South Carolina

UNIFORM APPLICATION
FY 2024/2025 Only ApplicationBehavioral Health Assessment and Plan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 08/25/2023 2.24.47 PM)

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

State Information

State Information

Plan Year

Start Year 2024

End Year 2025

State Unique Entity Identification

Unique Entity ID KGLNFGPQMFB4

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

Agency Name South Carolina Department of Mental Health

Organizational Unit Office of the State Director

Mailing Address Robert L. Bank, M.D. P. O. Box 485

City Columbia

Zip Code 29201

II. Contact Person for the Grantee of the Block Grant

First Name Robert

Last Name Bank

Agency Name South Carolina Department of Mental Health

Mailing Address Robert Bank, M.D. P. O. Box 485

City Columbia

Zip Code 29201

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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**
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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**
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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 Bank

Signature of CEO or Designee[1]: _____

Title: Acting State Director

Date Signed: _____

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State of South Carolina
Department of Mental Health

2414 Bull Street•P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

Robert Bank, MD
Acting State Director

July 28, 2023

Ms. Odessa F. Crocker, Chief
Formula Grants Branch
Division of Grants Management, Office of Financial Resources
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Ms. Crocker:

Please find attached with this letter the following documents as required by the FY2024-2025 Substance Abuse and Mental Health Services Administration, Community Mental Health Services, Mental Health Block Grant Application due September 1, 2023. The documents conform to the requirements set forth in the *FFY 2024-2025 Community Mental Health Services Block Grant* letter dated June 30, 2023.

- State Information
- Chief Executive Officer's Funding Agreement
- Disclosure of Lobbying Activities

Please note that while the Disclosure of Lobbying Activities is not applicable to the South Carolina Department of Mental Health, it is being submitted in its blank form in order to remain consistent with prior years' block grant applications.

The Department looks forward to submitting this Mental Health Block Grant Application and appreciates the opportunities the associated funding affords those citizens of the State of South Carolina who are affected by mental illnesses.

Sincerely,

Robert L. Bank, MD
Acting State Director

HENRY MCMASTER
GOVERNOR

February 13, 2023

Ms. Odessa F. Crocker, Chief
Formula Grants Branch
Division of Grants Management, Office of Financial Resources
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Crocker:

I delegate authority to Robert Bank, MD, Interim State Director of the South Carolina Department of Mental Health, for all transactions required to administer the Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Block Grant (MHBG).

Yours very truly,

Henry McMaster

HDM/ss

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

State Information

Chief Executive Officer's Funding Agreement – Certifications and Assurances / Letter Designating Authority [MH]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
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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).
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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 Bank, MD

Signature of CEO or Designee[1]: 

Title: Acting State Director

Date Signed: 07/28/2023

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

South Carolina Department of Mental Health

The Bipartisan Safer Communities Act (BSCA)

Second Allotment

Funding Plan

September 1, 2023

Table of Contents

Introduction

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

In 2022, the South Carolina Department of Mental Health (SCDMH) received its first allotment of BSCA funds, in the amount of $768,496. SCDMH is on track to use its first allotment; the 2022 – 2024 BSCA funds will be used to implement NAVIGATE programs at Community Mental Health Centers (CMHCs), to employ Crisis Certified Peer Support Specialists, and to conduct Critical Incident Stress Management trainings.

This proposal provides information about how SCDMH plans to spend its second allotment of BSCA funds, for the period of September 30, 2023 – September 29, 2025, in the amount of $768,496.

Overview of SC Department of Mental Health

The mission of the South Carolina Department of Mental Health (SCDMH) is to support the recovery of people with mental illnesses. SCDMH is one of the largest hospital- and community-based systems of care in South Carolina; each year, it provides more than 500,000 inpatient bed days, almost half of which are nursing home residents. Since opening its first hospital in 1828, DMH has served approximately four million South Carolinians, including three million patients in SCDMH outpatient community mental health centers and clinics and one million patients in SCDMH inpatient facilities (hospitals and nursing homes).

SCDMH 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 SCDMH 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 DMH 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 SCDMH 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. SCDMH 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

Coronavirus Response and Relief Supplement Appropriations Act (CARES) Funding Plan South Carolina Mental Health Block Grant Proposed Expenditures for Sep. 30, 2021 - Sep. 29, 2025	
ESMI/FEP Set-Aside (10% of Total Award)	
NAVIGATE Program	$76,850
Subtotal	***$76,850***
Crisis Set-Aside (0% of Total Award)	
n/a	$0
Subtotal	***$0***
Community Mental Health Services (90% of Total Award)	
Alliance Program	$345,823
Mental Health Services for Incarcerated People Program	$345,823
Subtotal	***$691,646***
Total	**$768,496**
Award	$768,496
Difference	$0

Scope of Services and Budget Narrative

In consultation with its 16 Community Mental Health Centers (CMHCs) and other stakeholders, SCDMH proposes the use of the second round of BSCA funding to expand three current initiatives: the addition or support of a NAVIGATE program at a CMHC; embedding more mental health professionals in first responder agencies throughout the state as part of the Alliance program; and hiring more mental health professionals to provide services through the Mental Health Services for Incarcerated Individuals (MHSII) Program.

Ten Percent Set-Aside for ESMI/FEP

SCDMH proposes using ten percent of the second round of BSCA funding to support or start a NAVIGATE program at a CMHC. This amount of funding will be $76,850.

Funding for NAVIGATE Program

Program Description – 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.

NAVIGATE – Statement of Need

Over the past few years, SCDMH'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 six different types of ESMI/FEP services. However, only two CMHCs – the Charleston Dorchester MHC and the Aiken Barnwell MHC – offer NAVIGATE. Because NAVIGATE is one of the most rigorous and highest quality ESMI/FEP programs in the nation, SCDMH leadership has encouraged its other CMHCs to begin implementing NAVIGATE programs. SCDMH wants to ensure that all individuals experiencing FEP will benefit from the rigorous, comprehensive set of services that NAVIGATE provides.

Several CMHCs are currently establishing NAVIGATE programs. SCDMH plans to use the full ten percent set-aside, in the amount of $76,850, to support one of its CMHCs as it develops a NAVIGATE program, or to support a CMHC as it continues its NAVIGATE program.

Five Percent Set-Aside for Crisis Services

SCDMH is not specifically setting aside any funding for crisis services. However, the overall focus of the remaining BSCA funds will be spent on activities that are related, in large part, to crisis response and interventions designed to help and support people experiencing behavioral health crises and addressing large-scale disasters throughout the state.

Community Mental Health Services Funding

After the ten percent set-aside has been used, $691,646 of the second allotment of BSCA funds will remain. SCDMH proposes using these funds to strengthen and expand two current initiatives: the Alliance program and the Mental Health Services for Incarcerated People (MHSIP) program.

Each of the sixteen CMHCs will receive an equal allotment of the BSCA funds; each center will receive $43,227.88. The centers will decide if they want to spend their money on expanding their Alliance program or their MHSIP Program. If a CMHC declines the funding, SCDMH will split the remaining funding evenly among the remaining centers. While the Budget Overview shows a 50% split between each program, it is possible that more money will be spent on one program, and less on another program, because the CMHCs will decide how they want to spend the funds.

Funding for Alliance Program

Alliance – Program Description

Alliance is a program in the SCDMH Office of Emergency Services. This program provides opportunities for first responders to collaborate with SCDMH 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, detention 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. MHPs working in detention centers and jails identify detained offenders who are in need of referrals to mental health care and continuity of care in the community. 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.

Alliance – Statement of Need

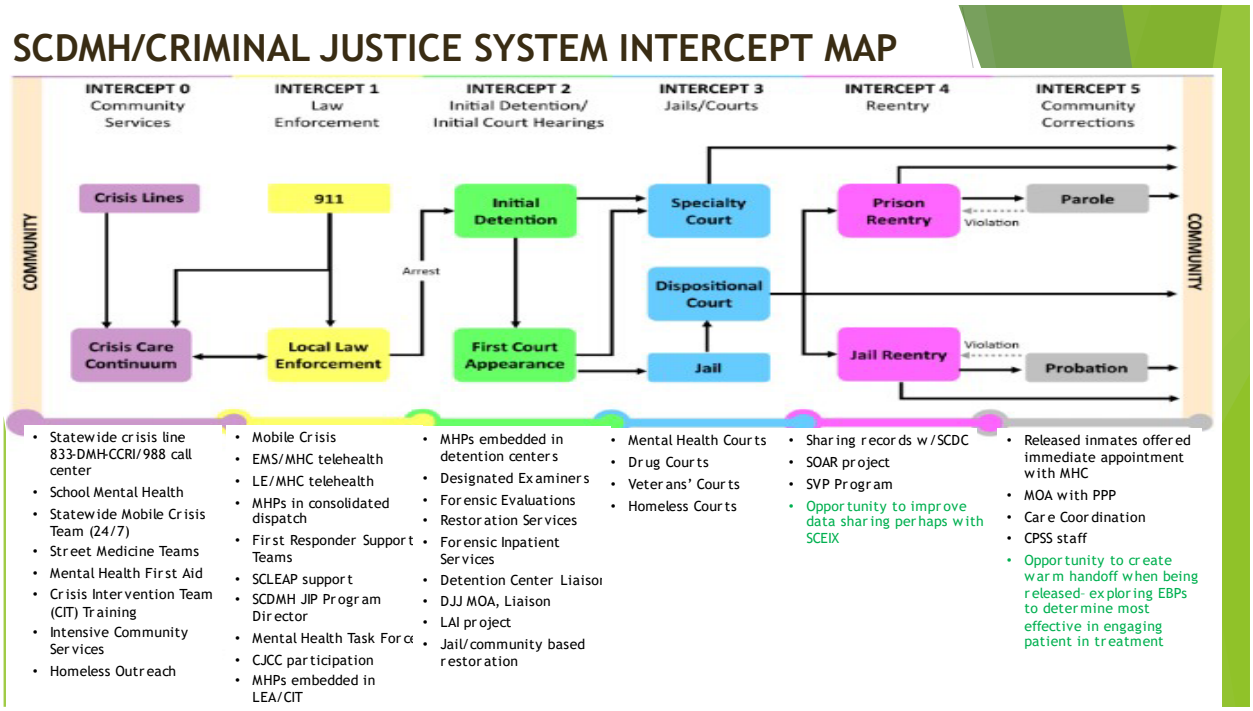
Currently, only thirteen CMHCs have Alliance programs. While some of the CMHCs have developed robust programs with multiple embedded MHPs, other centers have struggled to start their programs or retain their employees. South Carolina – much like the rest of the nation – continues to struggle with mental healthcare workforce expansion and retention. Due to a complex set of factors, SCDMH is unable to offer competitive pay for its positions, which means that many MHPs choose employment in the private sector instead of accepting SCDMH's lower compensation rates. Additional funding for the Alliance program will help CMHCs continue to recruit new employees to expand the provision of crisis services to people in need.

Funding for Mental Health Services for Incarcerated People Program

Mental Health Services for Incarcerated People – Program Description

The SCDMH Criminal Justice System Intercept Map presented below demonstrates six service areas for people with mental illnesses who become involved in the criminal justice system. This map was developed using the SAMHSA GAINS Center's Sequential Intercept Model (SIM).

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, SCDMH 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. 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.



The Mental Health Services for Incarcerated People (MHSIP) Program embeds Mental Health Professionals (MHPs) in South Carolina jails. These embedded MHPs provide a variety of mental health services to incarcerated individuals, including crisis response services. Currently, SCDMH has 13.6 MHPs embedded in jails throughout the state.

Mental Health Services for Incarcerated People – Statement of Need

As discussed in SCDMH's 2024 Block Grant application, the agency has already developed many strong partnerships with law enforcement agencies, including in SC jails and prisons. Yet, SCDMH recognizes that there is a profound need to expand the mental health and crisis response services it provides to incarcerated people. As described above, SCDMH has successfully developed partnerships to provide services in Intercept 3, which includes jails, prisons, and courts. However, most of those partnerships are with courts; not many are with jails, and none are with prisons. Currently, the SC Department of Corrections operates 21 prisons throughout the state, and these prisons house approximately 16,000 inmates.[1] As of 2020, South Carolina had 50 jails located in all 46 counties, and the jail population was made up of 12,820 people.[2] The jails are operated by local jurisdictions. The SC Department of Juvenile Justice operates one long-term youth detention facility, and three regional evaluation centers. In State Fiscal Year 2019, a daily average of 329 children and adolescents were housed in SCDJJ's "hardware-secure facilities."[3]

[1] https://www.doc.sc.gov/about-scdc
[2] https://nicic.gov/resources/nic-library/state-statistics/2020/south-carolina-2020
[3] https://djj.sc.gov/sites/djj/files/Documents/Report%20Cards/2019%20Report%20Card.pdf

The vast majority of incarcerated women and girls are survivors of extreme violence and trauma, including tremendously high rates of sexual violence and domestic violence.[4] [5] While incarcerated men and boys experience much lower rates of sexual violence and domestic violence prior to imprisonment, they enter carceral institutions with high rates of other forms of trauma, including surviving physical violence and witnessing the violent deaths of loved ones.[6] Traumatic events can lead to or contribute to mental illnesses as well as unhealthy psychological and physical coping mechanisms. Even if an individual does not experience any trauma before he or she is incarcerated, the very aspect of surviving incarceration – even for a short time in a jail or juvenile facility – can be traumatizing and distressing. Such high rates of trauma undoubtedly mean that many incarcerated people are suffering from undiagnosed, untreated mental illnesses and mental health challenges, including anxiety, depression, PTSD, CPTSD, and co-occurring Substance Use Disorder (SUD). Being confined in close quarters, having an almost total lack of control over their environments and bodies, fearing violence or abuse, and feeling despondent about the future make it likely that many incarcerated people will experience mental health crises. With all of these things in mind, it is not unreasonable to suggest that *all* incarcerated individuals would benefit from robust mental health services.

Currently, SCDMH employees 13.6 MHPs in jails throughout the state. There are no MHPs embedded in prisons, and no MHPs embedded in juvenile detention facilities. Clearly, 13.6 mental health providers cannot provide enough services to the tens of thousands of traumatized people who are housed in carceral institutions. There is an obvious need for embedded MHPs throughout South Carolina's prisons, jails, and youth detention facilities. Additional funding for the MHSIP Program will help SCDMH recruit new employees to expand the provision of crisis services, and regular mental health services, to incarcerated individuals who are in dire need of psychological assessments and support.

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

SCDMH does not plan to use its second allotment of BSCA funding to develop or enhance its mental health emergency preparedness and response plan. This decision is due, in part, because SCDMH'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.[7] Annex 8 of the SCEOP provides information about the responsibility of each state agency, including SCDMH, to provide Health and Medical Services.[8] In 2018, SCDMH developed the South Carolina Behavioral Health Plan, which is Attachment 1 to Annex 8.[9] The plan

[4] https://www.law.georgetown.edu/poverty-inequality-center/wp-content/uploads/sites/14/2019/02/The-Sexual-Abuse-To-Prison-Pipeline-The-Girls%E2%80%99-Story.pdf
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9385127/
[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7377264/
[7] https://www.scemd.org/em-professionals/plans/emergency-operations-plan/
[8] https://www.scemd.org/media/1214/19-annex-08-health-and-medical-services.pdf
[9] https://www.scemd.org/media/1356/behavioral-health-attachment-to-annex-8-final.pdf

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. SCDMH's responsibilities include:

1. Provide staff as required to support ESF-8's disaster behavioral response efforts.
2. Maintain a listing of available Disaster Behavioral Response Staff and Community Disaster Response Coordinators with contact information.
3. Coordinate the provision of crisis counseling and outreach to victims and responders in affected communities.
4. Support of evacuation of behavioral health facilities, assist in restoration of services afterward.
5. Coordinate the availability of disaster response behavior health services to survivors and responders in affected communities.
6. Assist SCDHEC with the coordination of the behavioral health services and resources with support agencies such as The American Red Cross and The Salvation Army.
7. Maintain records of behavioral response teams state-level activations and records of response activities.

Because SCDMH already has a comprehensive statewide plan for addressing mental health emergencies in the event of widespread disasters, terrorist events, and other traumatic events, the agency plans to spend its second allotment of BSCA funding on programmatic expansion for more localized crisis response initiatives.

Plans to Develop/Enhance State Behavioral Health Team

SCDMH does not plan to use its second 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 SCDMH's mobile crisis call center is already robust and provides services throughout the state.

The South Carolina Mobile Crisis Call Center (SCMCCC), based in Charleston, SC, was first implemented in 2020 by SCDMH. This center assists individuals statewide and communicates with community mental health centers in every county to assist with triage and emergency assessment. The 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 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 is able to arrive on scene. In addition to those responsibilities, the SCMCCC 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. The center has assisted Mobile Crisis teams in being available to triage calls, develop safety plans, divert emergencies, and provide resources to individuals not needing immediate mobile crisis services or emergency response. The center also acts as a bridge for communication between first responders and Mobile Crisis clinicians. The SCMCCC is available at all hours to first responders to triage calls, gather information, or request Mobile Crisis response. Overall, the center works to assist and provide resources to individuals and families experiencing mental health emergencies throughout the 46 counties of South Carolina.

Plans to Develop/Enhance Mobile Crisis Team

SCDMH will use a portion of its second allotment of BSCA funding to develop or enhance its mobile crisis team, through the expansion of the Alliance program at various CMHCs throughout the state. Mental health professionals who are embedded in first responder agencies through SCDMH's Alliance program will be available to respond to individuals experiencing crises or emergencies.

SCDMH's mobile crisis team program is already robust and provides services throughout the state. The addition of more embedded MHPs at first responder agencies will enhance and expand SCDMH's ability to ensure that individuals in crisis will receive high-quality, trauma-informed mental health services.

The SC Mobile Crisis is a program created by DMH in partnership with SC Department of Health and Human Services to enhance DMH'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. This program provides an extension of SCDMH community mental health center services; during business hours, DMH 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 but refuse to seek voluntary services. 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 DMH Call Center located within Charleston Dorchester Mental Health Center. 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.

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

A small portion of the second allotment of BSCA funding may be used to develop or enhance services provided to young adults, youth and children or their families. This includes individuals who are involved in the justice system and those who experience Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED). Services may be developed or enhanced through the expansion of the Alliance program, the MHSIP Program, and the NAVIGATE program.

Mental health professionals who are embedded in first responder agencies through SCDMH's Alliance program will be available to respond to individuals of all ages, as well as families. The MHSIP Program will make it possible for more children and adolescents to receive mental health services in juvenile detention facilities. The NAVIGATE program provides services to young adults age 18 – 30 who are experiencing psychotic disorders.

Please refer to the descriptions provided previously in this application for detailed information about the Alliance program, the MHSIP Program, and the NAVIGATE program.

Plans to Develop/Enhance Services Provided to Communities

A small portion of the second allotment of BSCA funding may be used to develop or enhance services provided to communities that are affected by trauma, mass shootings, and school violence, through the expansion of the Alliance program. Mental health professionals who are embedded in first responder agencies through the Alliance program will be available to respond to individuals experiencing crises or emergencies.

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

Plans to Develop/Enhance Culturally and Linguistically Tailored Messaging

A small portion of the second allotment of BSCA funding may be used to develop or enhance culturally and linguistically tailored messaging related to the NAVIGATE program, the Alliance program, and the Incarcerated Support Services Program. Each CMHC will decide how to spend its BSCA allocation, and it is likely that many CMHCs will use a small portion of their funds to develop or enhance messaging about their programs, to ensure that they can better support community members in need of services.

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

SCDMH does not plan to use its second allotment of BSCA funding to develop or enhance other mental health emergency or crisis behavioral health practices.

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

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Not Applicable

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 M/SUD prevention (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 M/SUD 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 M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. 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."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Step 1: Assess the Strengths and Organizational Capacity of the Service System to Address the Specific Populations

Assessing Strengths and Organizational Capacity

To assess the strengths and organizational capacity of its mental healthcare service system, the South Carolina Department of Mental Health (SCDMH) systematically reviews its programs and services on an ongoing basis. As a result, SCDMH is able to identify the areas in which it excels, as well as the areas in which gaps or needs have arisen. The agency is continually evaluating, assessing, and refining its programs, services, and service delivery systems for its patients. The strength of SCDMH is its structure, comprehensiveness, and control over the continuum of mental healthcare services throughout the state of South Carolina.

The History of Mental Health in South Carolina

In the 18th century, ideas about what to "do" with a mentally ill person depended upon the individual's social status, domestic situation, location, and medical condition. "Insanity" was viewed as a private matter and family responsibility; society expected families to provide care by themselves, or pay for caregivers. It was not uncommon for people with mental illnesses to live in workhouses or debtors' prisons. Colonel Samuel Farrow, a member of the South Carolina House of Representatives, and Major William Crafts, a member of the South Carolina Senate, worked zealously to sensitize their fellow lawmakers to the needs of the mentally ill. On December 20, 1821, the South Carolina State Legislature passed a statute-at-large approving $30,000 to build the SC Lunatic Asylum. This legislation made South Carolina one of the first states in the nation (following Virginia and Maryland) to provide funding for the care and treatment of people with mental illnesses; South Carolina's mental health system was the third established system in the U.S., as well as the third funded by a state government. Renowned architect Robert Mills was enlisted to design the new SC Lunatic Asylum, the cornerstone for which was laid in July of 1822. It featured such innovations as central heating and fireproof ceilings. However, the asylum did not reach its full capacity of 192 patients until 1860 – more than 30 years after opening its doors. Many families preferred to care for mentally ill relatives at home, while others wanted them closer to home even if it meant they lived in county jails or workhouses.

Dr. Fred Williams, who served as SC State Hospital superintendent from 1915 to 1945, realized that South Carolina's mental health system needed community mental health clinics. As such, he encouraged a program to educate the public about mental illness, its causes, and methods of prevention. The first clinic to provide services for the mentally ill who did not need hospitalization was opened at the SC State Hospital in 1920. The first permanent outpatient clinic opened in Columbia in 1923. The success of this clinic inspired the opening of traveling clinics in Greenville and Spartanburg in 1924. By 1927, clinics were established in Florence, Orangeburg, and Anderson. In 1928, a clinic opened in Charleston, with plans for one in Rock Hill. Reopening of the clinics, which had closed as staff served in WWII, was delayed until late 1947 due to a lack of adequately trained personnel. As clinics continued to grow throughout the state, the need for state and federal funding increased. Help came in 1946 with the passage of Federal Public Law 79-487, also known as the National Mental Health Act.[1]

[1] https://www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-mental-health-nimh

In addition to establishing the National Institute of Mental Health (NIMH), the National Mental Health Act provided for a Mental Health Commission to oversee all mental health facilities. Communities were required to contribute one third of the cost of clinic or center operation and the state would furnish the remaining two thirds. The South Carolina Mental Health Commission is still in place to this day and meets monthly. By 1957, clinics were in operation in six SC counties. Major functions of these clinics included: cooperation and consultation with other agencies and professional people in the community; evaluation and treatment of emotional disturbances in adults and children; public education; and training psychiatric and pediatric resident doctors from the Medical College Hospital. The 1960s ushered in the beginnings of the community mental health movement. The introduction of Medicaid and other improvements in the social welfare system underwrote the treatment of patients in their own communities, and the 1963 Federal Community Mental Health Centers Act provided matching federal funds for construction of community mental health centers.

In 1967, the Columbia Area Mental Health Center (CAMHC) became the first comprehensive community mental health center in the Southeast. In that same year, William S. Hall, MD, the first South Carolina State Commissioner of Mental Health, participated in a ceremony in which part of the wall surrounding the State Hospital came down. During Dr. Hall's 21-year tenure as commissioner, SCDMH made strides in community-based care. A comprehensive, statewide mental health care delivery system emerged, and grew to encompass 10 major inpatient facilities and 17 community mental health centers, providing services in all of the state's 46 counties, with more than 6,000 employees.

During the 1970s, South Carolina experienced a number of firsts, including the establishment of a transitional living project to help patients return to the community after long hospital stays, a facility for psychiatric patients who needed long-term care, an alcohol and drug addiction treatment center, and a patient advocacy system to protect the rights of people served by SCDMH.

In 1983, SCDMH adopted a plan calling for the development of community-based services, the decentralization of hospital services, and a significant decrease in the population of its psychiatric facilities in Columbia. This is what we often hear referred to as “deinstitutionalization.”

Joseph J. Bevilacqua, Ph.D., who became state commissioner of Mental Health in 1985, led with the view that patients treated in the community progress better clinically; people with mental illnesses need and benefit from family and community support. SCDMH’s philosophy was – and continues to be – that patients recover faster and stay well longer when receiving services in their communities if such programs are reasonably funded, well organized, and readily available.

In 1989, SCDMH, with support from the National Institute of Mental Health, hosted a national conference to explore how other states shifted to community-based services, how they defined priority populations, and how they planned and located services. Findings from the national conference concluded that services necessary for the successful transition of patients into communities did not exist and must be developed. Experts and professionals attending the conference also made it clear that some patients could not be safely discharged into the community; these patients should continue to be cared for in SCDMH facilities until appropriate services could be created.

At first, some communities struggled to develop community-care programs. Patients faced a shortage of appropriate housing options, a lack of crisis care for short-term acute situations, and a lack of employment opportunities. Still, SCDMH moved forward. In 1993, 127 patients from the South Carolina and Crafts-Farrow State Hospitals moved into seven customized mental health programs in Aiken,

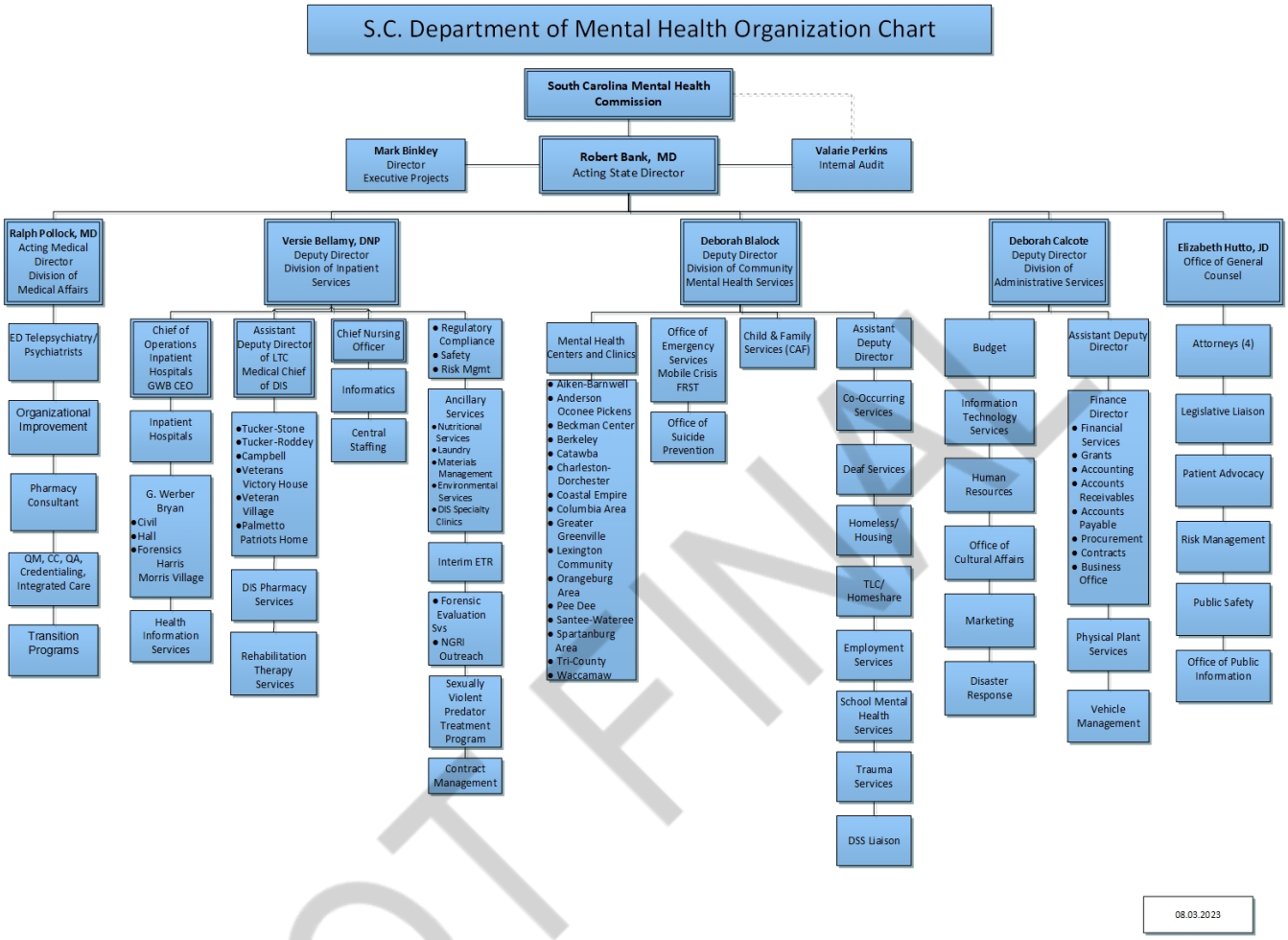
Charleston, Columbia, Lexington, Orangeburg, and Sumter. These patients were provided with appropriate housing, medication monitoring, psychiatric and medical services, supportive community services, meaningful activity, and employment assistance. In two separate moves between 1992 and 1995, 265 patients were discharged from inpatient facilities to Toward Local Care projects in community mental health centers across the state.

The State Hospital, or "Bull Street" campus was closed in 1996. The SCDMH system is now comprised of numerous entities: 16 community mental health centers (CMHCs); three psychiatric hospitals, one of which is for treatment of substance use disorders; five veterans' nursing homes; one community nursing home; and a Sexually Violent Predator Treatment Program. Each CMHC operates clinics and satellite offices.

Agency Overview

- The mission of SCDMH is "to support the recovery of people with mental illnesses."
- Since opening its first hospital in 1828, SCDMH has served approximately 4 million South Carolinians.
    - Approximately 3 million patients have been served in SCDMH outpatient community mental health centers and clinics; approximately 1 million patients have been served in DMH inpatient facilities (hospitals and nursing homes).
- SCDMH is one of the largest hospital- and community-based systems of care in South Carolina:
    - In FY23, SCDMH provided 479,755 inpatient bed days.
    - 1,011 veterans resided in veterans nursing homes during FY 2023, resulting in 72,538 bed days at Campbell, 15,408 bed days at Stone, 66,524 bed days at Veterans' Victory House, 20,546 at Palmetto Patriots Home, and 19,731 at Veteran Village for a total of 194,747 bed days.

South Carolina Department of Mental Health Organizational Chart



SCDMH's System of Care

The South Carolina Department of Mental Health:

- Comprises 16 community-based, outpatient mental health centers and dozens of associated clinics and satellite offices, serving all 46 counties in our state;
- Provides services to approximately 100,000 patients per year, approximately 30,000 of whom are children;
- Operates three licensed hospitals, including one for treatment of substance use disorders;
- Operates six nursing homes, including five for veterans;
- Is one of the largest hospital- and community-based systems of care in South Carolina;
- Includes operation of a large Forensics program for defendants referred from the state's criminal courts; and
- Includes operation of a Sexually Violent Predator Treatment Program.

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 DMH CMHCs are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), an independent, nonprofit accreditor of health and human services. Each DMH community mental health center has an advisory board, with 7 to 15 members, including at least one medical doctor. Center boards meet monthly.

SCDMH's Inpatient Services comprises three hospitals, one community nursing care center, five veterans nursing homes, and a Sexually Violent Predator Treatment Program. Each of SCDMH's psychiatric hospitals is accredited by the Joint Commission, which aims to improve healthcare by evaluating healthcare providers and inspiring them to excel in the provision of safe, effective care of the highest quality and value. Morris Village Treatment Center, the agency's inpatient drug and alcohol treatment facility, is licensed by the South Carolina Department of Health and Environmental Control (SCDHEC) and accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), an independent, nonprofit accreditor of health and human services. Each of SCDMH's six nursing homes is licensed by SCDHEC and certified by the Centers for Medicare & Medicaid Services. Five of the agency's six nursing homes serve veterans exclusively and are certified by the Department of Veterans Affairs.

- *G. Werber Bryan Psychiatric Hospital (Columbia)* – G. Werber Bryan Psychiatric Hospital (Bryan) 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, and has three distinctive parts:
    - Adult Services – Bryan's Adult Services patients are admitted primarily from the 33-county Midlands, Pee Dee, and Lowcountry regions of South Carolina. The majority of patients are civil involuntary admissions.
    - Forensics – The 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.
    - William S. Hall Psychiatric Institute at Bryan Psychiatric Hospital (Hall) – Hall 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.
- *Patrick B. Harris Hospital (Anderson)* – Harris Hospital 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. In 2015, Harris was recognized as a 2014 Top Performer on Key Quality Measures by The Joint Commission. The award recognizes accredited hospitals and critical access hospitals that attain and sustain excellence in accountability measure performance. Recognition in the program is based on an aggregation of accountability measure data reported during the previous calendar year.
- *Morris Village Alcohol & Drug Addiction Treatment Center (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 State of South Carolina and is accredited by the Commission on Accreditation of Rehabilitation Facilities. 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.

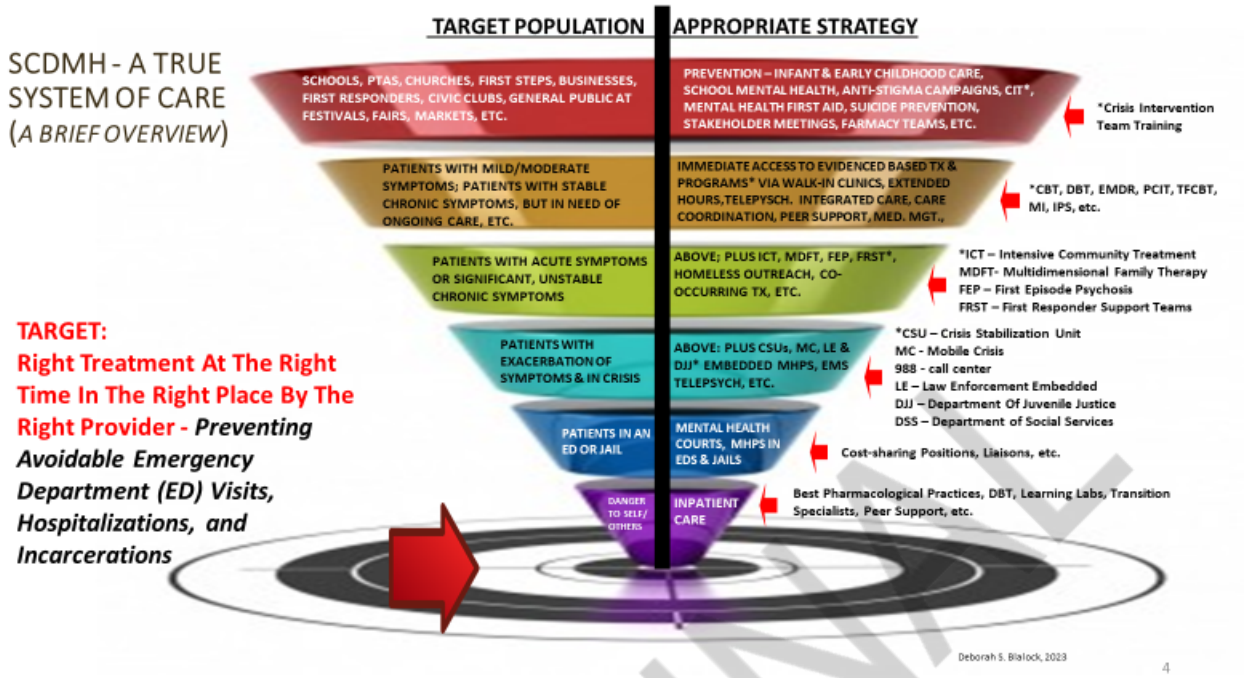
Anticipating a growing veteran population, SCDMH applied for funds in 2015 to construct additional State Veterans nursing homes. With guidance from the State's Joint Bond Review Committee, DMH identified areas with a significant need for new veterans nursing homes. DMH submitted additional State Veterans nursing home construction grant applications to the U.S. Department of Veterans Affairs. In 2022, two new State Veterans Nursing Homes, each comprising 104 beds, opened in Florence (Veteran Village) and Gaffney (Palmetto Patriots Home). One additional 104-bed veterans nursing home is currently under construction in Sumter with an expected opening in fall 2024. An additional two homes are currently in planning phase. These homes will be located in Orangeburg and Horry counties.

A System of Care Designed for Patients: The Right Treatment, at the Right Time, at the Right Level

South Carolina is one of the only states in the US with a state-operated, comprehensive mental health system, resulting in numerous benefits for South Carolinians in need of services. This structure means that SCDMH:

- Is comprised of a network of community mental health centers (CMHCs) and associated clinics, covering geographical catchment areas, that provide an inclusive, uniform array of core mental health services;
- Provides and/or coordinate the necessary vital, non-medical supports for successful recovery, e.g., care coordination, tailored to each patient's needs;
- Provides transition services to and from inpatient care, including non-clinical services, to support long-term recovery;
- Facilities are able to provide support as needed to patients of other DMH centers and hospitals, e.g., sharing psychiatrist time via telehealth, providing services to anyone in need following a natural disaster;
- Is a trauma-informed system, supporting the development and implementation of 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 offers evidence-based treatment options to patients experiencing trauma-related symptoms.
- Utilizes a system-wide, secure, electronic medical record, allowing all clinical components access to patient information and providing seamless access to care for patients who may move to a new area in SC but wish to continue services with SCDMH;
- Operates according to uniform policies and procedures.

This unique design also results in decreased costs compared to systems that utilize privatization and contracted services.



A True System of Care

The programs, services, and divisions highlighted in this document are designed to ensure that South Carolinians in need 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.

Today, we know:

- Patients treated in the community fare better clinically.
- People with mental illnesses need family and community support.
- Patients recover faster and stay well longer when receiving services in their communities.

Hence, the need for a continuum of services providing safe, effective, cost-efficient care, including:

- Early identification, and prevention.
- Intensive community treatment, when needed.
- Community crisis response, intervention, and stabilization.
- Diversion from unnecessary emergency department visits, hospitalizations, and incarcerations.
- Inpatient commitment for only those who need it.

Community Services

A robust system of community-based services, serving children, adolescents, adults and families, are vital to successful early identification and intervention, stable community placement, and successful recovery. To that end, SCDMH provides core mental health services at all 16 of its community MHCs, including:

- Psychiatric services
- Individual and family counseling
- Services for children, adolescents, adults, and families

- Peer support
- Clinical care coordination
- Housing assistance
- Vocational services

Highlighted below are several community-based services:

Child and Family Services – CAF Services develops and aspires to implement a seamless statewide system of caring for the children, adolescents, and families of South Carolina including ensuring the use of best practices when appropriate and possible. Best Practice programs, which vary among SCDMH locations, include: Multi-Dimensional Family Therapy, Trauma-Focused Cognitive Behavioral Therapy, Dialectic Behavioral Therapy, Parent-Child Interaction Therapy, Attachment and Biobehavioral Catchup, Motivational Interviewing, and the National Adoption Competency Mental Health Training. The CAF Division assumes a leadership role and provides staff support to the Joint Council on Children and Adolescents in the development of a system of care to increase access to services and supports for families living with mental health, substance abuse, and co-occurring concerns.

School Mental Health Services – The mission of SMHS is to promote academic and personal success by identifying and intervening at early points and to support social and emotional/behavioral well-being of children and youth in South Carolina. In 1993, SCDMH began providing services in schools full-time including prevention, early intervention, clinical assessment, individual/family/group therapy, crisis intervention, psychiatric assessment and evaluation, care coordination, and mental health awareness. Partnering with the University of South Carolina in 2019, SCDMH launched the John H. Magill School Mental Health Certificate Program to develop a well-qualified workforce of school mental health clinicians. Since then, 35 master's level students in 5 cohorts completed the paid internship program that offers 30 hours of SMHS-specific professional development in addition to 100s of hours of in-person training.

Intensive Community Treatment – Some SCDMH patients need a higher level of care to prevent hospitalization. These patients can be referred to Centers' 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.
- Provide a wide range of therapeutic services.
- Patients are offered appointments at least weekly and can likely receive multiple services weekly.
- Each ICT mental health professional has no more than 35 patients.
- ICT services can be delivered in patients' homes or other community locations at times that work best for patients.

Office of Transition Programs – In 2019, SCDMH created the Office of Transition Programs to assist patients who have been hospitalized in SCDMH facilities for longer-term treatment to move from a hospital setting to the community and toward independent living. The office assists patients with their identified psychosocial needs, so they can access community resources in an effective and efficient way post-discharge. Transition Specialists work with patients to determine their recovery needs, their preference of where they want to live in the community, and to collaborate with stakeholders to ensure continuous communication as it relates to the patient's discharge plans. Transition Specialists ensure effective communication between inpatient/outpatient staff regarding patients' discharge needs and

coordinate with all stakeholders (patient, family, clinical care coordinators, certified peer support specialists), streamlining the discharge process and improving the chance for successful transition to the community. In FY23, the Office of Transition Programs assisted in 146 discharges. Of those discharges, 69% were to Community Residential Care Facilities, a decrease from 83% in FY22, and 22% were to family, an increase from 10% in FY22.

Clinical Care Coordination and Community Long-Term Care – In 2013, SCDMH launched the Office of Clinical Care Coordination with internally transferred staff, with 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. It 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. As of June 2023, 16 case managers provide services statewide, and case managers served 998 participants with an average of 10-15 new cases added monthly.

Community Placement – SCDMH sponsors or supports a variety of living arrangements for patients transitioning out of psychiatric hospital settings or receiving mental health services from one of its 16 community mental health centers. SCDMH community residential options include:

- Housing & Homeless Services, which funds the development of affordable housing options for people with mental illnesses across the state.
- The TLC Program, which includes community care residences, Homeshare, supported apartments, rental assistance, and supportive services.
- Community Residential Care Facilities (CRCFs), DHEC-licensed facilities that offer room, board and a degree of personal care for 2 or more people.

Individual Placement and Supported Employment Program (IPS) – This supported employment evidence-based program is located in 14 out of 16 SCDMH community mental health centers. Each center partners with the local Vocational Rehabilitation Department to provide opportunities for people with serious mental illnesses to become gainfully employed in the community. In state fiscal year 2023, SCDMH supported employment programs achieved a 54% average competitive employment rate for people with severe mental illness. During this period, IPS had a total of 870 new people enroll in its programs and placed 495 people in competitive employment. In fiscal year 2023, IPS received 1,264 new referrals and provided employment services to 812 patients. Nationally, among the 26 states participating in the IPS Dartmouth/Johnson & Johnson studies, South Carolina was ranked in the top 5 highest average employment rates based on data from the first three quarters of fiscal year 2023.

Crisis Services

South Carolina Mobile Crisis – SC Mobile Crisis is a program created by SCDMH in partnership with SC Department of Health and Human Services to enhance SCDMH'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. This program provides an extension of DMH community mental health center services; during business hours, SCDMH 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 but refuse to seek voluntary services. 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.

Crisis Stabilization – SCDMH operates one Crisis Receiving and Stabilization Facility (CRSF). This program helps reduce hospitalization by providing services in people's communities.

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. During SC's State Fiscal Year 2023, 372 people were referred to the TCSC, and 190 were admitted. The majority of referrals were for SI, psychosis, and hospital stepdowns. 249 referrals came from emergency departments. Out of the 190 admitted patients, 170 were diverted from emergency departments and hospitals due to their involvement at the TCSC, and one person was diverted from jail.

Telepsychiatry Programs

SCDMH has been providing telehealth services since 1996 in a wide range of settings, from inpatient treatment to community care settings. SCDMH currently has six telepsychiatry programs: Emergency Department Telepsychiatry, Community Telepsychiatry, Inpatient Services Telepsychiatry, EMS Telehealth, School Telehealth and Telepsychiatry, and Nursing Home Telepsychiatry.

SCDMH's Emergency Department (ED) Telepsychiatry program has 26 hospital partners across the state and is in the process of adding new partners. In FY23, the ED Telepsychiatry program provided over

9,000 psychiatric consultations, which is approximately 750 consults each month. Psychiatric care is available through the ED program 17 hours per day, 365 days per year.

SCDMH'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 Mental Health Centers and satellite county clinics statewide. The Community Telepsychiatry program has provided psychiatric treatment services to SCDMH patients since August 2013. Almost exclusively (99%), the Community Telepsychiatry program service codes are for psychiatric medical assessment.

Specialty Programs and Services

As part of its treatment continuum, SCDMH offers programs and services to reach populations with particular needs that require specialized care. These initiatives are designed to ensure those in need receive appropriate services, at the right time, in the right place, from the most appropriate provider, helping preventing avoidable emergency department visits, hospitalizations, and incarcerations. They focus on: Prevention; Diversion; Early Identification & Intervention; Education & Support for Special Populations. The following describes some of these programs and services within SCDMH.

Office of Suicide Prevention – Established in 2019, the SCDMH Office of Suicide Prevention (OSP) implements a wide range of activities, including the following:

- South Carolina Strategy for Suicide Prevention
- South Carolina Zero Suicide Initiative
- South Carolina Suicide Prevention Student Identification Act
- Trainings for SCDMH Staff Members and Community Members
- Best-Practice Policies and Procedures in SCDMH Facilities
- Post-Intervention Consultation and Resources
- Statewide Coalition and Taskforce Development
- 988 Suicide and Crisis Lifeline Center at CDMHC
- Implementation of Hope.ConnectsYou.org
- South Carolina Mobile Crisis Call Center
- Faith Community Outreach
- Military Populations Support
- Enactment of New Law Regarding Crisis Stabilization Units

In late 2018, after nearly two years of collecting data, evaluating research, and reviewing evidence-based trainings, strategies, and procedures, the Coalition released the South Carolina Strategy for Suicide Prevention: 2018-2025 with the goal of reducing suicide by 20% by 2025. The Strategy is a living document that contains a wealth of information for how any organization, community or individual can help fight suicide in South Carolina. In 2022, the Coalition released an updated State Plan to reflect the progress made, emerging trends and needs, as well as new goals for the state.

In addition to numerous other suicide prevention trainings, OSP provides the Applied Suicide Intervention Skills Training (ASIST). ASIST is a two-day, face-to-face workshop that trains participants how to prevent suicide by recognizing signs, providing skilled intervention, and developing a safety plan to keep someone alive. Developed more than 35 years ago, ASIST is a continually updated, evidence-

based training. In 2023, 119 people were trained by SCDMH. Since the ASIST training's inception in 2016, SCDMH has trained 1,797 professionals, first responders, and community members.

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. The H2H program was initially supported by a federal grant, and additional RVs were purchased using SAMHSA block grant funding.

Mental Health Courts – Mental Health Courts aim to divert non-violent, adult offenders with serious mental illness from the criminal justice system. These Courts generally function as partnerships comprised of an assigned judge (frequently a Probate Court judge), the local DMH community mental health center, Public Defender's Office, jail/detention center administration, and the Solicitor's Office. South Carolina currently has Mental Health Courts in the following counties: Aiken, Berkeley, Charleston, Greenville, Horry, Richland, and York. In 2017, SCDMH received a grant from The Duke Endowment to increase the number of Mental Health Courts and/or increase the capacity of existing courts, standardize policies and procedures, and to evaluate the outcomes of existing Courts. This grant is expected to end December 30, 2023. SCDMH continues to use agency resources to fund clinical positions to support mental health courts.

Alliance Program – Alliance is a program in the SCDMH Office of Emergency Services. This program provides opportunities for first responders to collaborate with SCDMH 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, detention 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. MHPs working in detention centers and jails identify detained offenders who are in need of referrals to mental health care and continuity of care in the community. 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 Responders Support – SCDMH's First Responder Support Team (FRST) was originally established to support firefighters. The Charleston Firefighter Support Team (CFST) was created in partnership with SCDMH, City of Charleston, South Carolina State Firefighter Association, National Fallen Firefighters Association, and Charleston Dorchester Mental Health Center (CDMHC) in response to the catastrophic Sofa Superstore fire in June 2007. After six years serving firefighters, SCDMH and CDMHC launched the First Responder Support Team (FRST) and opened its doors to all branches of first responders and their families. Its mission and purpose are to provide behavioral health services to all first responders in an environment where they feel safe, protected and understood. Utilizing the same marketing strategies as CFST, this team will continue to go into 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.

In addition to providing behavioral health services to the first responders, the FRST clinicians are also trained to assist with Critical Incident Stress Debriefings. Critical Incident Stress Management Training, which is taught through the International Critical Incident Stress Foundation (ICISF), is a comprehensive, phase-sensitive, and integrated multi-component approach to crisis/disaster intervention. Through CISM, mental health professionals (MHP) and first responders learn how to facilitate a Critical Incident Stress Debriefing (CISD), which can be provided one-on-one, in small groups, or in a large group format. SCDMH has used CISM to support local agencies who have experienced workplace violence, traumatic deaths, prolonged exposure to traumatic stress, etc.

Metropolitan Children's Advocacy Center - The Metropolitan Children's Advocacy Center (Met CAC) is accredited through the National Children's Alliance in Washington, DC. It is the only state-funded CAC in South Carolina. SCDMH collaborates with the USC School of Medicine's Department of Pediatrics and Prisma Health Children's Hospital to provide integrated services for children suspected of being abused or neglected. In partnership with the Children's Law Center of the University of South Carolina School of Law, the Met CAC also provides ChildFirst, a training in forensic interviewing techniques provided quarterly for law enforcement and child protection professionals. The Met CAC, which is a program under SCDMH's Columbia Area Mental Health Center, serves more than 1,000 children each year. The Metropolitan Children's Advocacy Center provides: forensic interviews and medical exams; expert testimony in Family and Criminal Court; victim advocacy services; and, Coordination of the Richland County Child Abuse Investigation Multidisciplinary Team.

Deaf Services – SCDMH's Deaf Services Program provides a continuum of outpatient and inpatient mental health services to persons who are Deaf and Hard of Hearing. The Program uses innovative technological and human service program initiatives to ensure all services are delivered in a cost-effective and timely manner, statewide. Services include:

- Outpatient services for children, families, and adults, using itinerant counselors who are part of regional teams located across the state.
- School Mental Health services in collaboration with public school systems statewide.
- Residential services in supported apartments at locations statewide.
- Use of telemedicine across a variety of platforms to provide accessible services to rural areas.
- Inpatient services at Patrick B. Harris Hospital and William S. Hall at Bryan Hospital.
- A 24/7 crisis hotline (803) 339-3339 or DEAFHOTLINE@scdmh.org for Deaf and Hard of Hearing SC residents.

- Sign language interpreters and Communication Access Realtime Translation by request for DMH appointments and crisis interventions.

Additional Specialty Services at SCDMH – Additional specialty services include 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), Infant and Early Childhood Mental Health Consultation (IECMHC), and First Episode Psychosis (FEP) Programming.

Collaborations and Affiliations

SCDMH has affiliations with more than 60 educational institutions in South Carolina and more than 5 other states. DMH works closely with independent advocacy organizations to improve the quality of life for people with mental illness, their families, and the citizens of South Carolina.

The agency's affiliation with the University of South Carolina includes activity therapy, clinical counseling, medical students, nursing students, social work, psychology interns, psychology graduate studies, and residents and fellows in psychiatry. SCDMH has contracts with the University of South Carolina's School of Medicine (USCSOM) and the Department of Neuropsychiatry and Behavioral Science. There has been a long collaborative relationship between SCDMH and the Department of Neuropsychiatry and Behavioral Science at the USCSOM, which provides clinical consultation and training delivery to DMH staff on a range of clinical topics. Additionally, SCDMH provides clinical rotation for 1st-, 2nd-, 3rd-, and 4th-year medical students from the University of South Carolina School of Medicine. The students are assigned SCDMH physician preceptors and rotate through DMH's centers and facilities through a written agreement. There are four fully accredited Psychiatric Residency Fellowship Training Programs (Child, General, Forensics and Gero-Psychiatry) that rotate through SCDMH centers and facilities, which the Agency supports via contract with the University of South Carolina School of Medicine.

Residents from the MUSC Residency Training Program receive educational experiences and supervision in Psychiatry through scheduled rotations at the Charleston Dorchester Mental Health Center (CDMHC). CDMHC is involved with learning collaborative including SCDMH, the Crime Victim's Center at MUSC, and the Dee Norton Lowcountry Children's Center. This initiative revolves around Trauma-Focused Cognitive Behavioral Therapy. Residents train with CDMHC's First Responder Support Team and Mobile Crisis. Medical students rotate regularly though CDMHC throughout the academic year. DMH has a contract with MUSC to provide forensic evaluation of adult criminal defendants in 10 counties in South Carolina.

Emergency Preparedness and Response – SCDMH provides staff to the State Emergency Operations Center (SEOC) when it is activated. SCDMH Staff act as liaisons for the agency and provide guidance and access to meet the behavioral health needs of numerous support agencies, primarily in the health and medical and mass care emergency support functions. SCDMH is the primary agency to support the Department of Health and Environmental Control (DHEC) for coordinating and providing behavioral health services during emergencies and disaster response and recovery. SCDMH staff across the state are partners of and provides support to one of the four regional healthcare coalitions in the state and local healthcare preparedness programs. A member of SCDMH sits on the state advisory council for healthcare preparedness as part of the Statewide Healthcare Coalition. Other SC partners served in this effort include the South Carolina Emergency Management Department (SCEMD), South Carolina

Department of Social Services (SCDSS), and the State Substance Abuse Authority, South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS).

Internal Oversight and Quality Assurance – In the life cycle of an award, related expenditures may be reviewed by any combination of SCDMH'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.

SCDMH 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, SCDMH 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.

In collaboration with the South Carolina Mental Health Commission, SCDMH built and implemented a Compliance Program consistent with the procedural and structural guidance provided by the Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS) 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. The South Carolina Mental Health Commission and SCDMH expect all staff members to conform to the standards of conduct as stated in the Compliance Program's Code of Ethics and Conduct.

SCDMH's Compliance program:

- is ongoing and the objectives are consistent with the agency's mission;
- provides employees education regarding compliance;
- 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;
- includes a system to investigate allegations of noncompliance;
- regularly monitors and audits activities; and,
- enforces appropriate conduct and discipline.

SCDMH's Quality Management Advisory Committee (QMAC) includes compliance and quality assurance. Compliance promotes and monitors SCDMH'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 SCDMH's patients.

SCDMH's Compliance Committee comprises 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. SCDMH's Compliance Officer provides the South Carolina Mental Health Commission with timely and accurate information at least twice a year, 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 SCDMH serves as an independent function to examine and evaluate Agency activities as a service to the South Carolina Mental Health Commission and the DMH state director. Internal Audit's overall objectives are to: evaluate internal controls and safeguard Agency assets; test for compliance with State, Federal, and Agency 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.

Office of Cultural Affairs (OCA) and Office of Cultural Affairs Director - SCDMH considers cultural competence part of its mission, believing that cultural competency is driven by leadership, and should be staff and patient-oriented. Furthermore, SCDMH understands that services are more effective when they are provided within the most relevant and meaningful cultural, gender-sensitive, and age-appropriate context for the people being served. The agency believes that multiculturalism should be embedded in all organizational units and that continuous efforts must be made to recruit, retain, and develop a culturally diverse workforce. The SCDMH OCA is charged with the responsibility of advising and guiding Agency leadership in the creation and maintenance of a linguistically and culturally competent workforce, service divisions, programs, and collaborative endeavors, reflective of the diversity of the population served and local communities. In 2020, SCDMH hired its first ever Office of Cultural Affairs Director, who works to help define the overarching vision, identity, and strategy of all agency divisions and programs, and collaborates with leadership to assess and remove existing policies, practices, procedures, and norms that may support unfair or biased delivery of services, hiring/promotional practices, and conduct/performance approaches.

Patient Advocacy – SCDMH's Advocacy Program is designed to: prevent patient rights violations and advocate for the provision of quality of care in a humane environment; review, investigate and resolve patient rights complaints or issues; and, monitor the number and types of complaints to identify systemic areas of concern. All SCDMH 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.

Patient Advisory Boards – Patient Advisory Boards (PABs) 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 SCDMH is among only a few state systems that have mandated the establishment of PABs not only at the state level, but also at every SCDMH community mental health center and hospital.

Research and Institutional Review Board – SCDMH recognizes the need for safeguarding the rights and welfare of research subjects and their private health information. In accordance with U.S. Department of Health and Human Services regulations, SCDMH has an established Institutional Review Board (IRB). SCDMH's online IRB manual, posted on the agency website, provides researchers with tools and information necessary to ensure these obligations are met and facilitates the research process. The SCDMH IRB meets monthly.

Coordination of Mental Health and Substance Use Disorder State Systems

SCDMH is the mental health authority in the State of South Carolina and serves as the lead state agency in the provision of mental health services to citizens of the state. SCDMH partners with the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) to support DAODAS' role as the lead state agency for funding Substance Use Disorder (SUD) services. SUD services are provided by local non-profits commonly referred to as "301 clinics" because of Act 301, which was passed in 1973 and established drug and alcohol commissions throughout the state.

SCDMH and DAODAS share a long history of partnerships to address situations affecting people with mental illnesses, people with SUDs, people with co-occurring disorders, and people in crisis. DAODAS is the cabinet agency charged with ensuring the provision of quality services to prevent or reduce the negative consequences of substance use and addictions. To accomplish this goal, DAODAS contracts with a broad network of service providers and recovery organizations, highlighted by a system of 32 public agencies that provide prevention, intervention, treatment and recovery services in all 46 counties of South Carolina.

As stated earlier, SCDMH 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 SCDMH CMHCs are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), an independent, nonprofit accreditor of health and human services. Each SCDMH community mental health center has an advisory board, with 7 to 15 members, including at least one medical doctor. Center boards meet monthly.

Community services are offered to people of all ages, including adults and children. These services include, but are not necessarily limited to, assessments, individual therapy, group therapy, family therapy, psychiatric medical assessment (PMA), nursing services, medication administration, medication

monitoring, psychosocial rehabilitation services, certified peer support services, crisis intervention, and care coordination.

It is the mission of SCDMH to support recovery initiatives through the development of empowered patient leadership. SCDMH empowers patients by hiring them to serve as planners, policy makers, program evaluators, and service providers. SCDMH 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.

SCDMH's Inpatient Services is comprised of three hospitals, among other facilities. Each of SCDMH's psychiatric hospitals is accredited by the Joint Commission. Morris Village Treatment Center, the Agency's inpatient drug and alcohol treatment facility, is licensed by the South Carolina Department of Health and Environmental Control (DHEC) and accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

- *G. Werber Bryan Psychiatric Hospital (Columbia)* – G. Werber Bryan Psychiatric Hospital (Bryan) provides inpatient psychiatric treatment to adults and children.
    - *William S. Hall Psychiatric Institute at Bryan Psychiatric Hospital (Hall)* – Hall 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.
- *Patrick B. Harris Hospital (Anderson)* – Harris Hospital provides inpatient treatment to adults.
- *Morris Village Alcohol & Drug Addiction Treatment Center (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."

SCDMH maintains partnerships with the South Carolina Department of Education, South Carolina Department of Health and Human Services, South Carolina Department of Corrections, Department of Juvenile Justice, South Carolina Department of Social Services, South Carolina Department of Vocational Rehabilitation, South Carolina State Housing Finance and Development Authority, South Carolina Department of Alcohol and Other Drug Abuse Services, and many other state agencies, universities, non-profits, and other stakeholder organizations, such as counties – some of which provide funding to support SCDMH operations – to ensure a comprehensive mental health continuum and supporting services for the citizens SCDMH serves.

An unmet need and a gap in the current system is the inclusion of consultation sessions – defined by SAMHSA as government-to-government interactions – with the State of South Carolina's only federally recognized tribe: the Catawba Indian Nation. Since 2012, SCDMH has attempted to obtain tribal input. In 2023, the South Carolina Mental Health State Planning Council secured a representative from the Pine Hill Indian Community Development Initiative, a state-recognized nonprofit tribal organization dedicated to serving the minority, underserved and tribal communities of South Carolina.

SCDMH's systems address the needs of diverse racial, ethnic, sexual, and gender minorities, as well as American Indian/Alaskan Native populations in the state, in a variety of ways:

- Tracking access or enrollment in services, types of services received, and outcomes for services by race, ethnicity, gender, sexual orientation, gender identity, and age.
- Using a data-driven plan to address and reduce disparities in access, service use, and outcomes for the above sub-populations.
- Following a plan to identify, address, and monitor linguistic disparities.
- Using a workforce-training plan to build the capacity of mental health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations.
- Establishing directives related to cultural competence:
    - Directive 958-22: Culturally and Linguistically Appropriate Services to Patients/Residents who have Limited English Proficiency (LEP), or are Hard of Hearing or Deaf
        - The purpose of this Directive is to ensure each Facility and Community Mental Health Center has a policy and procedures to provide culturally and linguistically appropriate services to its patients/residents who are not proficient in the English language and/or Hard of Hearing or Deaf, to the extent that they cannot access the services or programs offered by the agency without language assistance.
        - It is the policy of the Department of Mental Health (DMH) to recognize and respect the cultural diversity of its patients/residents and to provide culturally and linguistically appropriate services to all of its patients/residents. Moreover, it is the policy of the DMH to provide services to those needing them without regard to national origin or disabilities. Included are individuals who have limited English proficiency, or are hard-of-hearing or deaf. The Department recognizes that in order to provide meaningful access to its behavioral health services to patients/residents who have limited English proficiency, or are hard-of-hearing or deaf, DMH facilities and Community Mental Health Centers must have procedures in place to provide communication services, including interpreter services at no cost to the patient/resident. Accurate and adequate communication between patients/residents and providers is a necessary element for providing good quality care, and it is a recognized right of patients/residents. The treatment staff needs to have the capability to effectively communicate with and relate to the experiences of patients/residents from diverse cultures, as this is an important component of culturally competent treatment.
    - Directive 966-23 – Cultural Competence
        - The purpose of this directive is to establish the policy for the creation and maintenance of a culturally and linguistically competent system of care at the South Carolina Department of Mental Health (SCDMH).
        - It is the policy of the Department to recognize that culture is dynamic, and that cultural competence must be an ongoing process, believing that valuing individual and group cultural differences is critical to achieving organizational goals. SCDMH considers cultural competence a necessary part of good clinical services. Initially organized under the Division of Community Mental Health Services, but now led by the Office of Cultural Affairs (CA), the Statewide Office of Cultural Affairs Committee (formerly known as the Statewide Multi-cultural Council) and Center/Facility/Division Cultural Affairs Committees (formerly known as the Center/Facility Multi-Cultural Committees) are charged with the

responsibility to advise and guide SCDMH leadership in the creation and maintenance of a linguistically and culturally competent workforce, service divisions, programs, and collaborative endeavors reflective of the diversity of the population served and the community.

Statutory Criterion for Mental Health Block Grant (MHBG)

The information provided below is a summary of SCDMH's fulfillment of the five (5) statutory criteria for the MHBG as further detailed in Environmental Factors and Plan, Item 9. Statutory Criterion for MHBG.

Criterion 1. Comprehensive Community-Based Mental Health Service Systems

- SCDMH has a long-established and existent organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Services and resources are available within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Criterion 2. Mental Health System Data Epidemiology

- SCDMH participates in SAMHSA's Uniform Reporting System (URS). The Statewide Prevalence rates for adults and children are taken from URS Table 1, using SAMHSA estimation methodologies. SCDMH uses the URS rates in conjunction with community-centric feedback to evaluate and substantiate planning and implementation activities for its mental health system of care.

Criterion 3. Children's Services

- SCDMH provides for 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.

Criterion 4. Targeted Services to Rural and Homeless Populations and to Older Adults

- SCDMH provides outreach to and services for individuals who experience homelessness; ensures community-based services to individuals in rural areas; and cooperates in community-based services to older adults.

Criterion 5. Management Systems

- SCDMH 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, SCDMH 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 regular basis; they are encouraged to participate in these CEU opportunities online as time permits. SCDMH'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. SCDMH 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. SCDMH understands that collaboration is invaluable in providing the best possible care to our patients. As such, the agency encourages its staff to pursue and participate in research opportunities.

Public Mental Health in South Carolina

As discussed throughout this document, SCDMH addresses the needs of people with mental illness by providing a comprehensive structure to the mental health service system in South Carolina. SCDMH meets the expectation that it will not only offer a core array of usual and customary psychiatric services, but that it will also be the leader in innovative and technologically advanced approaches to the delivery of mental health and other ancillary and support services.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the 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. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), 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 and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

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Footnotes:

Planning Step 2: Identify the Unmet Service Needs and Critical Gaps within the Current System

Identifying Unmet Service Needs and Critical Gaps

In order to identify the unmet service needs and critical gaps within the current system to address the specific populations of children with SED and adults with SMI, among other identified groups, the South Carolina Department of Mental Health (SCDMH) systematically reviews its programs and services throughout the fiscal year. As a result of such reviews, SCDMH is able to determine the areas in which it particularly excels. Similarly, SCDMH is also able to determine the areas in which gaps or needs have arisen and then address these specific areas through its Senior Leadership and staff. Based on data-driven analyses, performance measurements, and feedback mechanisms, SCDMH continually evaluates, assesses, and refines its programs, services, and service delivery systems for its patients.

External Comprehensive Review

In May 2018, SCDMH began a formalized review of its operations under Chapter 2, Title 2 of the 1976 Code (Legislative Oversight of Executive Departments) as the South Carolina House of Representatives exercised its option to conduct an information request under the authority of an oversight review.[1] The specific task of the South Carolina House of Representatives, House Legislative Oversight Committee, Healthcare and Regulatory Subcommittee is to conduct legislative oversight studies and investigations of state agencies at least once every seven years. As explained in the letter sent to SCDMH by the Chairman of the House Legislative Oversight Committee, "It is the Legislative Oversight Committee's goal to partner with the agency to help it identify areas in which it can continue to improve upon the positive results it has generated for the people of South Carolina."[2]

During this formalized review process, SCDMH provided the following abbreviated list of agency challenges that demonstrated unmet service needs and critical gaps within the current system:

- Increasing Access to Veterans Nursing Home Beds – Based on a formula promulgated by the Department of Veterans Affairs, there exists in South Carolina the need for additional veterans' long-term beds. Title 38, Part 59 provides the total number of allowed State Home beds, which, when netted with the number of current State Home beds (530), indicates a need for an additional 559 veterans nursing home beds.
- Reducing the Time for Forensics Admissions – By law, criminal defendants found incompetent to stand trial due to a mental illness must go through a commitment process to a SCDMH hospital. Because of a significant increase in commitment orders, the length of time that defendants must wait for admission substantially increased. As a result, in June, 2016, SCDMH made reducing the wait time for forensic admissions its first priority and developed a multi-faceted Action Plan.
- Increasing Hospital Capacity without Increasing Hospital Beds – If SCDMH is able to increase the availability of intensive community mental health services and increase the availability of

1 https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyPHPFiles/MentalHealth.php

2 https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/MentalHealth/LOC_Letter_to_DMH-5.9.18.PDF

supported community housing, it will lead to shorter hospital lengths of stay. In effect, expanding community housing and intensive mental health services will result in SCDMH being able to hospitalize more patients with its current number of beds. The challenge is to fund increased community housing and additional mental health services delivered at a patient's residence. SCDMH has requested recurring appropriations to support these services.

- Addressing Crisis Stabilization – It is critical the SCDMH be able to partner with local hospitals and other community officials to increase residential crisis stabilization programs. Such programs help divert individuals in a psychiatric crisis who can be safely cared for outside of a hospital from emergency departments. Charleston has opened a 10-bed Crisis Stabilization Center and discussions are ongoing with other communities.
- Addressing Workforce Recruitment and Retention - Like many healthcare providers, SCDMH is faced with enormous challenges in recruiting and retaining all of the healthcare professionals it needs, including competing with other public and private healthcare providers for a limited supply of psychiatrists, nurses, and counselors. SCDMH is pursuing a number of new measures to reach prospective employees, including dedicating recruiting staff to attend job fairs, expanding its presence on social media, and placing job announcements in professional publications. SCDMH's Human Resources office is also streamlining the hiring process with the goal of significantly shortening the time between receiving job applications and being able to offer positions.

SCDMH also provided an abbreviated list of emerging issues agency representatives anticipate having an impact on agency operations in the upcoming five (5) years. Many of the articulated issues also demonstrated unmet service needs and critical gaps within the current system.

- Changes continue to occur throughout healthcare regarding third party payors and proposed models of reimbursement. Whether this will increase the demand on the Department or possibly increase services by private sector is uncertain.
- Population growth, especially along coast, is increasing demand for services in those areas.
- Cost of housing and appropriate services affects the ability of people to remain in their home communities and will continue to bring challenges.

This list of significant challenges that SCDMH will encounter in the future is not complete; however, the items listed above are ongoing and, consequently, require ongoing consideration.

The Healthcare and Regulatory Subcommittee produced a study report in March 2020 with recommendations concerning SCDMH.[3] SCDMH provided quarterly updates on the report recommendations to the House Legislative Oversight Committee for the two-year period ending March 2022.

The challenges and emerging issues discussed above are still relevant.

3 https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/MentalHealth/Full_Comm_Report_DMH_2020.pdf

FY2024 Budget Requests

SCDMH's FY2024 budget requests to the Governor of the State of South Carolina and the General Assembly of South Carolina, which were submitted in November 2022 and were requests for additional state appropriations, validate the strength of its performance measurement/system oversight capacity by consistently identifying and consequently formulating systemic needs into requests for appropriated funding. The budget requests reflect SCDMH's acknowledgement of the unmet service needs and critical gaps in the current system and the possibility that other unmet service needs and gaps could develop.

The recurring operational funding requests of the Department of Mental Health, listed below, fall under the categories of Community Mental Health; Inpatient Services; Veterans Nursing Homes/Long Term Care; and Sexually Violent Predator Treatment Program (SVPTP).

While the budget requests are arranged in separate categories, Community Mental Health and Inpatient Mental Health are closely interrelated. The needed number of inpatient psychiatric beds – the most restrictive and expensive level of care for persons in need of mental health treatment – correlates to the volume and types of available community mental health services. The more robust and comprehensive a state's community mental health services system—in particular, its crisis services--the fewer the number of needed State hospital beds.

Moreover, both Community Mental Health and Inpatient Mental Health, as well as Long-Term Care, depend on very similar support staff to be able to efficiently and effectively deliver clinical care to patients and residents.

Community Mental Health

988 Crisis Continuum of Care

On July 16, 2022, the 988-telephone number replaced the previous 10-digit National Suicide Prevention Lifeline. Although short-term grant funding accompanied the introduction of 988 to support local call centers, it is up to each State to provide its own Crisis Continuum of Care to assist callers in serious emotional distress.

Crisis Continuum of Care Total - $8,508,000

An effective 988 crisis response system includes three key components:

(1) Someone to answer the call: this component requires 24/7 call centers adequately staffed to by specially trained individuals to answer all 988 calls originating from persons in South Carolina;
(2) Someone to respond: this component requires a sufficient number of mobile crisis teams which can be dispatched to a scene 24/7 in a timely manner to effectively assist people in crisis and assess their immediate needs;
(3) A safe place to go for care: this component requires a regional network of crisis stabilization units to safely provide short-term observation, treatment and linkage to follow-up care.

When all three components are available, most behavioral health crisis can be successfully resolved without the need for hospitalization, saving both lives and resources.

1. 988 Suicide Prevention Lifeline Call Center
    - The State's only current certified call center has been operated since 1990 by a nonprofit organization. The Department's Charleston Dorchester Mental Health Center (CDMHC) is

creating and will operate the state's second certified 988 call center, being fully operational by early 2023.

- DMH requests $2,208,000 for the recurring operational costs of the CDMHC call center. Ensuring SC callers in distress will be able to reach an in-State certified call center requires stable, consistent funding.

2. Mobile Crisis Dispatch and Response Teams
    - DMH operates a statewide Mobile Crisis program. Mobile Crisis provides telephonic, telehealth and in-person emergency mental health screening and assessment 24/7/365. A mobile crisis team is based at each of the 16 DMH community mental health centers, which cover all 46 counties.
    - The agency requests $4,800,000 in recurring funding to support additional operating costs for existing MC staff and the expansion of an additional two-person mobile crisis team for each of the 16 mental health centers.
3. Crisis Stabilization Units and Crisis Receiving Units
    - Crisis Stabilization Units (CSUs) are short-term residential psychiatric programs where non-violent persons in a behavioral crisis can be cared for and safely assessed, generally as a more appropriate and less expensive alternative to a hospital emergency department or inpatient psychiatric hospital unit.
    - Currently, DMH operates one CSU in Charleston and is developing a Midlands CSU in Columbia with one-time appropriated funds. The Department's eventual goal is a total of 8 CSUs across the state to be determined in collaboration with DHHS.
    - The agency requests an additional $1,500,000 in recurring funding for the operation of the Midlands CSU.

Mental Health Professionals Salary Increase - $10,740,000

- The vast majority of the agency's community mental health services are delivered by its master's prepared clinical staff known as mental health professionals (MHPs). Whether providing clinic-based services to adults and children, school mental health services or mobile crisis services, MHPs are the backbone of the community mental health service delivery system.

- Because of its relatively low salaries, the Department unsuccessfully competes with schools, private providers, other state agencies, FQHCs, and now out-of-state telehealth networks for MHPs. In a recent report, the Department of Administration, Office of Human Resources found that DMH salaries for its MHPs were approximately 40% below market, with a resulting high vacancy rate. Without the needed number of MHPs, average caseloads in DMH mental health centers have become unacceptably high, well-above the agency's recommended guidelines. More citizens in need of mental health care will suffer if DMH cannot raise its MHP salaries in order to successfully recruit the needed staff.

Alternative Transportation - $4,000,000

- DMH has utilized $1 million in one-time funding from the General Assembly to develop a pilot program to transport non-violent adults who are the subject of an involuntary psychiatric emergency admission. Transports are provided by a private contractor using specially equipped unmarked vehicles and drivers with extensive mental health training wearing professional civilian attire. The goal of the pilot program is to demonstrate that

many psychiatric patients can be safely and securely transported without the need to call law enforcement.

- The program will not replace the need for law enforcement to provide some patient transports. However, it is hoped that the program will help to significantly reduce the number of law enforcement transports by providing a more appropriate and humane alternative for non-violent patients who have committed no crime.
- DMH is requesting recurring funds to both continue the current program and expand it beyond its current 10-county pilot region to cover an additional 20 counties, including those with large population centers.

Office of Suicide Prevention - $648,000
The DMH Office of Suicide Prevention started as a program funded by a five-year federal grant to reduce suicide among youth and young adults. Through trainings and presentations to more than 20,000 state citizens and the creation of partnerships with it has raised awareness and created suicide prevention and care pathways through state agencies, school systems, nonprofits, faith-based communities, and numerous health care providers. Grants, all of which end on or before December 2023, are currently the sole funding for the office. DMH requests recurring funding of $648,000 to continue its critical and important suicide prevention efforts.

Assertive Community Treatment - $790,000
ACT is an evidence-based practice that provides intensive community-based behavioral health services for those individuals with serious mental illnesses and co-occurring disorders whose impairments are such that they do not readily engage in clinic-based treatment and who are correspondingly at high risk for hospitalization or arrest. While ACT is a proven multi-disciplinary team approach which is highly successful for the challenging sub-set of patients who are most at risk of involvement in the criminal justice system, it requires a high staff/patient ratio with low-caseloads and frequent travel to meet patients where they are.

Inpatient Services

Total Request - $12,740,000
The Department's mission of providing needed mental health care and long-term care services requires an adequate work force consisting of many diverse types of qualified staff. Each category of staff needed by SCDMH corresponds to a category that is also in demand from other government agencies and private sector employers. Based on the enormous difficulty the agency has been experiencing in filling its hundreds of vacant positions, it is clear that the agency must significantly raise salaries if it is to retain its current staff as well as recruit new employees to fill its vacant positions.

- *Restoring and sustaining hospital and long-term care services - $7,310,000*
  There are multiple types of clinical staff other than psychiatrists and registered nurses needed to provide psychiatric hospital services and long-term nursing care services – LPNs, Behavioral Health Assistants, Certified Nursing Assistants, Social Workers, Counselors, Lab and Pharmacy Techs. There are additionally other positions critical to ensuring the health and safety of patients in hospitals and the vulnerable residents of nursing homes. Those include Food Service, Environmental Services and Building Maintenance staff. Because of a current salary structure well below the current market, SCDMH is struggling with high vacancy rates in all of these critically needed staff categories. In order to both restore and maintain adequate numbers of staff in these vital clinical support areas, the recurring funds requested -- $7,310,000 –

represents the amount needed to increase salaries for these essential categories of staff to a near market rate.

- *Expansion of Bed Capacity - $5,430,000*
  DMH operates two State psychiatric hospitals, G. Werber Bryan Psychiatric Hospital (Bryan) in Columbia and the Patrick B. Harris Psychiatric Hospital (Harris) in Anderson, as well as Morris Village, its hospital for the treatment of patients with substance use disorders. In the current fiscal year, DMH has undertaken an effort to increase the available bed capacity at both Bryan and Harris through hiring additional staff. The agency's goal for FY 23 is an average daily census of 112 at Bryan and an average daily census of 98 at Harris. DMH is requesting funds to further increase available bed capacity at Bryan Psychiatric Hospital by 24 beds.

  The recurring funds requested -- $5,430,000 – represents the cost to hire the needed additional staff to further increase the number of available beds at Bryan Psychiatric Hospital by 24 beds, to an average daily census of 136.

Contracted Community Beds - $10,000,000
The requested funds are used to contract with community and private hospitals to pay for indigent patients' psychiatric hospital admissions. The funding has been very beneficial in enabling community and private hospitals to increase the number of indigent patients they care for, benefiting both the patients and the hospital emergency departments around the State where such patients are often held awaiting the acceptance into an available psychiatric hospital bed.

SCDMH through its mental health centers has an established process for (i) managing requests for funding of indigent patients' admission; (ii) making approval/disapproval decisions; and (iii) a record keeping/tracking system which details how the contract funds were utilized, the number of patients helped and their lengths of hospitalization.

This funding directly benefits patients in a psychiatric crisis by enabling them to get needed care in a timelier manner, and indirectly aids South Carolina's hospital emergency rooms by reducing the length of stay of behavioral health patients.

State Operated Intensive Group Home - $900,000
In addition to a current project to create of a State (DMH) operated Psychiatric Residential Treatment Facility (PRTF), there is an additional ongoing need for a Group Home with intensive therapeutic services to serve those adolescents in State care or custody, frequently from DJJ, who because of past behaviors are not accepted for services in the State's privately operated licensed Group Homes. have mental health treatment needs.

The requested funds would enable DMH to issue a request for proposals (RFP) from a private contractor to provide a small – under 17 beds – licensed group home offering on-site therapeutic services. The estimated contractual cost for such a facility is estimated to be $1.8 million annually. The requested amount is based on the expectation that the RFP process would require approximately 6 months to complete.

DMH Medical Clinic - $318,000
The DMH Medical Clinic is located off of Farrow Road on the Midlands Center campus in close proximity to Bryan and Morris Village. It houses both an employee health clinic for those hospitals, as well as specialty ambulatory health care services for patients of the Department's psychiatric hospitals.

The recurring funding requested will replace one-time funding for the clinic's operating budget ($257,000), as well as funding to support the increasing contract staffing costs of the specialty clinics ($61,000).

State Veterans Nursing Homes/Long-term Care

State Nursing Homes - $8,840,000
There are pending rate increase requests for all four of the contractually operated State Veterans Nursing Homes. The amounts provided below for Campbell, Veteran Village, and Palmetto Patriots Veterans Nursing Homes will increase, but the amount of the increases is still being determined.

1. Campbell State Veterans Nursing Home (Anderson) - $3,092,000
    - The average daily census for Campbell nursing home should remain stable in FY 23-24.
    - The requested amount will fund the annual increase for the contracted management, staffing and operation of Campbell.
2. Veteran Village Veterans Nursing Home (Florence) - $1,574,000
    - Veteran Village opened January 2022.
    - The average daily census for FY 23-24 will continue to increase.
    - The requested amount is needed for the cost of the census increases and the annual increase for the contracted management, staffing an operation of the facility.
3. Palmetto Patriots Veterans Nursing Home (Gaffney) - $1,339,000
    - Palmetto Patriots opened March 2022.
    - The average daily census during FY 23 - 24 will continue to increase.
    - The requested amount is needed for the cost of the census increases and the annual increase for the contracted management, staffing an operation of the facility.
4. C.M. Tucker Nursing Care Center - Stone Veterans Pavilion $920,000
    - The average daily census for Stone should remain stable in FY 23-24.
    - The requested amount is needed to pay for the increased cost of nursing and direct care staffing at Stone.
5. C.M. Tucker Nursing Care Center - Roddey Pavilion - $1,915,000
    - The average daily census for Roddey should remain stable in FY 23-24.
    - The requested amount is needed to pay for the increased cost of nursing and direct care staffing at Roddey.

Sexually Violent Predator Treatment Program

Sexually Violent Predator Treatment Program (SVPTP) - $1,455,000

$1,360,355 represents the Department's expected annual increase for the contracted management, staffing and operation for the state's Sexually Violent Predator Treatment Program.
- DMH projects a 3% increase in the average daily census based on trends.

- With a rising census, DMH requests additional funding paying for the associated contractual obligation of $215,255.
- The contract requires that SCDMH to seek an annual rate increase for its contractor based on the most recent South Region Medical Services Consumer Price Index (CPI) cost increase. of 5.2% or $1,145,400.

$94,345 represents the expected increase in its direct expenses, consisting of DMH contract oversight staff, building utilities, and supplies.

Data-Driven Decision Making

Through consistent data collection and analysis, SCDMH is well-positioned to measure its performance as it encounters and addresses unmet service needs and gaps. The key to SCDMH's successful evaluation is its data systems:

- CIS – The Client Information System (CIS) is SCDMH's outpatient fee-for-service billing system. It is utilized in the community mental health centers, Care Coordination, and Telepsychiatry.
- EMR – The outpatient EMR is an internally developed electronic medical record used in conjunction with CIS. SCDMH is currently transitioning to a new Electronic Health Record (HER) system that will replace the EMR.
- AvatarPM – AvatarPM is a vendor supported inpatient billing system used in SCDMH inpatient facilities.
- EHR - The inpatient EHR is a vendor supported electronic health record used in conjunction with AvatarPM.
- SCEIS – South Carolina Enterprise Information System: The South Carolina Enterprise Information System consolidated more than 70 state agencies onto a single, statewide enterprise system, built on SAP software, for finance, materials management and human resources/payroll.
- Dashboard – Used by SCDMH leadership to review trends, patterns, and relevant data.

The specific attention that has been placed by SCDMH senior leadership on data and its meaning, and the importance of usefulness that has been emphasized for underlying electronic databases, document management systems, business intelligence systems, and associated programs has provided SCDMH with a means to effectively navigate current and future situations.

Current Needs and Gaps

SCDMH is continually striving to improve and expand its services for South Carolinians, ensuring that adults with SMI, children with SED, and all people struggling with mental health challenges will have access to high-quality mental health services. In this section, two of SCDMH's major challenges are discussed.

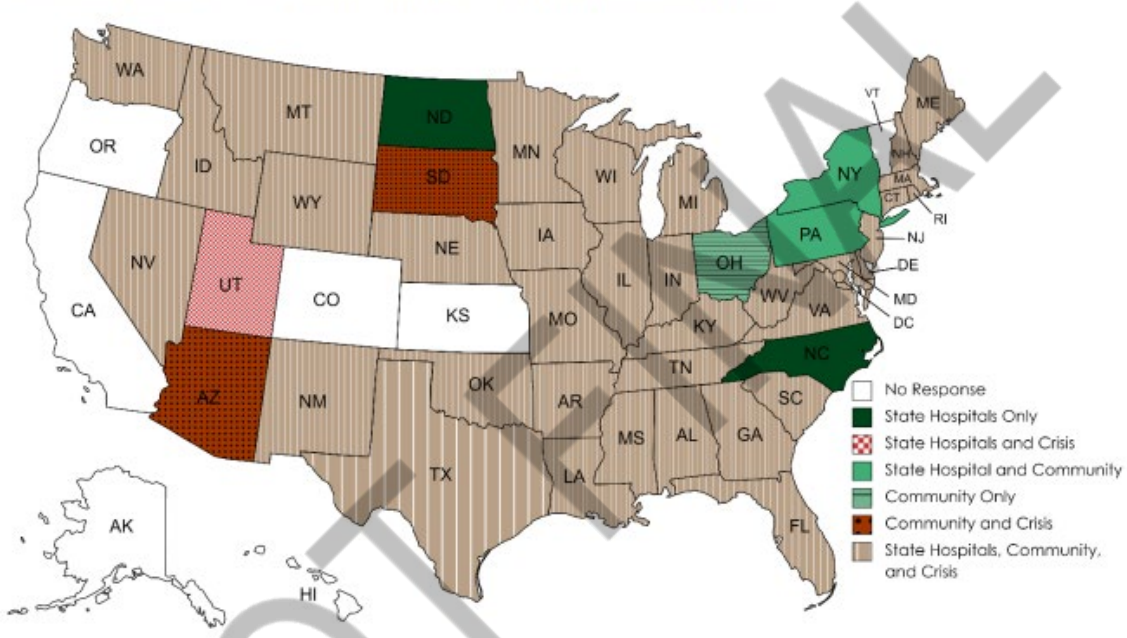
Workforce Challenges: Employee Recruitment and Retention

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 has caused ongoing challenges for providers, as they struggle to maintain the workforce necessary to deliver quality healthcare services.

According to a December 2022 NRI report, 100% of state mental health agencies are experiencing workforce shortages, and almost all agencies (82%) are struggling with insufficient staffing levels in state hospitals, community, across the crisis care continuum. As demonstrated in the image below, provided by NRI, every state in the nation has experienced staffing challenges.[4]

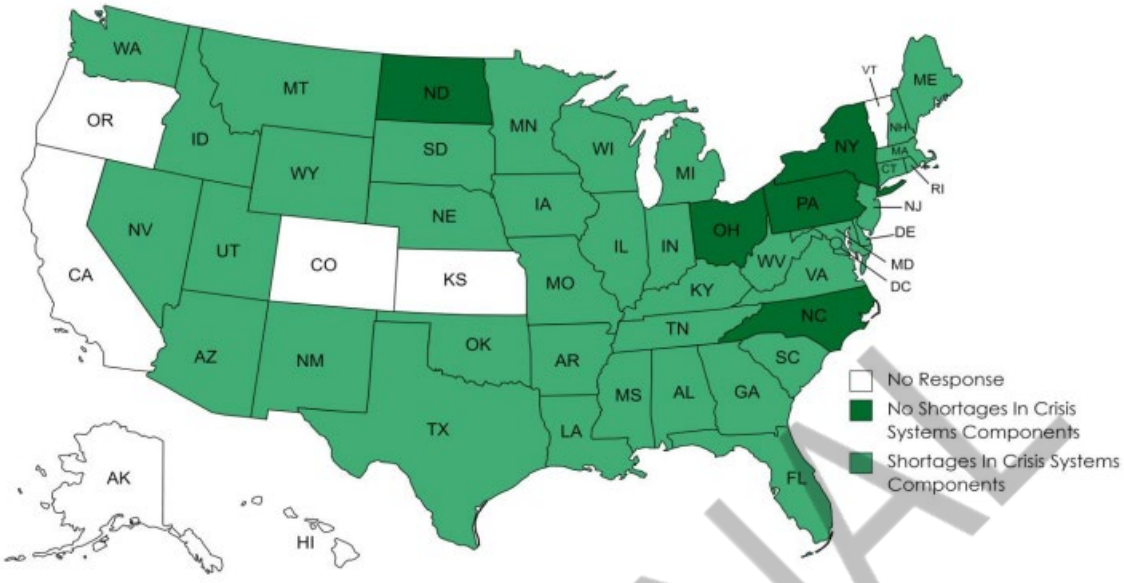
Figure 1. States Experiencing Behavioral Health Workforce Shortages, by System Setting, 2022



Furthermore, mental health crisis services throughout the United States have been especially hard hit by workforce shortages. The vast majority (89%) of states reported workforce shortages within the crisis system. Inadequate staffing levels were reported for crisis stabilization units in 80% of states, for residential crisis programs in 64% of states, and for crisis call centers in 64% of states.[5]

[4] https://www.nri-inc.org/media/hz2lygyh/workforce-shortages_final.pdf
[5] https://www.nri-inc.org/media/tmtdueze/workforce-shortages-across-the-crisis-continuum_final.pdf

Figure 1. States Reporting Workforce Shortages In At Least One Crisis System Component



As demonstrated in Table 1, below, SCDMH experienced a steep decline in average full-time equivalent (FTE) employees during the past three years. In State Fiscal Year 2020, SCDMH employed slightly more than 4,200 FTE staff members; however, as the stressors and traumas of the pandemic increased, SCDMH lost a significant number of employees, both clinical and support staff, through a combination of resignations and retirements. During the past two state fiscal years, SCDMH has struggled to maintain more than 3,500 FTEs.

Table 1.

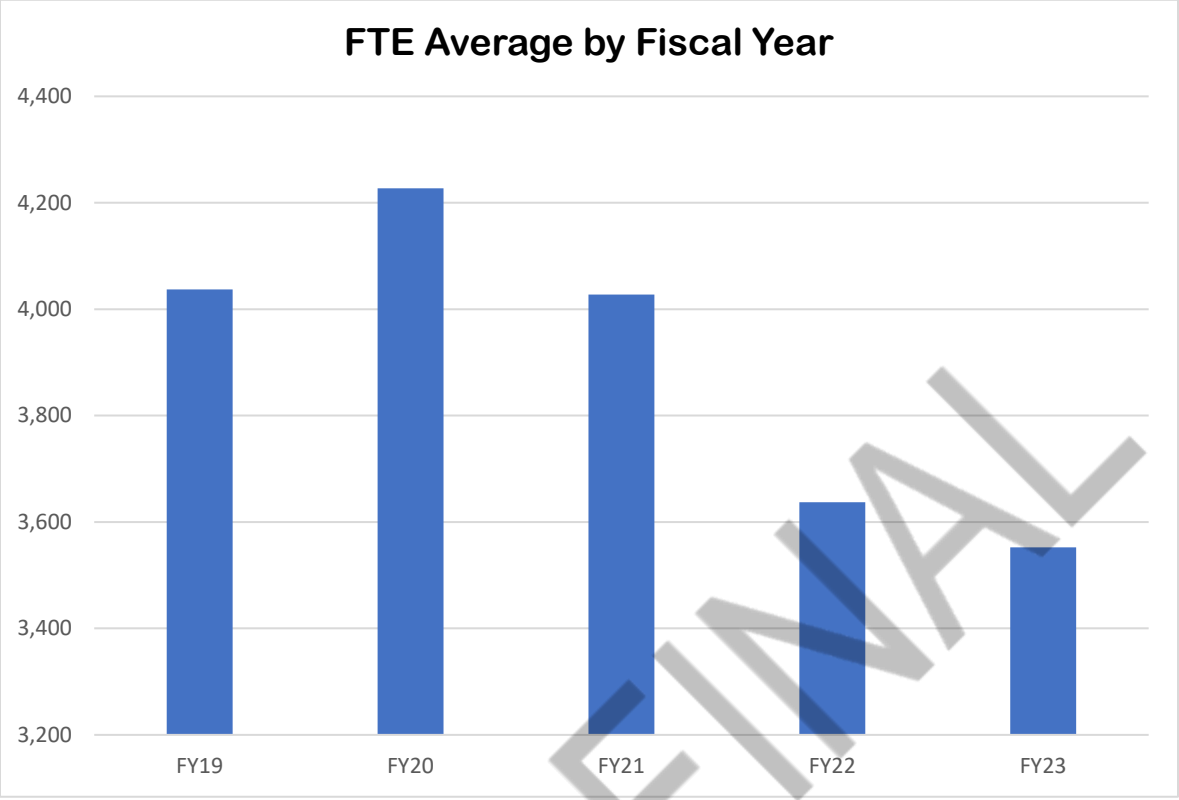
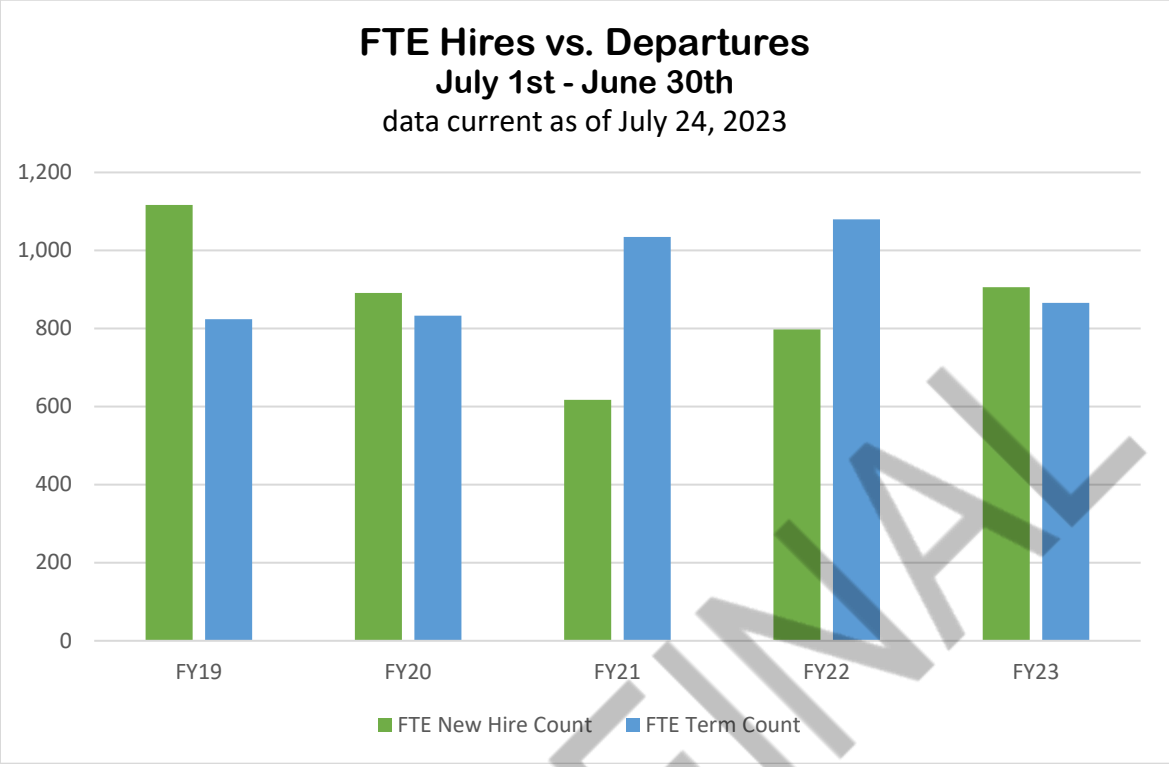


Table 2, provided below, compares the number of new hires and departures by fiscal year. Departures include resignations, retirements, and terminations. In Fiscal Years 2021 and 2022, the number of SCDMH departures far exceeded the number of new hires, causing ongoing workforce challenges. In Fiscal Year 2023, the number of new hires and departures was more even; however, an equal balance of hirings and departures is clearly not ideal. Constant turnover creates ongoing challenges for staff members. 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 SCDMH community mental health centers are tracked monthly. The turnover rate for all 16 CMHCs was 28.27% in June 2021. By June 2022, this turnover rate had increased to 32.12%, and by June 2023, this turnover rate was 23.20%.

Table 2.



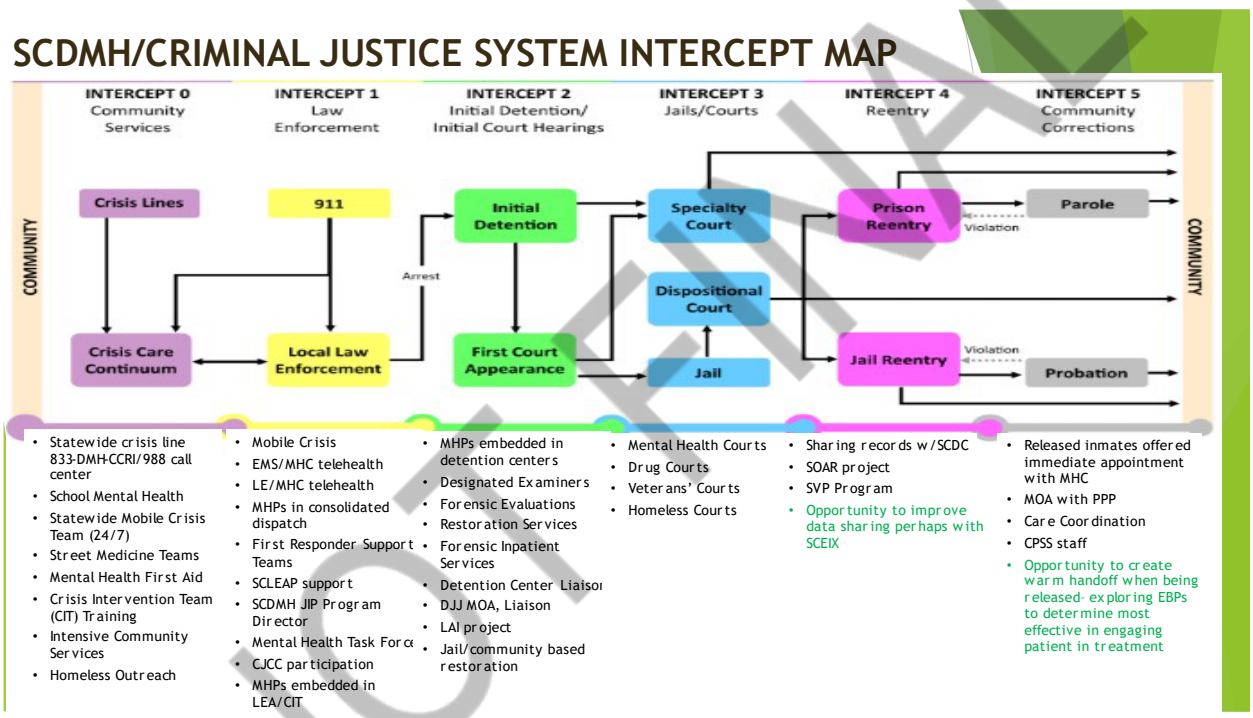
Criminal Justice Services and Collaborations

In addition to its ongoing challenges with workforce shortages, SCDMH also acknowledges that there are opportunities to improve mental health services within the criminal justice system. The SCDMH – Criminal Justice System Intercept Map presented below demonstrates six service areas for people with mental illnesses who become involved in the criminal justice system. This map was developed using the SAMHSA GAINS Center's Sequential Intercept Model (SIM). SCDMH is actively providing robust services in Intercepts 0 – 3; however, SCDMH recognizes the need to improve efforts in Intercepts 4 and 5. This will require further collaborations with criminal justice agencies and community partners.

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, SCDMH 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, SCDMH 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. However, SCDMH has had limited success in providing adequate and comprehensive services in Intercepts 4 and 5. Over the next few years, SCDMH will continue to focus on improving its services in the areas of reentry and community corrections.



Conclusion

SCDMH implements a proactive mental healthcare continuum; agency leadership constantly monitors data, identifies new challenges and patterns, and adjusts its strategies depending on the needs of its clients, South Carolina communities, and its employees. The agency uses key performance indicators to measure progress and identify continuing areas for improvement. SCDMH's continuous systemic analysis provides a blueprint from which the agency can continue to positively impact mental health services for all people throughout the state of South Carolina.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Accountability Report Baseline Performance Measures

Priority Type: MHS

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

Goal of the priority area:

The goal of this priority area is to maximize the effective use of SCDMH's resources in order to achieve the outcomes reflected in the 2022 Accountability Report Baseline Performance Measures. Each measure represents a key area of focus for SCDMH, and correlates closely with the agency's Strategic Planning initiatives.

Strategies to attain the goal:

Given the comprehensiveness of the measurement tools, changes in results from one year to the next are generally a reasonable determinant of the effectiveness of SCDMH's efforts to improve the mental health continuum. SCDMH has significant influence and control over South Carolina's integrated system of care; SCDMH is the state's primary service provider for inpatient and community services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of under 18 year-old population in SC served by DMH will be within 0.1% of previous year's percentage.

Baseline Measurement: 2.75%

First-year target/outcome measurement: 2.43%

Second-year target/outcome measurement: 2.43%

Data Source:

Calculated using current FY patient count and US census estimate of previous year (most recent). Data from Central Office Internet Technology (IT).

Description of Data:

Patients under the age of 18. (Calculation: Under 18 population of SC served by DMH / total population of SC under 18)

Data issues/caveats that affect outcome measures:

Indicator #: 2

Indicator: Percentage of adult population in SC served by DMH will be within 0.1% of previous year's percentage.

Baseline Measurement: 1.51%

First-year target/outcome measurement: 1.46%

Second-year target/outcome measurement: 1.46%

Data Source:

Calculated using current FY patient count and US Census estimate of previous year (most recent).

Description of Data:

Patients 18 years of age and older. (Calculation: Percentage of adult population in SC served by DMH / total adult population of SC)

Data issues/caveats that affect outcome measures:

Indicator #: 3

Indicator: Number of inpatient "bed days" used at Bryan Civil Hospital will be equal to or great than

Baseline Measurement: 40,528

First-year target/outcome measurement: 41,316

Second-year target/outcome measurement: 41,316

Data Source:

Avatar - IT database.

Description of Data:

Citizens in need of inpatient psychiatric services. Calculated using reporting software.

Data issues/caveats that affect outcome measures:

Due to staffing shortages, the availability of beds for Civil Commitments at Bryan was reduced. This is a new performance measure beginning FY 2021.

Indicator #: 4

Indicator: Number of inpatient "bed days" used at Harris Hospital will be equal to or great than

Baseline Measurement: 31,528

First-year target/outcome measurement: 33,530

Second-year target/outcome measurement: 33,530

Data Source:

Avatar - IT database

Description of Data:

Citizens in need of inpatient psychiatric services. Calculated using reporting software.

Data issues/caveats that affect outcome measures:

Due to staffing shortages, Harris was forced to close two lodges for much of FY 2022. This is a new performance measure beginning FY 2021.

Indicator #: 5

Indicator: Number of inpatient "bed days" used at Morris Village will be equal to or greater than

Baseline Measurement: 16,953

First-year target/outcome measurement: 15,827

Second-year target/outcome measurement: 15,827

Data Source:

Avatar - IT database

Description of Data:

Persons requiring substance abuse treatment services. Calculated using reporting software.

Data issues/caveats that affect outcome measures:

This is a new performance measure beginning FY 2021.

Indicator #: 6

Indicator: Number of inpatient "bed days" used at Bryan Forensic will be equal to or greater than

Baseline Measurement: 63,238

First-year target/outcome measurement: 60,247

Second-year target/outcome measurement: 60,247

Data Source:

Avatar - IT database

Description of Data:

Citizens in need of forensic services. Calculated using reporting software.

Data issues/caveats that affect outcome measures:

This is a new performance measure beginning FY 2021.

Indicator #: 7

Indicator: SCDMH will admit people into the inpatient forensic setting at a number equal to or greater than previous four years average.

Baseline Measurement: 243

First-year target/outcome measurement: 236

Second-year target/outcome measurement: 236

Data Source:

Calculated using reporting software - Central Office IT

Description of Data:

Number of new patients admitted to inpatient forensic setting.

Data issues/caveats that affect outcome measures:

Indicator #: 8

Indicator: Patients requiring CMHC appointments will be seen in a timely manner according to protocol (priority, urgent, or routine). Target is average of previous five years.

Baseline Measurement: 97%

First-year target/outcome measurement: 95.4%

Second-year target/outcome measurement: 95.4%

Data Source:

Calculated using reporting software - Central Office IT

Description of Data:

Percent of patients seen in a timely manner / total number of patients.

Data issues/caveats that affect outcome measures:

Indicator #: 9

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

Baseline Measurement: 2.5

First-year target/outcome measurement: 3.8

Second-year target/outcome measurement: 3.8

Data Source:

Calculated using reporting software - Central Office IT

Description of Data:

Average number of days between inpatient discharge and first scheduled CMHC appointment for previous five years.

Data issues/caveats that affect outcome measures:

Indicator #: 10

Indicator: Percentage of patients requiring readmission within thirty days of discharge will be equal to or less than previous five-year average.

Baseline Measurement: 1.85%

First-year target/outcome measurement: 1.76%

Second-year target/outcome measurement: 1.76%

Data Source:

Calculated using reporting software - Central Office IT

Description of Data:

Number of patients requiring readmission within thirty days of discharge / total number of patients discharged

Data issues/caveats that affect outcome measures:

Indicator #: 11

Indicator: The number of hospitals utilizing SCDMH Telepsychiatry services will remain constant or increase.

Baseline Measurement: 27

First-year target/outcome measurement: 27

Second-year target/outcome measurement: 27

Data Source:

Internal Records - Telepsychiatry Department

Description of Data:

Total number of community mental health centers participating in Telepsychiatry services on June 30, 2021

Data issues/caveats that affect outcome measures:

Indicator #: 12

Indicator: The number of Community Mental Health Centers utilizing Telepsychiatry services will remain constant or increase. Note: Please see comment in "Meaningful Use of Measure" column.

Baseline Measurement: 16

First-year target/outcome measurement: 16

Second-year target/outcome measurement: 16

Data Source:

Internal Records - Telepsychiatry Department

Description of Data:

Total number of hospitals particiating with Telepsychiatry Program on June 30, 2021.

Data issues/caveats that affect outcome measures:

Indicator #: 13

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

Baseline Measurement: 57.2%

First-year target/outcome measurement: 56.7%

Second-year target/outcome measurement: 56.7%

Data Source:

Calculated using reporting software - CMHS

Description of Data:

Number of SCDMH patients having competitive employment / Total Number of SCDMH patients

Data issues/caveats that affect outcome measures:

Indicator #: 14

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

Baseline Measurement: 8.6

First-year target/outcome measurement: 7.5

Second-year target/outcome measurement: 7.5

Data Source:

Calculated using reporting software - Central Office IT

Description of Data:

Average lifespan per patient in years. (Actual calculation is length of stay.)

Data issues/caveats that affect outcome measures:

Indicator #: 15

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

Baseline Measurement: 3.4

First-year target/outcome measurement: 2.4

Second-year target/outcome measurement: 2.4

Data Source:

Calculated using reporting software - Central Office IT

Description of Data:

Average lifespan per patient in years. (Actual calculation is length of stay.)

Data issues/caveats that affect outcome measures:

Indicator #: 16

Indicator: Use of restraints in SCDMH Bryan Hospital inpatient facility will be equal to or below the average of the previous five years' data. National average = 1.09 hours per 1,000 hours of inpatient service (CY2021).

Baseline Measurement: .07

First-year target/outcome measurement: .16

Second-year target/outcome measurement: .16

Data Source:

Calculated using reporting software - Department of Inpatient Services, Quality Management

Description of Data:

Average number of hours in restraints per patient per 1000 hours.

Data issues/caveats that affect outcome measures:

Data does not include June 2022. That information is not yet available.

Indicator #: 17

Indicator: Use of restraints in Patrick Harris Hospital inpatient facility will be equal to or below the average of the previous five years' data. National average = 1.09 hours per 1,000 hours of inpatient service (CY2021).

Baseline Measurement: .04

First-year target/outcome measurement: .25

Second-year target/outcome measurement: .25

Data Source:

Calculated using reporting software - Department of Inpatient Services, Quality Management

Description of Data:

Average number of hours in seclusion rooms per patient per 1000 hours.

Data issues/caveats that affect outcome measures:

Indicator #: 18

Indicator: Use of seclusion rooms in SCDMH Bryan Hospital inpatient facility will be equal to or below the average of the previous five years' data. National average = 0.58 hours per 1,000 hours of inpatient service (CY2021).

Baseline Measurement: .34

First-year target/outcome measurement: .27

Second-year target/outcome measurement: .27

Data Source:

Calculated using reporting software - Department of Inpatient Services, Quality Management

Description of Data:

Average number of hours in restraints per patient per 1000 hours.

Data issues/caveats that affect outcome measures:

Data does not include June 2022. That information is not yet available.

Indicator #: 19

Indicator: Use of seclusion rooms in Patrick Harris Hospital inpatient facility will be equal to or below the average of the previous five years' data. National average = 0.58 hours per 1,000 hours of inpatient service (CY2021).

Baseline Measurement: .44

First-year target/outcome measurement: .44

Second-year target/outcome measurement: .44

Data Source:

Calculated using reporting software - Department of Inpatient Services, Quality Management

Description of Data:

Average number of hours in restraints per patient per 1000 hours.

Data issues/caveats that affect outcome measures:

Indicator #: 20

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

Baseline Measurement: 0%

First-year target/outcome measurement: 92%

Second-year target/outcome measurement: 92%

Data Source:

Calculated using reporting software - Central Office IT

Description of Data:

number of adults expressing satisfaction with SCDMH services / total number surveyed

Data issues/caveats that affect outcome measures:

Indicator #: 21

Indicator: Percentage of youths in School Mental Health Services receiving SCDMH services will remain consistently high (no national average available for youth satisfaction rates).

Baseline Measurement: 0%

First-year target/outcome measurement: 92%

Second-year target/outcome measurement: 92%

Data Source:

Calculated using reporting software - Central Office IT

Description of Data:

number of youths in School Mental Health Services receiving SCDMH services / number of youths in School Mental Health Services

Data issues/caveats that affect outcome measures:

Indicator #: 22

Indicator: 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).

Baseline Measurement: 100%

First-year target/outcome measurement: 100%

Second-year target/outcome measurement: 100%

Data Source:

Internal Records - CMHS

Description of Data:

number of community mental health center meeting compliance / number of community mental health centers surveyed

Data issues/caveats that affect outcome measures:

Indicator #: 23

Indicator: 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).

Baseline Measurement: 100%

First-year target/outcome measurement: 100%

Second-year target/outcome measurement: 100%

Data Source:

County Records - Administration

Description of Data:

Each staff member represents 25%

Data issues/caveats that affect outcome measures:

Indicator #: 24

Indicator: Number of people awaiting beds will be equal to or less than average of previous five years' data.

Baseline Measurement: 2,562

First-year target/outcome measurement: 2,313

Second-year target/outcome measurement: 2,313

Data Source:

Calculated using reporting software - Central Office IT

Description of Data:

Total count of people awaiting beds. Data is based upon a "Monday morning snapshot" of hospital emergency departments.

Data issues/caveats that affect outcome measures:

Indicator #: 25

Indicator: The number of patients awaiting beds, at time of Monday snapshot (8:30AM), not discharged by 5:00PM, will be equal to or less than average of previous five years' data.

Baseline Measurement: 1,667

First-year target/outcome measurement: 1,720

Second-year target/outcome measurement: 1,720

Data Source:

Calculated using reporting software - Central Office IT

Description of Data:

Number indicates patients in ED at 8:30 AM still in ED at 5:00PM.

Data issues/caveats that affect outcome measures:

Indicator #: 26

Indicator: The percentage of schools in South Carolina with Mental Health Services will increase.

Baseline Measurement: 49.60%

First-year target/outcome measurement: 62.17%

Second-year target/outcome measurement: 62.17%

Data Source:

Internal Records - CMHS

Description of Data:

schools in South Carolina with Mental Health Services / 1292 schools

Data issues/caveats that affect outcome measures:

Two factors appear to have resulted in a lower number than previous baseline. 1) Staffing shortages are having a negative impact on all but mandated services (such as SVPTP or Bryan Forensic). 2) School districts are now hiring non-DMH clinicians to provide mental health services at salaries above what DMH is currently able to offer.

Priority #: 2

Priority Area: Crisis Services 5% Set-Aside: Suicide Prevention

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

The Office of Suicide Prevention (OSP) is a program of the South Carolina Department of Mental Health (DMH) that is working to make South Carolina a Zero Suicide state. We do this through training, awareness, and collaboration with other state agencies, nonprofits, communities, and medical and behavioral health care systems. We operate under the firm belief that suicide is preventable, especially when communities are equipped with the knowledge and ability to help individuals struggling with thoughts of suicide. OSP would like to expand the number of people trained in suicide prevention, intervention, or postvention trainings across the state. Trainings include LivingWorks Applied Suicide Intervention Skills Training (ASIST), LivingWorks safeTALK, Assessing and Managing Suicide Risk (AMSR), Talk Saves Lives, Trauma Informed Suicide Prevention, AS+K, Mental Health First Aid, Connect Postvention, Survivor Voices, etc. This training will be offered to SCDMH employees and community partners. Expanding the number of people trained will assist in communities and mental health providers gaining more confidence to help and treat someone who is having thoughts of killing themselves.

Strategies to attain the goal:

OSP will keep an up-to-date trainer database of people who are trained in various suicide prevention training to be able to respond to training requests from the community and from SCDMH Community Mental Health Centers (CMHC) and Facilities. OSP will also send updates to trainers to ensure they are keeping to the fidelity of the training. OSP will reach current and new suicide prevention training to remain up to date with what is available. The office will also work on providing outreach materials to SCDMH CMHS and facilities, as well as providing outreach to the community through presentation requests, sharing flyers, and partnering with communities to distribute resources and bring awareness to the training offered.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of community partners trained in suicide prevention

Baseline Measurement: 1,500

First-year target/outcome measurement: 1,600

Second-year target/outcome measurement: 1,700

Data Source:

Office of Suicide Prevention Access Tracking Database

Description of Data:

Information about participants who attend trainings

Data issues/caveats that affect outcome measures:

n/a

Indicator #: 2

Indicator: Number of SCDMH staff members trained in suicide prevention

Baseline Measurement: 1,000

First-year target/outcome measurement: 1,100

Second-year target/outcome measurement: 1,200

Data Source:

Office of Suicide Prevention Access Tracking Database

Description of Data:

Information about participants who attend trainings

Data issues/caveats that affect outcome measures:

n/a

Indicator #: 3

Indicator: Number of people reached through outreach efforts

Baseline Measurement: 3,000

First-year target/outcome measurement: 3,500

Second-year target/outcome measurement: 4,000

Data Source:

Office of Suicide Prevention Access Tracking Database

Description of Data:

Information about people who received or saw outreach efforts

Data issues/caveats that affect outcome measures:

n/a

Priority #: 3

Priority Area: Crisis Services 5% Set-Aside: First Responder Support Team

Priority Type: BHCS

Population(s): BHCS

Goal of the priority area:

The First Responder Support Team would like to expand its ability to provide Critical Incident Stress Management (CISM) to first responders and civilians across the state. CISM, which is taught through the International Critical Incident Stress Foundation (ICISF), is a comprehensive, phase-sensitive, and integrated multi-component approach to crisis/disaster intervention. Critical incidents are defined as unusually challenging events that have the potential to create significant human distress and can overwhelm one's usual coping mechanisms. Through CISM, mental health professionals (MHP) and first responders learn how to facilitate a Critical Incident Stress Debriefing (CISD), which can be provided one-on-one, in small groups, or in a large group format. In the first responder community, having a team comprised of both MHPs and peer support staff increases the effectiveness of the intervention. CISM's format provides those who have been through a critical incident with both an opportunity to discuss/process the traumatic event, as well as receive psychoeducation regarding expected/understandable stress and trauma reactions. CISM has been proven to help the participants process the traumatic event and prevent the stress reactions from developing into PTSD or a more serious disorder. Although CISM is used most often within the first responder community, this practice can also be applied to a community setting after a tragedy. SCDMH has used CISM to support local agencies who have experienced workplace violence, traumatic deaths, prolonged exposure to traumatic stress, etc.

Strategies to attain the goal:

The program manager for the First Responder Support Team will research training opportunities for Basic CISM and Advanced CISM classes that are offered in person across the state as well as those offered virtually, He/she will also explore training opportunities through community partners, such as South Caroline Law Enforcement Assistance Program (SCLEAP), South Carolina Firefighters Association Support Team (SCFAST), and Lowcountry Firefighter Support Team (LFST) that will enhance relationships between DMH clinicians and the first responder communities across the state. He/she will share these training opportunities with DMH clinicians. The program manager will communicate and coordinate responses from DMH clinicians when there are requests for assistance with debriefings across the state.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: SCDMH clinicians trained in Basic Critical Incident Stress Management (CISM)

Baseline Measurement: 40

First-year target/outcome measurement: 50

Second-year target/outcome measurement: 60

Data Source:

SCDMH Office of Emergency Services

Description of Data:

Information about participants who attend trainings

Data issues/caveats that affect outcome measures:

n/a

Indicator #: 2

Indicator: SCDMH clinicians with advanced training in Critical Incident Stress Management (CISM)

Baseline Measurement: 10

First-year target/outcome measurement: 15

Second-year target/outcome measurement: 20

Data Source:

SCDMH Office of Emergency Services

Description of Data:

Information about participants who attend trainings

Data issues/caveats that affect outcome measures:

n/a

Indicator #: 3

Indicator: Number of Critical Incident Stress Debriefings (CISD) with SCDMH participation

Baseline Measurement: 100

First-year target/outcome measurement: 120

Second-year target/outcome measurement: 140

Data Source:

SCDMH Office of Emergency Services

Description of Data:

Information about participants who attend trainings

Data issues/caveats that affect outcome measures:

n/a

Indicator #: 4

Indicator: Number of civilians and first responders served by SCDMH's participation in Critical Incident Stress Debriefings (CISDs)

Baseline Measurement: 1,000

First-year target/outcome measurement: 1,400

Second-year target/outcome measurement: 1,800

Data Source:

SCDMH Office of Emergency Services

Description of Data:

Information about participants who attend trainings

Data issues/caveats that affect outcome measures:

n/a

Indicator #: 5

Indicator: New Referrals to First Responder Support Team (FRST)

Baseline Measurement: 300

First-year target/outcome measurement: 320

Second-year target/outcome measurement: 340

Data Source:

SCDMH Office of Emergency Services

Description of Data:

Information about participants who attend trainings

Data issues/caveats that affect outcome measures:

n/a

Priority #: 4

Priority Area: ESMI/FEP 10% Set-Aside

Priority Type: ESMI

Population(s): ESMI

Goal of the priority area:

Expand and continue services related to NAVIGATE programs at Community Mental Health Centers to ensure that more young adults with ESMI and FEP will receive effective, high-quality treatments, services, and support.

Strategies to attain the goal:

Provide funding, trainings, technical assistance, and other forms of support to Community Mental Health Centers so that they can successfully establish and continue their programs. Ensure that CMHCs adhere to NAVIGATE model to provide effective services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of NAVIGATE programs at CMHCs

Baseline Measurement: 2

First-year target/outcome measurement: 3

Second-year target/outcome measurement: 4

Data Source:

SCDMH Grants Management

Description of Data:

The number of NAVIGATE programs that have been successfully established and have started serving patients.

Data issues/caveats that affect outcome measures:

n/a

Indicator #: 2

Indicator: Number of NAVIGATE participants at CMHCs

Baseline Measurement: 71

First-year target/outcome measurement: 100

Second-year target/outcome measurement: 120

Data Source:

SCDMH Grants Management

Description of Data:

Number of NAVIGATE participants who are enrolled in programs during grant reporting period.

Data issues/caveats that affect outcome measures:

n/a

Indicator #: 3

Indicator: Number of NAVIGATE graduates from CMHCs

Baseline Measurement: 14

First-year target/outcome measurement: 20

Second-year target/outcome measurement: 30

Data Source:

SCDMH Grants Management

Description of Data:

Number of NAVIGATE participants who graduate from CMHC programs

Data issues/caveats that affect outcome measures:

n/a

Indicator #: 4

Indicator: Number of NAVIGATE participants who avoid hospitalization

Baseline Measurement: 44

First-year target/outcome measurement: 55

Second-year target/outcome measurement: 65

Data Source:

SCDMH Grants Management

Description of Data:

Number of NAVIGATE participants who are not hospitalized during the time that they are enrolled in NAVIGATE and during the 6-month period after their graduation from NAVIGATE.

Data issues/caveats that affect outcome measures:

n/a

Indicator #: 5

Indicator: Number of NAVIGATE participants who are employed or in school

Baseline Measurement: 3

First-year target/outcome measurement: 6

Second-year target/outcome measurement: 9

Data Source:

SCDMH Grants Management

Description of Data:

Number of NAVIGATE participants who maintain steady employment, or are enrolled in school, or graduate from school during the time that they are enrolled in NAVIGATE and during the 6-month period after their graduation from NAVIGATE.

Data issues/caveats that affect outcome measures:

n/a

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	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) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$2,965,864.00	$0.00	$0.00	$0.00	$0.00	$0.00	$889,863.00		$2,148,080.00	$169,169.00
4. Other Psychiatric Inpatient Care			$0.00	$0.00	$15,757,916.00	$0.00	$1,944,994.00	$0.00		$0.00	$0.00
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital			$101,542,324.00	$0.00	$203,308,622.00	$2,741,434.00	$11,269,144.00	$0.00		$0.00	$0.00
8. Other 24-Hour Care		$0.00	$21,760,880.00	$66,686,858.00	$132,656,376.00	$0.00	$20,479,776.00	$0.00		$0.00	$0.00
9. Ambulatory/Community Non-24 Hour Care		$23,949,342.00	$126,029,527.00	$9,977,106.00	$214,425,766.00	$7,507,180.00	$63,785,303.00	$9,772,644.00		$13,709,482.00	$1,446,049.00
10. Crisis Services (5 percent set-aside)[f]		$1,482,932.00	$97,798.00	$0.00	$779,788.00	$4,145,195.00	$837,246.00	$321,611.00		$718,750.00	$0.00
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$1,260,492.00	$0.00	$13,718.00	$57,640,582.00	$0.00	$2,305,566.00	$514,350.00		$721,552.00	$76,108.00
12. Total	**$0.00**	**$29,658,630.00**	**$249,430,529.00**	**$76,677,682.00**	**$624,569,050.00**	**$14,393,809.00**	**$100,622,029.00**	**$11,498,468.00**	**$0.00**	**$17,297,864.00**	**$1,691,326.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[d]While the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

[f]Row 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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Footnotes:

CARES Grant: $937,772 has been spent so far. This leaves a remaining balance of $11,498,468 to be spent between July 1, 2023 and March 14, 2024.

ARPA Grant: $4,182,916 has been spent so far. This leaves a remaining balance of $17,297,865 to be spent between July 1, 2023 and June 30, 2025. It is possible that a small amount of ARPA funds will not be spent by June 30, 2025; SCDMH plans to spend the entire funding amount by the grant deadline of September 30, 2025.

BSCA Grant: These numbers reflect BSCA #1 and BSCA #2 grants. $364 from BSCA #1 has been spent so far. This leaves a remaining balance of $768,132, along with the new BSCA #2 balance of $923,194, for a total amount of $1,691,326 to be spent between July 1, 2023 and June 30, 2025. It is possible that a small amount of BSCA funds will not be spent by June 30, 2025; SCDMH plans to spend the entire funding amount by the grant deadline of September 29, 2025.

We are indicating $0 for mental health prevention, based on the assumption that prevention activities are already included in the regular activities performed by the Community Mental Health Centers (CMHCs). Therefore, the budgeted amount for prevention is included in the "Ambulatory/Community Non-24-Hour" section.

Planning Tables

Table 6 Non-Direct Services/System Development

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FY Block Grant	FY [1] COVID Funds	FY [2] ARP Funds	FY [3] BSCA Funds
.	$	$	$	$
8. Total			**$**	**$**

Please wait while data loads...

[1] The 24-month expenditure period for the COVID-19 Rel **21 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the ins res captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for mo oved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. 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 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: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. 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 seriousness 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 detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

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

f) Persons with substance use disorders in the justice system

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

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

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

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.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. 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

4. 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

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

5. 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.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Question 1: Access to Care, Integration, and Care Coordination

1. ***Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:***
    a) ***Adults with serious mental illness***
    b) ***Pregnant women with substance use disorders***
    c) ***Women with substance use disorders who have dependent children***
    d) ***Persons who inject drugs***
    e) ***Persons with substance use disorders who have, or are at risk for, HIV or TB***
    f) ***Persons with substance use disorders in the justice system***
    g) ***Persons using substances who are at risk for overdose or suicide***
    h) ***Other adults with substance use disorders***
    i) ***Children and youth with serious emotional disturbances or substance use disorders***
    j) ***Individuals with co-occurring mental and substance use disorders***

The South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) is the lead agency for recovery and recovery support services for individuals with substance use disorders in the state. Therefore, SCDMH is responsible for efforts to improve access to care for: A) adults with serious mental illness, I) children and youth with serious emotional disturbances, and J) individuals with co-occurring mental and substance use disorders. The responses provided for this section will include information about how SCDMH provides services for the populations described in categories A, I, and J of the above list.

SCDMH's efforts to improve patient access to care include the following:

Federally Qualified Health Center Partnerships
Two CMHCs have mental health services embedded in FQHCs utilizing mental health professionals to deliver services – one is located in four of its FQHC partner's 11 locations and another has a clinician embedded in its local FQHC to provide homeless outreach. Three CMHCs have primary care clinicians embedded in the CMHC. Of those three, one partners with four rural health clinics through the Highway to Hope initiative.

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. The H2H program was initially supported by a federal grant, and additional RVs were purchased using SAMHSA block grant funding. Currently, H2H is funded by several different grants, including the SAMHSA block grant.

Statewide Crisis Call Centers

SCDMH 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. One call center provides a wide range of services for callers in crisis. The other call center is a new 988 center that was just launched in June 2023. Additionally, there is another 988 center in South Carolina; this 988 center is operated by Mental Health America of Greenville County (MHA Greenville).

- South Carolina Mobile Crisis Call Center
    - The South Carolina Mobile Crisis Call Center (SCMCCC), based in Charleston, SC, was first implemented in 2020 by SCDMH. This center assists individuals statewide and communicates with community mental health centers in every county to assist with triage and emergency assessment. The 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 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 is able to arrive on scene. In addition to those responsibilities, the SCMCCC 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. The center has assisted Mobile Crisis teams in being available to triage calls, develop safety plans, divert emergencies, and provide resources to individuals not needing immediate mobile crisis services or emergency response. The center also acts as a bridge for communication between first responders and Mobile Crisis clinicians. The SCMCCC is available at all hours to first responders to triage calls, gather information, or request Mobile Crisis response. Overall, the center works to assist and provide resources to individuals and families experiencing mental health emergencies throughout the 46 counties of South Carolina.

- 988 Suicide and Crisis Lifeline Center at CDMHC
    - Originally, Mental Health America of Greenville County (MHAGC) operated the sole National Suicide Prevention Call Center in South Carolina. On June 1st, 2023, SCDMH 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). This center assists with requests from participants who contact the center

using SC area codes. Participants who are experiencing mental health or suicide crises are provided with crisis intervention services. Third-party callers also reach out to 988 if they are worried about people who may need mental health or substance abuse resources in their area. Currently, CDMHC is in Phase 1 of its 988 rollout; in Phase 1, only phone services are provided. Chat and text services are expected to be launched by the fall of 2023. 988 participants 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 connect participants to care and secondary referrals, as well as help them address any barriers to accessing care through referral sources.

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 SCDMH, alone or in partnership with the State's Department of Insurance or the State Medicaid Agency, specifically to advance parity enforcement and increase awareness of parity protections, beyond following federal statutes related to parity.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. 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

SCDMH provides strategic leadership throughout its delivery systems of care for the expansion of the agency's partnership with public and private primary healthcare providers and mental health and substance abuse stakeholders. Under SCDMH's leadership a number of alignment care initiatives have been implemented and expanded to support the identification of need and the provision of primary care services for its patients with both public and private primary care stakeholders.

SCDMH continues to strengthen its existing partnerships with both public and private primary healthcare providers. Designated community mental health centers (CMHC) have maintained longstanding alignment care arrangements to include: 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
Two CMHCs have mental health services embedded in FQHCs utilizing mental health professionals to deliver services – one is located in four of its FQHC partner's 11 locations and another has a clinician embedded in its local FQHC to provide homeless outreach. Three CMHCs have primary care clinicians embedded in the CMHC. Of those three, one partners with four rural health clinics through the Highway to Hope initiative.

Foundational Assessment Report
The SCDMH Foundational Assessment Report, released in September 2021, provided an inventory of integrated care services provided at the time through SCDMH and delineated major barriers and facilitators to implementing integrated care. It provided a basic strategic framework to develop and implement integrated care services moving forward, including the recommendation to focus on 1) Depression care 2) Metabolic health indices as related to Antipsychotic medication, and 3) Tobacco use disorder.

Because of the administrative and regulatory burden of providing primary care services directly under SCDMH auspices, SCDMH has gradually discontinued direct provision of these services and instead been able to develop partnerships with community health clinics to provide primary care services to our patients.

SCDMH has prioritized integrated care as an expanding and increasingly important area, and to that end created a new position, the Director of Integrated Care. This position is responsible for spearheading integrated care efforts. The current Director of Integrated Care was invited to be a member of the Advisory Board for the Southeastern Mental Health Technology Transfer Center Network in the Spring of 2022 and continues to serve in this capacity.

Grant Funding
The integrated care team applied for and awarded HRSA grant (American Rescue Plan Act – Pediatric Mental Health Care Access New Area Expansion) to develop the state's first child psychiatry access network to support the provision of mental health care by primary care providers. The network has been named the Youth Access to Psychiatry Program (YAP-P). The goal is to provide a continuum of supports to SC primary care providers who see children and youth ages 0-21 years. YAP-P provides resources to practices and providers including:

- a provider to provider consult line which connects primary care providers with child and adolescent psychiatrists to get guidance on how to manage specific cases
- patient and family education materials about psychotropic medications and other mental health topics
- clinical training and education to improve knowledge of mental and behavioral health conditions
- access to an online closed-loop care referral system to be able to connect patients with community resources and which also contains the registry used to track YAP-P cases for the provider to provider consult line

Funding began on September 30, 2021 and HRSA provides $445,000 per year for 5 years with a non-federal 20% match. The proposal for this project indicated that SCDMH would launch in Barnwell County and expand over the course of the grant time frame to Aiken County. SCDMH launched the provider to provider consult line on May 24, 2023 in Barnwell County at the Low Country Health Care System (LCHCS). YAP-P has employed 2 child and adolescent psychiatrists to staff the consult line, and a developmental pediatrician at LCHCS has served as our pediatric champion. As of July 24, 2023, YAP-P has 24 registered providers and has a short-term goal of registering 11 more providers at LCHCS so that 100% of eligible providers will be enrolled. To date, YAP-P has completed 3 provider-to-provider consults, with additional consults pending. YAP-P also has developed a registry in collaboration with SC Thrive to be able to track and coordinate the consults and registered providers. When fully functional, the registry will allow providers to log in and schedule consults directly. YAP-P is also developing clinical algorithms and resources to help providers manage mental health conditions. Once finalized these will

be a resource freely available for all SC clinicians through the newly launched YAP-P Website (www.YAP-P.org).

YAP-P also received a $300,000 expansion award in the fall of 2022 from HRSA to look at expanding the network to include school-based health centers (SBHCs). For the 1st year of this expansion, YAP-P has been working identifying where SBHCs are in SC and on developing and administering a needs assessment and a readiness assessment to administer to SC SBHCs. YAP-P has been able to convene a multi-disciplinary team to accomplish this including representatives from the Medical University of SC (MUSC), Prisma Health Children's Hospital, SC Department of Health and Environmental Control, SC Department of Education, and University of North Carolina Charlotte. The goal of these assessments is to prioritize SBHCs for partnership with YAP-P. SBHCs, with the ability to have longitudinal relationships with patients and have an interest in getting further support in their management of mental and behavioral health issues, will be prioritized for the YAP-P partnership. Because of the pioneering and comprehensive nature of our approach to locating and assessing the SBHCs in SC, a YAP-P collaborator has been invited to serve on the HRSA's Pediatric Mental Health Care Access (PMHCA) School-based Health Alliance National Advisory Board.

Metabolic Health Indices
Integrated Care leadership led the development of a guideline for metabolic and physical health monitoring for patients on antipsychotic medication to be used for potential use in the CCBHC model. Two CMHCs have been working towards building a CCBHC-like model including expanding collaborations with other community health organizations.

SCDMH has awarded a grant from its internal Ensor Trust to the Director of Integrated Care and a psychiatric epidemiologist at University of South Carolina Arnold School of Public Health to look at Long-Acting Injectable antipsychotic medication in the SCDMH patient population. Contracts have been signed and research is in the early stages. This will help to inform the need for routine monitoring of metabolic measures and other practices related to metabolic health.

Tobacco Cessation
SCDMH continues to collaborate with the SC Department of Health and Environmental Control (SC DHEC) and DAODAS in the SC Behavioral Health Tobacco Cessation Partnership which meets monthly. SC DHEC has provided funding to support staff education in the area of tobacco cessation which has facilitated 7 SCDMH Staff from 4 MHCs to complete Tobacco Treatment Specialist training. It is also supporting the development of a Continuing Medical Education (CME)/Maintenance of Certification (MOC) activity being developed by the Director of Integrated Care and a planning committee for SCDMH prescribing clinicians. Through the Cessation Partnership, SCDMH hosted a Special Grand Rounds Presentation on September 21, 2022 on "The Imperative for Smoking Cessation in Mental Health Settings" by a national expert which was attended by 37 people. Tobacco Cessation toolkits were developed jointly by SCDHEC, SCDMH and DAODAS for administrators, medical providers, youth/school providers and counseling professionals. These were disseminated in October 2022 through SCDMH's basecamp platform to facilitate a Community of Practice on this topic. SCDMH has continued to create monthly reports on the rates of tobacco use disorder diagnoses and these have been shared with SCDMH leadership. Tobacco use disorder diagnoses have doubled since July 2020.

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. The H2H program was initially supported by a federal grant, and additional RVs were purchased using SAMHSA block grant funding. Currently, H2H is funded by several different grants, including the SAMHSA block grant.

4. 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

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

In 2013, SCDMH launched the Office of Clinical Care Coordination with internally transferred staff, with 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. It 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. As of June 2023, 16 case managers provide services statewide, and case managers served 998 participants with an average of 10-15 new cases added monthly.

The SCDMH Office of Clinical Care Coordination is funded by state allocated funds and Medicaid. Referrals received in the clinics are prioritized based on patient needs. Care Coordinators are tasked with assisting patients with such needs as emergency housing, affordable housing, utility bill assistance, food, clothing, primary care, specialized care, dental care, and other daily living needs.

5. 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.

The agency participates in ongoing multi-agency stakeholder policy platforms, which includes medical service providers, behavioral health entities and payors, in its efforts to support expansion of service alignment capacity for systems of care for individuals with co-occurring mental and substance use disorders.

To further these efforts, key stakeholder partnerships are being sustained, to include the SC Rural Health Association, Federally Qualified Health Centers (FQHCs), Medicaid Managed Care Organizations, South Carolina Health Information Exchange Office, and the SC Department of Health and Human Services (SCDHHS), which is the state's Medicaid agency.

The South Carolina Behavioral Health Coalition in which SCDMH is a partner, 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
- Children and youth ages 0 through 25 access to services
- Behavioral health and the justice system involved population

SCDMH maintains active participation in the expansion of the South Carolina Health Information Exchange (SCHIEx) partnership. This partnership provides enhanced capacity for health information exchange to ensure continuity of care for patients with co-occurring disorders. The strategic plan includes statewide rollout of the SCHIEx/DIRECT Messaging initiative among 16 CMHCs, the SCDMH Office of Clinical Care Coordination and local SCHIEx participating providers (e.g. hospitals, federally qualified health centers, rural health clinics, primary care partners and alcohol and other substance use disorder providers.)

The agency has contracted with Case Western Reserve University to provide dual diagnosis capability studies for SCDMH and county drug and alcohol authorities. Thus far, nine drug and alcohol authorities and eight mental health centers/clinics have completed studies. The studies assess center capability (or capacity) to provide treatment to those diagnosed with co-occurring substance use disorders and mental health disorders and to develop and implement a plan to do so with increasing capacity over time. Centers interested in an assessment of their dual-diagnosis capabilities collaborate with the

consultants who use the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index and the Dual Diagnosis in Mental Health Treatment (DDCMHT) Index to explore your organization's policies, clinical practices, and workforce capabilities. Once the capability studies are completed for interested centers, training will be provided by Case Western Reserve University on the Integrated Dual Disorders Treatment (IDDT) Model.

SCDMH has an Integrated Care Workgroup which focuses on improving treatment and access to those diagnosed with co-occurring substance abuse disorders and mental health disorders. This group is tasked with improving the rates of diagnoses of tobacco use disorder in SCDMH centers/clinics, metabolic monitoring for patients prescribed antipsychotics, and FQHC partnerships.

SCDMH continues to provide Motivational Interviewing (MI) training for staff statewide. MI is a person-centered, evidenced-based, goal-oriented method for enhancing intrinsic motivation to change by exploring and resolving ambivalence with the individual.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested.

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

[6] **https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf**

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race — (●) Yes ( ) No

b) Ethnicity — (●) Yes ( ) No

c) Gender — (●) Yes ( ) No

d) Sexual orientation — (●) Yes ( ) No

e) Gender identity — (●) Yes ( ) No

f) Age — (●) Yes ( ) No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? — (●) Yes ( ) No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? — (●) Yes ( ) No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? — (●) Yes ( ) No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? — (●) Yes ( ) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? — ( ) Yes (●) No

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Question 2: Health Disparities

1) ***Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, and age?***

a)	race	☒ Yes	☐ No
b)	ethnicity	☒ Yes	☐ No
c)	gender	☒ Yes	☐ No
d)	sexual orientation	☒ Yes	☐ No
e)	gender identity	☒ Yes	☐ No
f)	age	☒ Yes	☐ No

2) ***Does the state have a data-driven plan to address and reduce disparities in access, service use, and outcomes for the above subpopulation?***

☒ Yes ☐ No

3) ***Does the state have a plan to identify, address, and monitor linguistic disparities/language barriers?***

☒ Yes ☐ No

4) ***Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?***

☒ Yes ☐ No

5) ***If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?***

☒ Yes ☐ No

6) ***Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?***

☐ Yes ☒ No

7) Does the state have any activities related to this section that you would like to highlight?

The following are two SCDMH Directives related to the subject matter.

Directive 958-22 – Culturally and Linguistically Appropriate Services to Patients/Residents who have Limited English Proficiency (LEP) or are Hard of Hearing or Deaf.

- The purpose of this Directive is to ensure each Facility and Community Mental Health Center has a policy and procedures to provide culturally and linguistically appropriate services to its patients/residents who are not proficient in the English language and/or Hard of Hearing or Deaf, to the extent that they cannot access the services or programs offered by the agency without language assistance.
- It is the policy of the Department of Mental Health (DMH) to recognize and respect the cultural diversity of its patients/residents and to provide culturally and linguistically appropriate services to all of its patients/residents. Moreover, it is the policy of the DMH to provide services to those needing them without regard to national origin or disabilities. Included are individuals who have limited English proficiency, or are hard-of-hearing or deaf. The Department recognizes that in order to provide meaningful access to its behavioral health services to patients/residents who have limited English proficiency, or are hard-of-hearing or deaf, DMH facilities and Community Mental Health Centers must have procedures in place to provide communication services, including interpreter services at no cost to the patient/resident. Accurate and adequate communication between patients/residents and providers is a necessary element for providing good quality care, and it is a recognized right of patients/residents. The treatment staff needs to have the capability to effectively communicate with and relate to the experiences of patients/residents from diverse cultures, as this is an important component of culturally competent treatment.

Directive 966-23 – Cultural Competence

- The purpose of this directive is to establish the policy for the creation and maintenance of a culturally and linguistically competent system of care at the South Carolina Department of Mental Health (SCDMH).
- It is the policy of the Department to recognize that culture is dynamic, and that cultural competence must be an ongoing process, believing that valuing individual and group cultural differences is critical to achieving organizational goals. SCDMH considers cultural competence a necessary part of good clinical services. Initially organized under the Division of Community Mental Health Services, but now led by the Office of Cultural Affairs (CA), the Statewide Office of Cultural Affairs Committee (formerly known as the Statewide Multi-cultural Council) and Center/Facility/Division Cultural Affairs Committees (formerly known as the Center/Facility Multi-Cultural Committees) are charged with the responsibility to advise and guide SCDMH leadership in the creation and maintenance of a linguistically and culturally competent workforce, service divisions, programs, and collaborative endeavors reflective of the diversity of the population served and the community.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested.

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence for the efficacy and value of various mental and substance use prevention, SUD treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM/NASEM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center (EBPRC) assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's EBPRC provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

[2] United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[3] The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

[4] National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

[5] **https://www.samhsa.gov/ebp-resource-center/about**

[6] **http://psychiatryonline.org/**

[7] **http://store.samhsa.gov**

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☑ Leadership support, including investment of human and financial resources.
- **b)** ☑ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☐ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☐ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☑ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Question 3: Innovation in Purchasing Decisions

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?

☒ Yes ☐ No

2. Which value-based purchasing strategies do you use in your state? (check all that apply):

a) ☒ Leadership support, including investment of human and financial resources.

b) ☒ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

c) ☐ Use of financial and non-financial incentives for providers or consumers.

d) ☐ Provider involvement in planning value-based purchasing.

e) ☐ Use of accurate and reliable measures of quality in payment arrangements.

f) ☒ Quality measures focus on consumer outcomes rather than care processes.

g) ☐ Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).

h) ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Evidence-based practices provide proven tools to help patients achieve the goal of recovery. As the field moves forward, demand for EBPs by patients and other stakeholders has increased. Evidence-based practices do not exist for every problem nor do they work for every person. However, they do exist for certain conditions and they have been demonstrated by research to be effective. As resources continue to shrink, providing care that is proven effective seems an optimal way to stretch these resources.

In order to understand what services and treatments work best and for whom, and to build public support, it is essential that data on outcomes be measured and the results reported and used to inform decision-making. This activity is achieved through the combined efforts of internal programmatic resources and external program evaluators.

Providing evidence-based practices is essential to any plan striving to improve the quality of mental health treatment. Patients, family members, other stakeholders, and funders want to ensure that mental health practices with a strong evidence base are available. Evidence-based practices offer the greatest hope yet, through new treatments and services that have been proven to be effective through scientific evidence and research.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is required.

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required 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 consumers 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 before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's 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-5 (APA, 2013). 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 National Institute of Mental Health (NIMH) via its 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 with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH 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.

State 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 with 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.

* 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 a SMI.

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
Insights	1
NAVIGATE	2
New Directions	1
PREP	1
Youth in Transition	1

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
1482932	1482932

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

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

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

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

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

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 Percent Set-Aside

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
Insights	1
NAVIGATE	2
New Directions	1
PREP	1
Youth in Transition	1

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY 2025
$1,482,932	$1,482,932

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP 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/FEP.

Previously, SCDMH prioritized the use of Motivational Interviewing (MI) and Cognitive Behavioral Therapy (CBT) as the best treatment modalities for helping people who experience First Episode Psychosis (FEP). Over the past few years, in consultation with SAMHSA, SCDMH has shifted its focus to the implementation of NAVIGATE programs and other Coordinated Specialty Care (CSC) programs. Six SCDMH Community Mental Health Centers (CMHC) currently implement a total of five different CSC programs: Insights, NAVIGATE, New Directions, PREP, and Youth in Transition.

Program	**Community Mental Health Center**
Insights	Columbia Area MHC
NAVIGATE	Aiken Barnwell MHC Charleston Dorchester MHC
New Directions	Charleston Dorchester MHC
PREP	Pee Dee MHC
Youth in Transition	Lexington County CMHC

The following section includes information for each of the five programs implemented by SCDMH CMHCs, including program descriptions and program data for July 2021 – June 2023.

<u>Insights</u>

Insights is a comprehensive community-based program which serves patients between the ages of 18-30. Services include crisis intervention, medical assessments, mental health assessments, individual/ family/ group psychotherapy, psychosocial rehabilitation, care coordination, employment/ job coaching, and family education. Patients with any psychotic or mood disorders are eligible for participation. Patients with co-occurring disorders are also accepted as long as the psychiatric diagnosis is primary. The program focuses on transitional issues for patients ages 18-30. All new patients between the ages of 18-30 (except for high school students) are enrolled in the Insights program, as soon as they become clients at CAMHC.

Program Data:

From July 2021 – June 2023, approximately 600 patients participated in Insights at CAMHC. The number of graduates from the program is not tracked. At any given time, 20 Insights participants receive Individual Placement and Support (IPS) services. The number of Insights participants who are employed, in school, or who have avoided hospitalization is not tracked.

In the future, CAMHC plans to integrate NAVIGATE into the Insights program. Not all Insights participants will be eligible for NAVIGATE, but CAMHC hopes to provide NAVIGATE to any eligible Insights participants.

The following SCDMH Community Mental Health Centers implement Insights:

- Columbia Area Mental Health Center

NAVIGATE Program

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.

The Charleston-Dorchester CMHC is one of just twelve programs in the country participating in the Early-Phase Schizophrenia: Practice-Based Research to Improve Treatment Outcomes (ESPRITO) NAVIGATE grant. The ESPRITO NAVIGATE grant is a five-year research study examining the effectiveness and impact of NAVIGATE programs, including treatment outcomes, medication compliance, and engagement in services. In the ESPRITO NAVIGATE program, patients receive enhanced services based on improvements that have been made to the model over the past ten years. One of these services is Cognitive Adaptive Training (CAT), which is an evidence-based psychosocial treatment that helps people learn and develop strategies related to planning, organizing, remembering, and paying attention.

The following SCDMH Community Mental Health Centers implement NAVIGATE:

- Aiken Barnwell MHC
- Charleston Dorchester MHC

The following SCDMH Community Mental Health Centers participate in NAVIGATE ESPRITO:

- Charleston Dorchester MHC

The following SCDMH Community Mental Health Centers are in the planning stages to implement NAVIGATE; they plan to start or re-start the NAVIGATE program in the near future:

- Coastal Empire CMHC
- Lexington County CMHC
- Spartanburg Area MHC (previously implemented a NAVIGATE program but had to terminate it due to staff resignations)

Program Data:

- Aiken Barnwell MHC: The program was started in September 2022. From September 2022 – June 2023, 22 patients participated in NAVIGATE. 0 patients graduated. Since beginning the program, 9 patients avoided hospitalization. Since September 2022, 2 participants have maintained steady employment and 1 participant has been in school.
- Charleston Dorchester MHC: From July 2021 – June 2023, 49 patients participated in NAVIGATE. 14 patients graduated. Since beginning the program, 35 patients avoided hospitalization. As of July 2023, 5 New Directions participants have maintained steady employment and 1 participant is in school. The number of NAVIGATE graduates who are employed or in school is not tracked.
- Spartanburg Area MHC: No program data is available due to termination of program.

<u>New Directions</u>

The New Directions program is a Coordinated Specialty Care (CSC) treatment 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 majority of patients successfully graduate.

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 New Directions 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 New Directions prescriber's manual to follow the New Directions 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 New Directions 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.

The following SCDMH Community Mental Health Centers implement New Directions:

- Charleston-Dorchester MHC

Program Data:

- Charleston-Dorchester MHC: From July 2021 – June 2023, 56 patients participated in New Directions. 9 patients graduated. Since beginning the program, 45 patients avoided hospitalization. As of July 2023, 5 New Directions participants have maintained steady employment and 2 participants are in school. The number of New Directions graduates who are employed or in school is not tracked.

PREP - Prevention and Recovery in Early Psychosis

The Prevention and Recovery in Early Psychosis (PREP) program provides services to individuals 18 – 30 years of age who are experiencing early symptoms of psychosis, including Schizophrenia, Bipolar Disorder, Schizoaffective Disorder, and Borderline Personality Disorder. The goals of PREP include education and support for patients and families; improving patients' recovery; reducing the chances of relapse, and assist patients in setting individualized goals. The program offers individual counseling, family counseling, medication and psychiatric care, family education and support, case management, supported employment and education. Participants must choose to participate in at least two of the treatment components. The program enhances advocacy skills, encourages individual empowerment, decreases hospitalizations, decreases symptoms, and enhances the patients' quality of life.

The following SCDMH Community Mental Health Centers implement PREP:

- Pee Dee MHC

Program Data

- From July 2021 – June 2023, 30 patients participated in PREP at Pee Dee MHC. No patients have graduated from the program. Since beginning the program, 12 patients avoided hospitalization. As of July 2023, 6 patients (currently enrolled or graduated) have maintained steady employment and 4 patients (currently enrolled or graduated) have been in school.

Youth in Transition

The Youth in Transition (YIT) program provides treatment services to young adults who are experiencing symptoms of first episode psychosis, from any psychotic disorder. Using individual, group, and family therapy services, clinical staff educate patients about how to manage their newfound lifelong

diagnosis. Caseloads are much smaller in this program to allow for more frequent services based on the patients' levels of care and treatment goals. In providing these intensive services at the onset of their symptoms, patients stand to have a much better long-term prognosis while experience fewer setbacks with their mental and emotional stability. The YIT team includes two full-time Mental Health Professionals, as well as part-time medical support from a psychiatrist and nurse. YIT team members also work very closely with the Individual Placement and Support (IPS) program to help patients achieve stable employment in the community. Care Coordination services are also offered to help link patients to needed resources based on their assessed needs.

The following SCDMH Community Mental Health Centers implement Youth in Transition:

Lexington County CMHC

Program Data:

- The program started in 2015. From July 2021 – June 2023, 94 patients participated in Youth in Transition at LCCMHC. The number of patients who graduated from the program is not tracked. The number of current participants and graduates who are employed, in school, or who have avoided hospitalization is not tracked.

5. Does the state monitor fidelity of the chosen EBP(s)?

☐ Yes ☒ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

☒ Yes ☐ No

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

Strategies for improving client outcomes are unique to each Community Mental Health Center (CMHC) throughout the state.

Insights

- The Insights program focuses on transitional issues related to their clients, who are 18 – 30 years old.

NAVIGATE

- The center maintains relationships with therapists imbedded at the local jail. The center also maintains a close relationship with mobile crisis resources. (Aiken Barnwell MHC)
- All team members attempt to engage the patients, provide a variety of ways to meet for appointments (in person, in the community, and/or virtually), and are hands-on and flexible with ways to help the patients. (Charleston Dorchester MHC)

New Directions

- All team members attempt to engage the patients, provide a variety of ways to meet for appointments (in person, in the community, and/or virtually), and are hands-on and flexible with ways to help the patients.

PREP - Prevention and Recovery in Early Psychosis

- In the PREP Program, staff members work towards enhancing advocacy skills, encouraging individual empowerment, decreasing hospitalizations, decreasing symptoms, and enhancing the patient's quality of life.

Youth in Transition

- Caseloads are much smaller in this program which allows patients to receive more intensive services and community-based services when necessary. Staff also engage more with patients' families and other natural supports to help improve patients' stability.

8. **Please describe the planned activities in FY2024 and FY2025 for your state's ESMI/FEP programs.**

During FFY2024 and FFY2025, five different SAMHSA grants will support ESMI/FEP programs:

Funding Source	Amount
2024-2025 Block Grant	$1,482,932
Coronavirus Response and Relief Supplement Appropriations (CARES)	$600,00
American Rescue Plan Act of 2021 (ARPA)	$2,148,080
Bipartisan Safer Communities Act (BSCA), Allotment 1	$76,850
Bipartisan Safer Communities Act (BSCA), Allotment 2	$92,319
Total	*$4,000,181*

This money will be spent to support the ongoing operations or the establishment of NAVIGATE programs at SCDMH's CMHCs, including but not limited to these centers:

- Aiken Barnwell Mental Health Center
- Catawba Community Mental Health Center
- Charleston Dorchester Mental Health Center
- Coastal Empire Community Mental Health Center
- Columbia Area Mental Health Center
- Greater Greenville Mental Health Center
- Lexington County Community Mental Health Center
- Spartanburg Area Mental Health Center

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

Insights

- Any psychotic or mood disorder

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 - Prevention and Recovery in Early Psychosis

- Psychosis, including Schizophrenia, Bipolar Disorder, Schizoaffective Disorder, and Borderline Personality Disorder

Youth in Transition

- Any psychotic disorder

***10.* What is the estimated incidence of individuals with a first episode psychosis in the state?**

Unknown. In the past, SCDMH 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 with a first episode psychosis who need support from the public mental health system?**

Promotion and outreach for the programs are unique to each SCDMH Community Mental Health Center (CMHC).

Insights

- Specific outreach strategies are not provided to members of the community who might benefit from the program. Instead, all new patients between the ages of 18-30 (except for high school students) are enrolled in the program, as soon as they become clients at CAMHC.

NAVIGATE

- The center maintains a relationship with Aurora Pavilion, a local in-patient acute care center, and provides community care. (Aiken Barnwell MHC)
- The NAVIGATE program director visits community task force meetings, schools, and doctors' offices to provide outreach and education to community members. (Charleston Dorchester MHC)

New Directions

- The New Directions program director visits community task force meetings, schools, and doctors' offices to provide outreach and education to community members.

PREP - Prevention and Recovery in Early Psychosis

- Staff members share information about the program to various community fairs and forums, and also promote the program to individuals experiencing early signs of psychosis.

Youth in Transition

- Staff members participate in community outreach opportunities throughout the year to help reach patients who need services. The center also has staff members located in all school districts; these staff members proactively engage with patients who may be onsetting with SPMI. Staff members use PQ-16 at intake to help identify patients who may be experiencing psychosis.

12. Please indicate areas of technical assistance needed related to this section.

We would welcome technical assistance related to strategies to calculate the estimated incidence of individuals with a first episode psychosis in the state.

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP 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. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

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.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

4. Describe the person-centered planning process in your state.

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 SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Question 5: Person Centered Planning (PCP)

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 consumers and their caregivers in making health care decisions and enhances communication.

Following are some of the ways that SCDMH engages consumers and their caregivers in making healthcare decisions and enhancing communication:

- SCDMH offers psychiatric advanced directive information and assistance.
- SCDMH offers at admission the opportunity for the patient to identify family/supports to be involved in treatment.
- SCDMH offers at admission the opportunity for the patient to identify any designee(s) to have access to treatment information.
- SCDMH employs family-based care for children and adolescents in order to facilitate achievement of goals.
- SCDMH uses the Initial Clinical Assessment (ICA), which is strengths-based. It identifies goals, preferences, needs, desired outcomes in numerous dimensions.
- SCDMH uses initial individualized Plans of Care (POCs) with patient and family/support input and involvement, documented collaboratively, and patient signature.
- SCDMH uses POCs to identify discharge/transition parameters for each patient.
- SCDMH collaboratively completes POC progress summaries at least every 90 days that may result in updates to POCs.
- SCDMH focuses services on the whole person, including social, health, living, education, spirituality, employment, etc.
- SCDMH Care Coordinators identify options and resources and link patients to such.

- SCDMH Peer Support Specialists use Recovery for Life and WRAP (Wellness Recovery Action Plan) to promote/support balanced lives and skills for patients.
- SCDMH utilizes Engagement Specialists for outreach to patients who miss appointments.
- SCDMH uses Levels of Care - a tool to communicate to patient and families/support movement toward desired outcomes.
- SCDMH uses Collaborative Documentation to ensure patient and families/support contribute to information input into the electronic medical record (EMR).

4. Describe the person-centered planning process in your state.

SCDMH Community Mental Health Centers (CMHCs) provide training and education initially, and on-going thereafter, in order to communicate how to embody individualized care that includes families/supports. The CMHCs also teach how clinical documents from the Initial Clinical Assessment (ICA), to Individualized Plan of Care (POC), to 90-Day POC Summaries, to Service Notes, to Physician Medical Orders (PMO), to Nursing Notes all must reflect the patient's unique needs, progress, and other considerations.

Following are components of the person-centered planning process for the South Carolina Department of Mental Health:

- SCDMH offers psychiatric advanced directive information and assistance.
- SCDMH offers at admission the opportunity for the patient to identify family/supports to be involved in treatment.
- SCDMH offers at admission the opportunity for the patient to identify any designee(s) to have access to treatment information.
- SCDMH employs family-based care for children and adolescents in order to facilitate achievement of goals.
- SCDMH uses the ICA, which is strengths-based. It identifies goals, preferences, needs, desired outcomes in numerous dimensions.
- SCDMH uses initial individualized Plans of Care with patient and family/support input and involvement, documented collaboratively, and patient signature.
- SCDMH uses POCs to identify discharge/transition parameters for each patient.
- SCDMH collaboratively completes POC progress summaries at least every 90 days that may result in updates to POCs.
- SCDMH focuses services on the whole person, including social, health, living, education, spirituality, employment, etc.

- SCDMH Care Coordinators identify options and resources and link patients to such.
- SCDMH Peer Support Specialists use Recovery for Life and WRAP (Wellness Recovery Action Plan) to promote/support balanced lives and skills for patients.
- SCDMH utilizes Engagement Specialists for outreach to patients who miss appointments.
- SCDMH uses Levels of Care - a tool to communicate to patient and families/support movement toward desired outcomes.
- SCDMH uses Collaborative Documentation to ensure patient and families/support contribute to information input into EMR.

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 SAMHSA's A Practical Guide to Psychiatric Advance Directives)?***

SCDMH inquires during the ICA if the patient has a Psychiatric Advance Directive and if so, obtains a copy to maintain as part of their record. If the patient does not have a Psychiatric Advance Directive and is interested in developing one, SCDMH offers the patient a list of community resources that can assist them or the patient may be referred to Clinical Care Coordination. In addition, the SCDMH website provides an overview of Psychiatric Advance Directives to inform patients and their families.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested.

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA 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 M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 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), SAMHSA periodically conducts 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. SAMHSA 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 the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, 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 M/SUD 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 M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/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:

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?

   Please indicate areas of technical assistance needed related to this section

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Footnotes:

Question 6: Program Integrity

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 SCDMH'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.

SCDMH 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, SCDMH 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.

In collaboration with the South Carolina Mental Health Commission, SCDMH built and implemented a Compliance Program consistent with the procedural and structural guidance provided by the Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS) 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. The South Carolina Mental Health Commission and SCDMH expect all staff members to conform to the standards of conduct as stated in the Compliance Program's Code of Ethics and Conduct.

SCDMH's Compliance program:

- is ongoing and the objectives are consistent with the agency's mission;
- provides employees education regarding compliance;
- 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;
- includes a system to investigate allegations of noncompliance;

- regularly monitors and audits activities; and,
- enforces appropriate conduct and discipline.

SCDMH's Quality Management Advisory Committee (QMAC) includes compliance and quality assurance. Compliance promotes and monitors SCDMH'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 SCDMH's patients.

SCDMH's Compliance Committee comprises 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. SCDMH's Compliance Officer provides the South Carolina Mental Health Commission with timely and accurate information at least twice a year, 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 SCDMH serves as an independent function to examine and evaluate Agency activities as a service to the South Carolina Mental Health Commission and the DMH state director. Internal Audit's overall objectives are to: evaluate internal controls and safeguard Agency assets; test for compliance with State, Federal, and Agency 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, SCDMH 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, SCDMH determined that the non-profit organizations that receive MHBG funds through RFPs are contractors, not sub-recipients. Even though these organizations are contractors and not sub-recipients, SCDMH still closely monitors the programmatic and fiscal activities of these organizations. The SCDMH 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. SCDMH 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, SCDMH does not regularly conduct annual site visits to monitor the organizations.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested.

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Question 7: Tribes

1. How many consultation sessions have the state conducted with federally recognized tribes?

Zero.

Using SAMHSA's definition of "consultation" as "a government-to-government interaction that is distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands where such consultation is attended by elected officials of the tribe or their designees and by the highest possible state officials," SCDMH has not conducted consultation sessions with the State of South Carolina's only federally recognized tribe, the Catawba Indian Nation.

2. What specific concerns were raised during the consultation session(s) noted above?

Not Applicable

3. Does the state have any activities related to this section that you would like to highlight?

The South Carolina Mental Health State Planning Council secured a representative from the Pine Hill Indian Community Development Initiative, a state recognized nonprofit tribal organization dedicated to serving the minority, underserved and tribal communities of South Carolina.

In addition, both Orangeburg Area Mental Health Center and Catawba Community Mental Health Center have established relationships with local tribes. Orangeburg Area Mental Health Center partners with the Pine Hill Indian Community Development Initiative and Catawba CMHC partners with tribal leadership of the Catawba Indian Nation to provide crisis services as needed and requested.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested.

Environmental Factors and Plan

9. 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-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

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 misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	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.)

3. Describe your state's case management services

4. Describe activities intended to reduce hospitalizations and hospital stays.

Please indicate areas of technical assistance needed related to this section.

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

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate 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	218,018	Not indicated
2.Children with SED	59,002	Not indicated

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.

Please indicate areas of technical assistance needed related to this section.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care*?

a)	Social Services	○ Yes	◉ No
b)	Educational services, including services provided under IDEA	○ Yes	◉ No
c)	Juvenile justice services	○ Yes	◉ No
d)	Substance misuse preventiion 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

Please indicate areas of technical assistance needed related to this section.

**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.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

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 targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

Please indicate areas of technical assistance needed related to this section.

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.

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 for SAMHSA 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 or underserved 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 SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. Describe your state's management systems.

b. 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.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Question 9: Statutory Criterion for MHBG

Criterion 5: Management Systems

a. Describe your state's management systems.

The South Carolina Department of Mental Health (SCDMH) has a comprehensive Staff Development and Training Program. It is housed in the Office of Education, Training and Research (ETR).

A listing of programs is provided below. Programs listed below may be provided on a schedule other than that which may be cited depending upon need; not all programs are provided routinely.

Education, Training and Research (ETR)

- Reports through the SCDMH Office of Medical Affairs.
- Provides education and training for the entire agency though the traditional class room approach and an on-line learning management system.
- Trainings via zoom are also used for centers and facilities outside of Columbia. This saves on the cost of travel and allows the staff member to remain on site and be available before and after the training. This enhances their ability to continue to provide billable services.
- All of the training provided is evaluated by class participants and the results are used to improve existing training and/or create new training offerings to meet identified needs.
- Most of the training is done using in house topic experts which makes them budget neutral.

Supervisory Miniseries

- Designed for individuals in SCDMH who were promoted to a supervisory role and new hires who will be in a supervisory role.
- This program is offered live and via video conferencing.
- It started out as a three-part mini-series but has grown to four parts based on identified needs of class participants and/or their supervisors.

Executive Leadership Development Program

- Designed for individuals in the agency who may serve in Executive Leadership roles in the

future. The 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 SCDMH 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 SCDMH.

Psychiatric Grand Rounds

- Designed for physicians and other clinical staff.
- This program is offered monthly live and via zoom.
- Participants receive continuing education credit that they can use toward re-licensure.
- The topics are selected based on the results of the Needs Assessment that is sent out to the clinical staff each year.
- -Is done 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. It also provides Continuing Education for Social Workers (SW), Licensed Professional Counselors (LPC) and Marriage & Family Therapist's (MFT). SCDMH is also an approved provider of Continuing Nursing Education through the South Carolina Nurses Association.
- 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

- SCDMH has an On-line Learning Management System which staff use to take training that is required to meet regulatory and accrediting standards.
- All the 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 number of billable hours for clinical staff.

Psychiatric Residency/Fellowship Training Programs

- SCDMH has a long-standing agreement with Prisma Health (formerly Palmetto Health) for Psychiatric Residents to rotate in its facilities to gain hands-on psychiatric experience.
- There are four Residency/Fellowship training programs at the School of Medicine. They are General Psychiatry, Child and Adolescent, Forensics and Geropsychiatry. All use SCDMH as part of their clinical rotation.
- SCDMH Clinical psychiatrists provide supervision to the residents while in SCDMH.
- This 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 SCDMH facilities or centers.

Nursing Orientation & Training

- Nursing is a large and integral part of SCDMH. They 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 SCDMH 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.”

b. 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.

DMH has been providing telehealth services since 1996 in a wide range of settings, from inpatient treatment to community care settings. DMH currently has six telepsychiatry programs: Emergency Department Telepsychiatry, Community Telepsychiatry, Inpatient Services Telepsychiatry, EMS Telehealth, School Telehealth and Telepsychiatry, and Nursing Home Telepsychiatry.

DMH'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 Mental Health Centers and satellite county clinics statewide. The Community Telepsychiatry program has provided psychiatric treatment services to DMH 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 DMH's partnership with the SC Department of Juvenile Justice (DJJ) 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 onsite to support the DMH 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 Mental Health Centers. 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 on all the RVs.

DMH's Emergency Department (ED) Telepsychiatry program has 26 hospital partners across the state and is in the process of adding new partners. In FY23, the ED Telepsychiatry program provided over 9000 psychiatric consultations, which is approximately 750 consults each month. Psychiatric care is available through the ED program 17 hours per day, 365 days per year.

c. Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested.

Question 9: Statutory Criterion for MHGB

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

a. Describe your state's targeted services to rural population. See SAMHSA's Rural Behavioral Health page for program resources (https://www.samhsa.gov/rural-behavioral-health).

SC Mobile Crisis is a program created by DMH in partnership with the SC Department of Health and Human Services to enhance the Agency's crisis services array by providing statewide capacity for onsite, emergency, psychiatric screening and assessment. Mobile Crisis provides services 24/7/365. The program's goals are to provide access and link those experiencing psychiatric crises to appropriate levels of care, reduce hospitalizations, and reduce unnecessary emergency department visits. Mobile Crisis builds partnerships with local law enforcement, hospitals, judges, community providers, and other mental health providers. Mobile Crisis provides an extension of DMH community mental health center services:

- During business hours, DMH 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.
- After hours, weekends, and on holidays, teams of two mental health professionals respond in person, remotely, or by phone to those experiencing psychiatric emergencies.

Highway to Hope (H2H) is a mobile response program that serves adults and children in some of the most rural areas of South Carolina, using 16 RVs operated by SCDMH staff members. H2H is based on a long-running, highly successful model for rural patients operated by SCDMH's Charleston-Dorchester Mental Health Center since 2010. The program offers both mental health treatment and basic primary care services; the RVs are equipped with telehealth equipment, and the services can be delivered both in-person and virtually. These services are provided in the privacy of the RVs, which travel throughout the various counties and park in different locations. People who do not have the ability to travel far distances to urban health providers are able to more easily access these mental health and primary care services when the RVs are located closer to their homes and communities. Based on the patient's assessment, the professional care staff make referrals to other community resources. This program was initially supported by a federal grant, and additional RVs were purchased using SAMHSA block grant funding.

DMH has six telepsychiatry programs: Emergency Department Telepsychiatry, Community Telepsychiatry, Inpatient Services Telepsychiatry, EMS Telehealth, School Telehealth and Telepsychiatry, and Nursing Home Telepsychiatry.

As SCDMH began preparations to address COVID-19, telehealth became a focus for ensuring the safety and well-being of its patients, residents, and staff. While most of SCDMH's telehealth programs continued to deliver services without significant modifications, SCDMH's Community Telepsychiatry Program rapidly enhanced its community-based and school mental health services with a new telehealth component to ensure continuity of care for patients: direct-to-patient (DTP). All of SCDMH's Mental Health Centers (MHC) remained open, but each was complemented with any array of DTP telehealth services; each MHC equipped the majority of its clinical staff to work from home – more than 850 used a telehealth platform to do so. The majority of centers' existing patients – adults, as well as children and families – received services using DTP as the primary medium. Established, robust supervision practices and the peer consultation regimen helped ensure the highest standards of care for patients and their families. Feedback on DTP services has been positive, with patients and their families enjoying the convenience of DTP care.

b. Describe your state's targeted services to people experiencing homelessness. See SAMHSA's Homeless Programs and Resources for program resources.

- Statewide Housing Units for People With Mental Illnesses
    - Over approximately 30 years, SCDMH 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.

- Community Housing Rental Assistance Program
    - This program, launched in 2015, uses more than $2 million in state funds annually to provide rental assistance and related housing costs for DMH patients statewide.
    - All 16 CMHCs have state-funded Community Housing rental assistance programs, including one that also serves Deaf Services patients.
    - On June 30, 2023, the Program assisted 324 units/524 patients and family members at an average annual cost of under $7,000/unit.

- Housing and Urban Development (HUD) Continuum of Care Permanent Supportive Housing Program
    - DMH is the grantee for a HUD Continuum of Care Permanent Supportive Housing grant that provides almost $360,000 annually for rental assistance for formerly homeless individuals with mental illnesses and their family members in Greenville and Spartanburg counties.
    - As of June 30, 2023, this program was serving 43 formerly homeless individuals with mental illnesses and their family members.
    - SCDMH also provides state matching funds for this grant and two additional grants that serve this population in Richland and Lexington counties.

- SAMHSA Projects for Assistance in Transition from Homelessness (PATH) Program
    - This grant provides funding for outreach and clinical services for people with serious mental illnesses and co-occurring substance use disorders who are experiencing homelessness in the Columbia, Greenville, Myrtle Beach, and Charleston areas.
    - PATH programs are projected to serve more than 1,700 individuals annually.

- SOAR (SSI/SSDI Outreach, Access, and Recovery) Initiative
    - SCDMH serves as lead agency and partners with SSA and SC Disability Determination Services.
    - 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.
    - In FY 2022, the SC SOAR initiative achieved a 69% approval rate for initial SOAR applications with an average decision time of 99 days.

- SAMHSA Treatment for Individuals Experiencing Homelessness (TIEH) Grant
    - In 2018, DMH received a grant of $1 million per year for five years from SAMHSA to fund a new initiative called Treatment for Adults Experiencing Homelessness in SC.
    - The Project's target population is individuals experiencing homelessness who also have serious mental illnesses and co-occurring substance use disorders with the goal of increasing access to evidence-based treatment services, peer support, services that support recovery, and connections to permanent housing.
    - Treatment sites are located at Prisma Health in Columbia and DMH's Greater Greenville MHC in Greenville, with each providing intensive services using the Assertive Community Treatment (ACT) model to serve a total of 75 people over the five-year grant period.
    - This grant also funds four SOAR benefits specialists that assist eligible individuals with serious mental illnesses who are experiencing or at risk of homelessness in accessing SSA disability income supports. Of the four positions, three are located in SCDMH community mental health centers and one is based at the SC Department of Corrections.

c. Describe your state's targeted services to the older adult population. See SAMHSA's Resources for Older Adults webpage for resources.

Examples of SCDMH's targeted services to older adults include Pee Dee Mental Health Center's Silver Years Program and Santee Wateree Community Mental Health Center's Elder Services Program.

The Silver Years Program provides intensive outpatient services for older adults with symptoms of early dementia in addition to mental illness.

The Elder Services Program provides for staff who are trained in and sensitive to the needs of our older citizens. 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: problem assessment, to include full psychological and cognitive assessment; psychiatric assessment for treatment planning, medication intervention and management, and medical referral as needed; individual, family, and group counseling; medication monitoring by nurses; and case management to assist the client in accessing both mental health and appropriate health and social services.

Question 9: Statutory Criterion for MHBG

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a) Social Services

☐ Yes ☒ No

b) Educational services, including services provided under IDEA

☐ Yes ☒ No

c) Juvenile justice services

☐ Yes ☒ No

d) Substance misuse prevention and SUD treatment services

☐ Yes ☒ No

e) Health and mental health services

☐ Yes ☒ No

f) Establishes defined geographic area for the provision of the services of such systems

☒ Yes ☐ No

Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested.

Question 9: Statutory Criterion for MHBG

Criterion 2: Mental Health System Data Epidemiology

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate 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	218,018	Not indicated
2. Children with SED	59,002	Not indicated

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.

SCDMH 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 from September 2022. The report can be found here: https://www.samhsa.gov/data/sites/default/files/reports/rpt39369/adult_smi_child_sed_prev_2021_508.pdf

The rate for children was calculated at 10%, which is the average rate of the four estimated rates that were provided.

SCDMH uses the URS rates in conjunction with community-centric feedback to evaluate and substantiate planning and implementation activities for its mental health system of care.

The community-centric feedback is based on dashboard performance measures that SCDMH Senior Management reviews and refines on a periodic basis. The measures are quick reference global indicators to evaluate actual performance against the strategic plan. The dashboard measures rely on a response to demand approach that seeks to refine the efficiency of the service delivery system in order to create capacity to meet demand as it presents itself. Within the Community Mental Health Centers, the dashboard measures are evaluated by CMHC individually and by SCDMH as a system.

Please indicate areas of technical assistance needed related to this section.

We would welcome technical assistance to help us better understand which strategies we should use to estimate statewide incidence rates, as well as how to estimate the children's statewide prevalence rate.

Question 9: Statutory Criterion for MHGB

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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.***

   Services include assessment, crisis intervention, and individual and group therapy using evidenced based practices including CBT, TFCBT, AFCBT, DBT, EMDR, PCIT. PMA and nursing services are provided to monitor/reduce symptoms. Patients are offered PSS and PRS to assist in job placement, linking to the Vocational Rehabilitation Department, learning job and other skills to maintain stability in the community. Housing programs assist with placement and subsidy of rent to help patients maintain independent living. Mental Health Court programs, clinicians embedded at Department of Juvenile Justice sites, and the local jail provide interventions to engage patients in treatment and reduce recidivism. The EBP, NAVIGATE model, is used with patients in the FEP programs, as well.

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 misuse prevention and SUD treatment services
      ☒ Yes ☐ No
   h) Medical and dental services
      ☒ Yes ☐ No
   i) 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-occurring 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 SCDMH:

- Telepsychiatry
- School Mental Health Services
- Assessment/Mobile Crisis
- Metropolitan Children's Advocacy Center (MetCAC)
- 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

3. Describe your state's case management services

Care Coordinators provide targeted case management services to qualifying individuals beginning with a comprehensive needs assessment. In the needs assessment, medical, dental, housing, employment, education, behavioral, and other community support needs are identified. Working collaboratively with the client, a Care Coordinator, who is knowledgeable about the local community resources, links the client to those resources. The Care Coordinator continues to monitor the services until goals are met and needs are resolved. Successful transition to community settings and access to needed services are focus points for Clinical Care Coordination services.

4. Describe activities intended to reduce hospitalizations and hospital stays.

SCDMH provides a wide variety of services intended to reduce hospitalizations and hospital stays.

- Office of Transition Programs
    - In 2019, DMH created the Office of Transition Programs (OTP) to assist patients who have been hospitalized in DMH facilities for longer-term treatment to move from a hospital setting to the community and toward independent living. As of today, the OTP has expanded the program to not only assist those patients who have been in the hospital long term, but also now assisting patients that have placement issues, regardless of length of stay in the hospital. The office continues to assist patients with their identified needs so they can access community resources in an effective and efficient way post-discharge. Transition Specialists work with patients to determine their recovery needs, their preference of where they want to live in the community, and to collaborate with stakeholders to ensure continuous communication as it relates to the patient's discharge plans. Transition Specialists ensure effective communication between inpatient/outpatient staff regarding patients' discharge needs and coordinate with all stakeholders (patient, family, clinical care coordinators, certified peer support specialists), streamlining the discharge process and improving the chance for successful transition to the community. Community Transition Specialists are also actively developing relationships with stakeholders to improve housing access and placement for patients we are assisting with transitioning and maintaining in the community. Since 2019, the OTP has assisted with more than 500 patients transitioning to the community with a less than .3% recidivism rate.

- Clinical Care Coordination and Community Long-Term Care
    - In 2013, DMH launched the Office of Clinical Care Coordination with internally transferred staff, with 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. It 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. As of June 2023, 14 case managers provide services statewide, and case managers served 990 participants with an average of 10 -15 new cases added monthly.

- Improved Infrastructure for Family and Peer Support

  - As discussed in our response to Question 18, SCDMH recently implemented a new program called Project FOCUS. In collaboration with SCDMH's partner agencies from the joint Council on Children and Adolescents, this new program will expand the system of care 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 mental disturbance (SED) and their families.

  - 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:

    1. To expand 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.
    2. To improve client level outcomes for children, adolescents, and their families.
    3. To enhance and sustain evidenced-based and culturally competent mental health services and supports for youth with SED/SMI and families in South Carolina.

- SCDMH Emergency Department Telepsychiatry Program

    - Begun in 2008, the goals of the Emergency Department Telepsychiatry Program are to achieve timely mental health comprehensive evaluations and recommendations; initiate quality treatment services; reduce overall hospital length of stay; affect return on investment through hospital savings; and, provide successful post-emergency department transfer to aftercare services in community settings. DMH's Emergency Department (ED) Telepsychiatry program has 26 hospital partners across the state and is in the process of adding new partners. In FY23, the ED Telepsychiatry program provided over 9000 psychiatric consultations, which is approximately 750 consults each month. Psychiatric care is available through the ED program 17 hours per day, 365 days per year. More information about SCDMH's telehealth services is provided in our response to Question 9, Criterion 5.

- SC Mobile Crisis Services

    - SC Mobile Crisis (MC) is a program created by SCDMH, 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 SCDMH community mental health center services; during business hours, SCDMH 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 SCDMH Mobile Crisis Call Center, which is operated by the 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.

- **Alliance Program**
    - Alliance is a program in the SCDMH Office of Emergency Services. This program provides opportunities for first responders to collaborate with SCDMH 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, detention 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. MHPs working in detention centers and jails identify detained offenders who are in need of referrals to mental health care and continuity of care in the community. 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.

- **Housing and Community Placement**
    - Statewide Housing Units for People With Mental Illnesses
        - Over approximately 30 years, DMH has invested Agency funds in the development of over 1,200 housing units. 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.
    - Community Housing Rental Assistance Program
        - This program, launched in 2015, uses more than $2 million in state funds annually to provide rental assistance and related housing costs for DMH patients statewide. All 16 CMHCs have state-funded Community Housing rental assistance programs, including one that also serves Deaf Services patients. On June 30, 2023, the Program assisted 324 units/524 patients and family members at average annual cost of under $7,000/unit.

- Housing and Urban Development (HUD) Continuum of Care Permanent Supportive Housing Program
    - SCDMH is the grantee for a HUD Continuum of Care Permanent Supportive Housing grant that provides almost $360,000 annually for rental assistance for formerly homeless patients and their family members in Greenville and Spartanburg counties. As of June 30, 2023, this program was serving 43 formerly homeless patients and their family members. SCDMH also provides state matching funds for this grant and two additional grants that serve this population in Richland and Lexington counties.

- Substance Abuse and Mental Health Services Administration (SAMHSA) Projects for Assistance in Transition from Homelessness (PATH)
    - This grant's funds enable DMH to provide outreach and clinical services to people with serious mental illnesses/co-occurring disorders who are experiencing homelessness in the Columbia, Greenville, Myrtle Beach, and Charleston areas. PATH programs are projected to serve more than 2,000 individuals annually.

- Treatment for Individuals Experiencing Homelessness (TIEH) Grant
    - In 2018, DMH received a grant of $1 million per year for five years from the Substance Abuse and Mental Health Services Administration (SAMHSA) to fund a new initiative called Treatment for Adults Experiencing Homelessness in SC. The Project's target population is individuals experiencing homelessness who also have serious mental illnesses and co-occurring substance use disorders with the goal of increasing access to evidence-based treatment services, peer support, services that support recovery, and connections to permanent housing. Treatment sites are located at Prisma Health in Columbia and DMH's Greater Greenville MHC in Greenville, with each providing intensive services using the Assertive Community Treatment model to serve a total of 75 people over the five-year grant period. This grant also funds four SOAR (SSI/SSDI Outreach, Access, and Recovery) benefits specialists that assist eligible individuals with serious mental illnesses who are experiencing or at risk of homelessness in accessing SSA disability income supports. Of the four positions, three are located in SCDMH community mental health centers and one is based at the Department of Corrections.

- **Crisis Receiving and Stabilization Facility**
    - **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.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested.

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? ○ Yes ◉ No

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Question 11: Quality Improvement Plan

1. Has your state modified its CQI plan from FFY 2022-FFY 2023?

a) ☐ Yes ☒ No

Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested.

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

[2] *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1.	Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?	(•) Yes ( ) No
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	(•) Yes ( ) No
3.	Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?	(•) Yes ( ) No
4.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	(•) Yes ( ) No
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	(•) Yes ( ) No
6.	Does the state use an evidence-based intervention to treat trauma?	(•) Yes ( ) No
7.	Does the state have any activities related to this section that you would like to highlight. Please indicate areas of technical assistance needed related to this section.	

Footnotes:

Question 12: Trauma

1. ***Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?***
   ☒Yes ☐ No

2. ***Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?***
   ☒Yes ☐ No

3. ***Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?***
   ☒Yes ☐ No

4. ***Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?***
   ☒ Yes ☐ No

5. ***Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?***
   ☒ Yes ☐ No

6. ***Does the state use an evidence-based intervention to treat trauma?***
   ☒ Yes ☐ No

7) Does the state have any activities related to this section that it would like to highlight.

SCDMH Trauma-Informed Systems accomplish the following goals:

- Support development and implementation of policies, procedures, and practices.
- Offer evidence-based trauma assessments to all patients.
- Offer evidence-based treatment options to all patients experiencing trauma-related symptoms.

Trainings

The SCDMH Director of Trauma-Informed Systems regularly develops and facilitates a wide range of trainings to help staff members enhance and improve their skills related to the provision of trauma-informed services.

Three of the most commonly provided trainings are:

- Trauma-Informed Care: Foundations Training
    - This introductory training is for all SCDMH employees. This training explains how, in a trauma-informed organization, staff in every part of the organization have changed their language, behaviors and policies. These changes take into consideration the experiences of trauma among children and adults receiving services and among the staff that provide these services. This training presents SAMHSA's Four R's to support participants in realizing the widespread impact of trauma, recognizing the signs and symptoms of trauma by presenting the symptoms of posttraumatic stress disorder and the results of the Adverse Childhood Study as well and potential impact trauma has on the developing brain. Participants are also presented with ways to respond to all individuals in ways that resist retraumatizing individuals by incorporating the above information into their daily routines and by implementing SAMHSA's Six Key Principles of Trauma-Informed Care.
    - In 2023, SCDMH provided monthly Foundations trainings. A total of 47 SCDMH staff graduated from these trainings.

- Trauma Focused-Cognitive Behavioral Therapy For Children And Adolescents (TF-CBT)
    - Trauma-Focused-Cognitive Behavioral Therapy (TF-CBT) is an evidence-based practice for youth ages 3-18 and their families. This is a short-term intervention that takes between 12 and 16 sessions.
    - This six-session (18 hour) training on TF-CBT teaches the intervention components of TF-CBT and allows participants the opportunity to practice these intervention components. These components include psychoeducation to identify the impact of trauma on the youth and set a course for treatment; coping skills to prepare for the trauma narration process which include relaxation, affect modulation and expression, and cognitive coping; the trauma narration process during which the youth tells their story repeatedly in a safe setting to lower the intensity of their emotions related to the traumatic event, and cognitive processing to support the youth in exploring the accuracy of their trauma related beliefs. Additional components include in-vivo exposure and enhancing safety. Participants also learn the underlying concepts that will allow them to increase engagement with families to best support the youth and family in healing from the impact of trauma.
    - In 2023, SCDMH provided five TF-CBT trainings. A total of 49 SCDMH staff members graduated from these trainings.

- Interactive Cognitive Behavioral Therapy for PTSD for Adult Services
    - Interactive CBT for PTSD Training teaches participants ways to provide psychoeducation to their patients on how past traumatic events could be currently impacting them and how this impact makes sense given the traumatic experience(s) they have encountered.

This training provides participants with strategies to provide psychoeducation and other components in a way that increases the individual sense of control and efficacy. Additionally, participants learn ways to provide patients with coping skills to regulate and understand their emotional and cognitive responses to their environments, including when their traumatic memory is triggered. Participants learn strategies to utilize Socratic Questioning to eventually support patients in exploring their trauma related beliefs to identify beliefs that are accurate and supported by evidence.

- The goal of these trainings is to have graduates feel ready and comfortable in providing these interventions to their patients and their families who would benefit from these interventions with support through consultation.
- In 2023, SCDMH provided three CBT for PTSD trainings. A total of 40 SCDMH staff members graduated from these trainings.

Other Trauma-Related Services

- Child and Family Services
    - Trauma-Focused Cognitive Behavioral Therapy are made available to SCDMH's child and adolescent patients.

- Suicide Prevention Trainings
    - SCDMH Office of Suicide Prevention includes a variety of cultural competency trainings that focus on high-risk populations (e.g., LGBTQI+, individuals living with serious mental illnesses, trauma-informed care, etc.).

- Alliance Project
    - The agency's Mental Health / Law Enforcement Alliance Project makes it possible for mental health clinicians to be embedded in law enforcement agencies around the state. These clinicians regularly support survivors of trauma.

- Psychiatric Residence Training Program
    - Residents from the MUSC Residency Training Program receive educational experiences and supervision in Psychiatry through scheduled rotations at the Charleston Dorchester Mental Health Center (CDMHC). CDMHC is involved with a learning collaborative including DMH, the Crime Victim's Center at MUSC, and the Dee Norton Lowcountry Children's Center. This initiative revolves around Trauma-Focused Cognitive Behavioral Therapy. Residents train with CDMHC's First Responder Support Team and Mobile Crisis.

Medical students rotate regularly though CDMHC throughout the academic year. DMH has a contract with MUSC to provide forensic evaluation of adult criminal defendants in 10 counties in South Carolina.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested.

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- ☑ Coordination across mental health, substance use disorder, criminal justice and other systems
- ☑ Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- ☑ Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- ☑ Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- ☑ Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- ☑ Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- ☑ Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- ☑ Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- ☑ Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- ☑ Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- ☑ Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- ☑ Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- ☑ Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- ☑ Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- ☑ Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe.

◉ Yes ○ No

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

◉ Yes ○ No

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Question 13: Criminal and Juvenile Justice

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

☒ Coordination across mental health, substance use disorder, criminal justice and other systems
☒ Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
☒ Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
☒ Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
☒ Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
☒ Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
☒ Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
☒ Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
☒ Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
☒ Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
☒ Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
☒ Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
☒ Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
☒ Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
☒ Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe.

☒ Yes ☐ No

SCDMH actively participates in Criminal Justice Coordinating Councils (CJCCs) in five areas of the state: Charleston, Richland, Lexington, Florence, and Anderson. A CJCC describes a body of criminal justice leadership who meets regularly to address systemic challenges and to coordinate system-wide response. They vary by location in their structure and membership.

CJCCs are collaborations of elected and senior officials, law enforcement leaders, judicial and court leadership, behavioral health professionals, victim and legal advocates, and community leaders. Their vision is to foster a criminal justice system that is fair, just and equitably applied, with a mission to assist in making sustainable, data-driven improvements to the criminal justice system and thereby to improve public safety and community well-being.

CJCCs work collaboratively to improve the administration of justice and promotion of public safety through planning, research, education, and system-wide coordination of criminal justice initiatives. CJCCs utilize data to identify system challenges, enact solutions and monitor progress with an ongoing commitment to accountability and transparency.

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

☒ Yes ☐ No

4. Does the state have any activities related to this section that you would like to highlight?

Mental Health Courts

Mental Health Courts aim to divert non-violent, adult offenders with serious mental illness from the criminal justice system. These Courts generally function as partnerships comprised of an assigned judge (frequently a Probate Court judge), the local DMH community mental health center, Public Defender's Office, jail/detention center administration, and the Solicitor's Office. South Carolina currently has Mental Health Courts in the following counties: Aiken, Berkeley, Charleston, Greenville, Horry, Richland, and York. In 2017, DMH received a grant from The Duke Endowment to increase the number of Mental Health Courts and/or increase the capacity of existing courts, standardize policies and procedures, and to evaluate the outcomes of existing Courts. This grant is expected to end December 30, 2023. DMH continues to use agency resources to fund clinical positions to support mental health courts.

Alliance Program

Alliance is a program in the SCDMH Office of Emergency Services. This program provides opportunities for first responders to collaborate with SCDMH 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, detention 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. MHPs working in detention centers and jails identify detained offenders who are in need of referrals to mental health care and continuity of care in the community. 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. Alliance is supported by a variety of funding sources. This program was originally funded by a Blue Cross Blue Shield Grant, and is now partially supported by the SAMHSA Block Grant as well as supplemental block grant funding.

Crisis Intervention Training (CIT)

This 5-day training teaches law enforcement officers how to respond safely and appropriately to people with serious mental illness in crisis. Officers learn to recognize the signs of psychiatric distress, de-escalation techniques, and how to link people with treatment., avoiding officer injuries, consumer deaths, and tragedy for the community, as well as linking people with appropriate treatment. Classes are taught by a CIT Trainer from the National Alliance on Mental Illness-SC, DMH staff, law enforcement peers, and sometimes other community providers (e.g., county substance use disorder treatment providers).

Applied Suicide Intervention Skills Training (ASIST)

ASIST is a two-day, face-to-face workshop that trains participants how to prevent suicide by recognizing signs, providing skilled intervention, and developing a safety plan to keep someone alive. Developed more than 35 years ago, ASIST is a continually updated, evidence-based training. In 2023, 119 people were trained by SCDMH. Since the ASIST training's inception in 2016, SCDMH has trained 1,797 professionals, first responders, and community members.

Governor's Juvenile Justice Advisory Council (GJJAC)

SCDMH participates on the Governor's Juvenile Justice Advisory Council (GJJAC). This Council was created by South Carolina statute (Section 23-4-210) in 1975 in accordance with the requirements of the Juvenile Justice and Delinquency Prevention Act of 1974 (Section 223(a)). Its members, appointed by the Governor, are volunteer, private citizens with an abiding interest and training in children's issues as well as representatives from state and local government agencies involved in juvenile justice and delinquency prevention. The Council is charged with the responsibility of advising policy makers on the state level about areas of need related to children and the juvenile justice system, recommending improvements in juvenile justice services, and offering technical assistance to state and local agencies in planning and implementing programs for the improvement of juvenile justice.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested.

Environmental Factors and Plan

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (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 evidenced-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 expend 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 expanding 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 will have 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. SAMHSA expects that states will build on the emerging and growing body of evidence 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 service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, 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 this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

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 SAMHSA 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 SAMHSA*

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.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

2. 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 first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

3. Safe place to go or to be:

- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

a. 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 talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to go or to be	☐	☐	☑	☐	☐	☐

b. Briefly explain your stages of implementation selections here.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

Please indicate areas of technical assistance needed related to this section.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Question 15: Crisis Services

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

A. Crisis Call Centers

SCDMH 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.

- South Carolina Mobile Crisis Call Center
    - The South Carolina Mobile Crisis Call Center (MCCC), based in Charleston, SC, was first implemented in 2020 by SCDMH. 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 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, the 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.
    - The SC Mobile Crisis Call Center assists SCDMH's Mobile Crisis teams by triaging calls, developing safety plans, diverting emergencies, and providing resources to individuals not needing immediate Mobile Crisis or emergency response. The 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. Overall, the MCCC works to assist and provide resources to individuals and families experiencing mental health emergencies throughout the 46 counties of South Carolina.
- 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 1st, 2023, SCDMH 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, CDMHC is in Phase 1 of its 988 rollout, and only provides telephonic services; chat and text services are expected to be launched by the fall of 2023. 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. South Carolina Mobile Crisis Program

SC Mobile Crisis (MC) is a program created by SCDMH, 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 SCDMH community mental health center services; during business hours, SCDMH 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 SCDMH Mobile Crisis Call Center, which is operated by the 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.

C. Crisis Receiving and Stabilization Facilities

SCDMH operates one Crisis Receiving and Stabilization Facility (CRSF). 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. The CRSF operated by SCDMH is the Tri-County Crisis Stabilization Center (TCSC) located at Charleston Dorchester Mental Health Center (CDMHC), on SC's east coast.

- 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.

SCDMH also operates a program that meets many of the criteria for a CRSF; this program is operated by Spartanburg Area Mental Health Center (SAMHC), in the northwest part of SC. Because this center does not provide 24/7 services, it is not categorized as a CRSF.

- 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 DMH'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 3 Peer Support

Specialists, 2 clinicians, and 1 part-time care coordinator. 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. 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 SAMHSA 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 SAMHSA 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.

a. 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 talk to						X
Someone to respond						X
Safe place to go or to be			X			

b. Briefly explain your stages of implementation selections here.

Stage 1: Someone to Talk To

- South Carolina Mobile Crisis Call Center
    - In 2022, the statewide DMH Mobile Crisis Call Center fielded more than 25,000; with over 7,200 of those being crisis calls requiring additional support, resources, or response. As of May 2023, the call center has answered over 13,000 incoming calls. The call center focuses on fielding and triaging crisis calls while providing knowledge of available resources, deploying mobile crisis teams and diverting those in need to local crisis stabilization services.
- SCDMH 988 Suicide and Crisis Lifeline Center
    - From June 1 – July 31, 2023, the new SCDMH 988 Center responded to 732 calls. The center opened on June 1, 2023.
- MHAGC 988 Suicide and Crisis Lifeline Center
    - No data available as of August 4, 2023

Stage 2: Someone to Respond:

- SC Mobile Crisis Program
    - The SC Mobile Crisis Program is available in all 46 counties of South Carolina, 24/7/365, for children, adolescents, and adults. All the Mobile Crisis teams utilize a co-responder model responding on-scene with the local law enforcement agency. 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. SC Mobile Crisis was recently awarded a 4-year, $3,000,000 award from SAMHSA for Community Crisis Response Partnerships. This expansion is allowing the program to add Certified Peer Support Specialists to their Mobile Crisis teams in ten counties: Aiken, Anderson, Chesterfield, Laurens, Newberry, Greenwood, Edgefield, McCormick, Abbeville, and Saluda. These counties were chosen due to the high suicide rates as well as other health disparities highlighted by the grant. The grant will also support the opportunity to add telehealth response to these counties to increase access and decrease response time.
    - In 2022, DMH mobile clinicians responded to more than 2,600 crisis calls in the communities of South Carolina averaging 231 on-site responses per month. As of May 2023, they have already responded to almost 1,300 with an average of 310 on-site responses per month. DMH has set a goal response time to 60 minutes or less for on-site from the time the team receives the dispatch to deploy. The average response time currently is just over 33 minutes.

Stage 3: Somewhere to Go:

- Tri-County Crisis Stabilization Center (TCSC) at Charleston Dorchester Mental Health Center (CDMHC)
    - This is South Carolina's only CRSF. During SC's State Fiscal Year 2023, 372 people were referred to the TCSC, and 190 were admitted. The majority of referrals were for SI, psychosis, and hospital step-downs. 249 referrals came from emergency departments. Out of the 190 admitted patients, 170 were diverted from emergency departments and hospitals due to their involvement at the TCSC, and one person was diverted from jail.

- The Eubanks Center at Spartanburg Area Mental Health Center (SAMHC)
    - Because this program does not provide 24/7 services, it is not categorized as a CRSF. The program has resulted in the diversion of 55 individuals from emergency rooms or hospitals from its opening to the start of the COVID-19 pandemic. The center reopened to full service after the pandemic receded. During the first 5 months of 2023, 7 people were diverted from the emergency room and another 147 people were served at the peer living room.

- Crisis Stabilization Unit at Columbia Area Mental Health Center (CAMHC)
    - The Columbia Area Mental Health Center (CAMHC) is in the exploration stage of developing a CRSF. A site has been identified and architects are working on a report to indicate what updates and renovations will be required before CSU licensure can be obtained. The entire amount of the 2024-2025 Block Grant Five Percent Set-Aside Funds for Crisis Services will be allocated to CAMHC to support the development of its new CRSF.

- Number of Emergency Departments
    - South Carolina has approximately 77 individual emergency departments; this data was provided by the SC Revenue and Fiscal Affairs Office. There may be more emergency departments in the state, but according to the South Carolina Hospital Association, 77 is the most reliable estimate.
    - From October 2021 – September 2022, South Carolina emergency departments responded to 75,878 visits from patients diagnosed with mental, behavioral, and neurodevelopmental disorders. This data was provided by the SC Revenue and Fiscal Affairs Office.

- Number of Emergency Departments that operate a specialized behavioral health component.
    - Currently, there are no SC emergency departments that operate specialized behavioral health units.
    - However, in June 2023, the South Carolina Department of Health and Human Services (SCDHHS) announced that it was awarding one-time infrastructure grants 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. Once completed, the units will provide 24/7 services, and will be staffed by multi-disciplinary teams. The recipients of these grants are:
        - AnMed Health Medical Center
        - Beaufort Memorial Hospital
        - Grand Strand Medical Center
        - Hampton Regional Medical Center
        - Lexington Medical Center
        - McLeod Regional Medical Center
        - MUSC Health, Kershaw Medical Center
        - MUSC Health, Orangeburg Medical Center
        - MUSC Health, University Hospital
        - MUSC Shawn Jenkins Children's Hospital
        - Prisma Health Oconee Memorial Hospital
        - Prisma Health Tuomey Hospital
        - Trident Medical Center

3. Based on SAMHSA's National Guidelines for 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." SCDMH 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. <u>Regional Crisis Call Center</u>

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.

In 2023, SCDMH 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 SCDMH's new 988 center, which is operated by operated by Charleston Dorchester Mental Health Center (CDMHC), responds to requests from callers with South Carolina area codes. The introduction of this second 988 center means that significantly more South Carolinians will be 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.

Currently, CDMHC is in Phase 1 of its 988 rollout, and only provides telephonic services; chat and text services are expected to be launched by the fall of 2023. 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.

The 988 center operated by MHAGC is located in the northwest part of South Carolina. The new CDMHC 988 center is located in the eastern part of the state. These two regional crisis call centers serve residents throughout the state. SCDMH recognizes the benefits of adding even more crisis call centers in the future, and hopes to establish several more 988 centers. Future centers could be operated by other SCDMH Community Mental Health Centers, or by nonprofits.

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.

SCDMH 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 South Carolina Mobile Crisis Call Center (MCCC), which is operated by the Charleston Dorchester Mental Health Center (CDMHC). First implemented in 2020, 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 de-escalate callers in crisis, and dispatch MC 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 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, the 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.

The SC Mobile Crisis Call Center assists SCDMH's MC teams by triaging calls, developing safety plans, diverting emergencies, and providing resources to individuals not needing immediate Mobile Crisis or emergency response. The 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. Overall, the MCCC works to assist and provide resources to individuals and families experiencing mental health emergencies throughout the 46 counties of South Carolina.

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.

While SCDMH has successfully implemented a statewide mobile crisis team program, and has significantly expanded its regional crisis call centers, the CRSF portion of its statewide crisis program still has many opportunities for improvement. Currently, SCDMH operates only one CRSF. SC's sole CRSF is the Tri-County Crisis Stabilization Center; this program is operated by Charleston Dorchester Mental Health Center (CDMHC) on the east coast of the state.

The Eubanks Center, which is operated by the Spartanburg Area Mental Health Center (SAMHC), is located the northwest corner of the state. The Eubanks Center meets almost all CRSF requirements, but it does not provide 24/7 services. Therefore, it is not categorized as a CRSF.

The Columbia Area Mental Health Center (CAMHC), which is located in the middle of the state, is exploring the possibility of starting a CRSF. Several other SCDMH Community Mental Health Centers (CMHCs) are also interested in establishing these types of facilities.

South Carolina has at least 77 emergency departments, which are spread across the state. Currently, there are no specialized behavioral health units to provide services to individuals experiencing behavioral health crises. To address this need, the South Carolina Department of Health and Human Services (SCDDH) recently awarded infrastructure grants to 13 hospitals to develop behavioral health units. SCDMH applauds this new effort to expand and improve emergency department services. SCDHHS did not provide a timeline for the expected completion of these units. It is likely for the construction projects to take several years to complete. In the meantime, individuals experiencing behavioral health crises will continue to need safe places to seek help.

SCDMH recognizes that its current CRSF services are extremely limited, and it also recognizes the importance of providing these facilities. In the future, SCDMH plans to develop significantly more CRSF programs throughout the state. Ideally, every SCDMH CMHC would have a CRSF. However, there are numerous logistical and financial challenges related to the development of these specialized programs. SCDMH is experiencing an ongoing challenge related to workforce retention and expansion, and the development of new CRSFs would certainly be affected by these workforce challenges. Nevertheless, SCDMH 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. In the following section, SCDMH will explain how it will use the five percent Crisis Services set-aside to begin expanding its CRSFs.

4. ***Briefly describe the proposed/planned activities utilizing the 5% set aside.***

The entire amount of the five percent set-aside funds for Crisis Services will be used to help establish a new Crisis Receiving and Stabilization Facility (CRSF) at the Columbia Area Mental Health Center (CAMHC). In the past few years, $1.2 million was committed to CAMHC to develop its CRSF. However, the construction costs to develop this new unit have increased, and additional funding is needed to complete the project. Once completed, this will be the state's second CRSF.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested.

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote 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 disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality 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 recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

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, SAMHSA identified 10 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 **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

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 SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations 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 M/SUD treatment system.

Please respond to the following:

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 funding of recovery support services?	(•) Yes ( ) No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD 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.

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

5. Does the state have any activities that it would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Question 16: Recovery

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 funding of 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 M/SUD 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.***

It is the mission of SCDMH to support Recovery Initiatives through the development of empowered patient leadership for persons served through the agency. SCDMH empowers patients by hiring them to be: planners; policy makers; program evaluators; service providers. SCDMH also supports recovery through training and education on recovery principles and recovery-oriented practice and systems, including the role of peers in care; required peer accreditation or certification; block grant funding of recovery support services; involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the mental health system; and measurement of the impact of consumer and recovery community outreach activities.

Patient Advisory Boards – Patient Advisory Boards (PABs) 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, policy-making, program evaluation, and service provision. Most states have only a statewide or regional PAB, but SCDMH is among just a few state systems that have mandated the establishment of PABs not only at the state level, but also at every SCDMH 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.

Recovery is the process by which an individual overcomes the challenges of a mental illness to lead a life of meaning and purpose.

The South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) is the lead agency for recovery and recovery support services for individuals with substance use disorders in the state.

5. Does the state have any activities that it would like to highlight?

The Art of Recovery – The Art of Recovery 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.

DMH 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, 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.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	(•) Yes ( ) No
Home and community-based services	(•) Yes ( ) No
Peer support services	(•) Yes ( ) No
Employment services.	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

DMH South Carolina Department of Mental Health

CONTINUITY OF CARE PLAN

Approved March 2020
Reviewed and Revised March 2021

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Table of Contents

1. **Introduction and Statement of Purpose**

The South Carolina Department of Mental Health (SCDMH) 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. SCDMH provides, maintains, and develops appropriate inpatient and outpatient services to those persons in need of SCDMH services consistent with the U.S. Supreme Court *Olmstead* decision[1]. SCDMH partners with other state agencies, health care providers, housing providers, as well as those individuals receiving SCDMH services ("Patients" as defined by Code of Laws of South Carolina), their families and their communities to continue to develop available resources together to provide appropriate mental health services to SCDMH Patients in both inpatient and community settings.

In furtherance of its mission and policy, and consistent with *Olmstead,* SCDMH supports and promotes a Patient's right to live in the community when:

1.1. The Patient's treatment professionals determine that the Patient is able to live successfully in the community;

1.2. The Patient does not object to living in the community and;

1.3. Provision of services in the community can be provided without fundamentally altering the way SCDMH serves other Patients.

The purpose of this Plan is to provide a high-level overview of clinical values and processes that facilitate Patient movement throughout the SCDMH system of care. This Continuity of Care Plan is operationalized through the Continuity of Care Policy and Procedures.

2. **Continuity of Care Policy Statement**

It is the policy of SCDMH to provide needed treatment in local communities whenever possible; however, whenever inpatient care is needed, adequate information about Patients' treatment history and current treatment needs will be shared in a timely manner between SCDMH hospitals (inpatient) and community mental health centers (CMHCs) when Patients are admitted to or discharged from inpatient care. DMH strives for and is committed to an effective and efficient transition between outpatient and inpatient services.

3. **Clinical Values**

The SCDMH Continuity of Care Plan reflects several key clinical values:

3.1. Commitment to regular Patient-Centered review to determine readiness for appropriate inpatient discharge to the community, including assistance by

[1] In *Olmstead v. L.C.,* the US Supreme Court held that unnecessary isolation of individuals in institutions may constitute discrimination based on disability in violation of the Americans With Disabilities Act (ADA). In the event that a State is not always able to timely provide all of the needed treatment or services to an otherwise eligible individual with a disability in a community setting, the state must have a comprehensive, and effective working plan to provide such treatment or services to eligible individuals with disabilities in community settings, and appropriate progress must occur at a reasonable pace given available resources.

Transition Specialists. SCDMH Transition Specialists assist with the movement of Patients identified by the treatment team from appropriate inpatient services to integrated community services.

3.2. Inpatient Discharge Initiative programs;

3.3. Availability of Intensive Community Treatment (ICT) statewide;

3.4. Availability of community housing assistance programs statewide;

3.5. Care Coordination services that provide targeted case management to address the changing needs of Patients by identifying appropriate community resources and services and assisting with access to these services to facilitate community tenure;

3.6. Seeking the most effective, appropriate services in the least restrictive available environment consistent with Treatment Team recommendations and Patient wishes;

3.7. Availability of Peer Support Services in the community and inpatient settings;

3.8. Availability of Mobile Crisis , and other crisis intervention and stabilization programs statewide.

4. Definitions and Program Descriptions

4.1. Mobile Crisis provides adults and children with mobile clinical screening either in person at the location of crisis, in person at a CMHC clinic, or telephonically, in order to de-escalate the crisis and provide linkage to appropriate treatment and other resources. Mobile Crisis is available 24 hours, seven days per week and prevents unnecessary hospitalizations, emergency department utilization, and involvement with law enforcement.

4.2. "Community Residential Care Facility" ("CRCF") is a facility which meets the definition found in S.C. Code. Regs. 61-84, § 101 et seq. ("Standards for Licensing Community Residential Care Facilities").

4.3. Evidence Based Therapy is a research based and nationally recognized modality of treatment with proven outcomes of clinical effectiveness, such as "Dialectical Behavior Therapy" ("DBT"), Trauma Focused Cognitive Behavioral Therapy (TFCBT) and Trauma Informed Care.

4.4. "Intensive Community Treatment" ("ICT") services provide comprehensive community-based treatment that may include psychiatric treatment, vocational rehabilitation, peer support services to persons experiencing mental illness.

4.5. "Level of Care" ("LOC") is an outpatient systemic treatment approach, utilizing a clinical pathway so that Patients who present similarly may receive the same patterns of services. The Level of Care system guides movement of Patients from

a more intensive level of care (level 5) to a less intense level of care (level 1) in an outpatient setting.

4.6. "Peer Support" or "Peer Support Services" ("PSS") link people who have been successful in the recovery process to those experiencing similar situations. Certified Peer Support Specialists use shared understanding, respect, and mutual empowerment to help Patients become and stay engaged in the recovery process and reduce the likelihood of relapse, while extending the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process.

4.7. "Tele psychiatry" or "Telehealth" refers to the provision of psychiatric or other health services, where the Patient is at a location remote from the consulting provider, over a secure video connection.

4.8. "Toward Local Care" ("TLC") programs provide residential and rehabilitative services to help Patients integrate into their communities. TLC community-based programs focus on Patients in SCDMH inpatient facilities, Patients with multiple hospitalizations and/or Patients in the community who are at risk of becoming hospitalized in an acute psychiatric facility.

4.9. "Transition Specialists program" assists Patients with transferring from inpatient facilities to the community, when the inpatient treatment team has determined they are ready for discharge. Transition Specialists are mental health professionals credentialed in the CMHCs and oriented to DIS systems that expeditiously, effectively, and appropriately facilitate transition. Transition Specialists work with patients to determine their recovery needs and collaborate with stakeholders to ensure continuous communication as it relates to their discharge plans.

5. SCDMH System of Care

5.1. In the SCDMH system of care, CMHCs have the primary responsibility for providing outpatient mental health treatment services.

5.2. SCDMH inpatient facilities provide inpatient treatment and support the CMHCs by providing timely information about the Patient's treatment needs, coordinating and assisting Patient discharge, and aftercare planning with the local community mental health center.

5.3. SCDMH Care Coordinators and Transition Specialists provide an array of related services. SCDMH Transition Specialists assist with the movement of identified Patients from appropriate inpatient services to integrated community services.

5.4. The SCDMH "Continuity of Care Policy" Directive No. 943-20 is the official SCDMH policy and procedure for providing coordinated and continuous care services to SCDMH Patients. Specific Continuity of Care Procedures that are essential in facilitating Patient movement are:

5.4.1. Admission for SCDMH Services
5.4.2. SCDMH Inpatient Facility Admissions and Communication
5.4.3. Aftercare Following Inpatient Services
5.4.4. Patient Discharge Planning
5.4.5. Center Response to Initial Aftercare Appointments

5.5. CMHCs utilize the level of care pathway as a guidance for clinicians in treatment planning for frequency of services, service array, and length of stay; based on the Patient's severity of need and level of functioning. Level of care change is based on Patient needs and level of functioning:
5.5.1. Level 1 – Medication Management Only
5.5.2. Level 2 – Mild Symptoms / Problems
5.5.3. Level 3 – Moderate Symptoms / Problems
5.5.4. Level 4 – Serious Symptoms / Problems
5.5.5. Level 5 – Severe Symptoms / Problems

6. Primary Inpatient and Outpatient Policies and Procedures

6.1. SCDMH Division of Inpatient Services (DIS)

6.1.1. Upon admission, the DIS Social Worker will conduct a discharge assessment and develop a preliminary discharge plan. The treatment team consists of a psychiatrist, social worker, nurse, and/or additional team members as needed. The treatment team meets regularly to review medication and services provided, to discuss what other services may be appropriate and available so that the Patient, when clinically appropriate, can be discharged to the community in the most integrated setting appropriate and consistent with the Patient's wishes.

6.1.2. DIS Social Workers will provide to the SCDMH Transition Specialists Program, discharge readiness referrals to alert the Transition Specialists team when identified Patients are nearing discharge. The Transition Specialists will work to review and plan for identified Patient's nearing discharge. For Patients not referred to Transition Specialists, the Discharge Coordinator and/or DIS Social Workers will review and plan for discharge for those Patients.

6.1.3. At Bryan Psychiatric Hospital (BPH), data and monitoring of discharge needs is tracked through the BPH Discharge Coordinator. Tracking documentation identifies needs and barriers that are being addressed to facilitate a successful discharge. A similar monitoring and tracking process is in place for Patrick B. Harris Hospital, which is managed by the Director of Social Work and the Length of Stay Review Committee.

6.1.4. Prior to DMH inpatient discharge to the community, the DIS Social Worker or Transition Specialist will offer the Patient an appointment at their local community mental health resource for needed services. The appointment date offered shall be within three business days of discharge. On the rare occasion that the appointment cannot be scheduled within three days of discharge, the appointment must be offered within seven days of discharge.

6.1.5. Upon request by any member of a Patient's treatment team or the Patient, the treatment team will meet to evaluate the Patient's progress and potential readiness for discharge to the community.

6.1.6. DIS will continue its practice of a comprehensive review of DIS policies and procedures at least every two years.

6.2. SCDMH Division of Medical Affairs/Transition Specialists Program

6.2.1. For identified Patients, Transition Specialists will be integrated into the discharge planning process including:

6.2.1.1. Transition Team participates in treatment team meetings, as well as other various multidisciplinary, individual meetings.

6.2.1.2. Transition Team collaborates with Patients and DIS treatment team to assist with discharge plan development for local housing and Mental Health services options.

6.2.1.3. Transition Team collaborates with Care Coordination to ensure linkage for Patients psychosocial needs for community living.

6.2.1.4. Transition Team utilizes conference calls and/or telehealth as applicable to facilitate Patients meeting with community providers prior to discharge.

6.2.1.5. Transition Team maintains statewide resource database of residential, community resources and/or treatment providers, which is updated monthly.

6.2.1.6. Transition Team works closely with DIS in reviewing and planning for identified Patients nearing discharge within the next 30 to 60 days. Patients identified for the Transition Specialists Program includes those with limited support systems in place at the time of discharge and with needs for community resources to support a successful transition to the community.

6.2.1.7. Transition Specialists Team maintains identified data point outcomes as a means to track program effectiveness with transitioning Patients to the community. An example of a data point would be tracking the type of discharge housing for the Patients and kept aftercare appointments.

6.3. Community Mental Health Centers

6.3.1. All CMHCs have established Intensive Community Treatment (ICT) teams and are providing ICT services statewide. Each ICT Patient is offered ICT services at least once per week and more frequently if needed. ICT outcome measures are reported to the Mental Health Commission at the beginning of each fiscal year and more frequently if applicable. ICT fidelity measures include:

6.3.1.1. ICT staff have caseloads of less than 35 Patients.

6.3.1.2. ICT Patients must be offered at least one service per week at a minimum however they can receive multiple services per week.

6.3.1.3. ICT Patients must receive services from MHPs, nurses, and psychiatrists. They may also receive services from PSSs and Care Coordinators, as needed.

6.3.1.4. ICT Patients should receive services in the community if that is their preference. Services can be delivered in clinics as well.

6.3.1.5. While it is not a 24/7 program, ICT services should be delivered outside of normal business hours if that is what the Patient needs.

6.3.1.6. Additional reports are being developed in support of these fidelity measures.

6.3.2. All CMHCs have Permanent Supported Housing programs to assist Patients who are homeless or at risk of being homeless.

6.3.3. All CMHCs have Individual Placement and Support (IPS) programs to assist Patients with securing gainful employment. IPS is an evidence-based supported employment program that CMHCs operate in partnership with the South Carolina Department of Vocational Rehabilitation.

6.3.4. All CMHCs have funding to provide Peer Support Services by Certified Peer Support Specialists. PSSs are people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, PSSs help people become and stay engaged in the recovery process and reduce the likelihood of relapse.

6.3.5. Mobile Crisis provides crisis after-hours response coverage statewide 24 hours per day, seven days per week. Mobile Crisis staff respond within 60 minutes to mental health crises to provide de-escalation and crisis intervention.

6.3.6. The Charleston-Dorchester and Spartanburg Community Mental Health Centers currently operate Crisis Stabilizations Programs. Crisis Stabilization Programs are voluntary programs where individuals experiencing mental health crises can receive services to help resolve the crisis and prevent hospitalization.

6.3.7. CMHCs continually assess the training needs of their staff and provide trainings on an on-going basis. When possible, trainings in evidence-based practices and interventions are pursued. For example, training in Dialectical Behavioral Therapy (DBT) has been offered to staff at all CMHCs. Moreover, trainings in Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Trauma-Informed Care are continuously provided for CMHCs' clinical and clinical support staff, respectively.

7. Overall SCDMH Policies, Procedures, and Practices to be Updated and Enhanced

7.1. The BPH Discharge Initiative Pilot Program was established in April 2018 on Lodge F and was expanded to Lodge B in 2019. The program continues to progress, which also will include the learning lab.

7.2. Quality Management staff will continue to evaluate Level of Care implementation and quality of CMHC services on a regular basis and report these findings to the Commission at the beginning of each fiscal year.

7.3. CMHC staff will continue to evaluate outcome measures of the ICT programs and report those outcome measures and other CMHC data to the Commission at the beginning of each fiscal year.

7.4. Report trends in CMHC to Commission with explanation of variances e.g. volume of services at the beginning of each fiscal year.

7.5. Commit funding to increase Community Housing by 30-40 beds per year for five years by the development of supported housing.

7.6. On a regular basis, evaluate the statewide need for supported housing and other related housing assistance and report its findings to the Commission at the beginning of each fiscal year.

7.7. Ongoing programming enhancements and quality improvement efforts will continue to be explored and developed, and amendments will be made to this Continuity of Care Plan as needed.

8. Additional Resources:

8.1. SCDMH Directive 943-20, Continuity of Care Policy

8.2. SCDMH Continuity of Care Procedures

8.3. Protection and Advocacy Settlement Agreement

Question 17: Community Living and the Implementation of Olmstead

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	☒ Yes	☐ No
Home and community-based services	☒ Yes	☐ No
Peer support services	☒ Yes	☐ No
Employment services.	☒ Yes	☐ No

2. Does the state have a plan to transition individuals from hospital to community settings?
☒ Yes ☐ No

3. **What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?**

SCDMH finalized its Continuity of Care Plan (SCDMH's Olmstead Plan) in March of 2020. SCDMH reviews its Continuity of Care Plan (Olmstead Plan) annually and conducted its first update of the final plan in March of 2021. Disability Rights South Carolina (formerly known as Protection and Advocacy for People with Disabilities of South Carolina) reviewed and contributed to the 2020 finalized plan and the 2021 update.

SCDMH recently created an Olmstead Fund to assist in transitioning patients to the least restrictive setting. Establishing a financial platform for patients can take some time. The Olmstead Fund is used to cover financial costs as the patient awaits the establishment of their financial platform.

On July 6, 2023, the U.S. Department of Justice issued a report that finds reasonable cause to believe South Carolina violates Title II of the ADA by unnecessarily housing patients in Community Residential Care Facilities (CRCFs). SCDMH works diligently to move patients to independence in the community as appropriate. SCDMH looks forward to working with DoJ and the state's Medicaid agency to reach the shared goal of improving services to individuals residing in CRCFs who have serious mental illness, consistent with professional standards, resource availability, and individual choice.

For more information, please see the SCDMH Continuity of Care plan, which has been included as an attachment in this section.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested.

Environmental Factors and Plan

18. 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 condition 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 smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five 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 abuse, 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, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach 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 SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on 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 child, youth and young adult functioning in home, school, and community. 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[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. 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:

- 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);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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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 Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: 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**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

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 misuse 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 FEP and Clinical High Risk for Psychosis (CHRP) systems?	(•) Yes	( ) No
d) Does the state have an established FEP program?	(•) Yes	( ) No
Does the state have an established CHRP program?	(•) Yes	( ) No
e) Is the state providing trauma informed care?	(•) Yes	( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Question 18: Children and Adolescents M/SUD Services

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 misuse 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 FEP and Clinical High Risk for Psychosis (CHRP) systems?
☒ Yes ☐ No

d) Does the state have an established FEP program?
☒ Yes ☐ No
A CHRP program?
☒ Yes ☐ No

e) 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.)

SCDMH provides for 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.

South Carolina used two federal grants, a System of Care Infrastructure Initiative awarded to the Mental Health Agency and an Adolescent Substance Abuse Treatment Coordination Grant to the Substance Abuse Agency, to combine efforts and implement the No Wrong Door Initiative. The most notable sustained outcome was the founding of the Joint Council on Children and Adolescents. Established in 2007, the Joint Council continues to strive to transform service delivery based on the values and principles of a system of care. This body is comprised of child-serving agency and organizational directors with the purpose of combining efforts to move the state towards a coordinated system of care which would reduce duplication and utilize the parent/youth voice to inform and improve services and supports.

Most recently noted is a partnership with SC's child welfare agency, utilizing a coordinated approach to human child trafficking and intensive in-home services. Clinicians are co-located in two large child welfare offices. This partnership began in 2021. The agencies and organizations agreed to use a universal screening and a coordinated approach to identification, referrals, and training. This coordinated approach is being developed for all providers and school personnel in the state. SCDMH also agreed to jointly establish a team of clinicians to provide Brief Strategic Family Therapy (BSFT). The agency recently finalized an arrangement to co-locate two clinicians in two of the state's largest child welfare offices. These clinicians provide services and support in a timely manner to families interfacing with child welfare.

SCDMH continues to be a leader in our school based mental health initiative with the goal, in partnership with the state department of education and our independent local school districts, to

increase access to mental health services for all children and adolescents across the state.

In partnership with the Child Welfare Agency, the Child Advocacy Agency, Family Court Judges and the South Carolina Infant Mental Health Association (SCIMHA), SCDMH is partnering in the implementation and roll out 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.

SCDMH is also partnering to provide 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 and Head Start Centers across the state.

7. Does the state have any activities related to this section that you would like to highlight?

SCDMH is the recipient of a Healthy Transition Grant, Roads of Independence, which is currently in its 5th year of implementation. This project is located in an area of the state that at one point was leading the nation in crime. 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. SCDMH has identified additional Block grant opportunities to expand this initiative to another critical part of the state. The HT grant uses a System of Care approach which supports young adults directing services and supports provided to reach their highly individualized goals.

Recently, SCDMH implemented a new program called Project FOCUS. In collaboration with SCDMH's partner agencies from the joint Council on Children and Adolescents, this new program will expand the system of care 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 mental disturbance (SED) and their families.

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:

1. To expand 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.
2. To improve client level outcomes for children, adolescents, and their families.
3. To enhance and sustain evidenced-based and culturally competent mental health services and supports for youth with SED/SMI and families in South Carolina.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested.

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies 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:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

3. Have you incorporated any strategies supportive of Zero Suicide? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? (●) Yes ( ) No

If yes, please describe how barriers are eliminated.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Question 19: Suicide Prevention

1. ***Have you updated your state's suicide prevention plan in the last 2 years?***
   ☒ Yes ☐ No

2. ***Describe activities intended to reduce incidents of suicide in your state.***

Established in 2019, the SCDMH Office of Suicide Prevention (OSP) implements a wide range of activities, including the following:

- South Carolina Strategy for Suicide Prevention: 2018 – 2025[1]
  - In late 2018, after nearly two years of collecting data, evaluating research, and reviewing evidence-based trainings, strategies, and procedures, the Coalition released the South Carolina Strategy for Suicide Prevention: 2018-2025 with the goal of reducing suicide by 20% by 2025. The Strategy is a living document that contains a wealth of information for how any organization, community or individual can help fight suicide in South Carolina. In 2022, the Coalition released an updated State Plan to reflect the progress made, emerging trends and needs, as well as new goals for the state.

- South Carolina Zero Suicide Initiative
  - In 2018, SCDMH 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 set of strategies in medical and behavioral health care systems. The OSP was established in order to emphasize that SCDMH's suicide prevention efforts would cover the entire lifespan of people, including those 24 and younger.
  - The Office of Suicide Prevention collaborates with numerous partners within and outside South Carolina. These partners all play crucial roles in reaching our goal of becoming a Zero Suicide state. These partners include the American Foundation for Suicide Prevention, the Education Development Center, the Substance Abuse and Mental Health Services Administration, National Alliance on Mental Illness-New Hampshire, SC National Guard, state and local chapters of NAMI, AFSP, and Mental Health America, the SC Hospital Association, the Medical University of South Carolina, the University of South Carolina School of Medicine and many other state agencies and nonprofits.

- South Carolina Suicide Prevention Student Identification Act
  - In July 2021, 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 Prevention Lifeline and an additional crisis resource on school-issued student identification cards. The SCDMH Director of Emergency Services assisted with drafting the bill's language, testified at the subcommittee hearings, and participated

[1] https://osp.scdmh.org/wp-content/uploads/2022/03/OSP_state_plan_012822_v17.pdf

in the signing. Schools are required to refer to the SCDMH website to confirm any updated resources that they want to list on the student identification cards. SCDMH provides trainings, outreach and postvention when needed.

- Trainings for SCDMH Staff Members and Community Members
    - Applied Suicide Intervention Skills Training (ASIST) – ASIST is a two-day, face-to-face workshop that trains participants how to prevent suicide by recognizing signs, providing skilled intervention, and developing a safety plan to keep someone alive. Developed more than 35 years ago, ASIST is a continually updated, evidence-based training. In 2023, 119 people were trained by SCDMH. Since the ASIST training's inception in 2016, SCDMH has trained 1,797 professionals, first responders, and community members.
    - SCDMH increased the number of trained providers in evidenced-based therapies: DBT (129 providers), CAMS (24 providers), CBT-SP (25 providers), ABFT for suicide care (17 providers), Suicide 2 Hope (21 providers), DBT Skills Coaches (16 providers), and Suicide Bereavement Clinician Training (16 providers).
    - De-stigmatization and awareness training for community members and professionals
    - Cultural competency trainings focused on high risk populations (e.g., LGBTQI+, individuals living with serious mental illnesses, trauma-informed care, etc.)
    - Continuing partnerships with other state agencies (SCPPP, SCDVA, SCDCA, SCDHEC, SCDSS, SCHHS, SCDOC, SCDE, DAODAS, SCCJA and SCFA) to provide training initiatives and increased access to resources.
    - South Carolina was the first state in the nation to train Department of Social Services staff and foster care parents using the SafeSide Prevention for Youth Services curriculum. More than 91% of participants in these trainings indicated that the training would help their teams communicate about suicide risks and responses.
    - Provision of SafeSide workshops for healthcare providers; these trainings were implemented at 45 healthcare facilities, including primary care facilities, women's healthcare clinics, and oncology centers. Lexington Medical Center was the first in the nation to be recognized by SafeSide and the American Foundation for Suicide Prevention for training its workforce in partnership with SCDMH.
    - Continuing partnership with the Texas Suicide Prevention Collaborative to implement the AS+K trainings. This is one of two trainings that SCDMH makes available in Spanish.

- Best-Practice Policies and Procedures in SCDMH Facilities
    - SCDMH continues to implement universal 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. SCDMH emphasizes the importance of having those in distress to know how to care for themselves and reach out before the distress begins. The vast majority of SCDMH patients have active safety plans; these plans are reviewed by clinicians throughout points of treatment. 90.4% of youth and young adults (age 10 – 24 years) and 95.1 % of adults (age 25 years and older) have activity safety plans. SCDMH also continues 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
    - SCDMH provides post-intervention consultation and resources for families, loved ones, and colleagues following loss to suicide. Additionally, SCDMH engages in continuing partnerships with 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. SCDMH also provides support resources to every SC coroner's office, to provide support for community members who are bereaved by suicide.

- Statewide Coalition and Taskforce Development
    - SCDMH cochairs the SC Suicide Prevention Coalition, along with Senator Katrina Shealy. This 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; the group has 31 coalition members, with an additional 35 attendees who regularly participate.

- 988 Suicide and Crisis Lifeline Center at CDMHC
    - On June 1st, 2023, SCDMH 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). This center assists with requests from participants who contact the center using SC area codes. Participants who are experiencing mental health or suicide crises are provided with crisis intervention services. Third-party callers also reach out to 988 if they are worried about people who may need mental health or substance abuse resources in their area. Partnership with National 988 Crisis Text Line. From June 1 – July 31, 2023, the new SCDMH 988 Center responded to 732 calls.
    - SCDMH continued to partner 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. There have been 96,250 conversations made possible through the Crisis Text Line; this is the all-time number of conversations, from the beginning of the initiative through June 2023.

- Implementation of Hope.ConnectsYou.org
    - SCDMH and DAODAS 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. The screening tool is accessible to the public on the SCDMH and DAODAS websites, as well as other partners. This screening tool implementation is the first of its kind in the U.S. All South Carolina residents over the age of 18 are eligible to participate in the screenings for mental health and substance use. People who complete the screenings receive responses from SCDMH or DAODAS staff members; the staff members offer guidance, support, and resources to help connect the participants with mental health and addiction services.

- South Carolina Mobile Crisis Call Center
    - This center assists individuals statewide and communicates with community mental health centers in every county to assist with triage and emergency assessment. The 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 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 is able to arrive on scene.

- Faith Community Outreach
    - Continued partnership with various churches and faith-based groups throughout the state. Since 2021, SCDMH has provided its LivingWorks Faith training to 146 individuals. This comprehensive online training equips participants with the necessary skills and knowledge to effectively support individuals in crisis within faith communities. In 2023, SCDMH has provided its Soul Shop training to 19 individuals in faith communities. This training is conducted in collaboration with the American Foundation for Suicide Prevention (AFSP). It helps participants from faith-based groups and communities gain a deeper understanding of suicide prevention. Additionally, the SCDMH Church Outreach Committee continues to explore new ways to engage with faith communities throughout the state.

- Military Populations Support
    - The SCDMH Director of WHATPOSITION continues to represent the agency at various conferences, events, and trainings, including the following:
        - Governor's Veteran's Summit (2021)
        - (SAMHSA Service Members, Veterans, and their Families (SMVF) Technical Assistance Center's Crisis Intercept Map for Suicide Prevention Pickens County, SC Team (2021 – present)
        - VA/SAMHSA Governor's Challenge to Prevent Suicide Among Service Members, Veterans, and their Families - State Team Lead (2020)
        - SC Violent Death Reporting System Advisory Council (2019 – present)
        - Armed Forces Work Group Member (2020 – present)
        - Midlands Veteran Engagement Council (2019 – present)
        - Military Suicide Prevention Panel of SC (2019 – present)
        - SC Domestic Violence Advisory Committee (February 2023 – present)
        - Post Critical Incident Seminars, SC Law Enforcement Assistance Program - Mental Health Clinician (January 2023 – present)
        - Aligning Health and Safety State Policy Community of Practice, The Council of State Governments - SC Team Lead (2022)
        - SC Child Fatality Advisory Committee, Suicide Review Subcommittee (July 2021 – present)

- Enactment of New Law Regarding Crisis Stabilization Units
    - S.343 was passed in May 2023; this new law gives children and youth, as young as the age of 5 years old, access to Crisis Stabilization Units (CSUs). Previously, access to CSUs was limited to people 18 years and older. This law also allows non-SCDMH entities to operate CSUs; it changed the definition of CSU to "a facility, other than a health care facility, that provides a short-term residential program, offering psychiatric stabilization services and brief, intensive crisis services to individuals five and older, twenty-four hours a day, seven days a week." The enactment of this new law may help prevent or reduce suicidal behavior among children and youth.

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 suicidal patients being discharged from inpatient units or emergency departments?***
☒ Yes ☐ No

If yes, please describe how barriers are eliminated.

SCDMH continues to collaborate with South Carolina Hospital Association (SCHA) to develop the Drive to Zero Suicide Award.[2] 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. The number of award winners in 2022 surpassed those in 2021, reflecting the fact that more hospitals are conscientiously working to decrease barriers and support patients in more holistic ways.

[2] https://scha.org/initiatives/zero-harm/the-drive-to-zero-suicide-award/

5. ***Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted?***
☒ Yes ☐ No

If so, please describe the population of focus?

In addition to numerous other suicide prevention activities, SCDMH's launch of the state's second 988 Contact Center, expansion of the Mobile Crisis Program, and expansion of the Hope.ConnectsYou.org interactive screening tool, were three of the major statewide initiatives that were prioritized since the previous plan was submitted. The populations of focus for these initiatives were adults with SMI and children with SED.

Please indicate areas of technical assistance needed related to this section.
No technical assistance is requested.

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, 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's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- 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.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. 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?

see attachment

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.

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Question 20: Support of State Partners

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?

SCDMH has a diverse portfolio of strategic partnerships that contribute to the achievement of its mission: to support the recovery of people with mental illnesses. Included in its portfolio of resources are other South Carolina state government agencies; entities representing service providers, advocates, associations, and other stakeholders; and educational institutions in South Carolina and other states. The number of such partnerships continues to increase as SCDMH constantly works to identify partners that will positively impact South Carolinians, especially those affected by mental illnesses.

Evidence of the support of state partners is best represented by the active role of certain agencies (listed below) in serving on the South Carolina Mental Health State Planning Council (Planning Council).

- South Carolina Department of Health and Human Services
- South Carolina Department of Social Services
- South Carolina Department of Vocational Rehabilitation
- South Carolina State Housing Finance and Development Authority
- South Carolina Department of Alcohol and Other Drug Abuse Services
- Department of Corrections
- Department of Education

SCDMH also maintains contracts, memorandums of agreement, and other working-level documents with agencies that demonstrate specific efforts and endeavors on which SCDMH and these agencies are partnered. Such relationships include the South Carolina Emergency Management Division, and South Carolina Department of Health and Environmental Control.

Additional partnerships are evidenced by the 603 schools in which SCDMH has placed a Master's or Bachelor's level staff. These relationships require a contractual basis and philosophical agreement. One example of successful partnerships with school is SCDMH's provision of clinical and psychiatric services via telemedicine for deaf and hard of hearing students. Additionally, early intervention is a hallmark of school mental health. Early intervention helps prevent hospital or other structured residential placement by providing treatment to children and adolescents before their mental health issues escalate.

SCDMH has affiliations with more than 60 educational institutions in South Carolina and more than 5 other states. The agency works closely with independent advocacy organizations to improve the quality of life for people with mental illness, their families, and the citizens of South Carolina.

The agency's affiliation with the University of South Carolina includes activity therapy, clinical counseling, medical students, nursing students, social work, psychology interns, psychology graduate studies, and residents and fellows in psychiatry.

SCDMH provides staff to the State Emergency Operations Center (SEOC) when it is activated. SCDMH employees act as liaisons for the agency and provide guidance and access to meet the behavioral health needs of numerous support agencies, primarily in the health and medical and mass care emergency support functions. SCDMH is the primary agency assigned to support the Department of Health and Environmental Control (SCDHEC) for coordinating and providing behavioral health services during emergencies and disaster response and recovery. SCDMH staff across the state are partners of, and provide support to, one of the four regional healthcare coalitions in the state and local healthcare preparedness programs. A member of SCDMH sits on the state advisory council for healthcare preparedness as part of the Statewide Healthcare Coalition. Other SC partners served in this effort include the South Carolina Emergency Management Department (SCEMD), South Carolina Department of Social Services (SCDSS), and the State Substance Abuse Authority, South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS).

SCDMH has contracts with the University of South Carolina's School of Medicine (USCSOM) and Department of Neuropsychiatry and Behavioral Science. There has been a long collaborative relationship between SCDMH and USCSOM's Department of Neuropsychiatry and Behavioral Science; the department provides clinical consultation and training delivery to SCDMH staff on a range of clinical topics.

Residents from the Medical University of South Carolina (MUSC) Residency Training Program receive educational experiences and supervision in Psychiatry through scheduled rotations at the Charleston Dorchester Mental Health Center (CDMHC). CDMHC is involved with learning collaborative including DMH, the Crime Victim's Center at MUSC, and the Dee Norton Lowcountry Children's Center. This initiative revolves around Trauma-Focused Cognitive Behavioral Therapy. Residents train with CDMHC's First Responder Support Team and Mobile Crisis. Medical students rotate regularly though CDMHC throughout the academic year. SCDMH has a contract with MUSC to provide forensic evaluation of adult criminal defendants in 10 counties in South Carolina.

The South Carolina General Assembly directed SCDMH to create a program in a limited pilot region of the state using a private contractor as an alternative to law enforcement for the transport of non-violent adults who have been determined by a licensed physician to need an involuntary emergency psychiatric hospitalization. SCDMH awarded the contract for this pilot program to Allied Universal Services (AUS).

The pilot region consists of the following 10 counties: Cherokee, Chester, Fairfield, Kershaw, Lancaster, Lee, Newberry, Sumter, Union and York.

Program specifics include:

- Unmarked vehicles designed for safe and secure transports of adult patients
  - Secure patient compartment allows patient to be transported w/o restraints;

- Camera system allows driver to monitor patient during the transport;
- Cameras record both patient and driver during transport;
- Equipped with secure storage area for patient belongings

• Google Smartsheet technology for tracking and responding to requests, as well as GPS for tracking vehicle locations

• Extensive driver training on mental health topics, including de-escalation

Phase I of this pilot program was implemented in September 2022, availability 7 am to 11 pm, Monday – Friday. Phase 2 began by January 2023, 24/7, daily.

SCDMH is also currently partnering with the SC Department of Administration to explore the restructuring of state healthcare agencies in South Carolina.

It should be noted that the information provided above serves only as a sample of the diverse portfolio of strategic partnerships that is maintained by SCDMH. These relationships demonstrate recognition by each agency that solutions to the issues facing individuals with mental illnesses are not constructed in isolation but require overlapping layers to address what are often times overlapping conditions and situations.

Alliance Program

In addition to working with a wide range of state partners, SCDMH has significantly expanded its partnerships with law enforcement agencies across the state.

Alliance is a program in the SCDMH Office of Emergency Services. This program provides opportunities for first responders to collaborate with SCDMH 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, detention centers, and hospital emergency departments throughout the state. 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. MHPs working in detention centers and jails identify detained offenders who are in need of referrals to mental health care and continuity of care in the community. 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. Over the past several years, SCDMH has successfully embedded MHPs with the following entities:

- Aiken County Department of Corrections
- Edgefield/McCormick County Sheriff's Office
- Newberry County Sheriff's Office
- Goose Creek Police Department
- Berkeley County Sheriff's Office
- Chester County Sheriff's Office
- Charleston 911 Dispatch
- Dorchester County Sheriff's Office
- Colleton County Sheriff's Office
- Beaufort County Sheriff's Office
- Columbia Police Department
- Richland County Sheriff's Department
- Greenwood County Sheriff's Office
- Darlington County Sheriff's Office
- Kershaw County Sheriff's Office
- Bishopville County Sheriff's Office
- Cherokee/Spartanburg County Sheriff's Office
- Myrtle Beach Police Department

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.***

South Carolina is one of the only states in the US with a state-operated, comprehensive mental health system, resulting in numerous benefits for South Carolinians in need of services. For example, this structure means SCDMH:

- Comprises a network of community mental health centers (CMHCs) and associated clinics, covering geographical catchment areas, that provide an inclusive, uniform array of core mental health services;
- Provides and/or coordinate the necessary vital, non-medical supports for successful recovery, e.g., care coordination, tailored to each patient's needs;
- Provides transition services to and from inpatient care, including non-clinical services, to support long-term recovery;
- Facilities are able to provide support as needed to patients of other DMH centers and hospitals, e.g., sharing psychiatrist time via telehealth, providing services to anyone in need following a natural disaster;
- Is a Trauma-Informed System, supporting the development and implementation of 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 offers evidence-based treatment options to patients experiencing trauma-related symptoms.

- Utilizes a system-wide, secure, electronic medical record, allowing all clinical components access to patient information and providing seamless access to care for patients who may move to a new area in SC but wish to continue services with DMH;
- Operates according to uniform policies and procedures.

As a result, SCDMH is able to more feasibly 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 patients to function outside of inpatient or residential institutions. This includes services to be provided by local school systems under the Individuals with Disabilities Education Act.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested.

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

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 meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

Planning Councils are required by statute to review state plans and implementation 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 an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

Please consider the following items as a guide when preparing the description of the state's system:

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, etc.)

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

5. 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.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

SOUTH CAROLINA MENTAL HEALTH STATE PLANNING COUNCIL BYLAWS

ARTICLE I. NAME

The name of this organization shall be the South Carolina Mental Health State Planning Council. The South Carolina Mental Health State Planning Council may also be informally referred to as the "Council," the "Planning Council" or the "State Planning Council."

ARTICLE II. PURPOSE

As required under the Public Health Services Act, 42 U.S.C. 300x-3, the purpose of the Council is to:

a. Review the Community Mental Health Services Block Grant Uniform Application and Behavioral Health Report and make recommendations.
b. Serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses.
c. Monitor, review, and evaluate – not less than once a year – the allocation and adequacy of mental health services within the state.

ARTICLE III. MEMBERSHIP

Section 1. Qualifications

a. Council membership composition shall reflect the mental health stakeholder community.
b. Council members shall include adults with serious mental illness who are receiving or have received mental health services, family members of such adults or families of children with emotional disturbance, public and private community-based providers, advocacy organizations, and state agency representatives from mental health, education, vocational rehabilitation, criminal justice, housing, social services, alcohol and drug, and health and human services Medicaid division.
c. The ratio of parents of children with a serious emotional disturbance to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council.
d. At least fifty-one percent (51%) of the Council shall be comprised of adults with serious mental illness who are receiving or have received mental health services or who are family members of such adults or families of children with emotional disturbance.
e. The Council, upon recommendation of the Nominating/Membership Committee, shall determine status as a "provider" of mental health services. Such determination

shall be made upon recommendation of election by the Council and may be changed upon receipt of new or changed information. In order to facilitate such determination, applicants for and members of the Council shall be required to disclose to the Nominating/Membership Committee any work regularly performed for pay as, or for, a provider of mental health services.

f. Volunteers, advisory, and governing board members shall not be considered as providers solely based on such status.
g. Under general ethical principles, members of the Council shall recuse themselves when they have a direct financial stake in the outcome of a Council decision, independent of their status as a provider.

Section 2. Election

a. Prospective members and returning members shall be elected by a majority vote of current members present and voting.
b. Elections should be held at the last regular meeting of the fiscal year, no later than June 30. However, upon approval by a majority vote of current members present and voting, elections may be held out-of-cycle.
c. Current members may recommend prospective members to the Nominating/Membership Committee.
d. Current members with expiring terms who wish to continue serving on the Council may submit their interest in writing to the of the Nominating/Members Committee to be included in voting according to Article III, Section 2a. to be voted according to Article III, Sections 2 a.
e. Prospective members must complete the Application for Election to the South Carolina Mental Health State Planning Council and submit said application, and any other supplemental information requested and related thereto, within reason, to the Nominating/Membership Committee.
f. Upon review and proper vetting of the application of a prospective member by the Nominating/Membership Committee, the names of those prospective members deemed qualified to serve on the Council, along with the respective applications, will be submitted to the State Director of the South Carolina Department of Mental Health for review and recommendation(s). Said recommendation(s) will then be submitted to the Chair of the Nominating/Membership Committee for presentation to the Council on which the Council will then vote according to Article III, Sections 2 and 5.

Section 3. Terms

a. The terms of the Council members shall be three (3) years and staggered.
b. A member may serve multiple terms subject to Article III, Sections 2 and 5.
c. A term is established by and follows the state fiscal year – July 1 to June 30.

Section 4. Vacancies

a. Any member appointed to fill a vacancy for an unexpired term, subject to Article III, Section 2, Items d and e, shall serve for the remainder of such term. Upon completion of said unexpired term, said member may be re-elected to the Council for a full-term.

Section 5. Resignation and Removal

a. A Council member may resign at any time by giving written notice to the Chair, which will take effect upon receipt of the notice.
b. A Council member may be removed at any time upon a majority vote of those members of the Council present at the meeting during which the vote is scheduled to be taken.
    a. Causes for removal include one or more of the following:
        i. Absence from three (3) consecutive Council meetings without a justifiable medical, business, or personal excuse;
        ii. When the member is no longer a resident of the state; or
        iii. When a conflict of interest renders an individual unqualified to serve on the Council pursuant to Article III. Section 1.

ARTICLE IV. FISCAL YEAR

The fiscal year of the Council shall be July 1 through the following June 30.

ARTICLE V. MEETINGS

Section 1. Schedule

a. The Council shall meet at least four (4) times per fiscal year.
b. The purpose of these meetings shall comport with the duties of the Council as defined by PL 102-321 and Article II above.

Section 2. Quorum

a. For the purpose of conducting the business of the Council, the members present shall constitute a quorum.
b. Any member of the Council who has been absent from two consecutive meetings will forfeit their voting privileges. Voting privileges will be reinstated at the next attended meeting.

Section 3. Compensation

a. The members of the Council shall serve without pay.

b. The Council may authorize or recommend the timely payment of reasonable and necessary expenses incurred by members in the performance of their duties. Such payment is subject to the availability of Community Mental Health Services Block Grant Funds appropriated for said purposes and the approval of the South Carolina Department of Mental Health.
    a. Members of the Council whose participation is not being rendered in the course of a job function, or as the result of an affiliation with any organization, are eligible for mileage reimbursement at the maximum mileage reimbursement rate for state employees when a state vehicle is not available as set forth in the Appropriations Act of the General Assembly of the State of South Carolina under the proviso entitled "Travel – Subsistence Expenses & Mileage."
        i. Members whose participation in Council activities are rendered on a volunteer basis, generally those whose Type of Membership as described in Article III, Section 1 is designated as either "Individuals in Recovery (from Mental Illness and Addictions)" and "Family Members of Individuals in Recovery (from Mental Illness and Addictions" according to the prevailing definitions by the Substance Abuse and Mental Health Services Administration (SAMHSA) at the time of request for reimbursement qualify for mileage reimbursement.
        ii. The value per mile for mileage reimbursement shall be calculated according to the prevailing rate utilized by the South Carolina Department of Mental Health at the time at which the request for reimbursement is initially received.

Section 4. Open Meetings

a. All meetings of the Council shall be open to the public.
b. A reasonable period shall be set aside at all meetings of the Council for members of the public to address the Council.
c. Members of the public shall be permitted to propose "new business" for the next meeting of the Council. Subject to veto by the Council, such new business shall be placed on the next Council meeting agenda.

ARTICLE VI. ELECTION OF OFFICERS

The officers of the Council shall be Chair, Vice Chair, and Secretary.

Section 1. Election and Terms

a. Officers should be elected for a two (2) year term by a majority vote of Council during the last regular meeting of the fiscal year. However, upon approval by a majority vote of current members present and voting, elections may be held out-of-cycle.

b. Officers shall be elected either upon the expiration of the term of the respective office as defined by Article VI, Section 1, Item a, or upon the resignation of the member of the Council holding said office. A member of the Council filling a vacancy shall serve for the remainder of such term. Upon completion of said unexpired term, said member may be re-elected to the office for a full-term.
c. Officers shall assume their official duties beginning July 1.
d. Only a member of the Council who has served for at least one (1) year shall be eligible to hold office.
e. Only those persons who have signified their consent to serve, if elected, shall be nominated for, or elected to, such office.
f. There shall be no restrictions upon the number of terms an elected member may serve, either consecutively or in total.

Section 2. Role of the Nominating/Membership Committee and Council in the Election of Officers for the South Carolina Mental Health State Planning Council

a. The Nominating/Membership Committee shall solicit from the Council names of eligible members of the Council for specific officer positions.
    1. No member serving on the Nominating/Membership Committee, nor any member of the Council who has served on the Nominating/Membership Committee within one (1) year of the current election of officers, may be nominated for an officer position until such time as one (1) year has elapsed between said service and the election of officers.
b. The Nominating/Membership Committee shall report the slate of prospective officers to the Council fourteen (14) days prior to the last regular Council meeting of the fiscal year. Nominations for said officer positions may also be accepted from the floor.
    1. If more than one candidate is presented for a specific officer position, then a separate vote must be held for said position. The candidate receiving the majority of the votes of quorum will be awarded the office.
c. Upon acceptance of the slate of prospective officers by the Council, the slate shall be elected by a majority vote of the quorum, or, if no alternate candidates are proposed, by acclamation.

Section 3. Vacancies

a. Upon vacancy of an office, the Nominating/Membership Committee shall recommend an eligible member to the Council with a fourteen (14) day notice before the next regular Council meeting.
b. A vacancy occurring in any office shall be filled for the unexpired term by a qualified member elected by a majority vote of the remaining members of the Council.

ARTICLE VII. DUTIES OF OFFICERS

Section 1. The Chair shall:

a. Oversee all regular and called meetings of the Council;
b. Serve as ex-officio member of all committees;
c. Work in partnership with the state planner to ensure Council resolutions are carried out;
d. Call special meetings of the Council, or its respective standing, or ad hoc committees, if necessary;
e. Appoint, with approval by the Council, all committee members and committee chairs, excluding the Nominating/Membership Committee, in consult with the planner;
f. Assist in preparing the agenda for Council meetings;
g. Assist in conducting new member orientation;
h. Work with the Nominating/Membership Committee to recruit new Council members;
i. Act as a spokesperson for the Council;
j. Periodically consult with members on their roles and help them assess their performance.

Section 2. The Vice Chair shall:

a. Attend all Council meetings;
b. Understand the responsibilities of the Chair and be able to perform these duties in the absence of the Chair;
c. Participate in Council leadership.

Section 3. The Secretary shall:

a. Attend all Council meetings;
b. Review meeting minutes;
c. Assist the Chair with attendance, quorum and action of the Council;
d. Assume responsibilities of the Chair in the absence, or inability, of both the Chair and Vice Chair.

ARTICLE VIII. COMMITTEES

Section 1. The following committee(s) of the Council is provided for by reference in these Bylaws in Article VI, Section 2.

a. The Nominating/Membership Committee

Section 2. Nominating/Membership Committee

a. At a regular meeting of the Council in the month of January a Nominating/Membership Committee and Chair consisting of an uneven number - not less than three (3) – of members of the Council shall be elected by the Council to serve a one (1) year term.
b. The role of the Nominating/Membership Committee is designated within the respective Articles of these Bylaws.

Section 3. Ad Hoc Committees

The Chairperson may appoint special or standing committees as may be deemed advisable. Each such committee shall have such powers and authority as shall be specified by the Council. The Chairperson shall appoint members of committees and shall designate the chairperson of each committee.

Section 4. Removal

The chair or any member of any committee may be removed for willful misconduct by a majority of a quorum of the Council at any time at a properly called meeting of the Council.

ARTICLE IX. ANTI-DISCRIMINATION

The Council shall not discriminate in any regard with respect to race, creed, color, sex, sexual orientation, marital status, religion, national origin, ancestry, pregnancy, parenthood, custody of a minor child or physical or mental disability.

ARTICLE X. PARLIAMENTARY AUTHORITY

The rules contained in the current edition of Robert's Rules of Order. Newly Revised shall govern the Council in all cases to which they are applicable and in which they are not in conflict with these bylaws and any special rules of order that the Council may adopt.

ARTICLE XI. PROCEDURES

Section 1. Quorum

See Article V, Section 2.

Section 2. Voting

a. Council decisions should be made by consensus.
b. If voting becomes necessary, a simple majority of the members present at the meeting will be sufficient for a vote on any issue.
    1. Types of Voting
        i. By Voice – The Chairperson may ask the members of the Council to indicate in the affirmative those members in favor of a motion, and to indicate an objection those members not in favor of a motion. Any member may move for an exact count.
        ii. By General Consent – The Chairperson may present all members with the opportunity to object, which by their silence will indicate agreement with the motion. If a member indicates an objection, the motion must be put to a vote.
        iii. By Ballot – Any member may request that a ballot vote be conducted regardless of the subject matter.

ARTICLE XII. AMENDMENT OF BYLAWS

The bylaws may be amended at any regular meeting of the Council by a two-thirds vote of all members listed on the Membership Roster of the Council provided that the proposed amendment has been submitted in writing to all members fourteen (14) days in advance of the meeting. The bylaws may be reviewed every two (2) years and any amendments and revisions shall be in accordance with PL 102-321.

Adopted the 18th day of May 20 22.

Chair _____
Signature

Notification of 2023 Meeting Schedule
South Carolina Mental Health State Planning Council

Notice is hereby given that at the November 16, 2022 meeting of the South Carolina Mental Health State Planning Council (Council), the Council approved the dates and times upon which it will convene its meetings in 2020.

The 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.

January 18, 2023	March 15, 2023	May 17, 2023
July 19, 2023	September 20, 2023	November 15, 2023

Please note that the Council may also convene subcommittee meetings on the same dates. Additional information will follow. Please refer to the published agenda for each respective date to determine if subcommittee meetings are intended.

For additional information, please contact Michele Murff, Director of Housing and Homeless Program, at 803-898-7767, or via email at michele.murff@scdmh.org, or via postal mail at 2414 Bull Street, Suite 312, Columbia, SC 29201.

August 9, 2023

Ms. Odessa F. Crocker, Chief
Formula Grants Branch
Division of Grants Management,
Office of Financial Resources
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Ms. Crocker.

The South Carolina Mental Health State Planning Council is tasked with evaluating, monitoring and reviewing the MHBG application and SCDMH services. We have reviewed the application and affirm that we support the application as is - with no changes.

The Council is also required to advocate for mental health services for adults and children. This past South Carolina Legislative session provided opportunity for Council members to directly contact Senators on a subcommittee regarding a bill that many of us opposed. Dozens of Council members reached out to all five senate subcommittee members. For now, that bill will not be taking effect

The Council has also been supported by SCDMH leadership in fighting stigma. The Acting State Director, Dr. Robert Bank, sent an email to employees, agency wide. He spoke of looking within and recognizing that mental illness is an illness in the brain like any illness affecting other organs. As Chair, I wrote an article about the unfairness in the way people with mental illness are treated as opposed to those with a "physical" illness. Dr. Bank included my writings in his email to all staff.

We have evaluated community mental health services within SCDMH. The Deputy Director of community mental health services, Ms. Deborah Blalock, brought mobile crisis RVs from the all 16 community mental health centers to Columbia, SC to coincide with our May planning council meeting. All members and guests were able to tour the mobile crisis RVs. Each of the 16 mental health centers were represented with staff offering information about services. Council members were extremely impressed. We are also pleased that SCDMH will have peer support specialists as part of the mobile crisis teams

We are monitoring services year round. At each Planning Council meeting, the State Director and Deputy Directors give updates on not only community mental health service, but legislation that is going through the State House. We also monitor the total SCDMH budget.

Attached to this letter is a Flyer provided to the Council by Ms. Blalock. The Flyer gives a "glance" at Community Mental Health Services for FY2022. It's informative and aides the Council in monitoring services

SCDHM is consistently supportive of the Council meeting its goals. We are grateful for such a positive relationship with SCDMH. Together, we are able to ensure South Carolinians are provided quality mental health services

In closing, the South Carolina Mental Health State Planning Council supports this application. After reviewing the document, evaluating services, and monitoring services throughout the year, we can say we stand behind SCDMH and the quality services they provide

Best regards.

Janie Simpson

Janie Simpson
Chairperson
SC Mental Health State Planning Council

Community Mental Health AT A GLANCE

FISCAL YEAR 2022

South Carolina Department of Mental Health DMH

www.scdmh.net

The information below represents important data pertaining to critical community mental health services provided by the South Carolina Department of Mental Health.

Total South Carolinians Served = **92,045** *(unduplicated)*

Total Services Provided = **1,095,795**

Crisis Response Services

Community Impact Data *(Fiscal Year 2022)*

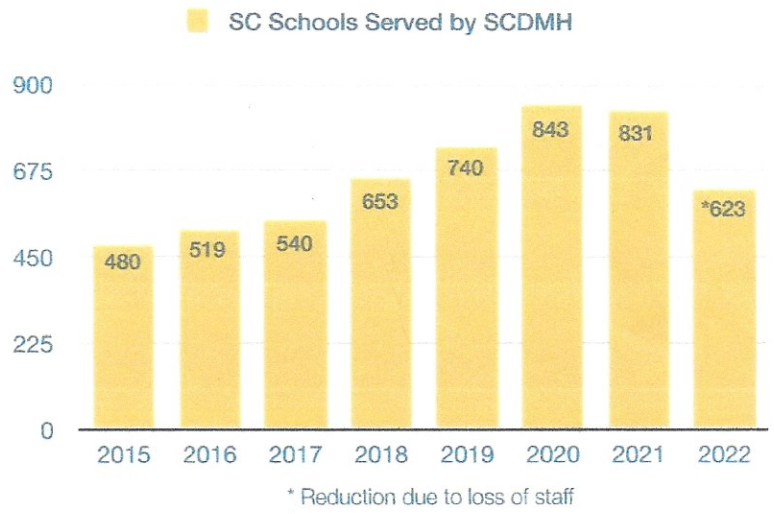
- 23,820 Mobile Crisis Call Center Calls *(all mental health inquiries)*
- 7,380 Crisis Calls Taken
- 3,857 Mobile Crisis Responses in the Community
- 1,835 Diversions from ERs, Jail, Psychiatric Hospitals

1,554 Uninsured Patients Admitted to Local Community Hospitals

12,576 Bed Days

$7.5 Million Uninsured Patients Covered

- **23,171** Children Served *(FY 2022)*
  A 9,627 increase since 2014
- **258,948** Services Provided *(FY 2022)*



* Reduction due to loss of staff

SOUTH CAROLINA MENTAL HEALTH STATE PLANNING COUNCIL

July 19, 2023

Minutes

Members Present

Janie Simpson	Robert Bank	Tray Stone	John Kendall	Joan Herbert	Maria Beth Smith
Candy True	Bill Lindsey	Chris Kunkle	Amy Jolly	Keith Jackson	Deborah Blalock
Robin Crawford	Phoebe Malloy	Carol Rudder	Stuart Shields	Shelina Flarisee	Michele Mitchum

Guests

Mahri Irvine	Kimberly Rudd	Eillen Schell	Valarie Perkins	Stacey Floyd	Bonita Shropshire
Mike Weaver	Lavinia Holder				

Staff

Erin Patlax

Michele Murff

Documents Distributed

May 17, 2023 Minutes

July 19, 2023 Agenda

Welcome and Introductions

Janie Simpson called the meeting to order at 10:01AM. Everyone in attendance introduced themselves.

Approval of Agenda

On the motion of Ms. Maria Beth Smith and seconded by Mr. Bill Lindsey the Agenda was approved with one change.

Approval of Minutes

On the motion of Mr. Bill Lindsey, seconded by Mr. Tray Stone, the Minutes were approved.

Comments from the Acting State Director

Dr. Robert Bank reported that the budget was finalized, and the current Legislative session adjourned for the year. One request the department had was to increase salaries for those who work closest with patients to combat inflation due to the pandemic. Every employee at DMH also got a 5% increase in salary.

Next, Dr. Bank shared that since funding for the 988-call center in Charleston was procured there has been an increase from 68% of SC calls answered in May to 76% answered in June. The end goal is 100% of SC calls to be answered.

Dr. Bank reported that funding for Suicide Prevention Office initiatives to get suicide resource information out into the community is to continue.

Lastly, Dr. Bank shared that monies have been procured for additional funding for the Alternative Private Transport project and to contract additional beds at group homes which would mainly be for adolescents under 18.

There were questions and discussion amongst the Council about these topics.

Legislative Update

Ms. Robin Crawford introduced her new coworker Ms. Bonita Shropshire. She then shared that Legislation would meet again in January.

Community Mental Health Services Update

Ms. Deborah Blalock shared that vacant positions are filling thanks to the recent salary increase.

Next, she reported that the Intensive Community Treatment Teams were converting to Assertive Community Treatment Teams (ACT Teams). ACT Teams are evidence-based models with a 1:10 staff to patient ratio that utilized multidisciplinary teams. ACT serves patients in the community within their homes daily or weekly. DHHS increase the funding using Bipartisan Safer Community ACT dollars to support the conversion. There are currently two full fidelity ACT teams in SC located in Columbia and Greenville and within six to nine months should increase to sixteen with one at every center.

Ms. Blalock then shared the MHCs to date have served 761 individuals in the community residential care facilities. There is ongoing effort at the center level to ensure they individuals are ready to move out of the facilities and have somewhere to go.

She then reported that a grant was awarded that will be used to add more peer support specialists to mobile crisis units in Laurens, Greenwood, McCormick, Saluda, Abbeville, Edgefield, and Newberry counties.

Lastly, Ms. Blalock shared that DMH is receiving technical assistance from the National Association for State Mental Health Program Directors. The Former Commissioner of Kentucky, Ms. Wendy Morris, will

work alongside DMH and other stakeholders to create a report. The report will contain recommendations and investigate the idea of restructuring the agency.

There were questions and discussion amongst the Council about these topics.

Inpatient Services Update

Dr. Kimberly Rudd gave the Inpatient Update for Dr. Versie Bellamy.

Dr. Rudd reported that by July of 2024 the veterans nursing homes will officially be moved to the Veterans Affairs agency.

She then shared that Roddey received a 5-star rating for the first-time which places them in the top 10% of the nations nursing homes.

Dr. Rudd reported that Harris is currently working on a ligature project which is part of joint commission requirements and workforce development.

She then reported that Bryans jail-based competency restoration program has decreased its waitlist by 40% by helping discharge and find placement for long-term patients. Forensic leadership, legal, and patient advocacy are ensuring that education is provided statewide with the different counties to those who need competency training.

Dr. Rudd shared that Bryans activity stoppage due to COVID has been lifted. These activities are important in helping with treatment and transition.

Lastly, she shared that Hall is holding a community outreach event that will include a barber and hair salon area for patients.

There were questions and discussion amongst the Council about these topics.

Block Grant Update

Ms. Michele Murff first introduced Mahri Irvine who works in Grants Administration Division and is the new Block Grant writer. She then gave an overview and timeline of the 2024-2025 Mental Health Block Grant application. The full application is due on September 1. The draft application will be ready for internal review by senior management by August 8. August 15 the draft will be posted for public comment in newspapers, and the SCDMH website. The comment period will last from August 15 to August 29.

There was discussion amongst the Council about the topic.

Navigate Program Presentation

Ms. Angel Smith introduced the NAVIGATE first episode psychosis program. She explained the patient acceptance criteria, who is involved, and the treatment model. A PowerPoint presentation was provided.

There was discussion amongst the council about the presentation and the PowerPoint.

Council Comments

Eillen Schell: A spaghetti dinner fundraiser and auction for Bridges Club House and Grahams Garden will be held July 26, 2023, at 6PM. Contact Jasen Hutto at jhutto@MHA-SC.org or (803) 796-6179.

Stuart Shields/Dr. Bank: A new Florence behavioral health hospital, which will be owned by MUSC, is being built that will house 63 beds. 16 of those beds will be reserved for adult crisis and 4 beds for children. Governor McMaster allotted 100 million dollars to fund the project.

Lavinia Holder: SC Share has received money from the Block Grant to hire two full time salary peer support employees. She shared info on how to go on the SC Share website and conditions to apply.

Bill Lindsey: 988 The Hill held a press conference which covered a legislative updated. The conference was NAMI sponsored and available online.

Renaye Long: SC Housing has collaborated with the school of Business at USC to conduct a demand analysis on housing. Monies were provided by legislature to help predict future needs and challenges.

Chief Mitchum: SC Share has two pending SAMHSA grants that will be used to train peer support specialists in Allendale County.

Adjournment

The meeting adjourned at 12:00PM. The next meeting of the South Carolina Mental Health State Planning Council will be held September 20, 2023 from 10:00AM – 12:00PM at The Department of Mental Health, 2414 Bull Street, Suite 323, Columbia, SC 29201.

Question 21: State Planning/Advisory Council and Input on the Mental Health/Substance Use Disorder Block Grant Application

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, etc.)***

The SCDMH staff liaison provided an overview, including timeline, of the FFY 2024/2025 Mental Health Block Grant Application at the July 19, 2023 meeting of the South Carolina Mental Health State Planning Council (see attached meeting minutes). SCDMH's new Mental Health Block Grant Planner was also in attendance and was introduced to the Council.

Prior to the public comment period, the draft FFY 2024/2025 Mental Health Block Grant Application was provided to the Planning Council Chairperson for review and comment.

The Council Chairperson submitted the attached letter of support on behalf of the Council.

At the beginning of the comment period, Planning Council members were notified via email of the availability of the draft FFY 2024/2025 Mental Health Block Grant Application.

2. ***What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?***

The South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) is responsible for planning and implementing substance misuse prevention, SUD treatment, and recovery support services.

3. ***Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work?***

☒ Yes ☐ No

4. ***Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children?***

☒ Yes ☐ No

5. ***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.***

Please see the attached South Carolina Mental Health State Planning Council Bylaws; specifically, Article II.

As a function of the South Carolina Mental Health State Planning Council's classification as a body politic, it publishes each year, and places on the SCDMH website, a Notification of Meeting Schedule (see attached document) which provides an opportunity for the public to interface with the Planning Council and SCDMH.

Please also see the Letter from the South Carolina Mental Health State Planning Council Chairperson.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested.

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 Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Harriet Abner	State Employees	SC Vocational Rehabilitation		
Chris Allen	Others (Advocates who are not State employees or providers)			
Robert Bank	State Employees	SC Department of Mental Health		
Versie Bellamy	State Employees	SC Department of Mental Health		
Debbie Blalock	State Employees	SC Department of Mental Health		
Hannah Bonsu	State Employees	SC Dept. of Alcohol and Other Drug Abuse Services		
Zee Brown	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Aaron Brown	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Debbie Calcote	State Employees	SC Department of Mental Health		
Angela Caroll	State Employees	SC Department of Social Services		
Ramona Carr	Others (Advocates who are not State employees or providers)			
Ryan Chitwood	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Robin Crawford	State Employees	SC Department of Mental Health		
Katie Durkee	Parents of children with SED			
Shelina Flarisee	Parents of children with SED			
Beth Franco	Others (Advocates who are not State employees or providers)			

Raj Gavurla	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Mandy Halloran	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Melanie Hendricks	State Employees	SC Department of Health and Human Services		
Joan Herbert	Providers			
Joy Jay	Others (Advocates who are not State employees or providers)			
Louise Johnson	State Employees	SC Department of Mental Health		
Amy Jolly	Providers			
John Kendall	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Chris Kunkle	State Employees	SC Department of Corrections		
Bill Lindsey	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Renaye Long	State Employees	SC State Housing Finance and Development Authority		
Phoebe Malloy	Parents of children with SED			
Lisa McCliment	State Employees	SC Department of Education		
Michelle Mitchum	Representatives from Federally Recognized Tribes			
Melissa Reitmeier	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Carol Rudder	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Stuart Shields	Others (Advocates who are not State employees or providers)			
Janie Simpson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Maria Beth Smith	Parents of children with SED			
Cindy Smith	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Candy True	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			

*Council members should be listed only once by type of membership and Agency/organization represented.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	5	
Parents of children with SED	4	
Vacancies (individual & family members)	0	
Others (Advocates who are not State employees or providers)	5	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**21**	**55.26%**
State Employees	13	
Providers	2	
Vacancies	2	
Total State Employees & Providers	**17**	**44.74%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	0	
Individuals/Family Members from LGBTQI+ Populations	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	1	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**38**	

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

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, 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 SAMHSA.

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:

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

c) Other (e.g. public service announcements, print media) (●) Yes ( ) No

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Question 22: Public Comment on the State Plan

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://scdmh.net/public-information/reports/

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:
https://scdmh.net/public-information/reports/

c) ***Other (e.g., public service announcements, print media)***
☒ Yes ☐ No

Please indicate areas of technical assistance needed related to this section.
No technical assistance is requested.