bed per day to CRCFs in this program.

44. The State knows that there are many people with SMI in CRCFs. In April 2024, the State identified 953 people in CRCFs receiving some DMH services. There are additional people with SMI in CRCFs receiving OSS and OSCAP and the associated CRCF services who are not currently receiving DMH services.

THE VAST MAJORITY OF SOUTH CAROLINIANS WITH SMI ARE QUALIFIED TO RECEIVE SERVICES IN INTEGRATED SETTINGS AND WOULD NOT OPPOSE PLACEMENT IN SUCH SETTINGS.

45. South Carolinians who are Medicaid-eligible adults who live in CRCFs, or who need community-based mental health services to avoid unnecessary CRCF admission, are individuals with disabilities that substantially limits one or more major life activities, as defined in 28 C.F.R. § 35.108.

46. These individuals are qualified to receive community-based services.

47. If they were provided with access to the community-based mental health services described above, many of these individuals could and would live in integrated, community-based settings, and could avoid placement in CRCFs.

48. Community-based services are appropriate for the vast majority of these individuals. As of July 2021, CMHCs were reportedly serving in the community nearly 6,100 adults whose level of need for support was four on a scale of one to five, and more than 500 adults with a level of five, with five indicating the most intensive level of need. Given this capacity to serve individuals with intensive needs for mental health services in the community, the State could support more people in integrated settings who are diverted from, or transition from, CRCFs. In fact, DMH's "mission and policy is to support the recovery of people with mental illness, serving them in the most appropriate, integrated, and least restrictive setting consistent with professional standards, needs, and individual choice."

49. The State designed its CMHC services to serve people with a wide range of needs in the community. These services include supportive housing, ACT, peer support, supportive employment, and crisis services, which are aimed at people with the most significant needs.

50. Many of these individuals, if presented with individualized, realistic alternatives to CRCF placement, would not oppose receiving services in community-based settings.

51. Providing choice includes offering alternatives that are realistic and specific to the individual, which enables the person to make an informed choice about whether to remain in a segregated setting.

52. Even with minimal discussion about what services might be available in the community, interviews with a sample of people living in CRCFs indicated that nearly 80 percent did not oppose moving to the community.

53. Beginning in October 2023, DMH had initial conversations with some of the people it was serving who live in CRCFs. Through these conversations, DMH identified close to 200

people who wanted to leave, confirming that there are significant numbers of people who do not oppose moving to most integrated settings.

54. Essentially all those individuals who currently live in the community would choose to continue receiving services in the community if the State improves access to those services.

PROVIDING SERVICES IN INTEGRATED SETTINGS CAN BE ACCOMMODATED THROUGH REASONABLE MODIFICATIONS OF THE STATE'S EXISTING SERVICES.

55. South Carolina can implement reasonable modifications that would enable many of its current CRCF residents to transition to, and live successfully in, the community and that would prevent numerous other South Carolinians with SMI from unnecessarily entering CRCFs.

56. Individuals with SMI often need access to a variety of services to avoid unnecessary institutionalization. For CRCF residents to transition into the community, most would need alternative services. South Carolina provides these very services to some people with SMI in the State.

A. *Existing Community-Based Services*

57. South Carolina uses Medicaid financing to fund and administer services like ACT, peer support, and individualized support to regain community living skills. These services are generally designed to be provided in community-based settings (*e.g.*, in their private owned or rented home) and to support stable community living for people with SMI.

58. Medicaid is a health care system created by federal law but administered by states who are subject to certain federal statutory requirements. In broad terms, Medicaid's purpose is to provide government-funded health coverage and related services for low-income individuals and individuals with disabilities. When these individuals receive authorized services from providers that are enrolled with Medicaid, the providers' costs are reimbursed with Medicaid funds. In

South Carolina, the State contributes approximately 30% of the costs, while the federal government contributes 70%. *See* 88 Fed. Reg. 81090 at 81092.

59. Federal law requires every state that participates in Medicaid to designate a state agency to administer its Medicaid services. That agency must create a "Medicaid State Plan," which describes and defines the services that it will cover through Medicaid. These services are called "medical assistance."

60. DHHS is the state agency that administers South Carolina's Medicaid system. Through DHHS, the State has created a Medicaid State Plan that covers the Medicaid-funded services relevant to this matter.

61. DMH provides mental health services through 16 state-operated CMHCs. Generally, CMHC catchment areas cover two or three counties.

62. DMH establishes the list of services provided through its regional network of CMHCs and oversees that system of services, many of which are also included in the State's Medicaid program and reimbursed through Medicaid. Currently, the CMHCs provide supportive housing, ACT, peer support, supported employment, crisis services, psychiatric and psychological services, independent living skills services, and case management.

63. Supportive housing offers housing, typically scattered throughout the community, along with services aimed at meeting the individual's needs. CMHCs can provide a variety of services to people in supportive housing, depending on their specific needs to support them in maintaining stable housing and in accomplishing daily activities that a CRCF would manage. As of March 2024, the State was providing supportive housing for 304 individuals and had the

capacity to support 326. This was a decrease from June 2022 when the State was providing 349 individuals with supportive housing and had the capacity to support 393.

64. DMH targets limited supportive housing to individuals transitioning out of CRCFs. As of 2021, the State dedicated 15 supportive housing slots to individuals who are transitioning out of CRCFs.

65. Assertive Community Treatment ("ACT") is a service that provides individualized support in the community to people with the most significant mental health needs, including those with a history of multiple inpatient admissions. The federal Substance Abuse and Mental Health Services Administration recognizes ACT as an evidence-based practice. ACT involves a team-based approach with small caseloads.

66. Although the State Medicaid program began reimbursing providers for ACT as of July 1, 2023, the service is not available to everyone who needs it to transition from a CRCF because it is not available throughout the State. As of May 2024, DMH operated just two fully staffed ACT teams. There are three additional teams operated in the State by private mental health providers.

67. Individualized, person-directed services aimed at enabling people to develop or regain independent living skills, sometimes provided through Psychosocial Rehabilitative Services, can promote recovery, full community integration, and improved quality of life for individuals with SMI. For example, this service may support people in developing skills related to communication, household management, and budgeting. This service should occur in the place where the person will typically be performing the skill, such as the person's home or workplace. These services are often especially critical in the period after a transition out of the hospital or a CRCF to support the development or re-development of community-living skills.

68. In South Carolina, Psychosocial Rehabilitative Services are Medicaid-billable, and they can be provided individually or in a group. However, there appears to be wide variation by CMHC catchment area in how they are provided, with some offering the services primarily as a group activity and others providing it on an individual basis.

69. Similarly, supported employment assists people with SMI to attain integrated, paid, competitive employment, and provides supports so that they are successful in that job, which can enable stability in the community and support successful transitions out of a CRCF. Individual Placement and Support ("IPS") is an evidence-based supported employment service. Since 2020, the State has required all 16 CMHC catchment areas to provide IPS supported employment.

70. The State provides case management, which is Medicaid-billable, to many people with SMI, both in the community and in CRCFs. However, South Carolina's case management service rarely assists individuals in CRCFs with moving to an integrated setting or avoiding institutionalization. Instead, case managers generally provide therapy or referrals and do not promote transitions by directly assisting people to engage in intensive supports, locate housing, and access skill building services, even for people who have expressed a desire to move into integrated settings.

71. Peer support specialists are individuals who have succeeded in their own recovery process, and then help others experiencing similar situations. Peers provide support by sharing their own lived experience and practical guidance. Peer support can be especially helpful when individuals with SMI are transitioning from institutions to integrated settings.

72. While peer support can be central to transitions, about a third of the State's 51 full-time equivalent peer support specialist positions were vacant as of March 2024, leaving people in some regions without any available peer support specialists to help with transitions.

B. *Expansion of Existing Services to Enable Transitions is Reasonable*

73. The State could expand the capacity of existing community-based services to meet the needs of people who want to transition out of or avoid CRCF placement. For example, the State could expand supportive housing, ACT, peer support, supported employment, individualized independent living skills, and case management.

74. It is reasonable for the State to expand these services because it has chosen to cover most of them through its Medicaid program. South Carolina has established systems to provide these services statewide, though some are not actually available throughout the state. In addition, the State already provides these services to some people with significant needs in the community.

75. Serving South Carolinians with SMI in the community is a cost-effective alternative to institutionalization. The State has invested millions of dollars in serving people with SMI in CRCFs and can shift that funding to provide alternative services that would support those individuals in the community.

76. Between state fiscal years 2017 and 2022, the State spent an average of $19 million per year on OSS, and $7 million per year on OSCAP. As of state fiscal year 2022, the average monthly expenditure per person for OSS and OSCAP was $756, or approximately $9,000 annually.

77. In contrast, the State's investment in supportive housing is limited. The State allocates approximately $2,350,000 annually for supportive housing, with an average cost of between $6,000 and $7,000 per person served.

78. Additionally, beginning in February 2019, the State committed to develop 30 to 40 units per year of supportive housing for a period of five years and set aside $6.5 million to meet this goal.

C. *Providing Timely Support for Transitions Is Reasonable*

79. The State can provide South Carolinians with SMI with information about the option to transition to an integrated setting. This would include conducting regular in-reach at CRCFs to identify individuals who are interested in transitioning to integrated housing, identifying their need for alternative services to support transition, and conducting comprehensive transition planning to support their moves.

80. The State can promptly transition all adults with SMI living in CRCFs who do not oppose community placement, and for whom such placement is appropriate, to the alternative community-based services they need to be successful post-transition.

VIOLATION OF TITLE II OF THE ADA, 42 U.S.C. §§ 12131–34

81. The allegations of Paragraphs 1 through 80 of this Complaint are hereby realleged and incorporated by reference.

82. Defendant, the State of South Carolina, is a public entity subject to Title II of the ADA, 42 U.S.C. § 12131(1).

83. South Carolinians who are Medicaid-eligible adults with SMI that live in CRCFs, or seek admission to a CRCF in the future, are persons with disabilities covered by Title II of the ADA,

and they are qualified to participate in the State's services, programs, and activities, including home and community-based services. 42 U.S.C. §§ 12102, 12131(2).

84. Community-based services are appropriate for the vast majority of CRCF residents with SMI and those seeking CRCF admission.

85. Many CRCF residents with SMI would not oppose receiving services in community-based settings.

86. The State violates the ADA by administering its service system for individuals with SMI in a manner that fails to ensure that they receive services in the most integrated setting appropriate to their needs. 42 U.S.C. § 12132.

87. Providing services to these individuals in the most integrated setting appropriate to their needs can be accomplished by making reasonable modifications to the State's system of providing mental health services.

88. The State's actions constitute discrimination in violation of Title II of the ADA, 42 U.S.C. § 12132.

REQUEST FOR RELIEF

The United States of America respectfully requests that the Court:

(A) Declare that the State of South Carolina has violated Title II of the ADA, 42 U.S.C. §§ 12131–34, by failing to administer its services, programs, and activities for adults with SMI in the most integrated setting appropriate to their needs.

(B) Enjoin the State of South Carolina to:

1. cease discriminating against adults with SMI, and instead provide them community-based services in the most integrated setting appropriate, consistent

with their individual needs;

2. take steps as may be necessary to prevent the recurrence of any discriminatory conduct in the future and to eliminate the effects of Defendant's unlawful conduct.

(C) Order other appropriate relief as the interests of justice may require.

Dated: December 9, 2024

Respectfully submitted,

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Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: The number of patients under 18 served by DMH will be equal to or greater than the previous year.

Priority Type: MHS

Population(s): SED, BHCS

Goal of the priority area:

The number of patients under 18 served by DMH will be equal to or greater than the previous year.

Strategies to attain the goal:

Priority #: 2

Priority Area: The number of adult patients served by DMH will be equal to or greater than the previous year.

Priority Type: MHS

Population(s): SMI, ESMI, BHCS

Goal of the priority area:

The number of adult patients served by DMH will be equal to or greater than the previous year.

Strategies to attain the goal:

Priority #: 3

Priority Area: Number of inpatient 'bed days' used at Bryan Civil Hospital will be equal to or greater than the previous year.

Priority Type: MHS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Number of inpatient 'bed days' used at Bryan Civil Hospital will be equal to or greater than the previous year.

Strategies to attain the goal:

Priority #: 4

Priority Area: Number of inpatient 'bed days' used at Harris Hospital will be equal to or greater than the previous year.

Priority Type: MHS

Population(s): SMI, ESMI, BHCS

Goal of the priority area:

Number of inpatient 'bed days' used at Harris Hospital will be equal to or greater than the previous year.

Strategies to attain the goal:

Priority #: 5

Priority Area: Number of inpatient 'bed days' used at Morris Village will be equal to or greater than the previous year.

Priority Type: MHS

Population(s): SMI, ESMI, BHCS

Goal of the priority area:

Number of inpatient 'bed days' used at Morris Village will be equal to or greater than the previous year.

Strategies to attain the goal:

Priority #: 6

Priority Area: Number of inpatient 'bed days' used at Bryan Forensic will be equal to or greater than the previous year.

Priority Type: MHS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Number of inpatient 'bed days' used at Bryan Forensic will be equal to or greater than the previous year.

Strategies to attain the goal:

Priority #: 7

Priority Area: SCDMH will admit people into the inpatient forensic setting at a number equal to or greater than previous year.

Priority Type: MHS

Population(s): SMI, ESMI, BHCS

Goal of the priority area:

SCDMH will admit people into the inpatient forensic setting at a number equal to or greater than previous year.

Strategies to attain the goal:

Priority #: 8

Priority Area: Patients requiring CMHC appointments will be offered an appointment within agency standards (Priority/Emergent - 24 hours, Urgent - 2 working days or Routine 1 week).

Priority Type: MHS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Patients requiring CMHC appointments will be offered an appointment within agency standards (Priority/Emergent - 24 hours, Urgent - 2 working days or Routine 1 week).

Strategies to attain the goal:

Priority #: 9

Priority Area: Upon discharge from an inpatient psychiatric facility, patients will have scheduled appointments at CMHCs at a rate equal to or less than the previous year. Data measured is the average number of days between discharge and scheduled appointment.

Priority Type: MHS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Upon discharge from an inpatient psychiatric facility, patients will have scheduled appointments at CMHCs at a rate equal to or less than the previous year. Data measured is the average number of days between discharge and scheduled appointment.

Strategies to attain the goal:

Priority #: 10

Priority Area: The number of Hospitals utilizing SCDMH Telepsychiatry services will remain constant or increase.

Priority Type: MHS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

The number of Hospitals utilizing SCDMH Telepsychiatry services will remain constant or increase.

Strategies to attain the goal:

Priority #: 11

Priority Area: The number of CMHCs utilizing Telepsychiatry services will remain constant or increase.

Priority Type: MHS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

The number of CMHCs utilizing Telepsychiatry services will remain constant or increase.

Strategies to attain the goal:

Priority #: 12

Priority Area: Percentage of patients participating in SCDMH employment programs, gaining meaningful employment, will meet or exceed average. (National benchmark = 40%).

Priority Type: MHS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Percentage of patients participating in SCDMH employment programs, gaining meaningful employment, will meet or exceed average. (National benchmark = 40%).

Strategies to attain the goal:

Priority #: 13

Priority Area: Life expectancy at Roddy Pavilion (skilled nursing facility) will be equal to or greater than the previous year. (National average = 1.2 years.)

Priority Type: MHS

Population(s): SMI, ESMI, BHCS

Goal of the priority area:

Life expectancy at Roddy Pavilion (skilled nursing facility) will be equal to or greater than the previous year. (National average = 1.2 years.)

Strategies to attain the goal:

Priority #: 14

Priority Area: Life expectancy at Stone Pavilion (skilled nursing facility for veterans) will be equal to or greater than the previous year. (National average = 1.2 years.)

Priority Type: MHS

Population(s): SMI, ESMI, BHCS

Goal of the priority area:

Life expectancy at Stone Pavilion (skilled nursing facility for veterans) will be equal to or greater than the previous year. (National average = 1.2 years.)

Strategies to attain the goal:

Priority #: 15

Priority Area: Use of restraints in SCDMH Bryan Hospital inpatient facility will be equal to or below the previous year.

Priority Type: MHS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Use of restraints in SCDMH Bryan Hospital inpatient facility will be equal to or below the previous year.

Strategies to attain the goal:

Priority #: 16

Priority Area: Use of restraints in Patrick Harris Hospital inpatient facility will be equal to or below the previous year. National average = 1.09 hours per 1,000 hours of inpatient service.

Priority Type: MHS

Population(s): SMI, ESMI, BHCS

Goal of the priority area:

Use of restraints in Patrick Harris Hospital inpatient facility will be equal to or below the previous year. National average = 1.09 hours per 1,000 hours of inpatient service.

Strategies to attain the goal:

Priority #: 17

Priority Area: Use of seclusion rooms in SCDMH Bryan Hospital inpatient facility will be equal to or below the previous year. National average = 0.58 hours per 1,000 hours of inpatient service.

Priority Type: MHS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Use of seclusion rooms in SCDMH Bryan Hospital inpatient facility will be equal to or below the previous year. National average = 0.58 hours per 1,000

hours of inpatient service.

Strategies to attain the goal:

Priority #: 18

Priority Area: Use of seclusion rooms in Patrick Harris Hospital inpatient facility will be equal to or below the previous year. National average =0.58 hours per 1,000 hours of inpatient service.

Priority Type: MHS

Population(s): SMI, ESMI, BHCS

Goal of the priority area:

Use of seclusion rooms in Patrick Harris Hospital inpatient facility will be equal to or below the previous year. National average =0.58 hours per 1,000 hours of inpatient service.

Strategies to attain the goal:

Priority #: 19

Priority Area: Percentage of adults expressing satisfaction with SCDMH services will meet or exceed the national average (US average 88%).

Priority Type: MHS

Population(s): SMI, ESMI, BHCS

Goal of the priority area:

Percentage of adults expressing satisfaction with SCDMH services will meet or exceed the national average (US average 88%).

Strategies to attain the goal:

Priority #: 20

Priority Area: The number of youths treated within contracted school mental health programs and the number of services delivered will be equal to or increase.

Priority Type: MHS

Population(s): SED, ESMI, BHCS

Goal of the priority area:

The number of youths treated within contracted school mental health programs and the number of services delivered will be equal to or increase.

Strategies to attain the goal:

Priority #: 21

Priority Area: All Community Mental Health Centers will meet Centers for Medicare and Medicaid Studies' rules for emergency preparedness when surveyed for compliance (at least once every three years).

Priority Type: MHS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

All Community Mental Health Centers will meet Centers for Medicare and Medicaid Studies' rules for emergency preparedness when surveyed for compliance (at least once every three years).

Strategies to attain the goal:

Priority #: 22

Priority Area: SCDMH will have trained personnel prepared to staff the State Emergency Operation's Center (SEOC) throughout all drills and "real world" emergency situations. (Minimum = 4 staff).

Priority Type: MHS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

SCDMH will have trained personnel prepared to staff the State Emergency Operation's Center (SEOC) throughout all drills and "real world" emergency situations. (Minimum = 4 staff).

Strategies to attain the goal:

Priority #: 23

Priority Area: The number of youths treated within contracted School Mental Health Programs and the number of services delivered will increase.

Priority Type: MHS

Population(s): SED, ESMI, BHCS

Goal of the priority area:

The number of youths treated within contracted School Mental Health Programs and the number of services delivered will increase.

Strategies to attain the goal:

Priority #: 24

Priority Area: The number of mental health crisis calls received by the Mobile Crisis Call Center will be equal to or greater than last year.

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

The number of crisis calls received by the Mobile Crisis Call Center will be equal or greater to last year.

Strategies to attain the goal:

CDMHC will continue to operate the Mobile Crisis Call Center.

Priority #: 25

Priority Area: The number of calls answered by both 988 Call Centers will be equal to or greater than last year.

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

The number of calls answered by both 988 Call Centers will be equal or greater to last year.

Strategies to attain the goal:

CDMHC and MHA Greenville will continue to operate the two 988 Call Centers.

Priority #: 26

Priority Area: The average answer rate of calls for both 988 Call Centers will be equal to or greater than last year.

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

The average answer rate of calls for both 988 Call Centers will be equal or greater to last year.

Strategies to attain the goal:

CDMHC and MHA Greenville will continue to operate the two 988 Call Centers.

Priority #: 27

Priority Area: The number of responses provided by Mobile Crisis teams will be equal to or greater than last year. This includes in-person, telephonic, and telehealth responses.

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

The number of responses provided by Mobile Crisis teams will be equal or greater to last year. This includes in-person, telephonic, and telehealth responses.

Strategies to attain the goal:

All 16 CMHCs will continue to implement Mobile Crisis teams.

Priority #: 28

Priority Area: The number of unduplicated people in crisis who receive services from Alliance staff members will be equal or greater to last year.

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

The number of unduplicated people in crisis who receive services from Alliance staff members will be equal or greater to last year.

Strategies to attain the goal:

The vast majority of CMHCs will continue to implement Alliance programs.

Priority #: 29

Priority Area: The number of first responders who receive services from the FRST program will be equal to or greater than last year.

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

The number of first responders who receive services from the FRST program will be equal to or greater than last year.

Strategies to attain the goal:

The vast majority of CMHCs will continue to implement the FRST program.

Priority #: 30

Priority Area: The number of admitted patients (unduplicated) who receive services from the Tri-County Crisis Stabilization Center at CDMHC will be equal to or greater than last year.

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

The number of admitted patients (unduplicated) who receive services from the Tri-County Crisis Stabilization Center at CDMHC will be equal to or greater than last year.

Strategies to attain the goal:

CDMHC will continue to operate its Crisis Receiving and Stabilization Facility, called the Tri-County Crisis Stabilization Center.

Priority #: 31

Priority Area: The number of unduplicated admitted patients who receive services from the Midlands Crisis Stabilization Unit at CAMHC will be equal to or greater than its estimate for its first year of operation.

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

The number of unduplicated admitted patients who receive services from the Midlands Crisis Stabilization Unit at CAMHC will be equal to or greater than its estimate for its first year of operation.

Strategies to attain the goal:

CAMHC will operate its new Crisis Receiving and Stabilization Facility, called the Midlands Crisis Stabilization Unit. The objective set for this priority area is based on an estimate; because this is the first year of operation, CAMHC does not have previous data to use as a baseline.

Priority #: 32

Priority Area: The number of unduplicated patients who receive services from the Eubanks Center at SAMHC will be equal to or greater than last year.

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

The number of unduplicated patients who receive services from the Eubanks Center at SAMHC will be equal to or greater than last year.

Strategies to attain the goal:

SAMHC will continue to operate the Eubanks Center.

Priority #: 33

Priority Area: The number of unduplicated patients who receive services from the FOCUS CAFE at SAMHC will be equal to or greater than last year.

Priority Type: BHCS

Population(s): SED, BHCS

Goal of the priority area:

The number of unduplicated patients who receive services from the FOCUS CAFE at SAMHC will be equal to or greater than last year.

Strategies to attain the goal:

SAMHC will continue to operate the FOCUS CAFE.

Priority #: 34

Priority Area: The number of unduplicated patients who receive services from The Living Room at ABMHC will be equal to or greater than its estimate for its first year of operation.

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

The number of unduplicated patients who receive services from The Living Room at ABMHC will be equal to or greater than its estimate for its first year of operation.

Strategies to attain the goal:

ABMHC will begin implementing its new Living Room program. 40 unduplicated patients is an estimate, because this will be the program's first year of operations; there is no baseline data to use as a target goal.

Priority #: 35

Priority Area: The number of FEP programs implemented will be equal to or greater than last year.

Priority Type: ESMI

Population(s): ESMI

Goal of the priority area:

The number of FEP programs implemented will be the same or greater than last year.

Strategies to attain the goal:

At least 6 CMHCs will implement the following FEP programs: NAVIGATE, New Directions, and/or PREP.

Priority #: 36

Priority Area: The number of unduplicated patients who receive services from FEP programs will be equal to or greater than last year. This number reflects the patients officially enrolled in NAVIGATE, New Directions, and/or PREP.

Priority Type: ESMI

Population(s): ESMI

Goal of the priority area:

The number of unduplicated patients who receive services from FEP programs will be the same as or greater than last year. This number reflects the patients officially enrolled in NAVIGATE, New Directions, and/or PREP.

Strategies to attain the goal:

At least 6 CMHCs will continue to implement NAVIGATE, New Directions, and/or PREP.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application *Funding Agreement/Certifications and Assurances.*

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds[a]
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis Services								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[b]		$4,721,715.00						$190,125.00
7. State Hospital			$94,232,922.00		$262,039,294.00	$2,928,752.00	$4,270,898.00	
8. Other Psychiatric Inpatient Care					$6,646,632.00			
9. Other 24-Hour Care (Residential Care)			$13,152,196.00		$27,870,470.00		$1,790,588.00	
10. Ambulatory/Community Non-24 Hour Care		$27,913,842.00	$141,432,306.00		$482,073,400.00	$8,602,626.00	$66,500,529.00	
11. Crisis Services (5 percent Set-Aside)[c]		$3,185,139.00	$102,804.00		$4,156,047.00		$943,540.00	$909,811.00
12. Other Capacity Building/Systems Development								
13. Administration[d]		$275,910.00			$66,074,890.00		$2,225,633.00	
14. Total		**$36,096,606.00**	**$248,920,228.00**	**$0.00**	**$848,860,733.00**	**$11,531,378.00**	**$75,731,188.00**	**$1,099,936.00**

[a]The expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Block Grant funds reflect the remaining amount of the 2024 block grant, the remaining amount of the 2025 block grant, 100% of the 2026 block grant, and 75% of the 2027 block grant.

BSCA funds reflect the remaining amount of BSCA #3, and the entire amount of BSCA #4.

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	24252143.00
1b. Crisis Services for Adults	3185139.00
1c. CSC/ESMI program for Adults	0.00
1d. Other outpatient/ambulatory services for Adults	19053.00
1e. *Other Direct Services for Adults	2885625.00
2. Subtotal of Services for Adults	30341960.00
3. Services for Children	
3a. EBPs for Children	757020.00
3b. Crisis Services for Children	0.00
3c. CSC/ESMI program for Children	4721715.00
3d. Other outpatient/ambulatory services for Children	0.00
3e. *Other Direct Services for Children	0.00
4. Subtotal of Services for Children	5478735.00
5. Other Capacity Building/Systems Development[a]	244546.00
6. Administrative Costs[b]	275910.00
7. *Any Other Cost	0.00
8. Total MHBG Allocation[c]	**36341151.00**

Please provide brief explanation for services with an asterisk* below:
Other direct services for adults include care coordination, non-EBP housing services (Homeshare), and language interpretation for patients.

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

[b] Administrative Costs should not exceed 5 percent of total MHBG allocation

[c] The total budget should be equal to your MHBG allocation for the next two years.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:
Block Grant funds reflect the remaining amount of the 2024 block grant, the remaining amount of the 2025 block grant, 100% of the 2026 block grant, and 75% of the 2027 block grant.

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 07/01/2025 MHBG Planning Period End Date: 06/30/2027

Activity	A. MHBG[1]	B. BSCA Funds[2]
1. Information Systems	$0.00	$0.00
2. Infrastructure Support	$0.00	$0.00
3. Partnerships, Community Outreach, and Needs Assessment	$0.00	$0.00
4. Planning Council Activities	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00
7. Training and Education	$244,546.00	$0.00
8. Total	**$244,546.00**	**$0.00**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Row 7 "Training and Education" will be funded by the 2024 TTA supplement, from July 1, 2025 - September 30, 2025.

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it**. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral health needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections**. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings**. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. **States should develop systems that vary the intensity of care coordination support based on the severity and complexity of individual need**. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve **access to care for mental disorders, substance use disorders, and co-occurring disorders**, including details on efforts to increase access to services for:

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

f) Persons with substance use disorders who have, or are at risk for, HIV or TB

g) Persons with substance use disorders in the justice system

h) Persons using substances who are at risk for overdose or suicide

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

l) Individuals with co-occurring mental and substance use disorders

Prior to April 2025, three different state government agencies were responsible for providing services related to mental healthcare, substance use healthcare, and healthcare for people with intellectual or developmental disabilities. In April 2025, Bill S.2 was signed into law by Governor McMaster. This law formed a new state agency named the SC Department of Behavioral Health and Developmental Disabilities (BHDD). Three offices are housed within the new agency: the Office of Mental Health (BHDD OMH), the Office of Substance Use Services (BHDD OSUS), and the Office of Intellectual and Developmental Disabilities (BHDD OIDD). The restructuring was designed as a system to promote more collaborative care for patients with diverse healthcare needs who might receive services from one, two, or all three of these offices.

As the restructuring evolves over the next few months and years, new initiatives may be created to ensure better communication and more integrated services for people who have any combination of co-occurring disorders or health challenges related to SMI/SED, SUD, and IDD. Currently, the three offices listed above continue to be responsible for oversight of services in their areas.

BHDD OMH is responsible for serving the individuals described in categories A, B, J, K, and L in the above list.

The South Carolina Department of Behavioral Health and Developmental Disabilities, Office of Substance Use Services (BHDD OSUS) is the designated Single State Authority for substance use disorder recovery services. BHDD OSUS is responsible for serving the individuals described in categories C, D, E, F, G, H, I, and L of the above list. BHDD OMH works collaboratively with BHDD OSUS, striving to ensure that people with co-occurring SMI/SED and SUD diagnoses receive consistent, evidence-based treatment. The recent agency merger will ensure that future collaborations are even more streamlined, ensuring the provision of high quality services for people who have co-occurring conditions.

The South Carolina Department of Behavioral Health and Developmental Disabilities, Office of Intellectual and Developmental Disabilities (BHDD OIDD), is responsible for serving individuals described in categories B and K. The recent agency merger will ensure closer collaborations between BHDD OMH and BHDD OIDD, ensuring the provision of better streamlined services for people who have co-occurring conditions.

All 16 of the BHDD OMH Community Mental Health Centers (CMHCs) offer a wide variety of services for patients who have co-occurring diagnoses of SUD and/or IDD. Additionally, several specialty programs help make it easier for patients to gain access to services through a “no wrong door” approach.

BHDD OMH initiatives include, but are not limited to, the following programs.

Tobacco Cessation Programs:

For the past few decades, BHDD OMH has collaborated with the SC Department of Public Health (SCDPH) and the Office of Substance Use Services (BHDD OSUS) in the SC Behavioral Health Tobacco Cessation Partnership; this group meets every other month. SCDPH has provided funding to support BHDD OMH staff education in the area of tobacco cessation. In SFY25, one BHDD OMH staff completed Tobacco Treatment Specialist trainings through Duke University, 11 completed training in Tobacco Dependence Pharmocotherapy, four attended training in Intensive Behavioral Approaches to Tobacco Treatment, and one attended training in Tobacco Treatment in Adolescent and Young Adult Populations through Duke University. Currently, two staff members at a CMHC are enrolled in the Tobacco Treatment Specialist training program for SFY26. The staff members who have been trained in tobacco cessation treatments are available to work with patients struggling with tobacco addiction.

Highway to Hope:

Highway to Hope (H2H) is a mobile response program that serves adults and children in some of the most rural areas of South Carolina. H2H is based on a long-running, highly successful model for rural patients that was first established by BHDD OMH’s Charleston-Dorchester Mental Health Center in 2010. Now, all sixteen of BHDD OMH’s Community Mental Health Centers (CMHCs) operate an H2H program. The program offers mental health treatment, including crisis services, as well as basic primary care services for physical healthcare needs. The healthcare staff make referrals to community resources, as needed. These services are provided within the privacy of RVs, which travel throughout various counties and park in different locations. The RVs are equipped with telehealth equipment, and the healthcare services can be delivered both in-person and virtually. H2H services are available to anyone, just like the services provided at the traditional CMHC locations. However, people who lack transportation receive the most benefit from the H2H program; when they cannot travel far distances to health providers, they can still access mental health and primary care services by visiting an H2H RV. H2H also provides crucially important crisis services for individuals who are experiencing behavioral health crises. Because the RVs are located closer than many hospitals or counseling centers, concerned family members or friends can bring their loved ones to the RVs to receive crisis counseling.

Statewide Crisis Call Centers:

People struggling with co-occurring SMI/SED and SUD may be more likely to experience mental health crises. BHDD OMH operates two statewide crisis call centers. Both call centers are operated by the Charleston Dorchester Mental Health Center (CSCOMHC), which is located in Charleston, SC. One call center provides a wide range of services for callers in crisis, while the second is a 988 call center. Mental Health America of Greenville County (MHA Greenville) operates another 988 call center that also serves the entire state. For detailed information about these call centers, see Section 15 of this application.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance **parity enforcement and increase awareness of parity protections** among the public and across the behavioral and general health care fields.

There are currently no efforts by BHDD OMH, alone or in partnership with the state agencies that provide services related to insurance and Medicaid, to specifically advance parity enforcement and increase awareness of parity protections, beyond following federal statutes related to parity.

3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

BHDD OMH screens youth and adults for co-occurring mental and substance use disorders. Adults, adolescents, and children who meet admission criteria for mental health services and who also have a co-occurring substance use disorder will not be excluded for treatment solely based on the co-occurring disorder. If the mental health clinic is not the desired and/or clinically appropriate provider, then every effort will be made to refer the individual to the appropriate provider.

Two BHDD OMH CMHCs have established look-a-like Certified Community Behavioral Health Clinics that follow the SAMHSA criteria but are not certified by the state or nationally. Those centers are the Beckman Center for Mental Health Services and Spartanburg Area MHC. The centers treat co-occurring patients and employ dual diagnosis clinicians.

Thirteen BHDD OMH CMHCs have been selected to provide Assertive Community Treatment (ACT). ACT is a community-based service for individuals with SMI who experience or are at risk for concurrent substance use, repeated hospitalization, homelessness, involvement I the criminal legal system and psychiatric crisis. BHDD OMH provides this service to adults, and its primary goal is to help individuals achieve recovery through support, rehabilitation and community treatment. This evidenced based service model is designed to utilize the transdisciplinary team approach. ACT Teams include a Psychiatric Care Provider, Nurse, Team Leader, Co-occurring Ddirorder Specialists, Employment Specialists, Peer Specialists, and Licensed Mental Health Providers. As of July 2025, 12 CMHCs have active ACT Teams providing services.

The BHDD OMH Division of Alcohol and Drug Addiction operates Morris Village Alcohol and Drug Addiction Treatment Center in Columbia. Morris Village provides inpatient treatment for adults with alcohol and drug use disorders, and, when indicated, addiction accompanied by psychiatric illness, often referred to as “dual diagnosis.” It is licensed by the South Carolina Department of Public Health (SCDPH) and is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) an independent, nonprofit accreditor of health and human services. Patients are admitted to Morris Village from throughout the state, with referrals from community mental health centers, county alcohol and drug commissions, community hospitals, and the judicial system. The patient population includes both individuals who are voluntarily admitted and individuals who are civil involuntary admissions.

BHDD OMH has an Integrated Care Program Manager who helps troubleshoot any issues with coordination of care related to co-occurring disorders. The recent restructuring of state government agencies will result in increased coordination of care for both adults and children who need treatment for co-occurring disorders.

a. Please describe how this system differs for youth and adults.

If a substance use disorder requires inpatient treatment, the referral may differ depending on the needs of the adult or youth. Referral options may include Adult Outpatient, Adolescent Outpatient, Adult Inpatient, Adolescent Inpatient, Intensive Outpatient, and/or Medication Assisted Treatment. For mental health services, children are seen by CMHC clinicians who specialize in children’s services. BHDD OMH operates its own alcohol and drug addiction treatment center for adults called Morris Village which has the capability to serve adults with co-occurring mental and substance use disorders.

Youth who enter through CCBHC programs would be evaluated by the APRN and then are referred to either adult services or CAF services based on their age.

ACT Teams and Morris Village provide services to adults only.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

BHDD OMH has been working with Multidimensional International Family Therapy International to get staff trained to provide Multidimensional Family Therapy (MDFT). MDFT is an evidence-based, comprehensive, and family-centered treatment for adolescents with substance use and behavioral problems. The primary goals are to reduce substance use,

improve family functioning, and enhance the adolescent's overall well-being.

c. How many IT-COD teams do you have? Please explain.

BHDD OMH has MDFT trained staff in 12 of 16 centers across the state with 28 certified MDFT clinicians and one MDFT statewide trainer. The goal is to have an MDFT team in each center if there is funding available.

d. Do you monitor fidelity for IT-COD? Please explain.

MDFT International provides training, Quality Assurance (QA), Implementation Services, and program licensing to MDFT programs. These services ensure that MDFT programs integrate the standards and practices consistent with MDFT requirements and quality improvement programming to ensure model fidelity that will result in excellent outcomes for the youth and families served.

All training, quality assurance and implementation services will be conducted by certified MDFT trainers following the MDFT training and quality assurance protocols and procedures.

BHDD OMH uses the Tool for Measurement of ACT (TMACT) to assess the fidelity of ACT services across the state. Fidelity reviews are conducted by an independent entity selected by the SCDHHS.

e. Do you have a statewide COD coordinator? (●) Yes ( ) No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

d) How the state provides integrated treatment for individuals with co-occurring disorders

BHDD OMH continues to strengthen its existing partnerships with both public and private primary healthcare providers. The BHDD OMH Director of Integrated Care is responsible for spearheading integrated care efforts with various partners. Designated community mental health centers (CMHC) have maintained longstanding alignment care arrangements including facilitated referrals, co-location and bi-directional partnerships with Federally Qualified Health Centers (FQHC), public and private primary healthcare providers, and mental health and substance abuse stakeholders.

Federally Qualified Health Center Partnerships:

Six CMHCs have staff members from Federally Qualified Health Centers (FQHCs) embedded in various clinics. This collaboration between CMHCs and FQHCs makes it easier for patients to receive a wider variety of healthcare services, including primary care services and medical services that are typically not available in a mental healthcare setting. The partnerships between CMHCs and FQHCs is especially beneficial for patients who live in rural areas or who have limited transportation access; they are able to meet with providers of mental health and medical services in just one location, during just one visit. This means that more patients, including people who have co-occurring conditions, can received coordinated services that meet their needs for both mental health and physical health.

Certified Community Behavioral Health Clinic, Phase 1:

There are nine program requirements to meet criteria for the Certified Community Behavioral Health Clinic (CCBHC) Model: Crisis Services; Screening, Assessment, and Diagnosis; Person-Centered and Family Centers Treatment Planning; Outpatient Mental Health and Substance Abuse Use Services; Primary Care Component; Targeted Case Management; Psychiatric Rehabilitation Services; Peer Supports, Peer Counseling, and Family/Caregiver Supports; and Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans.

BHDD OMH currently operates two Community Mental Health Centers (CMHCs) that are implementing all of the clinical components of a Certified Community Behavioral Health Clinic (CCBHC). The two CMHCs providing these services are the Spartanburg Area Mental Health Center (SAMHC) and the Beckman Center for Mental Health Services (BCMHS). Ten counties are served by these two centers. These programs have not yet been certified as CCBHCs by the SC Department of Health and Human Services (SCDHHS), due to logistical issues related to certification. However, BHDD OMH is pursuing certification for both of these CMHCs, with the goal of certification as soon as possible. Despite the fact that these CMHCs are not yet certified, they are implementing all of the program requirements to meet criteria for the national CCBHC Model.

At both the Spartanburg and Beckman locations, most of the programming is already provided in-house. BHDD OMH has contracted with local Substance Use Disorder (SUD) providers and local Federally Qualified Health Centers (FQHCs) to place Certified Addictions Counselors and primary care healthcare providers in each CCBHC location.

Metabolic Health Indices:

Over the past few years, BHDD OMH Integrated Care leadership led the development of a guideline for metabolic and physical health monitoring for patients who use antipsychotic medications. BHDD OMH awarded a research grant from its internal Ensor Trust to the BHDD OMH Director of Integrated Care and a psychiatric epidemiologist at University of South Carolina Arnold School of Public Health. This research study is currently in progress; it examines the impact of Long-Acting Injectable antipsychotic medications on the health and wellbeing of BHDD OMH patients. The results of this research will help inform clinicians and leadership about routine monitoring of metabolic measures and other practices related to metabolic health.

5. Describe how the state **provides care coordination**, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

The Office of Clinical Care Coordination pursues the goal of improving outcomes for patients and reducing healthcare costs. Care Coordinators help patients find and access resources such as primary care, housing, entitlement programs, etc. Provision of Care Coordination services results in decreased re-hospitalizations and emergency room visits, and increased utilization of primary care physicians. Key features of the service include in-home visits and reporting and monitoring of patients' progress in collaboration with referral sources. A special program under this division is Community Long-Term Care (CLTC). CLTC provides in-home support to participants eligible for nursing home care who opt to remain in their homes. Services may include home-delivered meals, personal care aides, incontinence supplies, adult day care, ramps, pest control, and other similar services. These services are provided to adults with Serious Mental Illnesses and children with Serious Emotional Disturbances.

Care Coordinators provide targeted case management services to qualifying individuals beginning with a comprehensive needs assessment. Medical, dental, housing, employment, education, behavioral, and other community support needs are identified in the needs assessment. Care Coordinators, who are knowledgeable about local community resources, work collaboratively with patients and link them to those resources. Care Coordinators monitor a wide variety of patient services until goals are met and needs are resolved. Clinical Care Coordination services focus specifically on patients' successful transition to community settings and access to needed services. From July 2024 through June 2025, 1,462 patients received services from Clinical Care Coordination, and 1,000 patients received services through the CLTC program.

6. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

BHDD OMH plans to continue sustaining key stakeholder relationships, including partnerships with the SC Rural Health Association, Federally Qualified Health Centers (FQHCs), Medicaid Managed Care Organizations, and the SC Department of Health and Human Services (SCDHHS), which is the state's Medicaid agency. These partnerships, along with others, help support integrated services; various initiatives include guidance and participation from medical service providers, behavioral health entities, and payors.

The South Carolina Behavioral Health Coalition, which includes BHDD OMH and Office of Substance Use Services (BHDD OSUS) representatives, is a statewide group comprised of public and private agencies, including a variety of organizations and healthcare providers. The coalition is based on the principles of understanding that mental illness and substance use disorders are diseases of the brain; recognizing the importance of education, early detection, intervention, and prevention; and recognizing that community needs are unique and specific to each community. The coalition is the result of collaborative work conducted by the SC Institute of Medicine and Public Health's Behavioral Health Task Force, the SC House Opioid Study Committee, and the Governor's Opioid Crisis Task Force. The coalition's charter focuses on five priority areas: crisis stabilization and management of patients with acute behavioral health disorders; alignment of behavioral health and primary care services and resources; substance use disorder prevention and treatment; access to services for children and youth ages 0 through 25; and behavioral health for people involved in the justice system.

BHDD OMH receives funding from the Department of Public Health (SCDPH) each year that can be used for tobacco treatment training or Nicotine Replacement Therapy (NRT). Previously, BHDD OMH has used this funding to send center staff to Tobacco Treatment Specialist Trainings, along with short continuing education courses. BHDD OMH will continue to use this funding to offer these educational opportunities to staff members. Additionally, BHDD OMH plans to continue its ongoing meetings with SCDPH to discuss and coordinate smoking cessation efforts around the state. Currently, smoking cessation "champions" are being identified at each BHDD OMH CMHC; these staff members will facilitate smoking cessation groups.

For the past few years, BHDD OMH has coordinated an Integrated Care Workgroup focused on improving treatment and access for patients diagnosed with co-occurring substance abuse disorders and mental health disorders. This group was tasked with

improving the rates of diagnoses of tobacco use disorder in BHDD OMH centers/clinics, metabolic monitoring for patients prescribed antipsychotics, and FQHC partnerships. The future of this workgroup is unclear; BHDD OMH leadership is exploring the next steps for this workgroup, and changes may be made, due to the recent agency merger.

Motivational Interviewing (MI) is an evidence-based practice that has proven particularly effective for patients with SUDs. MI is a person-centered, evidenced-based, goal-oriented method for enhancing intrinsic motivation to change by exploring and resolving ambivalence with the individual. BHDD OMH plans to continue offering Motivational Interviewing (MI) training for staff members statewide.

BHHD OMH will continue to provide a system of integrated services in order for children to receive care for their multiple needs. Services are coordinated to provide for a comprehensive system of care that includes social services; educational services including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services. School Mental Health Services clinicians ensure that children and adolescents with SED and SUDs receive evidence-based treatments that address their needs. BHHD OMH works collaboratively with the South Carolina Department of Juvenile Justice (SCDJJ) and the SC Department of Social Services (SCDSS) to address the needs of children and adolescents who have co-occurring disorders. The use of Multi-Dimensional Family Therapy (MDFT) at 12 CMHCs throughout the state provides a family-centered approach to helping children and adolescents who have SED and SUDs. Detailed information about services for children and adolescents can be found in Section 18 of this application.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

The SC Department of Behavioral Health and Developmental Disabilities Office of Intellectual and Developmental Disabilities (BHDD OIDD) is responsible for services and supports for individuals with IDD.

As the agency restructuring evolves over the next few months and years, new initiatives may be created to ensure better communication and more integrated services for people who have any combination of co-occurring disorders or health challenges related to SMI/SED, SUD, and IDD. Currently, BHDD OIDD continues to be responsible for services and supports for individuals with IDD, while BHDD OMH continues to be responsible for services and supports for individuals with SMI/SED.

8. Please indicate areas of **technical assistance needs** related to this section.

No technical assistance is requested.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

2. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) – 10 percent set aside – Required for MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by the Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative.Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

States shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals experiencing early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount, the state receives under this section for a fiscal year as required, a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
NAVIGATE	5.00
New Directions	1.00
PREP	1.00
	0.00
	0.00

	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
1,468,257.00	1,468,257.00

3. Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.

These services are billed to Medicaid, Medicaid MCOs, private payers and patients. If a patient has Medicare and the provider is eligible, the services could be billed to Medicare. These services are not bundled. They are billed a la carte.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.

BHDD OMH implements three different CSC programs at six Community Mental Health Centers (CMHCs): NAVIGATE, New Directions, and PREP. A total of 121 patients were served (officially enrolled) in these programs during SFY25.

NAVIGATE:

The NAVIGATE program is implemented at Aiken Barnwell MHC, Charleston Dorchester MHC, Coastal Empire MHC, Columbia Area MHC, and Lexington County CMHC.

The NAVIGATE program is a nationally recognized Coordinated Specialty Care (CSC) treatment model. Patients between the ages of 15 and 40 years of age who have been diagnosed in the schizophrenia spectrum, and are new to treatments in the past two years, are eligible to participate in NAVIGATE. This program is designed for patients to graduate within two years; the majority of patients successfully graduate. The NAVIGATE treatment team is comprised of a wide variety of professionals, including a psychiatrist, program director, mental health clinician (referred to as the Individual Resiliency Trainer), employment and education specialist, care coordinator, entitlements specialist, nurse, and peer support specialist. Patients who participate in NAVIGATE may meet with their Individual Resiliency Trainer (IRT) as often as weekly, or even more than once a week, depending on their needs. The IRT visits with patients not just in clinical settings, but also in their homes or in communities; sessions can be conducted in-person or through telehealth. The NAVIGATE Individual Resiliency Training Manual is used in every session to help patients learn and practice skills. This training manual includes modules on a wide range of topics, including education about psychosis and how to cope with hallucinations, skills to cope with stress and anxiety, gaining awareness of strengths, focusing on health and wellness, and relapse prevention skills. The psychiatrist can meet with patients as often as monthly, and uses the NAVIGATE prescriber's manual to follow the NAVIGATE model for medication adherence. Patients can meet as often as weekly with their Employment and Education Specialists, Peer Support Specialists, and Care Coordinators. Each week, the entire care team meets to discuss every patient. The IRT and program director also meet on a weekly basis; they review the NAVIGATE model and address any potential problems that have arisen. Support and education for family members and other loved ones is also provided through NAVIGATE. The NAVIGATE Family Education Manual is provided to patients' families and friends to help them learn how to support their loved ones and help them reach their goals.

New Directions:

The New Directions program is implemented at Charleston Dorchester MHC.

The New Directions program is a Coordinated Specialty Care (CSC) treatment program based on the NAVIGATE model. Patients between the ages of 15 and 40 years of age who have been diagnosed with a psychotic disorder, and are new to treatments in the past two years, are eligible to participate in New Directions. This program is designed for patients to graduate within two years. The New Directions treatment team is comprised of a wide variety of professionals, including a psychiatrist, program director, mental health clinician (referred to as the Individual Resiliency Trainer), employment and education specialist, care coordinator, entitlements specialist, nurse, and peer support specialist. Patients who participate in New Directions may meet with their Individual Resiliency Trainer (IRT) as often as weekly, or even more than once a week, depending on their needs. The IRT visits with patients not just in clinical settings, but also in their homes or in communities; sessions can be conducted in-person or through telehealth. The NAVIGATE Individual Resiliency Training Manual is used in every session to help patients learn and practice skills. This training manual includes modules on a wide range of topics, including education about psychosis and how to cope with hallucinations, skills to cope with stress and anxiety, gaining awareness of strengths, focusing on health and wellness, and relapse prevention skills. The psychiatrist can meet with patients as often as monthly, and uses the NAVIGATE prescriber's manual to follow the NAVIGATE model for medication adherence. Patients can meet as often as weekly with their Employment and Education Specialists, Peer Support Specialists, and Care Coordinators. Each week, the entire care team meets to discuss every patient. The IRT and program director also meet on a weekly basis; they review the New Directions model and address any potential problems that have arisen. Support and education for family members and other loved ones is also provided through New Directions. The NAVIGATE Family Education Manual is provided to patients' families and friends to help them learn how to

support their loved ones and help them reach their goals.

PREP:

The PREP program is implemented at Pee Dee MHC.

The Prevention and Recovery in Early Psychosis (PREP) program recognizes that coordinated specialty care is now the standard of care for treating early psychosis. Our program delivers services consistent with the Components of Specialty Care/RAISE core components. We deliver PREP services to individuals 18 – 30 years of age who are experiencing early symptoms of psychosis, including those diagnosed with Schizophrenia, Bipolar Disorder, Schizoaffective Disorder, and Borderline Personality Disorder. Like RAISE, our program provides coordinated specialty care including individual psychotherapy, family support and education programs, medication management, access to supported employment and education services, and case management. Participants agree to engage in at least two of the treatment components. As a result of receiving coordinated specialty care, we have observed that our patients, like those in the RAISE research study, stay in treatment longer and experience greater improvement in their symptoms, interpersonal relationships, and quality of life. They are more involved in work and school than those who received typical care. The multiple treatment components of our coordinated specialty care include: individual or group psychotherapy tailored to a person's recovery goals; family support and education programs; medication management; supported employment and education services; and case management. This CSC program for FEP patients provides five critical functions: (1) access to clinical providers with specialized training in FEP care; (2) easy entry into the FEP program through active outreach and engagement; (3) provision of services in home, community, and clinic settings; (4) acute care during or following a psychiatric crisis by collaborating with our 24-hour mobile crisis team; (5) transition to step-down services with the CSC team or discharge to regular care after 2-3 years depending on the client's level of symptomatic and functional recovery. We hope to add the sixth critical function of assurance of program quality through a formal process of continuous monitoring of treatment fidelity this year.

5. Does the state monitor fidelity of the chosen EBP(s)? ○ Yes ◉ No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? ◉ Yes ○ No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

Strategies for improving patient outcomes vary based on the needs identified by each Community Mental Health Center (CMHC):

Smaller caseloads create opportunities for patients to receive more intensive services (Lexington County CMHC; Charleston Dorchester MHC; Pee Dee MHC).

We offer a variety of ways for patients to meet for appointments (in the office as well as in homes or other settings; in-person and virtually) (Lexington County CMHC; Charleston Dorchester MHC; Columbia Area MHC; Pee Dee MHC).

We offer financial assistance, bus passes, and/or cab vouchers for transportation, to help patients who do not have reliable transportation (Charleston Dorchester MHC; Pee Dee MHC).

We pay for medication if patients are uninsured or cannot afford to pay for the medicine themselves (Charleston Dorchester MHC; Pee Dee MHC).

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

BHDD OMH plans to continue to support the ongoing operations of NAVIGATE, New Directions, and PREP at the CMHCs described above. Block grant funding will be used to pay for personnel expenses (salaries and fringe benefits), indirect costs, trainings for grant-funded staff, patient supplies (including medication and transportation passes), and/or other direct relevant program expenses.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

NAVIGATE: Schizophrenia spectrum newly diagnosed or newly treated in the past two years.

New Directions: Any psychotic disorder newly diagnosed or newly treated in the past two years.

PREP: Psychosis, including Schizophrenia, Bipolar Disorder, Schizoaffective Disorder, and Borderline Personality Disorder.

10. What is the estimated incidence of individuals experiencing first episode psychosis in the state?

Unknown. In the past, BHDD OMH has not calculated or tracked the estimated incidence of individuals with a first episode psychosis. The agency's leadership and IT department are currently exploring strategies to identify the estimated incidence rates.

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

Promotion and outreach for the programs are unique to each Community Mental Health Center (CMHC):

Our center maintains relationships with local hospitals and residential treatment facilities to identify patients who might be

eligible for our program (Lexington County CMHC; Charleston Dorchester MHC; Columbia Area MHC; Pee Dee MHC).

Our center maintains relationships with local detention centers, police departments, and courts to identify patients who might be eligible for our program (Charleston Dorchester MHC; Columbia Area MHC; Pee Dee MHC).

Our center maintains relationships with local private practices and other mental health professionals to identify patients who might be eligible for our program (Pee Dee MHC).

Our center actively reaches out to doctors' offices, including primary care providers, to educate them about the availability of our program (Pee Dee MHC).

Our center actively reaches out to schools and educational providers to educate them about the availability of our program (Lexington County CMHC; Charleston Dorchester MHC; Pee Dee MHC).

Our staff members participate in community task forces or coalitions to educate other organizations about the availability of our program (Pee Dee MHC).

Our center actively reaches out to other catchment areas, programs, and children's services to educate them about our program (Pee Dee MHC).

12. Please indicate area of technical assistance needs related to this section.

We welcome technical assistance related to calculating the estimated incidence of individuals with FEP in the state.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

Not applicable.

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances communication.

These are some of the ways that BHDD OMH engages consumers and their caregivers in making healthcare decisions and enhancing communication:

Offering psychiatric advanced directive information and assistance.

At admission, offering an opportunity to the patient to identify family and other supportive people to be involved in treatment.

At admission, offering an opportunity for the patient to identify any designee(s) to have access to treatment information.

Offering family-based care for children and adolescents in order to facilitate achievement of goals.

Using the Initial Clinical Assessment (ICA), which is strengths-based. It identifies goals, preferences, needs, desired outcomes in numerous dimensions.

Using initial individualized Plans of Care (POCs) with patient and family/support input and involvement, documented collaboratively, and patient signature.

Using POCs to identify discharge/transition parameters for each patient.

Collaboratively completing POC progress summaries at least every 90 days; these may result in updates to POCs.

Focusing services on the whole person, including social, health, living, education, spirituality, employment, etc.

Providing Care Coordinators to help patients learn about options and resources, and linking patients to these resources.

Providing Peer Support Specialists, who use Recovery for Life and WRAP (Wellness Recovery Action Plan) strategies to promote/support balanced lives and skills for patients.

Providing Engagement Specialists, who reach out to patients who miss appointments.

Using Levels of Care - a tool to communicate to patient and families/support movement toward desired outcomes.

Using Collaborative Documentation to ensure patient and families/support contribute to information input into the electronic medical record (EMR).

In addition to the strategies listed above, BHDD OMH offers ways for patients and family members to file complaints and express concerns about services. The BHDD OMH Advocacy Program is designed to prevent patient rights violations and advocate for the provision of quality of care in a humane environment. This program reviews, investigates and resolves complaints or issues related to patient rights, and it monitors the number and types of complaints to identify systemic areas of concern. All BHDD OMH inpatient and outpatient facilities have an assigned advocate. Advocates inform patients about their rights, help them speak for themselves, or speak on their behalf, assist patients with questions and complaints about rights and services, and bring issues to agency officials for resolution. If a patient or a family member has a question or concern regarding rights, an assigned advocate will interview the patient, staff, and others, as necessary. The advocate will then review records, documents, or policies and attempt to negotiate a satisfactory result on behalf of the patient.

4. Describe the person-centered planning process in your state.

In addition to the strategies listed in Question 3 above, BHDD OMH also maintains Patient Advisory Boards (PABs) throughout the state. These advisory boards exist to provide mechanisms for positive collaboration and communication, and to empower patients at all Departmental levels. PABs provide unique and independent opportunities for input and involvement in the areas of planning, policymaking, program evaluation, and service provision. Most states have only a statewide or regional PAB, but BHDD OMH is among only a few state systems that have mandated the establishment of PABs not only at the state level, but also at every BHDD OMH community mental health center and hospital.

It is the mission of BHDD OMH to support recovery initiatives through the development of empowered patient leadership. BHDD OMH also supports recovery through training and education on recovery principles and recovery-oriented practice and systems. These educational initiatives include the role of peers in care; required peer accreditation or certification; block grant funding of recovery support services; measurement of the impact of consumer and recovery community outreach activities; and how to involve people in recovery, their peers, and their family members in planning, implementation, or evaluation of the impact of the mental health system.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as **A Practical Guide to Psychiatric Advance Directives**)?

During the Initial Clinical Assessment (ICA), staff members ask if patients have Psychiatric Advance Directives. If they do, staff members obtain a copy to maintain as part of patient records. If patients does not have Psychiatric Advance Directives and they are interested in developing them, staff members offer patients a list of community resources that can assist them. Alternatively, the patients may be referred to Clinical Care Coordination, and the Care Coordinators may assist the patients. In addition, the BHDD OMH website provides an overview of Psychiatric Advance Directives to educate patients and their families about why these documents are important.

6. Please indicate areas of technical assistance needs related to this section.

No technical assistance is requested.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's program integrity efforts are to promote the proper expenditure of Block Grant funds, improve Block Grant program compliance nationally, and demonstrate the effective use of Block Grant funds

While some states have indicated an interest in using Block Grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 300x-31**, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under **42 U.S.C. § 300x-55(g)**, there are periodic site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

In the life cycle of an MHBG award, related expenditures may be reviewed by any combination of BHDD OMH's Division of Administrative Services, Office of Grants Administration, Office of Budgeting, Accounts Payable, Office of Procurement and Internal Audit, as well as other departments. MHBG expenditures are also subject to the scrutiny of other SC state government agencies, including the Office of the State Auditor, Office of the Comptroller General, and the Materials Management Office.

BHDD OMH has established internal controls sufficient to institute preventive controls - designed to discourage errors or fraud – and detective controls - designed to identify an error or fraud after it has occurred. It is also subject to external controls established by the State of South Carolina. Therefore, BHDD OMH has instituted measures that provide for appropriate separation of duties, assignment of roles and responsibilities to appropriately qualified staff, establishment of sound business practices, and sustainability to a system that ensures proper authorization and recordation of procedures for financial transactions.

BHDD OMH designed a Compliance Program consistent with the procedural and structural guidance provided by the SC Office of Inspector General (SCOIG) of the SC Department of Health and Human Services (SCDHHS) to advance the prevention of fraud, abuse, and waste and the Federal Sentencing Guidelines. The goal of the Compliance Program is to implement a process for the continuous development, implementation, and refinement of internal controls and practices that promote adherence to applicable federal and state laws, identify, address and correct areas of risk, and further relevant policies of the Department, particularly those that support compliance activities. BHDD OMH leadership expects all staff members to conform to the standards of conduct as stated in the Compliance Program's Code of Ethics and Conduct.

The BHDD OMH compliance program is ongoing and educates employees about compliance. It includes lines of communication for dissemination of information related to compliance and for the reporting of suspected violations of federal and state laws and regulations. It also includes a system to investigate allegations of noncompliance. The compliance program regularly monitors and audits activities, and it enforces appropriate conduct and discipline.

BHDD OMH's Quality Management Advisory Committee (QMAC) includes compliance and quality assurance. Compliance promotes and monitors BHDD OMH's adherence to state and federal laws and regulations, as well as to requirements of third-party payors for the delivery and billing of quality services. Quality Assurance establishes methods and procedures to ensure that services provided are of the highest quality; and, systematically monitors performance against established standards for practice and implements actions for improvements as needed to ensure that service delivery is appropriate and meets the needs of BHDD OMH's patients.

BHDD OMH's Compliance Committee is comprised of the state director, the director of Quality Management and Compliance (QMC), and directors of divisions and other key staff of the Department who are responsible for assisting and advising the QMC director in implementing and maintaining the integrity of the Compliance Program and ethical conduct of employees. Committee members are also responsible for the prevention, identification, monitoring, and control of risks in coordination with the director of QMC. BHDD OMH's Compliance Officer provides BHDD OMH leadership with timely and accurate information, so they may make informed judgments concerning compliance with law and business performance.

QMC's primary focus is addressing challenges and opportunities for improving efficiency and effectiveness of the compliance program by: routinely identifying opportunities for improvement in the delivery of services; ensuring the Agency's clinical programs meet the current requirements; and, remaining alert about the ever-changing reimbursement standards for providers of clinical services. Over time, QMC began to broaden its focus to include compliance and identifying opportunities for improvement in the delivery of services.

The Office of Internal Audit at BHDD OMH serves as an independent function to examine and evaluate the office's activities as a service to the BHDD OMH director. Internal Audit's overall objectives are to: evaluate internal controls and safeguard assets; test for compliance with state, federal, and office requirements; identify opportunities for revenue enhancement, cost savings, and overall operational improvements; coordinate audit effects (when requested) with the South Carolina Office of Inspector General, State Auditor's Office, Legislative Audit Counsel, and other external auditors; deter and identify theft, fraud, waste and abuse; and, protect the assets of the state of South Carolina. As a result, the Office of Internal Audit provides analyses, recommendations, counsel, and information about activities or processes reviewed, usually in the form of an audit report.

Beginning in SFY2018, BHDD OMH implemented an oversight procedure for non-profit organizations which are sub-recipients of MHBG funds. The implementation of this procedure was based on a recommendation from SAMHSA. In SFY23, BHDD OMH determined that the non-profit organizations that receive MHBG funds through RFPs are contractors, not subrecipients. Even though these organizations are contractors and not sub-recipients, BHDD OMH still closely monitors the programmatic and fiscal activities of these organizations. The BHDD OMH MHBG Planner is responsible for reviewing invoices submitted by the contractors, ensuring that all programmatic activities align with the stated goals, activities, and budgets provided in the contracts. BHDD OMH retains the right to conduct monitoring visits and review all related documentation during each contract period. However, because these organizations have been categorized as contactors instead of sub-recipients, BHDD OMH does not regularly conduct annual site visits to monitor the organizations.

4. Please indicate areas of technical assistance needs related to this section.

No technical assistance is requested.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

6. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

BHDD OMH provides a wide range of mental health services, treatments, and programs. Services include screenings and assessments, crisis intervention, and individual and group therapy using evidenced-based practices including CBT, TFCBT, AFCBT, DBT, EMDR, and PCIT. PMA and nursing services are provided to monitor and reduce symptoms. Patients are offered PSS and PRS to assist in job placement, linking them to the SC Vocational Rehabilitation Department; patients are provided with support in learning employment skills and other skills to help them maintain stability in their communities. Housing programs assist patients with placement in independent living or other appropriate housing arrangements, and help subsidize rent for some patients. Clinicians assigned to Mental Health Courts provide support and treatments to individuals who are involved in the justice system. The Alliance program operates throughout the state at almost all Community Mental Health Centers; this program embeds mental health professionals with first responder agencies. Clinicians are also embedded at various detention centers and SC Department of Juvenile Justice sites, providing support and treatments to children, adolescents, and adults. The NAVIGATE, New Directions, and PREP programs are implemented at six Community Mental Health Centers; these evidence-based Coordinated Specialty Care (CSC) programs are provided to patients who have experienced First Episode Psychosis (FEP). Family members of FEP patients also receive services through the CSC programs. The office plans to continue all of these services.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	○ Yes ● No
b)	Mental Health	● Yes ○ No
c)	Rehabilitation services	○ Yes ● No
d)	Employment services	○ Yes ● No
e)	Housing services	○ Yes ● No
f)	Educational services	○ Yes ● No
g)	Substance use prevention and SUD treatment services	○ Yes ● No
h)	Medical and dental services	○ Yes ● No
i)	Recovery Support services	● Yes ○ No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	○ Yes ● No
k)	Services for persons with co-occuring M/SUDs	● Yes ○ No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Best practice examples that are provided by BHDD OMH include:
Telepsychiatry
School Mental Health Services
Assessment/Mobile Crisis

Metropolitan Children's Advocacy Center
Child and Family Services
Parent-Child Interaction Therapy
Clinical Care Coordination
Deaf Services
Peer Support Services
Housing and Homeless Services
Individual Placement and Supported Employment Program (IPS)
Trauma Initiative
Dialectical Behavior Therapy
Towards Local Care (TLC)
Jail Diversion/Forensic Services
The Art of Recovery (art project)

3. Describe your state's case management services

The Office of Clinical Care Coordination pursues the goal of improving outcomes for patients and reducing healthcare costs. Care Coordinators help patients find and access resources such as primary care, housing, entitlement programs, etc. Provision of Care Coordination services results in decreased re-hospitalizations and emergency room visits, and increased utilization of primary care physicians. Key features of the service include in-home visits and reporting and monitoring of patients' progress in collaboration with referral sources. A special program under this division is Community Long-Term Care (CLTC). CLTC provides in-home support to participants eligible for nursing home care who opt to remain in their homes. Services may include home-delivered meals, personal care aides, incontinence supplies, adult day care, ramps, pest control, and other similar services. These services are provided to adults with Serious Mental Illnesses and children with Serious Emotional Disturbances.

Care Coordinators provide targeted case management services to qualifying individuals beginning with a comprehensive needs assessment. Medical, dental, housing, employment, education, behavioral, and other community support needs are identified in the needs assessment. Care Coordinators, who are knowledgeable about local community resources, work collaboratively with patients and link them to those resources. Care Coordinators monitor a wide variety of patient services until goals are met and needs are resolved. Clinical Care Coordination services focus specifically on patients' successful transition to community settings and access to needed services. From July 2024 through June 2025, 1,462 patients received services from Clinical Care Coordination, and 1,000 patients received services through the CLTC program.

The office plans to continue these case management services.

4. Describe activities intended to reduce hospitalizations and hospital stays.

BHDD OMH provides a wide variety of services intended to reduce hospitalizations and hospital stays. The office plans to continue all of these services.

Office of Transition Programs:

In 2019, BHDD OMH created the Office of Transition Programs (OTP). OTP provides support and resources for patients as they transition from hospitals to community settings. The Transition Specialists work with patients to determine their recovery needs and their preferences about where to live in the community. They also ensure effective communication between inpatient and outpatient staff members regarding patients' discharge needs and coordinate with all stakeholders (patient, family, clinical care coordinators, certified peer support specialists), streamlining the discharge processes and improving the chance for patients' successful transition into community settings. The Transition Specialists constantly develop and strengthen relationships with community stakeholders to improve housing access and placement for patients. From July 2024 through June 2025, OTP helped 359 patients transition to the community. Fewer than 5% of these patients returned to hospitals after their transitions into community settings.

Mobile Crisis Call Center:

The South Carolina Mobile Crisis Call Center (MCCC), based in Charleston, SC, was first implemented in 2020 by BHDD OMH. The MCCC assists individuals statewide and communicates with community mental health centers in every county to assist with triage and emergency assessment. The call center's responsibility is to triage calls, attempt to deescalate callers in crisis, and dispatch Mobile Crisis teams to mental health crises which are unable to be deescalated and require after-hours response. If immediate response is needed, the call center will contact local emergency services dispatch for individuals across the state to request first responders to respond so individuals can be stabilized until Mobile Crisis teams are able to arrive on scene. In addition to those responsibilities, the MCCC also provides callers with information regarding resources in their community, including alcohol and drug assistance programs, local mental health centers, referrals to 211, and referrals to suicide prevention lifelines. The SC Mobile Crisis Call Center assists BHDD OMH's Mobile Crisis teams by triaging calls, developing safety plans, diverting emergencies, and providing resources to individuals who do not need emergency response. Additionally, the MCCC acts as a bridge for communication between first responders and Mobile Crisis clinicians. First responders can contact the center 24/7 to triage calls, gather information, or request Mobile Crisis response. More information about this program can be found in Question 15.

988 Call Center:

BHDD OMH operates a 988 Suicide and Crisis Lifeline Center. Originally, Mental Health America of Greenville County (MHAGC) operated the sole National Suicide Prevention Call Center in South Carolina. On June 1, 2023, BHDD OMH launched a second 988 Suicide and Crisis Lifeline Center for South Carolina. This statewide call center is operated by Charleston Dorchester Mental Health Center (CDMHC). Callers with SC area codes who are experiencing mental health or suicide crises are assisted by this center. Callers are provided with telephonic crisis intervention services. Third-party callers can also reach out to 988 when they are concerned about people who may need mental health or substance abuse resources in their area. More information about this program can be found in Question 15.

Mobile Crisis Teams:

The Mobile Crisis program provides an extension of BHDD OMH community mental health center services; during business hours, BHDD OMH community mental health centers serve patients by appointment, during walk-in hours, and via phone. Mobile Crisis provides mobile response to patients in the community who cannot, or are unable to, access services; the program is able to provide a mobile response in the community for individuals in crisis who are in need of crisis intervention services when mental health centers are closed. For an on-site response, two-person teams comprised of at least one master's level clinician co-respond with local law enforcement. The team of two may also include a bachelor's level staff person or a peer with lived expertise. More information about this program can be found in Question 15.

Alliance Program:

Alliance provides opportunities for first responders to collaborate with BHDD OMH and better serve community members who are experiencing mental health or behavioral health issues, including crises. Through Alliance, Mental Health Professionals (MHPs) are embedded in law enforcement agencies, fire and rescue departments, 911 dispatch centers, and hospital emergency departments. The MHPs work collaboratively with first responders to identify and support children, adolescents, and families experiencing mental health issues. The MHPs also collaborate with other community agencies to provide information and resources to people in need. They provide mental health screenings, assessments, and crisis interventions, determine the need for inpatient admissions, and make appropriate referrals. MHPs working in hospital emergency departments support the mental health needs of patients, including referrals to community treatment and determining the need for inpatient admission. MHPs who are embedded in law enforcement agencies serve victims of crime, and respond alongside uniformed officers to calls that involve mental health situations; they help provide crisis response and de-escalation. Some Alliance staff are embedded or work closely in detention centers, which are a type of law enforcement agency. MHPs who are embedded at 911 dispatch centers respond to calls that are mental health related; they support dispatchers in determining the appropriate response to calls that may involve mental health crises. More information about this program can be found in Question 15.

FRST Program:

The First Responder Support Team (FRST) provides behavioral health services to all branches of first responders and their families, including firefighters, law enforcement personnel, and paramedics. The FRST Program's mission is to provide behavioral health services in ways that are confidential, accessible, effective, safe and comfortable for all first responders and their families. FRST clinicians provide an array of services designed to meet the needs of first responder personnel and their families including assessment, referrals, short term counseling, trauma-focused therapy, substance abuse treatment, medical consultation, couples counseling and family treatment. Clinicians work with law enforcement agencies, EMS agencies, dispatch centers, and fire houses to teach, train, educate and connect with peers. In addition to providing behavioral health services to the first responders, FRST clinicians are also trained to assist with Critical Incident Stress Debriefings. Critical Incident Stress Management (CISM) is a comprehensive, phase-sensitive, and integrated multi-component approach to crisis/disaster intervention. Through CISM trainings, mental health professionals and first responders learn how to facilitate Critical Incident Stress Debriefings (CISDs), which can be provided one-on-one, in small groups, or in large group formats. CISM's format provides those who have been through a critical incident with opportunities to process traumatic events, as well as receive psychoeducation regarding stress and trauma reactions. CISM has been proven to help participants process traumatic events and prevent stress reactions from developing into PTSD or other serious mental illnesses or disorders. Although CISM is used most often within the first responder community, this practice can also be applied to a community setting after a tragedy, and BHDD OMH also uses CISM to support communities who have experienced workplace violence, traumatic deaths, and prolonged exposure to traumatic stress, etc. FRST clinicians assist with these debriefings as well. More information about this program can be found in Question 15.

Crisis Receiving and Stabilization Facilities:

CRSFs reduce hospitalization by helping people receive services in their communities. CRSFs are generally viewed as a more appropriate and less expensive alternative to hospital emergency departments or inpatient psychiatric hospital units. Currently, BHDD OMH operates two CRSFs, the second CRSF just opened in July 2025. SC's two CRSFs are operated by the BHDD OMH Charleston Dorchester Mental Health Center (CDMHC) on SC's east coast, and the BHDD OMH Columbia Area Mental Health Center (CAMHC) in the central part of the state. BHDD OMH operates two programs that meet many, but not all, of the criteria for CRSFs. A third program will open its doors in the next few months. Because these programs do not provide 24/7 services, they are not categorized as CRSFs. More information about these programs can be found in Question 15.

5. Please indicate areas of technical assistance needs related to this section.

No technical assistance is requested.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	226,328	Not indicated
2.Children with SED	60,316	Not indicated

2. Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

BHDD OMH participates in SAMHSA's Uniform Reporting System (URS). The statewide prevalence rates for adults and children were taken from URS Table 1, a report produced by Hendall for SAMHSA, using the SAMHSA estimation methodology for 2023.

The rate for children was calculated by determining the average rate of the four estimated rates that were provided.

BHDD OMH uses the URS rates in conjunction with data and feedback from its staff members, patient surveys, and community partners, to evaluate and substantiate planning and implementation activities for its mental health system of care.

3. Please indicate areas of technical assistance needs related to this section.

BHDD OMH would welcome technical assistance to help staff better understand which strategies should be used to estimate statewide incidence rates for children and adults, as well as how to estimate the children's statewide prevalence rate.

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

a)	Social Services	○ Yes	● No
b)	Educational services, including services provided under IDEA	○ Yes	● No
c)	Juvenile justice services	○ Yes	● No
d)	Substance use prevention and SUD treatment services	○ Yes	● No
e)	Health and mental health services	○ Yes	● No
f)	Establishes defined geographic area for the provision of services of such systems	● Yes	○ No

2. Please indicate areas of technical assistance needs related to this section.

No technical assistance is requested.

[1] *A system of care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults
Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

BHDD OMH's 16 Community Mental Health Centers (CMHCs), along with their satellite offices and clinics, are strategically located throughout South Carolina. The strategic positioning of these facilities makes it possible for patients and their family members to drive no more than 45 minutes to receive in-person services. However, because transportation in rural areas can be a significant challenge for some people, especially people who are experiencing poverty, BHDD OMH has developed several programs and initiatives to help provide services to people who cannot easily travel to offices or clinics. Each of the initiatives discussed below are especially beneficial for people who live in rural areas with limited transportation or who have limited abilities to travel to providers in urban settings. BHDD OMH plans to continue all of these initiatives.

SC Mobile Crisis:

SC Mobile Crisis is a program created by BHDD OMH in partnership with SC Department of Health and Human Services to enhance SCOMH's crisis services array by providing statewide capacity for on-site, emergency, psychiatric screening, and assessment. Mobile Crisis provides services 24/7/365 in all 46 counties of South Carolina to children, adolescents, and adults. The program's goals are to increase access through linkage to the appropriate level of care for those experiencing psychiatric crises, reduce hospitalizations, and reduce unnecessary emergency department visits and incarcerations. The success of the Mobile Crisis program is built on the foundation of partnerships with local law enforcement, hospitals, judges, community providers, and other mental health providers. The Mobile Crisis program provides an extension of BHDD OMH community mental health center services; during business hours, BHDD OMH mental health centers serve patients by appointment, during walk-in hours, and via phone. Mobile Crisis provides mobile response to patients in the community who cannot, or are unable to, access services; the program is able to provide a mobile response in the community for individuals in crisis who are in need of crisis intervention services when mental health centers are closed. Mobile Crisis teams are able to provide assessment, intervention, and referral for people who are at imminent risk and need to be involuntarily committed to protect themselves or other people. After hours, weekends, and on holidays, teams of two respond in person, remotely via telehealth, or by phone to those experiencing psychiatric emergencies. Mobile Crisis teams, working collaboratively with the detention centers, may provide assessment and crisis intervention services in the jails.

Highway to Hope:

Highway to Hope (H2H) is a mobile response program that serves adults and children in some of the most rural areas of South Carolina. H2H is based on a long-running, highly successful model for rural patients that was first established by SCDMH's Charleston-Dorchester Mental Health Center in 2010. Now, all sixteen of SCDMH's Community Mental Health Centers (CMHCs) operate an H2H program. The program offers mental health treatment, including crisis services, as well as basic primary care services for physical healthcare needs. The healthcare staff make referrals to community resources, as needed. These services are provided within the privacy of RVs, which travel throughout various counties and park in different locations. The RVs are equipped with telehealth equipment, and the healthcare services can be delivered both in-person and virtually. H2H services are available to anyone, just like the services provided at the traditional CMHC locations. However, people who lack transportation receive the most benefit from the H2H program; when they cannot travel far distances to health providers, they can still access mental health and primary care services by visiting an H2H RV. H2H also provides crucially important crisis services for individuals who are experiencing behavioral health crises. Because the RVs are located closer than many hospitals or counseling centers, concerned family members or friends can bring their loved ones to the RVs to receive crisis counseling.

Telepsychiatry Programs:

The Community Telepsychiatry Program (CTP) was established in response to the pressing demand for comprehensive mental health services in rural regions of South Carolina. Since its inception in August 2013, CTP has been providing psychiatric services to BHDD OMH patients throughout the state. Originally designed to mitigate the shortage of mental health providers in rural locales, the program has expanded significantly over the past decade, and now offers telepsychiatry services to 60 centers and satellite clinics statewide, as well as schools across the state. Through its Emergency Department Telepsychiatry Program (EDTP), BHDD OMH currently contracts with more than 25 hospital emergency rooms around the state. The program provides over 5,000 psychiatric consultations per year to emergency room physicians. These consultations are for patients in emergency departments who appear to be experiencing behavioral health crises. Comprehensive consultations are generally provided to consulting ER physicians within four to six hours of a request. BHDD OMH psychiatrists are available 16 hours a day, 364 days a year. The psychiatrists provide diagnoses, treatment recommendations, and detailed clinical reports. The clinical care of the patient, supervision of staff, and prescribing duties remain the responsibility of the ER physicians. EDTP does not offer consultations for

patients on medical floors or in outpatient settings.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

BHDD OMH provides statewide housing units for people with mental illnesses. For approximately 30 years, BHDD OMH has invested agency funds in the development of affordable housing options for people with mental illnesses. There are currently over 1,200 housing units across the state for people with mental illnesses, including developments that are under construction or in planning phase. Proceeds from the sale of the "Bull Street" property are used to fund new housing developments, in partnership with public housing authorities, private non-profit and for-profit organizations. BHDD OMH also partners with SC Housing, developers, and property managers to make patient referrals for new supportive housing units made available through the Low-Income Housing Tax Credit program. To date, over 30 patients have accessed new affordable housing units through this new partnership.

The BHDD OMH Community Housing Rental Assistance Program also provides support to patients in need. This program, launched in 2015, uses more than $2.2 million in state funds annually to provide rental assistance and related housing costs for BHDD OMH patients statewide. All 16 CMHCs have state-funded Community Housing rental assistance programs, ranging in size from four to 42 units.

The Housing and Urban Development (HUD) Continuum of Care Permanent Supportive Housing Program provides another form of housing assistance. BHDD OMH is a recipient of a HUD Continuum of Care (CoC) Permanent Supportive Housing grant that provides almost $390,000 annually for rental assistance for individuals with serious mental illnesses and co-occurring disorders and their families who are experiencing chronic homelessness in Greenville and Spartanburg counties. This program is a partnership with United Housing Connections, the lead agency of the Upstate CoC. BHDD OMH provides a state match of $60,000 for this grant. More than $260,000 from two other CoC grants serve this population in Richland and Lexington Counties in the midlands area of the state. These programs will continue through 2026.

BHDD OMH is also a recipient of the SAMHSA Projects for Assistance in Transition from Homelessness (PATH) grant. This grant provides almost $700,000 in PATH funds for outreach and clinical services for people with serious mental illnesses and co-occurring disorders who are experiencing homelessness in the Columbia, Greenville, and Myrtle Beach areas. BHDD OMH currently funds three provider agencies through the PATH grant: Mental Illness Recovery Center, Inc., the BHDD OMH Greater Greenville Mental Health Center, and the BHDD OMH Waccamaw Center for Mental Health. SCOMH plans to issue a new solicitation in 2026 to award new contracts for this grant.

The SOAR (SSI/SSDI Outreach, Access, and Recovery) Initiative provides support to people who are risk of homelessness. BHDD OMH serves as the lead agency for this initiative, and partners with the Social Security Administration, SC Disability Determination Services, other state agencies, and local community organizations to implement this program. SOAR is a SAMHSA best practice that increases access to SSA disability programs for eligible individuals with serious mental illnesses who are experiencing or at risk of homelessness.

BHDD OMH plans to continue all of the housing and homelessness outreach services and programs described above.

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

BHDD OMH's 16 Community Mental Health Centers (CMHCs), along with other outpatient programs and inpatient facilities, offer services for people of all ages, including older adults. Two CMHCs provide special programs for older adults. Both of the CMHCs plan to continue these programs.

Silver Years Program at Pee Dee MHC:

Silver Years is an Older Adult Day Treatment Program in Florence. The program is designed to provide intensive outpatient services to adult with symptoms of early dementia/Alzheimer's disease in addition to mental illness. It is a structured and closely supervised clinical treatment service which focuses on therapeutic activities for individuals age 50 and older. Specialized services are provided in a group session with the intention of providing mental health services and emotional support to help each individual with creating and maintaining strong social relationships, effectively cope with painful experiences and rediscover individual strengths.

Service provided within the program include adult clinical day treatment, psychiatric medical assessment, medication monitoring, assessment/crisis management, psychosocial rehabilitation services, individual therapy and supportive services for families. The services are provided by a collaborative team of medical staff, program coordinators, and clinical counselors who are certified Dementia Specialist.

Elder Services Program at Santee Wateree CMHC:

The Elder Services Program provides staff who are trained in and sensitive to the needs of older patients. A staff psychiatrist oversees all client services. Staff work closely with each person's personal physician and other community and support agencies to ensure the highest quality of care. Staff work with the "whole person," not just a piece of the puzzle. Some of the services

provided include: full cognitive assessments; psychiatric assessments for treatment planning, medication interventions and management, and medical referrals as needed; individual, family, and group counseling; medication monitoring by nurses; and case management to assist patients in accessing both mental health and appropriate health and social services.

d. Please indicate areas of technical assistance needs related to this section.

see attached PDF

[1] **https://www.samhsa.gov/homelessness-programs-resources**

[2] **https://www.samhsa.gov/resources-serving-older-adults**

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

1. Describe your state's management systems.

BHDD OMH provides a comprehensive Staff Development and Training Program to help staff members meet regulatory and accrediting standards. This program is housed in the Office of Education, Training and Research (ETR). In order to minimize travel to and from Columbia, BHDD OMH provides online trainings for staff. Tailored curricula have been developed for staff who provide care to meet the special needs of our patients. Other online resources are made available for staff. Free or low-cost continuing education credits (CEUs) are offered for many trainings. Staff receive notifications about upcoming trainings and educational opportunities on a monthly basis; they are encouraged to participate in these CEU opportunities online as time permits.

BHDD OMH's clinical team, comprised of physicians, nurses, social workers, and psychologists, provides diagnostic and therapeutic services for patients. The skills of the clinical staff enhance patient care throughout this unified system of care. BHDD OMH understands that the single most important service the agency provides is compassionate care that respects each patient's dignity and individuality. Clinical staff serve in a variety of inpatient and outpatient care areas throughout the state, affording them the opportunity to use their full range of skills. BHDD OMH recognizes that collaboration is invaluable in providing the best possible care to our patients. As such, staff members are encouraged to pursue and participate in research opportunities.

The Education, Training and Research (ETR) Program is implemented under the guidance of the Office of Quality Management and Compliance. ETR provides education and training for all of BHDD OMH using traditional classroom approaches as well as an online learning management system. Virtual trainings are provided for CMHCs and facilities outside of Columbia. These virtual trainings help BHDD OMH reduce travel expenses, and allow staff members to remain on site so they can be available to patients before and after the trainings. This enhances their abilities to continue to provide important services to patients in a timely manner. All of the ETR trainings are evaluated by class participants; the results are used to improve existing trainings or create new trainings to meet needs identified by the participants. Most of the ETR trainings are facilitated by BHDD OMH staff members; this helps reduce expenses.

The following trainings and educational opportunities are provided by ETR.

Supervisory Miniseries:
This training is designed for individuals in BHDD OMH who were promoted to a supervisory role, as well as new hires who will be in a supervisory role. This program is offered virtually and in person. The program consists of a five-part series based on identified needs of class participants and/or their supervisors.

Mentoring/Succession Program:
This ten-month program is designed for individuals who demonstrate potential for leadership positions in the Office of Mental Health. Each participant is assigned a mentor. Participants spend one day in class and another day each month working with their mentor. Participants must attend all classes and complete all the written assignments to graduate.

Executive Leadership Development Program:
Designed for individuals in BHDD OMH who might serve in Executive Leadership roles in the future, this program was implemented in 2008 and is held on an as-needed basis. Class participants are required to complete a written Management Improvement Project. The purpose of this project is to give the program candidates the opportunity to use this experience to identify an area in BHDD OMH for targeted improvement and formulate a document about the improvement for all class participants. The project is required to focus on methods to create a new management initiative or improve or add value to one that is already in place in BHDD OMH.

Psychiatric Grand Rounds:
Designed for physicians and other clinical staff, this program is offered monthly on a virtual basis. Participants receive continuing education credit that they can use toward re-licensure. The topics are selected based on needs identified by management and staff members. Developed in collaboration with the faculty of the University of South Carolina School of Medicine-Prisma Health-Midlands and the Department of Neuropsychiatry and Behavioral Science at the University of South Carolina School of Medicine.

Continuing Education Offerings:
ETR provides Continuing Medical Education (CME) for physicians. ETR also provides Continuing Education for Social Workers (SW), Licensed Professional Counselors (LPC) and Marriage & Family Therapist's (MFT). BHDD OMH is also an approved provider of Continuing Nursing Education through the South Carolina Nurses Association. The number of hours awarded depends on the program offering. In order to receive continuing education credit for programs, the programs must meet specific criteria and an application requesting the credit must be completed and approved prior to the event. These credits can be used by staff to meet

the requirements for re-licensure at no cost to them.

On-Line Learning Modules:
BHDD OMH has an Online Learning Management System which staff use to take trainings required to meet regulatory and accrediting standards. All learning modules are designed and created in-house by topic experts. If the modules were not available staff would be required to attend the training in person. This would greatly reduce the availability of clinical staff to provide important services to patients.

Psychiatric Residency/Fellowship Training Programs:
BHDD OMH has a long-standing agreement with Prisma Health for psychiatric residents to rotate in Prisma facilities to gain hands-on psychiatric experience. There are four residency/fellowship training programs at the School of Medicine: General Psychiatry, Child and Adolescent Psychiatry, Forensics, and Geropsychiatry. All use BHDD OMH facilities or CMHCs as part of their clinical rotation. BHDD OMH clinical psychiatrists provide supervision to residents. This program has proven to be an excellent recruiting tool for the agency as psychiatrists are in high demand nationwide. ETR provides orientation to all residents who rotate in BHDD OMH facilities or CMHCs.

Nursing Orientation & Training:
Nursing is a large and integral part of BHDD OMH. Nurses have very stringent training requirements to meet regulatory and accrediting standards. ETR provides an extensive and in-depth classroom orientation for all new hires in nursing. ETR also provides annual competency verification of all nursing staff. This is an accrediting standard to ensure that staff remain qualified to perform the essential elements of their job duties. Nursing staff must take and pass written tests and demonstrate the ability to perform identified nursing skills in order to be deemed competent to perform their job duties.

Certified Public Manager Program:
Employees of BHDD OMH also participate in the South Carolina Certified Public Manager (CPM) Program. CPM is a "Nationally Accredited management development program for managers and supervisors in South Carolina state government. The program was initially accredited by the National CPM Consortium in 1996 and was reaccredited in 2006, 2011 and 2016. “The South Carolina Certified Public Manager (CPM) Program is a nationally accredited management development program for managers and supervisors in South Carolina state government. The program was initially accredited by the National CPM Consortium in 1996 and was reaccredited in 2016. Philosophically, the South Carolina CPM Program strives to encourage innovative management practices and high ethical standards. The mission of the CPM Program is to provide quality training for public administrators, to assist agencies in developing future leaders, and to recognize management as a profession in the public sector. The CPM Program promotes on-the-job application of learning and gives participants experience in solving agency problems.”

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access the federal resource guide **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.**

2. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

BHDD OMH has been providing telehealth services since 1996 in a wide range of settings, from inpatient treatment to community care settings. BHDD OMH currently has five telepsychiatry programs: Emergency Department Telepsychiatry, Community Telepsychiatry, Inpatient Services Telepsychiatry, School Mental Health and Telepsychiatry, and Nursing Home Telepsychiatry. Established, robust supervision practices and a peer consultation regimen helps ensure the highest standards of care for patients and their families. These telepsychiatry programs can be especially beneficial for people who live in rural areas with limited transportation or abilities to travel to psychiatrists in urban settings.

To better evaluate patient outcomes for BHDD OMH patients of the ED Telepsychiatry and Community Telepsychiatry programs, BHDD OMH plans to track a subset of BHDD OMH patients who visit emergency departments and follow up with treatment at their local Community Mental Health Center (CMHC). Since BHDD OMH provides services in both locations, it is possible to track administrative data for patients by analyzing select information from the electronic health record (EMR), which is shared among all BHDD OMH locations. The CMHC appointment kept rate following ED visits, timeliness of follow up care in the CMHCs, and ED readmission rates are three examples of possible metrics that can be used. Using a single EHR for both Emergency Department

and Community Telepsychiatry helps increase data transparency. Compared to most other states, South Carolina has an unusual behavioral health infrastructure, because BHDD OMH covers the state through the network of ED hospital partnerships and CMHCs or satellite clinics in every county.

The administrative data at the patient level does not include patient experience data or direct measures of effectiveness of care. Nonetheless, patient outcome data analysis may support process reform, including healthcare delivery improvements and actionable insights for improved health care access and continuity of care among BHDD OMH treatment settings. The patient data will be limited to medium- and short-term outcomes only. Long-term outcomes are possible but may be beyond the scope of this initial inquiry. However, long term outcomes may be studied with the existing data set given sufficient resources.

The BHDD OMH EHR provides interoperability by integrating data. One advantage of BHDD OMH's integrated system is the opportunity to improve care transitions and exchange data seamlessly in the EHR. With this system, BHDD OMH has the essential ingredients for better patient outcomes measurement.

State specific patient outcome data suggests that there is an opportunity for further research regarding healthcare quality and disparities in South Carolina. BHDD OMH's EHR includes demographic information on patients, which could support this possible research. In addition, state-specific patient outcome data better informs efforts to prioritize initiatives.

The EHR provides a longitudinal patient data set that could be used to compare trend data among multiple population groups. For example, the data could be used to examine the percentage of referrals to inpatient care in rural emergency departments for adult women by ethnic group from 2013-2023. Research topics may be chosen to delve into timely policy issues, chosen according to administration and agency priorities.

BHDD OMH's Community Telepsychiatry program, in partnership with other child-serving state agencies, is currently developing a panel of child and adolescent psychiatrists to help increase access to care. This panel will act in concert with existing telepsychiatry services at all 60 CMHCs and satellite county clinics statewide. The Community Telepsychiatry program has provided psychiatric treatment services to BHDD OMH patients since August 2013. Almost exclusively (99%), the Community Telepsychiatry program service codes are for psychiatric medical assessment.

Another example of cross-agency collaboration in Community Telepsychiatry to further health equity is BHDD OMH's partnership with the SC Department of Juvenile Justice (SCDJJ) to provide child telepsychiatry services to DJJ minors with mental health concerns. This partnership helps address the mental health needs of children involved with the juvenile justice system. To facilitate evaluation and treatment, there is an Advanced Practice Register Nurse on site at SCDJJ to support the BHDD OMH child and adolescent psychiatrist.

To "meet patients where they are" the Highway to Hope (H2H) Outreach Program provides telehealth services and telepsychiatry. H2H serves patients at local businesses and community organizations statewide and RV mobile clinics are available through all 16 CMHCs. The mobile clinical care team includes an adult mental health professional, child mental health professional, a registered nurse, and a nurse practitioner. Telepsychiatry services are available in all of the H2H vehicles.

BHDD OMH's Emergency Department (ED) Telepsychiatry program has 24 hospital partners across the state, and is constantly in the process of adding new partners. Psychiatric care is available through the ED program 17 hours per day, 365 days per year.

3. Please indicate areas of technical assistance needs related to this section.

No technical assistance is requested.

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Footnotes:

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

1. Briefly describe the SMHA 's data collection and reporting system and what level of data are reported currently (e.g., at the client, program, provider, and/or other levels).

South Carolina currently uses three different EMR systems to collect outpatient and inpatient data. The main outpatient EMR data system is referred to as Outpatient EMR, and was internally developed by agency staff members. A second outpatient data system, called CIS, is used to collect and report on administrative and billing data. CIS interfaces with both the outpatient and inpatient EMR systems in several areas vital to agency business needs. CIS is the system currently used to capture and store most of SAMHSA's required data elements for the block grant.

The inpatient EMR data system is software named Avatar; this software is provided by a vendor named Netsmart, Inc. This software is used to document clinical care and health data for the agency's patients served through its inpatient service delivery system. This software was implemented with a rolling go-live beginning in February 2017. Prior to Avatar, all patient data and health information was documented in a paper record.

Currently, BHDD OMH is transitioning to a new community Electronic Health Record (EHR) system; this new EHR is the outpatient version of Avatar. It will be referred to as Avatar NX. It is also provided by the same vendor (Netsmart, Inc) responsible for the inpatient EMR. This new system is expected to greatly enhance continuity of care between the outpatient and inpatient facilities. Leadership anticipates that Avatar NX will be fully implemented, statewide, by October 2025. The new EHR is being introduced in stages across the state's regions to ensure that adequate staff training and technical problem identification/resolution are addressed in ways that minimize disruptions to patient care documentation.

Together these data collection systems provide reporting capabilities that meet a variety of internal business and external stakeholder reporting needs. Data from these systems can be used to create reports at the patient, program, provider, and system level.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

South Carolina's current system exclusively collects data from mental health services provided in both inpatient and outpatient settings provided by the SMHA.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

South Carolina's Revenue and Fiscal Affairs Agency maintains a data warehouse that agencies submit various types of administrative data to on a reoccurring basis. The warehouse uses common demographic identifiers to assign a unique person ID based on a probabilistic matching technique. The ID assignment allows users to link data across agencies to answer a variety of questions that focus on how individuals interact with multiple state systems.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

South Carolina's current electronic health record system does not use a strategy to measure program participation or service delivery that could be used to provide a state-level snapshot of these types of information. The current electronic health record system uses office and location codes that were originally designed to track staff time and service provision for historical cost reporting needs. These codes are maintained at a local level and are used in ways that do not provide the ability to drill down to program participation and service delivery with the accuracy required for state level reporting needs. Staff at the state agency (primarily the Block Grant Planner) currently work in tandem with local provider staff to collect these data outside of our electronic health record in order to meet SAMSHA's emphasis on data collection for these areas.

5. Briefly describe the limitations of the SMHA 's existing data system.

South Carolina's administrative and electronic health record data systems have historically emphasized data collection needed for reimbursement from public and private third-party payment sources (ex. Medicaid and Private Insurance Companies). The current system was designed and is currently maintained by an in-house development team. Competing needs and limited staff have often impacted that system's ability to meet multiple revision needs. As a consequence, shifting data collection priorities have had the result of emphasizing new data collection practices at the expense of maintaining an equal emphasis on older administrative data collection tools. Additionally, no staff position currently maintains a comprehensive training program or data collection manual that can be referenced for continuous quality improvement needs.

6. What strategies are being employed by the SMHA to enhance data quality?

South Carolina is currently implementing a new outpatient electronic health record using the same vendor that is responsible for its inpatient electronic medical record. The implementation has included efforts to capture all SAMHSA required CLD and URS reporting needs. All other known external and internal data collection and reporting needs have been reviewed and considered as part of the information gathering and implementation process. Quality improvement efforts associated with the implementation will be coordinated by internal staff at the SMHA who have been trained in forms design for data collection revision, administrative maintenance for monitoring ongoing system change needs, and data access for reporting needs. These strategies will be used to ensure that timely and accurate information can be shared with internal staff and external stakeholders.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

No barriers have been identified at this time. Staff will begin testing data collection and sharing strategies shortly after the new health record implementation begins in the Fall of 2025.

8. Please indicate areas of technical assistance needs related to this section.

No technical assistance is requested at this time.

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Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system has the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

A. "Someone to Talk To": Crisis Call Centers

BHDD OMH operates two statewide crisis call centers. Both call centers are operated by the Charleston Dorchester Mental Health Center (CDMHC), which is located in Charleston, SC.

1. South Carolina Mobile Crisis Call Center:

The South Carolina Mobile Crisis Call Center (MCCC), based in Charleston, SC, was first implemented in 2020 by BHDD OMH. MCCC is operated by Charleston Dorchester Mental Health Center (CDMHC). MCCC answers all calls that are submitted through the state crisis number (833-364-2274), regardless of the time of day. However, during business hours, many law enforcement agencies directly call their local CMHCs instead of calling the state number. In these situations, the CMHCs will deploy their Mobile Crisis Teams without involving MCCC. During non-business hours, MCCC responds to all calls submitted through the state number as well as any calls directly from law enforcement agencies. MCCC acts as a bridge for communication between first responders and Mobile Crisis clinicians. First responders can contact the center 24/7 to triage calls, gather information, or request Mobile Crisis response.

MCCC assists individuals statewide and communicates with community mental health centers in all 46 counties to assist with triage and emergency assessment. MCCC's responsibility is to triage calls, attempt to de-escalate callers in crisis, and dispatch Mobile Crisis teams to mental health crises which are unable to be de-escalated and require after-hours response. If immediate response is needed, the call center will contact local emergency services dispatch for individuals across the state to request first responders to respond so individuals can be stabilized until Mobile Crisis teams are able to arrive on scene. In addition to those responsibilities, MCCC also provides callers with information regarding resources in their community, including alcohol and drug assistance programs, local mental health centers, referrals to 211, and referrals to suicide prevention lifelines. Hospitals and ERs throughout the state are also able to contact MCCC and receive mental health history information about patients; this type of information includes medication information and the most recent appointments with patients' psychiatrists or counselors. This information is shared for continuity of care purposes, to ensure patients receive safe comprehensive, well-informed care.

Operations and administrative oversight, as well as supervision of the call center staff, are the responsibility of the Charleston Dorchester Mental Health Center (CDMHC).

2. 988 Suicide and Crisis Lifeline Centers:

There are two 988 Call Centers in South Carolina.

BHDD OMH also operates a 988 Suicide and Crisis Lifeline Center. Originally, Mental Health America of Greenville County (MHAGC) operated the sole National Suicide Prevention Call Center in South Carolina. On June 1, 2023, BHDD OMH launched a second 988 Suicide and Crisis Lifeline Center for South Carolina. This statewide call center is operated by Charleston Dorchester Mental Health Center (CDMHC). Callers with SC area codes who are experiencing mental health or suicide crises are assisted by this center. Callers are provided with telephonic crisis intervention services. Third-party callers can also reach out to 988 when they are concerned about people who may need mental health or substance abuse resources in their area.

Currently, the 988 center at CDMHC is in Phase 1 of its 988 rollout, and only provides telephonic services; chat and text services will be launched as soon as possible. 988 callers are given the opportunity to participate in a follow-up care program; if they choose this service, the 988 center will schedule follow-up calls with the callers. The follow-up calls will connect the participants to care and secondary referrals, as well as address any barriers to care through referral sources.

B. "Someone to Respond": Mobile Crisis Teams

The Mobile Crisis Team program provides an extension of BHDD OMH community mental health center services; during business hours, BHDD OMH community mental health centers serve patients by appointment, during walk-in hours, and via phone. Mobile Crisis provides mobile response to patients in the community who cannot, or are unable to, access services; the program is able to provide a mobile response in the community for individuals in crisis who are in need of crisis intervention services when mental health centers are closed. Mobile Crisis teams are able to provide assessment, intervention, and referral for people who are at imminent risk and need to be involuntarily committed to protect themselves or other people. After hours, weekends, and on holidays, teams of two respond in person, remotely via telehealth, or by phone to those experiencing psychiatric emergencies. Mobile Crisis teams, working collaboratively with the detention centers, may provide assessment and crisis intervention services in the jails.
For an on-site response, two-person teams comprised of at least one master's level clinician co-respond with local law enforcement. The team of two may also include a bachelor's level staff person or a peer with lived expertise. Mobile Crisis teams are dispatched by the BHDD OMH Call Center, which is operated by the Charleston Dorchester Mental Health Center (CDMHC). Referral calls are received from individuals in crisis, law enforcement and other first responders, and third-party callers including family or community providers and the 988 Suicide and Crisis Lifeline Network.

Other "Someone To Respond" Initiatives: Alliance Program and FRST Program

Two other programs provide services for people who may be in crisis. These two programs are separate from Mobile Crisis Teams.

Alliance Program:

Alliance provides opportunities for first responders to collaborate with BHDD OMH and better serve community members who are experiencing mental health or behavioral health issues, including crises. Through Alliance, Mental Health Professionals (MHPs) are embedded in law enforcement agencies, fire and rescue departments, 911 dispatch centers, and hospital emergency departments. The MHPs work collaboratively with first responders to identify and support children, adolescents, and families experiencing mental health issues. The MHPs also collaborate with other community agencies to provide information and resources to people in need. They provide mental health screenings, assessments, and

crisis interventions, determine the need for inpatient admissions, and make appropriate referrals. MHPs working in hospital emergency departments support the mental health needs of patients, including referrals to community treatment and determining the need for inpatient admission. MHPs who are embedded in law enforcement agencies serve victims of crime, and respond alongside uniformed officers to calls that involve mental health situations; they help provide crisis response and de-escalation. Some Alliance staff are embedded or work closely in detention centers, which are a type of law enforcement agency. MHPs who are embedded at 911 dispatch centers respond to calls that are mental health related; they support dispatchers in determining the appropriate response to calls that may involve mental health crises.

First Responder Support Team (FRST):

The First Responder Support Team (FRST) provides behavioral health services to all branches of first responders and their families, including firefighters, law enforcement personnel, and paramedics. The FRST Program's mission is to provide behavioral health services in ways that are confidential, accessible, effective, safe and comfortable for all first responders and their families. FRST clinicians provide an array of services designed to meet the needs of first responder personnel and their families including assessment, referrals, short term counseling, trauma-focused therapy, substance abuse treatment, medical consultation, couples counseling and family treatment. Clinicians work with law enforcement agencies, EMS agencies, dispatch centers, and fire houses to teach, train, educate and connect with peers. This clinical team understands the public nature of first responder positions and offers services in a highly confidential environment; FRST services are offered in locations separate from BHDD OMH facilities. In addition to providing behavioral health services to the first responders, FRST clinicians are also trained to assist with Critical Incident Stress Debriefings. Critical Incident Stress Management (CISM) is a comprehensive, phase-sensitive, and integrated multi-component approach to crisis/disaster intervention. Through CISM trainings, mental health professionals and first responders learn how to facilitate Critical Incident Stress Debriefings (CISDs), which can be provided one-on-one, in small groups, or in large group formats. In the first responder community, having a team comprised of both MHPs and peer support staff increases the effectiveness of the interventions. CISM's format provides those who have been through a critical incident with opportunities to process traumatic events, as well as receive psychoeducation regarding stress and trauma reactions. CISM has been proven to help participants process traumatic events and prevent stress reactions from developing into PTSD or other serious mental illnesses or disorders. Although CISM is used most often within the first responder community, this practice can also be applied to a community setting after a tragedy, and BHDD OMH also uses CISM to support communities who have experienced workplace violence, traumatic deaths, and prolonged exposure to traumatic stress, etc. FRST clinicians assist with these debriefings as well.

C. "Somewhere to Go": Crisis Receiving and Stabilization Facilities

CRSFs reduce hospitalization by helping people receive services in their communities. CRSFs are generally viewed as a more appropriate and less expensive alternative to hospital emergency departments or inpatient psychiatric hospital units.

While BHDD OMH has successfully implemented two statewide crisis call centers and a statewide mobile crisis team program, there are still many opportunities for improvement related to Crisis Receiving and Stabilization Facilities (CRSFs). Currently, BHDD OMH operates two CRSFs. The second CRSF just opened its doors in July 2025. SC's two CRSFs are operated by the BHDD OMH Charleston Dorchester Mental Health Center (CDMHC) on SC's east coast, and the BHDD OMH Columbia Area Mental Health Center (CAMHC) in the central part of the state.

1. Tri-County Crisis Stabilization Center at Charleston Dorchester Mental Health Center (CDMHC):

The Tri-County Crisis Stabilization Center (TCSC) is operated by the Charleston Dorchester Mental Health Center (CDMHC). Established in 2017, TCSC is a 10 bed, voluntary, short-term facility for adults, with the primary focus of stabilizing psychiatric symptoms. The target population is people who are experiencing symptoms significant enough that they need more than outpatient services can provide, but not quite to the level of inpatient treatment. Many of these individuals have historically ended up in the local EDs, and this program is designed to route them to a more appropriate level of care, when possible. For someone to be admitted to the unit, they must be experiencing psychiatric symptoms, willing for admission and participation in treatment, medically stable, and able to perform ADLs. Patients can have co-occurring substance use disorders, but can't currently be under the influence of substances or in need of medical detox. The staff consists of masters prepared clinicians, bachelor's level clinicians, a nurse on each shift, and a psychiatrist who rounds on the facility each morning and is available by phone 24/7. The treatment services consist of group therapy, individual therapy, nursing services, assessment for medications by a psychiatrist, and psychosocial rehabilitation services. Since the average length of stay is 3-5 days, the clinical programming is intensive and requires patient participation throughout the day. We focus on what led to their current crisis, how to stabilize their symptoms, and how to set up skills and support systems to prevent this sort of crisis in the future. A part of this support system includes linking them to follow-up with the appropriate outpatient treatment when they are discharged.

2. Midlands Crisis Stabilization Unit:

The Midlands Crisis Stabilization Unit (MCSU) is operated by the Columbia Area Mental Health Center (CAMHC). Opening its doors in July 2025, MCSU is a 9-bed, voluntary, short-term facility for adults, with the primary focus of stabilizing psychiatric symptoms. The target population is people who are experiencing symptoms significant enough that they need more than outpatient services can provide, but not quite to the level of inpatient treatment. Many of these individuals have historically ended up in the local EDs, and this program is designed to route them to a more appropriate level of care, when possible. For someone to be admitted to the unit, they must be experiencing psychiatric symptoms, willing for admission and participation in treatment, medically stable, and able to perform ADLs. Patients can have co-occurring substance use disorders, but cannot currently be under the influence of substances or in need of medical detox. The staff consists of masters prepared clinicians, bachelors level clinicians, a nurse on each shift, and a psychiatrist who makes rounds in the facility each morning and is available by phone 24/7. The treatment services consist of group therapy, individual therapy, nursing services, assessment for medications by a psychiatrist, and

psychosocial rehabilitation services. Since the average length of stay is 3-5 days, the clinical programming is intensive and requires patient participation throughout the day. MCSU staff members focus on what led to the patients' current crises, how to stabilize their symptoms, and how to set up skills and support systems to prevent these types of crises in the future. A part of this support system includes linking the patients to follow-up services with appropriate outpatient treatments when they are discharged.

Facilities Similar to CRSFs:

BHDD OMH also operates two programs that meet many, but not all, of the criteria for CRSFs, and a third program will open its doors in the next few months. Because these programs do not provide 24/7 services, they are not categorized as CRSFs.

1. The Eubanks Center at Spartanburg Area Mental Health Center (SAMHC):

Named after the late Judge Ray C. Eubanks Jr., this program presents a supportive "living room" drop-in center where individuals experiencing heightened mental health symptoms can receive immediate peer support assistance. Established in 2019, the center is staffed and operated by BHDD OMH's Spartanburg Area Mental Health Center (SAMHC) in space donated by the Spartanburg Regional Healthcare System. The program has shown to be an effective alternative to emergency department visits for mental health crises. The Eubanks Center: provides individuals with mental illnesses an additional support system outside of clinical settings, and includes Peer Support Specialists, a clinician, and a care coordinator who works in conjunction with SAMHC's CCBHC pilot program. The Peer Living Room is uniquely designed to reduce the stigma of getting support for mental health symptoms by providing services in a home-like setting for anyone in the community, age 16 and older. Services are provided by certified peer support specialists. These specialists are active in their own mental health recovery and certified to provide support through strength-based approach. Hope, empathy, and respect are some of the guiding principles modeled at the Peer Living Room. These peer-to-peer interactions provide a safe place in times of mental health crisis. The program offers relapse prevention through individual and group appointments.

2. The CAFÉ through Project FOCUS (Family Options in Cherokee, Union, and Spartanburg Counties) at Spartanburg Area Mental Health Center (SAMHC):

Project FOCUS is a program that serves children and youth, ages 0-21, who have a serious emotional disturbance (SED). Their families are also served by this program. Project FOCUS provides services in three contiguous counties: Cherokee, Union, and Spartanburg. The Child and Family Engagement Center (CAFÉ), located in Spartanburg County, serves as a crisis diversion location for Project FOCUS. This location was where the greatest need was identified, based on the numbers of children that were often waiting in the hospital due to behavioral health crises. Along with crisis intervention services, the CAFÉ provides screenings, assessments, individual and group therapy, intensive in-home services, respite services, peer support and family/parental peer support services for children and youth ages 0-21 along with their families. The CAFÉ (Child, Adolescent, and Family Engagement Center) promotes the FOCUS project mission to provide culturally competent, evidence-based practices while ensuring meaningful participation from patients and their families. FOCUS aims to serve children, youth, and their families from diverse backgrounds and improve overall behavioral health outcomes for patients with SED who are experiencing crises. FOCUS clinicians are trained in a variety of Evidence Based Practices (EBPs) such as Motivational Interviewing, Cognitive Behavioral Therapy (CBT), Trauma-Focused CBT, Attachment Bio-Behavioral Catchup (ABC) and Multidimensional Family Therapy (MDFT) and Parent-Child Interaction Therapy (PCIT). These services are also accessible in the Cherokee and Union locations. The first floor of the CAFÉ, referred to as the Eubanks Center, is where nursing services are provided for those who may walk in. Telehealth services are also available for those in the Cherokee and Union areas. Services provided on the first floor include a comprehensive assessment, initial medication regime, and regular monitoring visits for medication. The array of services provided via the FOCUS project positively impact the lives of children, adolescents, and their families in the upstate region in South Carolina.

3. The Living Room program (LRP) at Aiken Barnwell MHC (ABMHC):

This program is designed as a response to community needs for mental health services outside of emergency room settings. The LRP will be for individuals in need of a crisis respite program with services and support designed to proactively divert crises and break the cycle of psychiatric hospitalization. The LRP will provide a safe, inviting, home-like atmosphere where individuals can calmly process crisis events as well as learn and apply wellness strategies to help prevent future crisis events. Hope, empathy and respect are some of the guiding principles modeled at the Peer Living Room. Staffing for this program includes a mental health professional, a peer support specialist, and a care coordinator.

This program is still in the process of being created; ABMHC anticipates opening its doors in fall 2025 or early 2026. 2025 Block Grant Crisis Services set-aside funding was allocated to support this program.

Additional "Somewhere to Go" Initiatives:

In addition to the three non-CRSF facilities discussed above, South Carolina also has several department specialized units, as well as an emergency transportation program.

Emergency Department Specialized Behavioral Health Units:

In June 2023, the South Carolina Department of Health and Human Services (SCDHHS) announced that it was awarding one-time infrastructure grants worth more than $45 million to 13 hospitals throughout the state. These grants will result in the establishment of specialized behavioral health units to respond to individuals who experience behavioral health crises. These units are based on a "no exclusion" philosophy and will be

designed to have environments that feel calm and safe. The units must adhere to an Emergency Psychiatric Assessment, Treatment & Healing (EmPATH) philosophy. Once completed, the units will provide 24/7 services, and will be staffed by multi-disciplinary teams. Five hospitals now have operational EmPath units; the other eight hospitals' units are under construction:

• AnMed Health Medical Center (EmPath unit is active; start date is unknown)
• Beaufort Memorial Hospital
• Grand Strand Medical Center
• Hampton Regional Medical Center
• Lexington Medical Center (EmPath unit is active; unit was started in fall 2024)
• McLeod Regional Medical Center
• MUSC Health, Kershaw Medical Center
• MUSC Health, Orangeburg Medical Center
• MUSC Health, University Hospital
• MUSC Shawn Jenkins Children's Hospital (EmPATH unit is active; unit was started in spring 2025)
• Prisma Health Oconee Memorial Hospital (EmPath unit is active; start date is unknown)
• Prisma Health Tuomey Hospital
• Trident Medical Center (EmPATH unit is active; unit was started in spring 2024)

BHDD OMH already partners with 11 of these 13 hospitals, and looks forward to collaborating with the hospitals when their EmPath units are launched.

Hospital Transportation Program:

Several years ago, the South Carolina General Assembly directed BHDD OMH to create a program using a private contractor as an alternative to law enforcement for the transport of non-violent adult patients who have been determined by a licensed physician to need an involuntary emergency psychiatric hospitalization. The program covers the entire state of South Carolina, and patient transports are available 24/7. Since the inception of the program in September of 2022, more than 6,000 patients have been successfully transported.

Patients who meet the following criteria can be transported:
• The patient is being hospitalized for initial emergency psychiatric treatment.
• The patient is an adult (18 years of age or older)
• The patient has been medically cleared
• The patient is non-violent (drivers do not restrain the patients like law enforcement)
• The patient is not an elopement risk
• The patient is ambulatory and able to get into and out of a vehicle on their own
• The patient is not oversized (excessive height/weight may impact patient comfort and safety)

Unmarked vehicles are designed for safe and secure transports of adult patients. These vehicles have secure patient compartments that allow patients to be transported without restraints. Camera systems allow drivers to monitor the patients during the transports. The cameras record both patients and drivers during transport. The vehicles are also equipped with secure storage area for patients' belongings. All of the drivers have received extensive trainings on mental health topics, including de-escalation strategies. The drivers are hand-selected to work on this program; they understand their role is to provide transportation safely and respectfully for people who are experiencing crises.

Patients who do not meet the above requirements may require law enforcement or non-emergency ambulance transport. The program reduces the use of law enforcement's limited resources and time unless unequivocally required.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to	☐	☐	☐	☐	☐	☑

contact						
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to be	☐	☐	☑	☐	☐	☐

3. Briefly explain your stages of implementation selections here.

Stage 1: Someone to Talk To:

This stage is at the "program sustainment" level. Individuals, families, and first responders throughout the state, in every county, are able to quickly and easily reach out for support during crises.

From July 2024 through June 2025, the Mobile Crisis Call Center received 13,171 crisis calls. The center received an additional 20,051 calls that were not related to mental health crises.

Between July 2024 and June 2025, the BHDD OMH 988 Center received 24,900 routed calls, and answered 19,529 calls, with an average answer rate of 78.4%.

Between July 2024 and June 2025, the MHAGC 988 Center received 34,081 routed calls, and answered 22,987 calls, with an average answer rate of 67.4%.

As a state, the SFY25 data reflects a total of 49,496 routed calls, 42,508 answered calls, and an average answer rate of 85.9%. These numbers do not match the numbers reflected by each individual call center, because the individual center data includes duplicated callers who had to be routed to both call centers before their calls were answered. For the most accurate 988 call center data, it is advisable to refer to the state numbers, instead of the individual center data.

Stage 2: Someone to Respond:

This stage is at the "program sustainment" level.

Throughout the state, in every county, BHDD OMH Mobile Crisis teams are ready to be deployed to respond to a variety of crises. The program has reached sustainment as it has been fully operational and implemented statewide since summer 2019. Data is gathered monthly and shared with stakeholders, partners, and other interested parties. Quality assurance protocols are in place for auditing purposes. A four-year SAMHSA for Community Crisis Response Partnerships supports the participation of Certified Peer Support Specialists on Mobile Crisis teams in ten counties: Aiken, Anderson, Chesterfield, Laurens, Newberry, Greenwood, Edgefield, McCormick, Abbeville, and Saluda. These counties were chosen due to high suicide rates in the counties, as well as other health disparities.

From July 2024, through June 2025, Mobile Crisis teams provided 5,642 in-person, telephonic, and telehealth responses. 4,667 of the responses were in person. The average response time for Mobile Crisis teams was 35.75 minutes.

From July 2024 through June 2025, Alliance staff members worked with 35 first responder agencies, responded to 8,272 calls for service, and assisted 5,565 people in crisis (unduplicated).

From July 2024 through June 2025, FRST clinicians provided 4,886 services to 5,346 first responders, many of whom were in crisis, at risk of crisis, or at risk of developing PTSD or other serious mental illnesses. This includes therapy sessions, critical incident stress debriefings, crisis support and post critical incident seminars.

Stage 3: Somewhere to Go:

This stage is still at the "early implementation" level, with fewer than 25% of counties benefiting from the services provided through Crisis Receiving and Stabilization Facilities (CRSFs). However, there are other places for people in crisis to seek assistance.

Tri-County Crisis Stabilization Center (TCSC) at Charleston Dorchester Mental Health Center (CDMHC): From July 2024 through June 2025, 453 people (unduplicated) sought help or were referred to the program. 274 patients (unduplicated) were admitted and received services from the program. The other 179 people received emergency assessments and then were referred to other services at CDMHC. 256 admitted patients were diverted from emergency departments, and 1 admitted patient was diverted from jail.

Midlands Crisis Stabilization Unit at Columbia Area Mental Health Center (CAMHC): After a series of unexpected logistical challenges related to its opening, CAMHC began serving patients in August 2025 at this new CRSF. Patient data for August 2025 was not available at the time of this grant application.

The Eubanks Center at Spartanburg Area Mental Health Center (SAMHC): From July 2024 through June 2025, 114 patients (unduplicated) received services from this program. This is not a CRSF.

The CAFÉ through Project FOCUS: From July 2024 through June 2025, 388 patients (unduplicated) received services from this program. This is not a CRSF.

The Living Room program (LRP) at Aiken Barnwell MHC (ABMHC): ABMHC hopes to open the doors to this program to begin serving patients in fall 2025 or January 2026. This is not a CRSF.

From October 2023 – September 2024, 79 emergency departments responded to 90,077 visits from patients diagnosed with mental, behavioral, and neurodevelopmental disorders. The number of duplicated or unduplicated patients is unknown. This data was provided by the SC Revenue and Fiscal Affairs Office.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

SAMHSA's National Guidelines for Behavioral Health Crisis Care outline minimum expectations to ensure that crisis services will be provided for "anyone, anywhere and anytime." SCOMH is committed to enhancing and expanding its services so that it has a fully integrated "no-wrong-door" crisis system that includes three core components, as recommend by SAMHSA:
A. Regional Crisis Call Center
B. Crisis Mobile Team Response
C. Crisis Receiving and Stabilization Facilities

A. Regional Crisis Call Center:

SAMHSA recommends that regional crisis call centers should be staffed 24/7, provide telephonic, text, and chat services, offer quality coordination of crisis care in real time, and meet the National Suicide Prevention Lifeline standards for risk assessment and engagement with people who are at risk of suicide.

The South Carolina Mobile Crisis Call Center (MCCC), which is operated by the BHDD OMH Charleston Dorchester Mental Health Center (CDMHC). First implemented in 2020, MCCC assists individuals statewide and communicates with community mental health centers in all 46 counties to assist with triage and emergency assessment. The call center's responsibility is to triage calls, attempt to de-escalate callers in crisis, and dispatch MC teams to mental health crises which are unable to be de-escalated and require after-hours response. If immediate response is needed, the call center will also call local emergency services dispatch for individuals across the state to request first responders to respond so individuals can be stabilized until Mobile Crisis teams are able to arrive on scene. In addition to those responsibilities, MCCC also assists with providing callers with information regarding resources in their community including alcohol and drug assistance programs, local mental health centers, referrals to 211, and referrals to suicide prevention lifelines. Hospitals and ERs throughout the state are also able to call and receive mental health history information, such as medication information and most recent appointments with a patient's psychiatrist or therapist for continuity of care purposes.

MCCC assists BHDD OMH's MC teams by triaging calls, developing safety plans, diverting emergencies, and providing resources to individuals not needing immediate Mobile Crisis or emergency response. MCCC also acts as a bridge for communication between first responders and Mobile Crisis clinicians. First responders can contact the center 24/7 to triage calls, gather information, or request Mobile Crisis response.

In 2023, BHDD OMH significantly expanded its services for crisis calls through the launch of a second 24/7 988 Suicide and Crisis Lifeline Center in South Carolina. Originally, there was only one 988 Center in the state; that center was operated by Mental Health America of Greenville County (MHAGC). The addition of BHDD OMH's new 988 center, which is operated by operated by Charleston Dorchester Mental Health Center (CDMHC), means that significantly more South Carolinians were given the opportunity to communicate directly with 988 staff members and volunteers who live in South Carolina; this shared residency can provide emotional relief for some callers, because they know that the people they are communicating with are familiar with South Carolina's culture. Callers with SC area codes who are experiencing mental health or suicide crises are assisted by this center. Callers are provided with telephonic crisis intervention services. Third-party callers can also reach out to 988 when they are concerned about people who may need mental health or substance abuse resources in their area.

The 988 center at CDMHC is in Phase 1 of its 988 rollout, and only provides telephonic services; chat and text services will be launched as soon as possible. 988 callers are given the opportunity to participate in a 988-follow-up care program; if they choose this service, the 988 center will schedule follow-up calls with the callers. The follow-up calls will connect the participants to care and secondary referrals, as well as address any barriers to care through referral sources.

B. Crisis Mobile Team Response:

SAMHSA recommends that mobile crisis teams be available to reach people in a timely manner in their homes, workplaces, and other community-based locations. Minimum expectations for these teams include the provision of a credentialed clinician capable of assessing needs of the individual; the capability of a team to respond at any time and to where the person in crisis is (home, work, etc.); and the ability to connect individuals in need of a higher level of care through warm hand-offs and transportation coordination.

BHDD OMH Mobile Crisis (MC) teams currently meet all three of these expectations. The two-person MC teams operate 24/7/365 in all 46 counties. They provide services in the community, and partner with local emergency departments, inpatient hospitals, and other community partners. In terms of the National Guidelines proposed best practices, the MC teams have begun to incorporate peers as team members. Due to the centralized nature of South Carolina's mental health system, the teams are able to offer next-day walk-in screenings for individuals who are stabilized in the community; these screenings help people get connected to outpatient services very quickly. The MC program also provides the following essential functions outlined in SAMHSA's National Guidelines: Triage/screening, assessment, de-escalation, peer support, coordination with additional medical providers or other resources, crisis safety planning, and follow-up services.

The MC teams work with the Mobile Crisis Call Center, as discussed in Section A above.

C. Crisis Receiving and Stabilization Facilities

SAMHSA has nine minimum expectations for Crisis Receiving and Stabilization Facilities (CRSFs): accept all referrals; provide assessment and support rather than requiring medical clearances; design services to address mental health and substance use issues; assess physical health needs; provide 24/7 services through a multi-disciplinary team; allow both walk-in and first responder drop-offs; have the capacity to accept all referrals with few exceptions and a no-rejection policy for first responders; screen for suicide risks; and screen for violence risks.

The CRSF portion of BHDD OMH's statewide crisis program still has many opportunities for improvement. Currently, BHDD OMH operates only two CRSFs, and the second one just opened its doors in July 2025. The Tri-County Crisis Stabilization Center is operated by Charleston Dorchester Mental Health Center (CDMHC) on the east coast of the state, and the Midlands Crisis Stabilization Facility, operated by the Columbia Area Mental Health Center (CAMHC), is located in the middle of the state.

Several other BHDD OMH Community Mental Health Centers (CMHCs) are interested in establishing these types of facilities, but establishing new CRSFs depends on future funding opportunities.

The Eubanks Center and the Project FOCUS CAFÉ, which are operated by the Spartanburg Area Mental Health Center (SAMHC), are both located in the northwest corner of the state. The Living Room program (LRP) at Aiken Barnwell MHC (ABMHC), located in the southwest part of the state, is designed as a response to community needs for mental health services outside of emergency room settings. The LRP will open its doors in fall 2025. These facilities meet almost all CRSF requirements, but they do not provide 24/7 services. Therefore, they are not categorized as CRSFs.

South Carolina has 79 emergency departments spread across the state. Currently, there are five emergency departments that operate EmPATH units, which are behavioral health units to provide services to individuals experiencing behavioral health crises. Eight more EmPATH units are planned for construction and should be completed in the next few years.

BHDD OMH recognizes that the state's current CRSF services are limited, and it also recognizes the importance of providing these facilities to divert people in crisis from emergency departments. In the future, BHDD OMH hopes to develop significantly more CRSF programs throughout the state. Ideally, every CMHC would have a CRSF. However, there are numerous logistical and financial challenges related to the development of these specialized programs. BHDD OMH is experiencing an ongoing challenge related to workforce retention and expansion, and the development of new CRSFs is certainly affected by these workforce challenges. Nevertheless, BHDD OMH leadership is actively involved in exploring the best possible ways to increase CRSFs, as well as other services designed to help individuals who are experiencing behavioral health crises. BHDD OMH committed the majority of its 2024 Crisis Services Set-Aside funding to establish a new CRSF at the Columbia Area Mental Health Center (CAMHC) and to support ongoing operations for the CRSF at the Charleston Dorchester Mental Health Center (CDMHC). BHDD OMH plans to commit the vast majority of its BSCA 4 supplemental block grant funding to support the new CRSF at CAMHC.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 2
   ii. Not in the suicide lifeline network: 1

b. Number of Crisis Call Centers with follow up protocols in place
   i. In the 988 Suicide and Crisis lifeline network: 2
   ii. Not in the suicide lifeline network: 1

c. Estimated percent of 911 calls that are coded out as BH related: 0

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 0

b. Integrated with public safety first responder structures (police, paramedic, fire): 0

c. Number that utilizes peer recovery services as a core component of the model: 0

Safe place to be

a. Number of Emergency Departments: 79

b. Number of Emergency Departments that operate a specialized behavioral health component: 5

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 2

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

CCBHC Connections:
Two of the 16 CMHCs are using a CCBHC model. These two CMHCs (like all CMHCs) have 24/7 Mobile Crisis response teams. They also coordinate closely with the 988 Call Centers. The two CMHCs that use a CCBHC model are the Beckman Center for Mental Health Services (BCMHS) and the Spartanburg Area Mental Health Center (SAMHC).

Allocations:
The 2026 Crisis Services Set-Aside will fund the following BHDD OMH programs located throughout the state.

Crisis Receiving and Stabilization Facility (Columbia Area MHC): $445,694
Mobile Crisis Team (Greater Greenville MHC): $25,000
Justice-Involved Program Manager: $154,511
FOCUS CAFÉ (Spartanburg Area MHC): $415,594
Mobile Crisis Team (all CMHCs): unknown
Alliance Program (all CMHCs): unknown
Total Planned Allocations: $1,040,799

Program Descriptions for the Above Allocations:

Crisis Receiving and Stabilization Facility – at Columbia Area MHC:
Funding for this program will include personnel expenses, training/professional development, and/or program supplies for CRSF staff members, as well as contracted providers.

Mobile Crisis Team – at Greater Greenville MHC:
Funding for this program will include personnel expenses, training/professional development, and/or program supplies for Mobile Crisis Team staff.

Justice-Involved Program Manager – FRST Program at Central Administration Office:
Funding for this program will include personnel expenses, training/professional development, and/or program supplies for the Justice-Involved Program Manager.

FOCUS CAFÉ – at Spartanburg Area MHC:
Funding for this program will include personnel expenses, training/professional development, and/or program supplies for FOCUS CAFÉ staff.

Mobile Crisis Teams – at Multiple CMHCs:
Funding for this program will include personnel expenses, training/professional development, and/or program supplies for Mobile Crisis team members at a variety of CMHCs. BHDD OMH does not yet know exactly which CMHCs will use block grant funding for its Mobile Crisis teams, or how much will be used.

Alliance Program – at Multiple CMHCs:
Funding for this program will include personnel expenses, training/professional development, and/or program supplies for Alliance staff members at a variety of CMHCs. BHDD OMH does not yet know exactly which CMHCs will use block grant funding for its Alliance program, or how much will be used.

7. Please indicate areas of technical assistance needs related to this section.

No technical assistance is requested.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:
The answers for Questions 5-c and 5-a, 5-b, and 5-c show "0," but the real answer is "unknown." The state does not have a coordinated, centralized mechanism to track this data.

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, there are 10 identified guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **Working Definition of Recovery.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing, and monitoring the state behavioral health treatment system.

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Use Block Grant funds for recovery support services? (●) Yes ( ) No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

According to SAMHSA, recovery is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." SCOMH strives to support and empower patients and people with SMI and SED engage in recovery processes.

It is the mission of BHDD OMH to support Recovery Initiatives through the development of empowered patient leadership for people served by BHDD OMH. BHDD OMH supports recovery for patients by training and educating clinicians, other service providers, and various other staff members about recovery principles and recovery-oriented practice and systems, including the following topics: the role of peers in care; required peer accreditation or certification; the involvement of people in recovery, peers, and family members in planning, implementation, and evaluation of the impact of the mental health system; and the measurement of the impact of consumer and recovery community outreach activities.

At BHDD OMH, Patient Advisory Boards (PABs) provide mechanisms for positive collaboration and communication, and to empower patients at all Departmental levels. PABs provide unique and independent opportunities for input and involvement in the areas of planning, policymaking, program evaluation, and service provision. Most states have only a statewide or regional PAB. BHDD OMH is among just a few state systems that have mandated the establishment of PABs not only at the state level, but at every SCOMH community mental health center and hospital.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

In April 2025, the Governor of South Carolina signed Bill S.2 into law. This bill formed the South Carolina Department of Behavioral Health and Developmental Disabilities (BHDD). This new department is comprised of three offices: the Office of Mental Health (BHDD OMH), the Office of Substance Use Services (BHDD OSUS), and the Office of Intellectual and Developmental Disabilities (BHDD OIDD). The restructuring was designed as a system to promote more collaborative care for patients with multiple health challenges, including mental illnesses and serious emotional disturbances, substance use disorders, and/or intellectual or developmental disabilities.

The Office of Substance Use Services (BHDD OSUS) is the designated state agency for recovery support services for individuals with substance use disorders in South Carolina.

BHDD OSUS provides prevention, treatment, and recovery services. The office contracts with 31 of the state's county alcohol and drug abuse authorities to provide most of the core substance use services in all 46 counties. These services include traditional group, individual, and family outpatient counseling for adults; post-discharge services; Alcohol and Drug Safety Action Program (ADSAP), the state's DUI program; youth and adolescent services; and primary prevention/education programs. Service delivery emphasizes evidence-based practices and is supported by BHDD OSUS quality assurance efforts. BHDD OSUS engages in close relationships with the county authorities and other contracted providers and supports systematic and continuous actions for quality improvement in service delivery.

Each county authority is licensed by the SC Department of Public Health and accredited by CARF International or the Joint Commission. Licensing and credentialing of substance use disorder counselors is regulated by state statute. This includes the requirement for certification of treatment counselors by Addiction Professionals of South Carolina and of prevention professionals by the S.C. Association of Prevention Professionals and Advocates. There are no financial intermediaries between BHDD OSUS and the county authorities, nor are there separate child and adult systems. BHDD OSUS and the county authorities' leaders have a strong relationship and work closely to optimize the efficiency and effectiveness of services.

5. Does the state have any activities that it would like to highlight?

The Art of Recovery initiative showcases the talents of those receiving services from DMH and the role that art can play in the recovery process, and gives individuals living with mental illnesses the opportunity to exhibit and sell their works of art. Pieces are submitted from across South Carolina by participants who use a variety of artistic media, not only as a means of empowerment, but also as a tool to educate the public about, and dispel the stigma associated with, mental illness. BHDD OMH staff volunteers mat, frame, hang, transport, and display pieces in venues throughout the state. Works rotate on a frequent basis.

Pieces from The Art of Recovery have traveled across South Carolina and have been featured in public galleries, community centers, and conferences across the state. The program has been an official exhibitor at the Internationally known Piccolo Spoleto Festival. A widely acclaimed program, The Art of Recovery received the 2006 Verner Governor's Award for the Arts, the highest Arts honor in South Carolina. It has received grant funding from Blue Cross Blue Shield of South Carolina and serves as a model for

other mental health groups in the U.S.

6. Please indicate areas of technical assistance needs related to this section.

No technical assistance is requested.

Footnotes:

Environmental Factors and Plan

11. Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health disorder and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1] Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance use, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to financing, workforce development, and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the functioning of children, youth and young adults in home, school, and community settings. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult, and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

1. non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? (●) Yes ( ) No

b) The resilience of children and youth with SED? (●) Yes ( ) No

c) The recovery of children and youth with SUD? ( ) Yes ( ) No

d) The resilience of children and youth with SUD? ( ) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Health care? (●) Yes ( ) No

c) Juvenile justice? (●) Yes ( ) No

d) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? (●) Yes ( ) No

d) Is the state providing trauma informed care? (●) Yes ( ) No

6. Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

BHHD OMH provides a system of integrated services in order for children to receive care for their multiple needs. Services are

coordinated to provide for a comprehensive system of care that includes social services; educational services including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

BHDD OMH plans to continue all of the initiatives discussed in this section.

Infant and Early Childhood Mental Health:
The BHHD OMH Infant and Early Childhood Mental Health Program (IECMH) in collaboration with other infant and early childhood serving partners, facilitates the building of strong organizational relationships, processes and plans, implementation of relevant IECMH activities and training to elevate the Infant and Early Childhood Mental Health initiatives within the BHHD OMH system. BHHD OMH also provides a consultation network across the state to childcare and early education centers in collaboration with South Carolina Infant Mental Health Association, Child Welfare, First Steps centers, and Head Start centers. BHHD OMH will continue to provide training opportunities for clinicians in Parent-Child Interaction Therapy, Child-Parent Psychotherapy, Infant and Early Childhood Mental Health Foundations, Facilitating Attuned Interactions, etc.) through its partnership with the South Carolina Infant and Mental Health Association.

Safe Baby Courts:
In partnership with the Child Welfare Agency, the Child Advocacy Agency, Family Court Judges and the South Carolina Infant Mental Health Association (SCIMHA), BHDD OMH will continue to partner in the implementation of Safe Baby Courts. Safe Baby Courts is an evidence-based approach focused on minimizing trauma for young children; this approach reduces the impact of trauma on children's early development by improving how courts, child welfare agencies, and child-serving organizations work together.

School Mental Health Services:
BHDD OMH will continue to be the leading provider of School Mental Health (SMH) programs in the state. These comprehensive, community-linked programs offer a range of treatment and intervention services on primary and secondary school campuses, including psychiatric care and individual, group, and family sessions. Master-level Mental Health Professionals (MHPs) and Bachelor-level Counselors deliver year-round services using Evidence-Based Practices (EBP) to assist families and schools. They develop comprehensive strategies for resolving emotional and behavioral challenges that impact student educational outcomes and overall well-being. MHPs also promote whole-school wellness and support school leadership in addressing the social, emotional, and academic needs of students. Counselors provide mental health awareness for students, offer additional mental health support for subsets of students targeting specific needs, and support the school's referral process. Studies show that children are more likely to receive mental health services when they are referred to on-site SMH programs. Families find that these services are easier to access, students spend more time in class and less time absent from school, and schools have help in times of crisis more readily available. The provision of SMH services on campus contribute to improved emotional health of students which improves academic performance and decreases the need for behavioral interventions.

Partnership with Child Welfare System:
BHDD OMH will continue to partner with the state's child welfare agency, the SC Department of Social Services (SCDSS). BHDD OMH and SCDSS have a coordinated approach to human child trafficking and intensive in-home services. Through this framework, clinicians are co-located in two large child welfare offices. The agencies and organizations agreed to use a universal screening and coordinated approach to identification of children in need, referrals, and training. This coordinated approach is now being developed for all providers and school personnel in the state. BHDD OMH and SCDSS have a team of clinicians who provide Brief Strategic Family Therapy (BSFT). BHDD OMH also has an arrangement with SCDSS for two co-located clinicians in two of the state's largest child welfare offices. These clinicians provide timely services and support for families who have been connected with the child welfare system.

Partnership with Juvenile Justice System:
BHDD OMH partners with SC Department of Juvenile Justice (SCDJJ) to provide face to face assessments for current BHHD OMH patients incarcerated at the Juvenile Detention Center. Additionally, BHHD OMH has three regional coordinators who participate in inter-agency meetings with DJJ and other state agencies to support coordination of care for our states' youth. This partnership has been beneficial and will continue.

Multi-Dimensional Family Therapy:
Twelve of the 16 CMHCs offer Multi-Dimensional Family Therapy (MDFT). MDFT is a comprehensive, family-centered treatment approach used to support teens and young adults facing challenges such as substance use, delinquency, and mental health disorders. MDFT aims to improve family functioning, prevent out-of-home placements, while enhancing coping skills for adolescents. MDFT serves youth ages 10-26 and their families. BHDD OMH's goal is to establish an MDFT team in every CMHC.

7. Does the state have any activities related to this section that you would like to highlight?

Youth Access to Psychiatry Program:

YAP-P is a Pediatric Mental Health Care Access (PMHCA) program jointly funded by the Health Resources and Services Administration (HRSA) and BHHD OMH. Housed within BHHD OMH, YAP-P provides a continuum of supports to PCPs across SC at no cost to improve youth access to quality mental, behavioral, and developmental health services. The continuum of supports includes: 1) training and resources for PCPs and their practices, 2) a child psychiatry consultation line, 3) referrals for patients to

community-based services, and 4) patient and family education materials disseminated via PCPs.

The consult line is a defining feature of YAP-P. It is a provider-to-provider resource for youth 0-25 years of age that enables PCPs to speak directly with a child and adolescent psychiatrist and/or a pediatrician specializing in developmental disabilities. The consult line was developed to address the severe shortage of access to pediatric psychiatrists and allows any prescriber to call M-F from 8:30-5. Consults can usually be scheduled within 24 hours and this quick turnaround time fills in gaps in care where a child may otherwise have to wait months to see a psychiatrist. The consult line, trainings and resources also increase provider capacity to manage patients with behavioral and mental issues within their office setting.

Because BHHD OMH directly oversees 16 community mental health centers (CMHCs) statewide, YAP-P serves as a central referral source for providers who use the consult line. All CMHCs accept Medicaid and offer a hardship reduction option for patients without insurance. The CMHCs play an especially critical health service role in SC rural settings as these centers are often the sole mental health service provider in rural counties and the only local providers who accept Medicaid. The CMHCs serve as mental health care safety net providers to almost half of the state's children; approximately 44% of children and youth in SC are covered by Medicaid.

Roads of Independence:

As the recipient of a five-year SAMHSA Healthy Transition Grant, BHDD OMH established a Roads of Independence (ROI) program in the Pee Dee area of South Carolina. At one point, this area led the nation in crime reports. The ROI program is currently in its final year of implementation for the grant. A robust group of community partners make up the advisory team which includes housing, employment/ local colleges, Child Welfare, Juvenile Justice, the Fatherhood Initiative, etc., with an average of 50 partners willing to assume a role on the advisory council to improve the plight of young adults in a tri-county area of the state. The Roads of Independence program uses a System of Care approach which supports young adults directing services and supports provided to reach their highly individualized goals. BHDD OMH has continually focused on developing a sustainability plan to ensure that ROI will continue after the grant ends.

Based on the success of the first Roads of Independence program, BHHD OMH launched similar initiatives in four other counties: Aiken, Sumter, Lee, and Kersha.

Project FOCUS:

In collaboration with its partner agencies, BHDD OMH will continue to implement Project FOCUS, a system of care program in three counties in upstate South Carolina. Project FOCUS (Family Options in Cherokee, Union, and Spartanburg Counties) serves children, youth, and young adults aged 0-21 who have or are at risk of a serious emotional disturbance (SED), and their families. This program was established in 2000; it continues to be a success after 25 years.

To prevent children and adolescents from being unnecessarily sent to emergency departments in the Project FOCUS counties, a comprehensive approach has been developed; this approach includes both formal and informal treatment and support. A building, owned by Spartanburg Regional Hospital, was provided for SC DMH and its partners to establish "the CAFÉ" – the Child and Adolescent Engagement Center. The CAFÉ provides screenings, assessments, and treatments for children, youth, and young adults who may be in crisis. Utilizing a Family and Peer Support and Living Room model designed to be both youth-friendly and family-friendly, the CAFÉ serves as a drop-in center and referral hub. The CAFÉ provides a vibrant location in walking distance to the local hospital and the local Mental Health Center.

The goals of Project FOCUS include expanding System of Care principles in South Carolina including improved infrastructure to support family and youth engagement, clinical coordination, cross-agency collaboration, evidence-based practices, and improvement in service gaps.

In June 2025, BHDD OMH submitted a no-cost extension request to SAMHSA to continue receiving grant funding for at least a few more months. BHDD OMH plans to use Crisis Services Set-Aside funds from the 2025 and 2026 MHBGs to fund the FOCUS CAFÉ, which provides crisis services to children, adolescents, and their families. BHDD OMH leadership will continue to seek other sources of funding to ensure the sustainability of this successful program.

8. Please indicate areas of technical assistance needs related to this section.

No technical assistance is requested.

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Footnotes:

Environmental Factors and Plan

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan since the FY2024-2025 Plan was submitted? ○ Yes ◉ No

2. Describe activities intended to reduce incidents of suicide in your state.

Established in 2019, the BHDD OMH Suicide Prevention Program (SPP) implements a wide range of activities. SPP plans to continue all of the initiatives discussed in this section.

The SC Suicide Prevention Coalition, hosted by SPP, is working on updating the South Carolina Strategy for Suicide Prevention. SPP staff plan to have the strategy updated by the first coalition meeting in March 2026. This plan covers suicide prevention best practices, statistics, coalition members, and goals.

The South Carolina Zero Suicide Initiative was launched in 2018, when BHDD OMH was awarded a Zero Suicide grant from SAMHSA. This project focused on addressing the suicidality of individuals aged 25 and older by implementing the Zero Suicide framework for medical and behavioral health care systems. The SPP was established in order to ensure that BHDD OMH's suicide prevention efforts would cover the entire lifespan of people, including those 24 and younger. SPP plans to expand Zero Suicide Framework with other state agencies. In 2023, SPP was awarded another Zero Suicide Grant from SAMHSA. Over the next few years, BHDD OMH will use the grant to support its collaboration with the SC Department of Corrections to assist them with adopting the Zero Suicide Framework. BHDD OMH will also work on ways to enhance transition of care between corrections, inpatient hospitals, and community mental health centers.

In July 2021, the South Carolina Suicide Prevention Student Identification Act (S. 231) was signed into law. This new law required all public schools serving 7th through 12th grade students, as well as all public and private higher education institutions, to provide the phone number of the National Suicide and Crisis Lifeline, on student identification cards. SPP plans to examine the possibility of expanding this bill so that it will include elementary age children, as well as private schools.

SPP's goal for SFY26 is to train more than 6,500 people in suicide specific trainings related to prevention, intervention, or postvention. Trainings will be offered to BHDD OMH employees, staff members of other state agencies and service providers throughout the state, and the general public.

BHDD OMH continues to implement universal safety planning within all divisions of its Community Mental Health Centers and hospitals. The universal planning approach is intended to be proactive, recognizing that all humans are vulnerable to having darkness overwhelm their abilities to cope on any given day. BHDD OMH emphasizes the importance of having those in distress know how to care for themselves and reach out before the distress escalates. BHDD OMH also plans to continue to use the Columbia-Suicide Severity Rating Scale (C-SSRS) for universal screenings at each point of contact with patients. Follow-up and aftercare planning is provided for all patients.

Post-intervention consultation and resources are provided by SPP for families, loved ones, and colleagues following loss to suicide. Additionally, BHDD OMH engages in continuing partnerships with many other state agencies (SCPPP, SCDVA, SCDCA, SCDHEC, SCDSS, SCHHS, SCDOC, SCDE, DAODAS, SCCJA and SCFA) to provide postvention support when their employees have experienced losses.

BHDD OMH co-chairs the SC Suicide Prevention Coalition. This statewide coalition is comprised of a diverse statewide group of stakeholders. Over the past few years, interest in this coalition has increased dramatically. Meetings are held quarterly.

BHDD OMH plans to expand its 988 response services, which are managed by the Charleston Dorchester Mental Health Center (CDMHC) to include chats and texts. The goal is to add this new service before the end of SFY26. BHDD OMH will continue its partnership with the Crisis Text Line by using a state specific code, HOPE4SC. Having a state specific code allowed to track data in SC, as well as being able to further the message that Hope Lives in SC.

BHDD OMH and BHDD OSUS will continue to partner with the American Foundation for Suicide Prevention (AFSP) national and South Carolina chapters to implement a statewide interactive screener program, Hope.ConnectsYou.org. BHDD OMH and SC Department of Children's Advocacy will continue to partner with AFSP to offer a screener for parents and guardians to take on behalf of a child or adolescent, hope.connectsSCKids.org.

SPP will continue to develop and strengthen partnerships with various churches and faith-based groups throughout the state. Staff members will work on providing suicide prevention training to both church leaders and congregation members.

SPP plans to continue to provide staff representation at the SC Department of Veteran's Affairs Health Promotion Workgroup and the Governor's Challenge Team, to show BHDD OMH's support for military populations and veterans.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments? (●) Yes ( ) No

If yes, please describe how barriers are eliminated.

BHDD OMH will continue to collaborate with South Carolina Hospital Association (SCHA) to develop the Drive to Zero Suicide Award. The award criteria are based on the seven principles of Zero Suicide, and ensure that SC hospitals are working to decrease a variety of barriers. Some of the strategies to eliminate barriers include specific training, policy enhancements, safety planning, screening, changes related to electronic medical records (for tracking and reporting suicide), and formal coordination with their local community mental health center.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

In addition to numerous other suicide prevention activities, BHDD OMH's SPP was awarded the SAMHSA 988 State and Territory Improvement Grant which has helped expand the states capacity to answer 988 calls to 89.7 as of May 2025. BHDD OMH was also awarded the SAMHSA Zero Suicide Grant and is working on improving transitions of care for individuals as they move from one provider to another. Finally, BHDD OMH was awarded the Garret Lee Smith Grant. This grant will support BHDD OMH's efforts to embed evidence-based suicide prevention strategies within elementary schools and pediatricians' offices to support children and adolescents who are at risk of suicide.

6. Please indicate areas of technical assistance needs related to this section.

No technical assistance is requested.

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Footnotes:

Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

BHDD OMH is continually seeking new ways to partner with state government agencies, educational institutions, nonprofit organizations, and other service providers. This section provides some highlights of new partnerships added since the last planning period.

Agency Restructuring:

In April 2025, the Governor of South Carolina signed Bill S.2 into law. This bill formed the SC Department of Behavioral Health and Developmental Disabilities (SCDBHDD). This new department is comprised of three offices: the Office of Mental Health (BHDD OMH), the Office of Substance Use Services (BHDD OSUS), and the Office of Intellectual and Developmental Disabilities (BHDD OIDD). The restructuring was designed as a system to promote more collaborative care for patients with multiple health challenges, including mental illnesses and serious emotional disturbances, substance use disorders, and/or intellectual or developmental disabilities. During the next few years, the newly created department will identify ways to improve comprehensive services for patients so that they can continue to receive the help they need.

Aiken Barnwell Mental Health Center:

ABMHC's Highway to Hope mobile outpatient service developed partnerships with St. Paul United Methodist Church, Aiken County ABBE Library System, and Christ Central Church; the Highway to Hope vehicles are parked at these locations. The Aiken Center has agreed to place a Narcan Vending Machine on site at ABMHC. The center is also partnering with Aiken County Government to embed an additional mental health professional at the county detention center, and to embed a new mental health professional at the Aiken Center Alcohol and Drug Agency.

Alliance Program:

Alliance provides opportunities for first responders to collaborate with BHDD OMH and better serve community members who are experiencing mental health or behavioral health issues, including crises. Through Alliance, Mental Health Professionals (MHPs) are embedded in law enforcement agencies, fire and rescue departments, 911 dispatch centers, and hospital emergency departments. In the past two years, BHDD OMH has significantly increased its partnerships with first responder agencies; there are now 48 first responder agencies with Alliance staff member positions. BHDD OMH plans to continue all of these partnerships in SFY26.

Berkeley Community Mental Health Center:

BCMHC's Highway to Hope mobile outpatient service developed partnerships with Belle Isle Church (Pineville, SC), Cross Community Center (Cross, SC; and The Alvin Recreation Center (Alvin, SC); the Highway to Hope vehicles are parked at these locations. BCMHC's clinical department now offers an opportunity for Music Therapy interns, in conjunction with Charleston Southern University. Each semester, an intern participates in a 10-week group or 10 hours of co-facilitating sessions. This agreement is valid for three years, and the school determines the fit for interns based on students' needs. BCMHC began participating in the Veteran Suicide Coalition in its service area. The center also began providing trainings to Berkeley County EMS, and embedded two clinicians with law enforcement agencies in the towns of Hanahan and Moncks Corner.

Charleston Dorchester Mental Health Center:

In July 2025, CDMHC conducted a ground-breaking ceremony with Dorchester County and the Medical University of South Carolina (MUSC) to provide mental health counseling and primary care services in St. George, which is a very rural area of South Carolina. CDMHC expects the new office to open in December 2025. Dorchester County is offering the clinic space to CDMHC free of charge because the county leaders value the provision of mental health services, and CDMHC could not afford an additional rental expense. This is exciting news for the town of St. George. CDMHC already has school mental health clinicians who help children in St. George schools, an Alliance staff member at the St. George Police Department, and a team of providers who provide in-home services to patients with SMI/SED. This new addition of an office space in St. George will improve services by making it easier for CDMHC clinicians to coordinate and offer services.

Mobile Crisis Teams:

In April 2024, in an effort to overcome recruitment and hiring challenges for peer support specialists to support best practices for Mobile Crisis teams, BHDD OMH contracted with SC SHARE, a statewide nonprofit. SC SHARE specializes in peer support services. SC SHARE is not a new partner for BHDD OMH in general, but this new collaboration was innovative. Through this enhanced partnership, SC SHARE and BHDD OMH worked together to hire peer supporters for four mental health centers: Aiken Barnwell MHC, Anderson Oconee Pickens MHC, Beckman Center for Mental Health Services, and Tri-County MHC. While there have still been challenges filling all the open Mobile Crisis peer supporter positions, SC SHARE has been able to fill 75% of the positions, which was a major improvement from BHDD OMH's previous efforts. BHDD OMH plans to continue this innovative approach to help ensure that peer support specialists continue to provide invaluable services during crisis situations.

Suicide Prevention Program:

The Suicide Prevention Program developed partnerships with numerous entities. The program now provides ASIST trainings for all clinical staff at the SC Department of Juvenile Justice. Collaborations with SC Parks Recreation and Tourism, the City of Columbia, the SC Vocational Rehabilitation Department, and the SC state fairgrounds resulted in the inclusion of 988 flyers in all state parks, 988 decals throughout Columbia, 988 flyers at all Vocational Rehabilitation centers, and 988 flyers distributed to all state fair vendors. The program partnered with SC Department of Corrections and SC Department of Probation, Parole, and Pardons for the Zero Suicide Grant in October 2023. The SC Department of Motor Vehicles advertised 988 information on their TV screens for a month, providing education to DMV visitors. The program also connected with Deaf LEAD to provide SC resources, in case they are contacted by SC callers.

Telepsychiatry Program:

The Emergency Department Telepsychiatry Program cultivated a partnership with MUSC Shawn Jenkins Children's Hospital Emergency Department; this partnership began in December 2024.

Transition Services:

The Office of Transition Services established a new partnership with Calhoun Convalescent Nursing Home to support patients leaving the hospital and returning to their communities. New relationships with BHDD OSUS were also established to ensure that patients with SUDs would be linked to community resources, ensuring that they would receive appropriate support for their needs related to both their mental health and substance use challenges.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

BHDD OMH recognizes the importance of helping patients live and function in their home communities, rather than in inpatient or residential institutions. BHDD OMH leadership constantly reviews policies and procedures to ensure that patients can be kept in outpatient settings as often as possible.

Clinical Care Coordination:

The Office of Clinical Care Coordination pursues the goal of improving outcomes for patients and reducing healthcare costs. Care Coordinators help patients find and access resources such as primary care, housing, entitlement programs, etc. Provision of Care Coordination services results in decreased re-hospitalizations and emergency room visits, and increased utilization of primary care physicians. Key features of the service include in-home visits and reporting and monitoring of patients' progress in collaboration with referral sources. A special program under this division is Community Long-Term Care (CLTC). CLTC provides in-home support to participants eligible for nursing home care who opt to remain in their homes. Services may include home-delivered meals, personal care aides, incontinence supplies, adult day care, ramps, pest control, and other similar services. These services are provided to adults with Serious Mental Illnesses and children with Serious Emotional Disturbances. Care Coordinators provide targeted case management services to qualifying individuals beginning with a comprehensive needs assessment. Medical, dental, housing, employment, education, behavioral, and other community support needs are identified in the needs assessment. Care Coordinators, who are knowledgeable about local community resources, work collaboratively with patients and link them to those resources. Care Coordinators monitor a wide variety of patient services until goals are met and needs are resolved. Clinical Care Coordination services focus specifically on patients' successful transition to community settings and access to needed services.

Crisis Receiving and Stabilization Facilities:

CRSFs reduce hospitalization by helping people receive services in their communities. CRSFs are generally viewed as a more appropriate and less expensive alternative to hospital emergency departments or inpatient psychiatric hospital units. Currently, BHDD OMH operates two CRSFs, the second CRSF just opened in July 2025. SC's two CRSFs are operated by the BHDD OMH Charleston Dorchester Mental Health Center (CDMHC) on SC's east coast, and the BHDD OMH Columbia Area Mental Health

Center (CAMHC) in the central part of the state. BHDD OMH operates two programs that meet many, but not all, of the criteria for CRSFs. A third program will open its doors in the next few months. Because these programs do not provide 24/7 services, they are not categorized as CRSFs. More information about these programs can be found in Question 15.

First Episode Psychosis Programs:

BHDD OMH implements three different Coordinated Specialty Care (CSC) programs at six Community Mental Health Centers (CMHCs): NAVIGATE, New Directions, and PREP. These programs are designed for patients between the ages of 15 and 40 years of age who have been diagnosed in the schizophrenia spectrum, other psychotic disorders or bipolar disorder. The treatment teams include a wide variety of professionals who focus on educating and empowering patients and their families. Teams include psychiatrists, program directors, mental health clinicians, employment and education specialists, care coordinators, entitlements specialists, nurses, and peer support specialists. Patients can meet with their counselors more than once a week, depending needs. Counselors meet with patients not just in clinical settings, but also in their homes or in communities; sessions can be conducted in-person or through telehealth. Education for patients and families include information about a wide range of topics, including psychosis and how to cope with hallucinations, skills to cope with stress and anxiety, gaining awareness of strengths, focusing on health and wellness, and relapse prevention skills. Each week, the entire care team meets to discuss every patient enrolled in these programs. Family members and other loved ones provided with education to help them learn how to support their loved ones and help them reach their goals. More information about these programs can be found in Question 2.

School Mental Health Services:

BHDD OMH is the leading provider of School Mental Health (SMH) programs in the state. These comprehensive, community-linked programs offer a range of treatment and intervention services on primary and secondary school campuses, including psychiatric care and individual, group, and family sessions. Master-level Mental Health Professionals (MHPs) and Bachelor-level Counselors deliver year-round services using Evidence-Based Practices (EBP) to assist families and schools. These staff members are located in almost 600 schools throughout the state. They develop comprehensive strategies for resolving emotional and behavioral challenges that impact student educational outcomes and overall well-being. MHPs also promote whole-school wellness and support school leadership in addressing the social, emotional, and academic needs of students. Counselors provide mental health awareness for students, offer additional mental health support for subsets of students targeting specific needs, and support the school's referral process. Studies show that children are more likely to receive mental health services when they are referred to on-site SMH programs. Families find that these services are easier to access, students spend more time in class and less time absent from school, and schools have help in times of crisis more readily available. The provision of SMH services on campus contribute to improved emotional health of students which improves academic performance and decreases the need for behavioral interventions.

Transition Services:

In 2019, BHDD OMH created the Office of Transition Programs (OTP). OTP provides support and resources for patients as they transition from hospitals to community settings. The Transition Specialists work with patients to determine their recovery needs and their preferences about where to live in the community. They also ensure effective communication between inpatient and outpatient staff members regarding patients' discharge needs and coordinate with all stakeholders (patient, family, clinical care coordinators, certified peer support specialists), streamlining the discharge processes and improving the chance for patients' successful transition into community settings. The Transition Specialists constantly develop and strengthen relationships with community stakeholders to improve housing access and placement for patients. Fewer than 5% of these patients returned to hospitals after their transitions into community settings.

Youth Access to Psychiatry Program:

YAP-P is a Pediatric Mental Health Care Access (PMHCA) program jointly funded by the Health Resources and Services Administration (HRSA) and BHHD OMH. Housed within BHHD OMH, YAP-P provides a continuum of supports to PCPs across SC at no cost to improve youth access to quality mental, behavioral, and developmental health services. The continuum of supports includes: 1) training and resources for PCPs and their practices, 2) a child psychiatry consultation line, 3) referrals for patients to community-based services, and 4) patient and family education materials disseminated via PCPs. YAP-P serves as a central referral source for providers who use the consult line.

4. Please indicate areas of technical assistance needs related to this section.

No technical assistance is requested.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in **42 U.S.C. §300x-3** for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)

The BHDD OMH Planning Council staff liaison provided an overview, including timeline, of the FFY26 Mental Health Block Grant Application at the July 2025 meeting of the South Carolina Mental Health State Planning Council.

The draft FFY26 Mental Health Block Grant Application was made available to BHDD OMH leadership and the Planning Council chairperson for review. The draft application was then provided to all Planning Council members for a one-week comment period, prior to a one-week public comment period that began on August 21, 2025. See attached comments received from Planning Council members by the end of their comment period. The draft 2025 Mental Health Block Grant Report was provided to all Planning Council members for review and comment in November 2024. No substantive comments were received during the comment period.

The Planning Council Chairperson submitted the attached letter of support for the FFY26 Mental Health Block Grant Application on behalf of the Council.

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan — (●) Yes ( ) No

b. State Report — ( ) Yes (●) No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

Prior to April 2025, the state's designated mental health authority was the SC Department of Mental Health (SCDMH). The SCDMH leadership team planned and implemented community health treatment and recovery support services for people with SMI/SED.

In April 2025, the Governor of South Carolina signed Bill S.2 into law. This bill formed the SC Department of Behavioral Health and Developmental Disabilities (SCDBHDD). This new department is comprised of three offices: the Office of Mental Health (BHDD OMH), the Office of Substance Use Services (BHDD OSUS), and the Office of Intellectual and Developmental Disabilities (BHDD OIDD). The restructuring was designed as a system to promote more collaborative care for patients with multiple health challenges, including mental illnesses and serious emotional disturbances, substance use disorders, and/or intellectual or developmental disabilities. Over the next few years, this restructuring will undoubtedly change some of the ways that community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services are planned and implemented.

Following any new guidance from BHDD leadership, BHDD OMH leadership will continue to plan and implement community health treatment and recovery support services for people with SMI/SED.

See also the attached support letter from the South Carolina Mental Health State Planning Council Chairperson.

The Office of Substance Use Services (BHDD OSUS) is responsible for planning and implementing substance misuse prevention, SUD treatment, and recovery support services.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) (●) Yes ( ) No

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The primary duties of the South Carolina Mental Health State Planning Council are to review the state's Mental Health Block Grant application and report and make recommendations to BHDD OMH; serve as advocates for people with mental illness, including adults with serious mental illness (SMI) and children and adolescents with serious emotional disturbance (SED); and monitor, review, and evaluate the allocation and adequacy of mental health services in the state (see attached South Carolina Mental Health State Planning Council Bylaws, specifically Article II).

The Council publishes its Notification of Meeting Schedule each year and maintains this notification on the BHDD OMH website, which provides an opportunity for the public to interface with the Planning Council and BHDD OMH.

The Planning Council Bylaws, meeting schedule, meeting agendas, and approved minutes are available on the Planning Council page on the BHDD OMH website (https://www.scdmh.org/about/sc-mental-health-state-planning-council/).

Bimonthly Planning Council meetings provide a forum for members, including people in recovery, families, and other stakeholders, to engage with SCOMH leadership and offer input on agency initiatives. Council meeting agendas include reports from SCOMH leadership, including the BHDD OMH Director, Deputy Director of Community Mental Health Services, Deputy Director of Long Term Care, or their designees. Council members receive agency reports, including legislative updates and budget requests, and are provided the opportunity to ask questions and provide input. Council meetings also typically include presentations on programs serving individuals with SMI or SED that highlight agency partnerships and best practices. These presentations inform the Council of a variety of mental health services being provided and offer another opportunity for input.

Council members have advocated for individuals with SMI or SED on legislative issues related to mental health services in South Carolina, including participating in committee hearings.

See also the attached support letter from the South Carolina Mental Health State Planning Council Chairperson.

7. Please indicate areas of technical assistance needs related to this section.

No technical assistance is requested.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

AGENDA
SOUTH CAROLINA MENTAL HEALTH STATE PLANNING COUNCIL
July 16, 2025
10:00AM-12:00PM
General Meeting

I.	(10:00AM-10:15AM) Welcome and Introductions	Aaron Brown
II.	(10:00AM-10:15AM) Approval of Agenda	Aaron Brown
III.	(10:00AM-10:15AM) Approval of Minutes from March 19, 2025	Aaron Brown
IV.	(10:15AM-10:45AM) Update from the Office Director Comments from the Floor	Robert Bank All Present
V.	(10:45AM-11:05AM) Community Mental Health Services Update Comments from the Floor	Melanie Gambrell All Present
VI.	(11:05AM-11:25AM) Inpatient Services/Long Term Care Update Comments from the Floor	Chad Pollock/Versie Bellamy All Present
VII.	(11:25AM-11:45AM) Block Grant Application Update	Michele Murff Aaron Brown
VIII.	(11:45AM-11:55AM) Announcements	All Members
IX.	(11:55AM-12:00PM) Old Business/New Business	Aaron Brown
X.	(11:55AM-12:00PM) Public Comment	All Present
XI.	(11:55AM-12:00PM) Adjournment	Aaron Brown

Meetings will be held from 10:00AM to 12:00PM on the following dates in Room 323 of the South Carolina Department of Mental Health Administration Building, located at 2414 Bull Street, Columbia, SC, Room 323. Beginning in July, meetings will be held at the State of South Carolina Health Campus, located at 400 Otarre Pkwy, Cayce, SC, unless otherwise indicated in the title section above. A virtual option is available for those who cannot attend in person.

January 15, 2025	March 19, 2025	~~May 21, 2025~~
July 16, 2025	September 24, 2025	November 19, 2025

SOUTH CAROLINA MENTAL HEALTH STATE PLANNING COUNCIL

July 16, 2025

Minutes - DRAFT

Members Present

Eileen Schell	Aaron Brown	Chief Michelle Mitchum
Amy Jolly	Ramona Carr	Angela Carrol
Bill Lindsey	Stuart Shields	Candy True
Joan Herbert	Ryan Chitwood	Hannah Bonsu
Mandy Halloran	Deborah Blalock	Renaye Long
Carol Rudder	Versie Bellamy	LaToya Abney
Janie Simpson	Robert Bank	Erin Laughter
Chris Kunkle	Tray Stone	Beth Hutto
Beth Franco	John Kendall	

Guests

Lauri Hammond	Valarie Perkins	K Holms-Gay
Jeffrey Gage	Karen Graydon	Chad Pollock
Lavinia Noel	Edward Grady	Melanie Gambrell
Jamie Chrisman	Robin Crawford	
Janet Bell	Ana Garcia	
Theresa Bishop	Melanie Saxon	

Staff

Michele Murff
Megan Knight

Documents Distributed

March 19, 2025 Minutes

July 16, 2025 Agenda

Welcome and Introductions

Aaron Brown called the meeting to order at 10:00am. Everyone in attendance introduced themselves.

Approval of Agenda

On the motion of Mandy Halloran and seconded by Chief Michelle Mitchum, the agenda was approved.

Approval of Minutes

On the motion of Janie Simpson and seconded by Chief Michelle Mitchum, the minutes for March 19, 2025 were approved.

Comments from the Office Director, Robert Bank

Dr. Bank gave an update on the merging of Department of Mental Health, Department of Alcohol and Other Drug Abuse Services, and Department of Disabilities and Special Needs into the Department of Behavioral Health and

Developmental Disabilities (BHDD) as the Office of Mental Health (OMH), Office of Substance Use Services (OSUS), and Office of Intellectual and Developmental Disabilities (OIDD). A director has not been named for BHDD as of July 15, 2025. The Department of Administration (DOA) is in charge of OMH administrative services in the interim. The DOA is working with the Boston Consulting Group on the upcoming budget ask that combines all three offices into one ask. The budget ask has been delayed from September to November.

There was time for questions and comments from the floor. Discussion included the benefits and challenges of the move to the new South Carolina Health Campus, possible positive impacts on patients of the agency merger, and the impact of the merger on future block grant applications.

Community Mental Health Services (CMHS) Update, Melanie Gambrell and Deborah Blalock

Melanie Gambrell shared the current efforts towards the "No Wrong Door" approach at community mental health centers across the state. Centers in Beckman, Spartanburg, Laurens, Lexington, Aiken-Barnwell, and Charleston-Dorchester are following the Certified Community Behavioral Health Clinic (CCBHC) model of care.

Ms. Gambrell gave an overview of the CMHS budget, which includes funds for Assertive Community Treatment (ACT) teams, additional Mobile Crisis teams, housing coordinators across the state, Peer Support Specialists (PSS), a crisis service model, community bed days, Crisis Stabilization Units (CSU's), jail programs, and an alternative transportation program. There are currently 10 full ACT teams across the state, and fidelity reviews have started with Columbia Area Mental Health Center (CAMHC) and Berkeley Community Mental Health Center (BCMHC). About $5.8 million were spent on community bed days in FY25. CAMHC's CSU received licensure on July 11, 2025 and will start serving patients at the beginning of August.

Deborah Blalock updated the Council that the previous application for funding through the Duke Endowment has been redacted and has not been resubmitted yet. CMHS still needs additional support from South Carolina organizations through financial backing or other means to show the sustainability of the plan. Ms. Blalock shared that they are waiting to hear back from the City of Columbia and the Medical University of South Carolina (MUSC), as well as the Department of Corrections (SCDC) for any support they can offer in addition to their in-kind support. Please review the attached business plan and share any organizations that may be interested.

There was time for questions and comments from the floor.

Inpatient Services and Longterm Care Update, Chad Pollock and Versie Bellamy

Dr. Chad Pollock updated the Council on changes in leadership across Inpatient Services. Dr. Bishop is the interim Chief Executive Officer (CEO) at Harris, Dr. Rudd is the interim CEO of Bryan. Both hospitals have Chief Operating Officers, and there is also now a separate director of Bryan Civil. Inpatient Services is optimizing the process for patients getting benefits, which helps patients get discharged more quickly. Dr. Pollock said the hospitals are also working on getting people to nursing home (NH) level of care as needed. These efforts have lowered the average length of stay; readmittance has not gone up, and less patients are going to Community Residential Care Facilities (CRCFs), so people are able to return to their community more quickly. Dr. Pollock shared that there are staffing challenges with the high turnover of Behavioral Health Assistants (BHAs), so they are working with State Human Resources (HR) to streamline the hiring process.

There was time for questions and comments about Inpatient Services. Discussion included George McConnel's retirement from Morris Village and Certified Nursing Assistants (CNAs) transferring from Stone Pavillion to the geriatric unit at Bryan Hospital.

Dr. Versie Bellamy gave an update on Longterm Care (LTC) and the transition of stone Pavillion to the South Carolina Department of Veterans Affairs (SCDVA) effective July 1, 2025. The private operator of Stone Pavillion is

Avalon. About half the OMH staff previously employed at Stone Pavillion wanted to stay with OMH and filled vacancies with Inpatient Services or Roddey Pavillion. Stone is still located in the same building.

There was time for questions and comments about LTC. Discussion included the number of operating beds at Roddey being about 85-90 currently, certification opportunities for CNAs, and salaries for CNAs, BHAs, and PSSs, which OMH is working on increasing and have been increased with the recent state-wide pay band changes.

Block Grant Application Update, Michele Murff and Aaron Brown

Michele Murff shared that the Block Grant application season started in early July. The 2026 application is the full application for federal fiscal year 2025. The application is for $14.6 million from October 1, 2025 to September 30, 2027 that will go towards four current non-profit contracts and other OMH programs. Current contracts with non-profits are ending soon, and new contracts will be effective for three years. The Bipartisan Safe Communities Act (BSCA) is in its 4th installment, and $776,000 for crisis services is part of the Block Grant application. BSCA funds from this application will be effective September 30, 2025 – September 29, 2027. Spending of Block Grant funds must include at least 10% for First Episode Psychosis (FEP) and 5% for crisis services.

There was time for questions about the Block Grant Application.

Aaron Brown gave an overview and explanation of his draft letter, which was sent out for Council feedback on July 15. Feedback has been requested by July 23.

There was also time during the meeting for questions and comments from the Council regarding the draft letter.

Ms. Murff also shared information with the Council about the $2,350 set aside from the Block Grant for mileage reimbursement for eligible members of the Council who are not attending as part of their job duties and who have need for reimbursement. OMH partners with Mental Health America of South Carolina (MHASC) to provide reimbursements. The current budget ends in September.

Announcements

Stuart Shields shared that the Behavioral Care Pavilion in Florence is opening in September with 53 beds and may be a great presentation to hear in the future.

Bill Lindsey shared that the National Alliance on Mental Illness (NAMI SC) state conference will be held on September 4 at the R2i2 building in Columbia. CEUs are available.

Hannah Bonsu shared that OSUS is hosting their Governor's Summit for Addiction, previously the Governor's Opiate Summit, on November 13-14.

Eileen Schell shared that Thriving in Recovery, a free conference, will be held September 5 at Philip's Market Center.

Old Business/New Business

There was no old business.

There was no new business.

Public Comment

There was no public comment.

Adjournment

On the motion of Joan Herbert and seconded by Hannah Bonsu, the meeting was adjourned at 11:52am.

The next meeting of the State Planning Council will be held Wednesday, September 24, 2025, from 10:00AM – 12:00PM at 400 O'Tarre Parkway Cayce, South Carolina or virtually.

August 6, 2025

Arthur Kleinschmidt, PH.D., MBA
Principal Deputy Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, Maryland 20857

Dear Dr. Arthur Kleinschmidt,

As the newly installed chairperson (as of eight months ago) of the South Carolina Mental Health State Planning Council, I am privileged to provide this update regarding the services currently funded through Block Grant initiatives. The programs/agencies presently supported or partially supported through Block Grant Funding include:

Dee Norton Child Advocacy Center
Work In Progress
Anderson-Oconee-Pickens Center (OMH)
Coastal Empire Center (OMH)
Lexington Center (OMH)
Santee-Wateree Center (OMH)
Waccamaw Center (OMH)
MHA-Greenville
Beckman Center (OMH)
Berkeley Center (OMH)
Columbia Area Center (OMH)
Orangeburg Area Center (OMH)
Spartanburg Area Center (OMH)
Aiken-Barnwell Center (OMH)
SC SHARE
Catawba Center (OMH)
Charleston-Dorchester Center (OMH)
Greater Greenville Center (OMH)
Pee Dee Center (OMH)
Tri-County Center (OMH)

Tasked with monitoring, reviewing, and evaluating the Behavioral Health Services provided by the South Carolina Office of Mental Health (OMH), which was formerly known as the South Carolina Department of Mental Health (SCDMH), and other Non-Profit organizations that provide services funded or partially funded through Block Grant allocation, the Planning Council provides unique perspective regarding these programs.

All volunteer and appointed members of the council also serve as dedicated advocates for fellow South Carolina citizens (children and adults) who live with mental health issues that cause them difficulties. The council meets once every two months and enjoys wide-ranging and active community participation by Council Members and by various guest presenters from throughout South Carolina. This broad and active participation ensures that the Council meets its responsibilities to South Carolina citizens while advancing to the goals of the Block Grant programs.

The Council embraces the task of monitoring the progress and quality of the mental health services provided in South Carolina using Block Grant funding throughout the year. Bearing that mission in mind, the Council solicits and receives presentations regarding special OMH programs as well as Non-Profit organizations who are funded or partially funded by the Block Grant mechanisms. Presentations regarding these programs broadly explain each program's goals and means of achieving those goals, and Council members engage with administrators and clinicians affiliated with those programs.

Over the past year, the Council has received presentations from the following organizations that accept Block Grant funding:

Berkeley Mental Health Jail Based Services

The goal of the program is to reduce recidivism by addressing the mental health needs of the over 400 incarcerated people at Hill-Finklea and continue treatment upon release. The program accepts referrals from anyone, assists with transitions upon release, attempts contact upon release, and has helped the detention center improve their classification system. The program also employs a part-time psychiatrist and provides long-acting injections in partnership with pharmaceutical companies, saving Berkeley County money in instances where someone loses medical coverage upon arrest.

SC SHARE (Free Rural Community Peer Support)

SC SHARE receives Block Grant funding to support counties selected based on poverty rates and to address the connection between socioeconomic status and mental health. The grant covers the costs associated with positions, so patients can receive free support from Certified Peer Support Specialists (CPSS) who have initialed more than 220 interactions over the last 12 months with rural community members who would otherwise not have access to mental health care or other community support.

OMH (Crisis Response Teams)

Mobile Crisis Response Teams respond during Mental Health Centers' normal non-operating hours to reported mental health crisis situations/locations within 60 minutes and divert individuals suffering mental or emotional distress from incarceration.

These services are provided 24/7 state-wide and are available to any residents in the state. Each OMH Center has at least one team on hand, as well as a Deaf Services team. Teams generally include one Licensed Clinician and one Peer Support Specialist, and all team members receive role-based training that enhances their skills at crisis calls response.

Over the past year, the Council has observed and determined that, regarding initiatives and services that rely partially or fully upon Block Grand funding:

QUALITY

The Council, tasked with evaluating the quality and effectiveness of the services being provided, determines that, to date, and based on data provided through our OMH liaison and discussions during presentations provided by the OMH Director has been able to determine that Centers and non-profit organizations which receive funding have largely provided services as projected. Based on the information provided, the Council determines that:

In state fiscal 2025, Dee Norton Advocacy Center has provided 177 unduplicated number of patients served, MHA Greenville 714 patients served, SC SHARE 281 peers served, and Work in Progress 61 clients served. Further, these agencies have provided a combined 1,233 unduplicated number of people served. Based on data provided, these agencies have, in most instances, met or exceeded projections of service base on their approved proposals. Patient survey data is not required and therefore not available for these programs, but there is no indication of community dissatisfaction with services provided.

OMH data for specific center information over the past fiscal year was unavailable at the time of this letter but, once adjusted for traditional trends based on the previous year's reporting, OMH has more likely than not as a whole served 96,000 to 100,000 adults and children. In the spirit of added transparency, the planning council will

in the future request specific center data to more accurately report the number of people served to ensure that previously determined allocation metrics remain accurate.

Patient satisfaction surveys provided by OMH indicate an overwhelming amount of satisfaction with both the youth and adult services provided. There is no indication at this time that any significant changes in service provision funded or partially funded by Block Grant allocation is warranted or should be recommended.

FUNDING SELECTION

The Council is also tasked with participating in the process to select which nonprofit programs should be funded or partially funded by Block Grant money. Pursuant to that responsibility, the Council chair designates no less than three members of the council who are identified as self-attested to have no conflicts of interest in reviewing and scoring applications submitted by agencies for funding. Those applications are reviewed for completeness, cost effectiveness, demonstration of best practices in proposed service(s), and any previous outcomes cited. Applications advanced by that committee are also reviewed by OMH procurement officials to ensure that all selected applicants meet the qualifications for funding and demonstrate the capacity to administer funding lawfully and report spending appropriately.

MONITORING

This Council is further tasked to monitor the allocations of Block Grant funding for the programs selected. The Council solicited data through its OMH Liaison and learned that allocation of block grant amounts resulted from application of metrics developed that incorporate overall population rates in catchment areas, number of staff employed by each center, and number of unique programs offered through each center. This metric was developed to address specific community needs as each center provides not only traditional mental health services, but also unique services specific to their individual community needs. Specific examples include Santee-Wateree's Young Adult Roads of Independence Peer Support, Spartanburg Area Peer Living Room, and Charleson-Dorchester's Crisis Stabilization programs. Based on the budget(s) provided both past and present we see no immediate need to change current service provision or funding allocations. Nonprofit organizations cited in this letter also indicate no immediate change is necessary at the time of this letter as all metrics previously cited in their initial application are mostly being met or exceeded.

In summation, the Planning Council continues to appropriately monitor the use and allocation of Block Grant funding. We are encouraged by the data provided by OMH and Nonprofits cited and reviewed by the Planning Council. The Council concludes the spirit and intent of the Block Grant funding program are being adhered to thoughtfully and in good faith to effectively serve the people of South Carolina.

Respectfully,

Aaron M. Brown, Chairperson and on behalf of SC Mental Health Planning Council

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
LaToya Abney	State Employees		1410 Boston Ave. West Columbia SC, 29170 PH: 803-896-4250	Labney@scvrd.net
Chris Allen	Advocates/representatives who are not state employees or providers		1225 Bluff Road Columbia SC, 29201 PH: 803-447-5094	christopher.j.allen2.mil@army.mil
Robert Bank	State Employees		400 Otarre Parkway Cayce SC, 29172 PH: 803-898-8319	robert.bank@scdmh.org
Versie Bellamy	State Employees		220 Faison Drive Columbia SC, 29203 PH: 803-935-5761	versie.bellamy@scdmh.org
Debbie Blalock	State Employees		400 Otarre Parkway Cayce SC, 29172 PH: 803-898-8348	deborah.blalock@scdmh.org
Hannah Bonsu	State Employees		400 Otarre Parkway Cayce SC, 29172 PH: 803-896-4198	hbonsu@daodas.sc.gov
Aaron Brown	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			abrown@scshare.com
Teri Browne	Advocates/representatives who are not state employees or providers		1512 Pendleton Stereet Columbia SC, 29208 PH: 803-777-6258	brownetm@mailbox.sc.edu
Ramona Carr	Advocates/representatives who are not state employees or providers			rwcarr1315@gmail.com
Angela Carrol	State Employees		1535 Confederate Ave. Columbia SC, 29202 PH: 803-727-2935	angela.carroll@dss.sc.gov
Ryan Chitwood	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			rchitwood@youturnhealth.com

Marilla Copeland	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			marillacopeland31@yahoo.com
Shelina Flarisee	Parents of children with SED			theskysurlimit@gmail.com
Beth Franco	Advocates/representatives who are not state employees or providers		3710 Landmark Drive, Suite 208 Columbia SC, 29204 PH: 803-782-0639	Franco@disabilityrightssc.org
Raj Gavurla	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			raj@rajgavurla.com
Beverly Griffin	Parents of children with SED			beverly.griffin@fedfamsc.org
Mandy Halloran	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			mhalloran@able-sc.org
Melanie Hendricks	State Employees		1801 Main Street Columia SC, 29201 PH: 803-898-1891	melanie.hendricks@scdhhs.gov
Joan Herbert	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			herbertj1112@hotmail.com
Elizabeth Hutto	State Employees		400 Otarre Parkway Cayce SC, 29172 PH: 803-898-8560	elizabeth.hutto@scdmh.org
Amy Jolly	Providers		2231 Devine Street Columbia SC, 29205 PH: 803-758-0066	ajolly@workinprogresscolumbia.com
John Kendall	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			Jkendall8810@gmail.com
Chris Kunkle	State Employees		4444 Broad River Rd. Columbia SC, 29210 PH: 803-896-1238	kunkle.chris@doc.sc.gov
Erin Laughter	State Employees		400 Otarre Parkway Cayce SC, 29172 PH: 803-898-4497	erin.laughter@scdmh.org
Bill Lindsey	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			bill.lindsey@namisc.org
Renaye Long	State Employees		300-C Outlet Pointe Blvd. Columbia SC, 29210 PH: 803-896-9292	renaye.long@schousing.com
Nichole Lowder	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			lowder.nichole@doc.sc.gov
Pheobe Malloy	Parents of children with SED			pheobe.malloy@fedfamsc.org
			428 Wholesale Lane	

Lisa McCliment	State Employees		West Columbia SC, 29172 PH: 803-734-4074	Lmccliment@ed.sc.gov
Michelle Mitchum	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			mmitchum@phhn.org
Carol Rudder	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			crudder@sc.rr.com
Eileen Schell	Advocates/representatives who are not state employees or providers		2201 Commerce Drive Cayce SC, 29033 PH: 803-920-1487	eschell@mha-sc.org
Stuart Shields	Advocates/representatives who are not state employees or providers			sjshields525@outlook.com
Janie Simpson	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			janebsimpson@yahoo.com
Cindy Smith	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			Cndysmth57@gmail.com
Maria Beth Smith	Parents of children with SED			mbs29485@yahoo.com
Tray Stone	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			traystone@gmail.com
Candy True	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			Cltrue613@yahoo.com

*Council members should be listed only once by type of membership and Agency/organization represented.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	12	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	3	
3. Parents of children with SED	4	
4. Vacancies (individuals and family members)	0	
5. Total individuals in recovery, family members, and parents of children with SED	**19**	**50.00%**
6. State Employees	12	
7. Providers	1	
8. Vacancies (state employees and providers)	0	
9. Total State Employees & Providers	**13**	**34.21%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	0	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	6	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	**6**	**15.79%**
16. Total membership (all members of the council)	**38**	

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. §300x-51) requires, as a condition of the funding agreement for the grant, that states will provide an opportunity for the public to comment on the state Block Grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the federal government.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? (●) Yes ( ) No

If yes, provide URL:

https://www.scdmh.org/office-of-public-information/reports-and-publications/

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://www.scdmh.org/office-of-public-information/reports-and-publications/

c) Other (e.g. public service announcements, print media) (●) Yes ( ) No

d) Please indicate areas of technical assistance needs related to this section.

No technical assistance is required.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes: