South Carolina

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

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 08/24/2026 8.33.10 AM)

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

State Information

State Information

Plan Year

Start Year	2027
End Year	2028

State Unique Entity Identification

Unique Entity ID	TATHMJ7UGBH3

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

Agency Name	South Carolina Department of Behavioral Health and Developmental Disabilities
Organizational Unit	
Mailing Address	P.O. Box 485
City	Columbia
Zip Code	29202

II. Contact Person for the Grantee of the Block Grant

First Name	Kimberly
Last Name	Rudd
Agency Name	South Carolina Department of Behavioral Health and Developmental Disabilities
Mailing Address	P.O. Box 485
City	Columbia
Zip Code	29202
Telephone	803-898-8319
Fax	
Email Address	kimberly.rudd@omh.bhdd.sc.gov

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	8/12/2026 8:51:01 AM

VI. Contact Person Responsible for Application Submission

First Name	Liza
Last Name	Watson

Telephone 8038988457
Fax
Email Address liza.watson@omh.bhdd.sc.gov

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

Footnotes:

State Information

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

Fiscal Year 2027

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		
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Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

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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).
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.
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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: Kimberly Rudd, M.D.

Signature of CEO or Designee[1]: _____

Title: Acting Office Director

Date Signed: _____

mm/dd/yyyy

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

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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: Kimberly B. Rudd, M.D.

Signature of CEO or Designee[1]: Kimberly B. Rudd, MD

Title: Acting Office Director

Date Signed: 8/11/2026

mm/dd/yyyy

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

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

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Name
Kimberly B. Rudd, M.D.

Title
Acting Office Director

Organization
SC BHDD, Office of Mental Health

Signature: K. B. Rudd, MD Date: 8/11/2026

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

Footnotes:

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

Kimberly Rudd, M.D.

Title

Acting Office Director

Organization

SC BHDD, Office of Mental Health

Signature: Date:

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

Footnotes:

Planning Tables

Table 2: MHBG Planned State Agency Budget for SFY2027

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

Table 2 addresses funds budgeted to be expended during State Fiscal Year (SFY) 2027 (for most states, the 12-month period is July 1, 2026, through June 30, 2027).

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

Planning Period Start Date: 7/1/2026 Planning Period End Date: 6/30/2026

Activity	Source of Funds						
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF, TANF, CDC, CMS (Medicare), SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Use Disorder Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children (PWWDC)							
b. All Other							
2. Recovery Support Services							
3. Primary Prevention							
4. Early Intervention Services for HIV							
5. Tuberculosis Services							
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[a]		$1,494,789.00					
7. State Hospital			$48,566,132.00		$131,019,647.00	$1,403,976.00	$2,097,665.00
8. Other Psychiatric Inpatient Care					$3,323,316.00		
9. Other 24-Hour Care (Residential Care)			$8,331,423.00		$13,935,235.00		$853,436.00
10. Ambulatory/Community Non-24 Hour Care		$11,664,903.00	$65,693,198.00	$2,162,086.00	$244,749,622.00	$4,411,925.00	$33,059,151.00
11. Crisis Services (5 percent set-aside) Set Aside[b]		$1,040,799.00	$36,417.00	$2,375,836.00	$2,108,816.00		$757,077.00
12. Other Capacity Building/Systems Development							
13. Administration[c]		$747,394.00			$33,037,445.00		$1,112,817.00
14. Total		**$14,947,885.00**	**$122,627,170.00**	**$4,537,922.00**	**$428,174,081.00**	**$5,815,901.00**	**$37,880,146.00**

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

[b] Row 11 in Column B: per statute, states are required to set-aside 5 percent of the total MHBG award for Behavioral Health Crisis Services (BHCS) programs.

[c] Per statute, administrative expenditures for the MHBG cannot exceed 5 percent of the fiscal year award.

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Footnotes:

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned SFY 2027 budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 12-month period (for most states, it is July 1, 2026 - June 30, 2027).

Planning Period Start Date: 7/1/2026 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	$2,009,683.00
1b. Crisis Services for Adults	$1,040,799.00
1c. CSC/ESMI program for Adults	$0.00
1d. Other outpatient/ambulatory services for Adults	$8,023,507.00
1e. *Other Direct Services for Adults	$252,500.00
2. Subtotal of Services for Adults	$$11,326,489.00
3. Services for Children	
3a. EBPs for Children	$1,013,198.00
3b. Crisis Services for Children	$0.00
3c. CSC/ESMI program for Children	$1,494,789.00
3d. Other outpatient/ambulatory services for Children	$366,015.00
3e. *Other Direct Services for Children	$0.00
4. Subtotal of Services for Children	$$2,874,002.00
5. Other Capacity Building/Systems Development	$0.00
6. Administrative Costs	$747,394.00
7. *Any Other Cost	$0.00
8. Total MHBG Allocation[c]	**$$14,947,885.00**

Please provide brief explanation for services with an asterisk* below:
Other direct services include the Homeshare program.

[a]This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6 for a 12 month period.

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

[c]The total budget should be equal to your MHBG allocation for the FY2027 12 month period.

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Footnotes:

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan Table 6 address MHBG funds to be expended on other capacity building /systems development activities during State Fiscal Year (SFY) 2027 (for most states, the 12-month period is July 1, 2026, through June 30, 2027). Please use these columns to capture how much the state plans to expend over a 12-month period.

MHBG Planning Period Start Date: 07/01/2026 MHBG Planning Period End Date: 06/30/2027

Activity	FFY 2026 MHBG[1]	FFY 2026 BSCA Funds[2]	FFY 2027 MHBG[3]
1. Information Systems	$0.00	$0.00	$0.00
2. Infrastructure Support	$0.00	$0.00	$0.00
3. Partnerships, Community Outreach, and Needs Assessment	$0.00	$0.00	$0.00
4. Planning Council Activities	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$0.00
7. Training and Education	$244,546.00	$0.00	$0.00
8. Total	**$244,546.00**	**$0.00**	**$0.00**

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

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

[3] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFY2027) [**July 1, 2026 – June 30, 2027**, for most states].

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Environmental Factors and Plan

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

Narrative Question

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

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

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

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

Please respond to the following items:

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

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

	0.00

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

FY2026	FY2027
	1,494,789.00

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

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

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

BHDD implements three different CSC programs at six Community Mental Health Centers (CMHCs): NAVIGATE, New Directions, and PREP. A total of 130 patients were served (officially enrolled) in these programs during SFY26.

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

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

PREP:
The PREP program is implemented at Pee Dee MHC.

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

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

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

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

Strategies for improving patient outcomes vary based on the needs identified by each Community Mental Health Center (CMHC):
• Smaller caseloads create opportunities for patients to receive more intensive services (Lexington County CMHC; Charleston Dorchester MHC; Pee Dee MHC)
• We offer a variety of ways for patients to meet for appointments (in the office as well as in homes or other settings; in-person and virtually) (Lexington County CMHC; Charleston Dorchester MHC; Columbia Area MHC; Pee Dee MHC)
• We offer financial assistance, bus passes, and/or cab vouchers for transportation, to help patients who do not have reliable transportation (Charleston Dorchester MHC; Pee Dee MHC)
• We pay for medication if patients are uninsured or cannot afford to pay for the medicine themselves (Charleston Dorchester MHC; Pee Dee MHC)

8. Please describe the planned activities in FY2027 for your state's ESMI programs.

BHDD plans to continue to support the ongoing operations of NAVIGATE, New Directions, and PREP at the CMHCs described above. Block grant funding will be used to pay for personnel expenses (salaries and fringe benefits), trainings for grant-funded staff, patient supplies (including medication and transportation passes), and/or other direct relevant program expenses.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

NAVIGATE: Schizophrenia spectrum newly diagnosed or newly treated in the past two years
New Directions: Any psychotic disorder newly diagnosed or newly treated in the past two years.
PREP: Psychosis, including Schizophrenia, Bipolar Disorder, Schizoaffective Disorder, and Borderline Personality Disorder.

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

Unknown. In the past, BHDD has not calculated or tracked the estimated incidence of individuals with a first episode psychosis. The agency's leadership and IT department are currently exploring strategies to identify the estimated incidence rates.

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

Promotion and outreach for the programs are unique to each Community Mental Health Center (CMHC):
• Our center maintains relationships with local hospitals and residential treatment facilities to identify patients who might be eligible for our program (Lexington County CMHC; Charleston Dorchester MHC; Columbia Area MHC; Pee Dee MHC)
• Our center maintains relationships with local detention centers, police departments, and courts to identify patients who might be eligible for our program (Charleston Dorchester MHC; Columbia Area MHC; Pee Dee MHC)
• Our center maintains relationships with local private practices and other mental health professionals to identify patients who might be eligible for our program (Pee Dee MHC)
• Our center actively reaches out to doctors' offices, including primary care providers, to educate them about the availability of our program (Pee Dee MHC)
• Our center actively reaches out to schools and educational providers to educate them about the availability of our program (Lexington County CMHC; Charleston Dorchester MHC; Pee Dee MHC)
• Our staff members participate in community task forces or coalitions to educate other organizations about the availability of our program (Pee Dee MHC)
• Our center actively reaches out to other catchment areas, programs, and children's services to educate them about our program (Pee Dee MHC)

12. Please indicate area of technical assistance needs related to this section.

We welcome technical assistance related to calculating the estimated incidence of individuals with FEP in the state.

Footnotes:

Environmental Factors and Plan

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

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of 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.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an Advisory: **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the live-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

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

A. "Someone to Talk To": Crisis Call Centers

BHDD operates two statewide crisis call centers. Both call centers are operated by the Charleston Dorchester Mental Health Center (CDMHC), which is in Charleston, SC.

1. South Carolina Mobile Crisis Call Center:

The South Carolina Mobile Crisis Call Center (MCCC), based in Charleston, SC, was first implemented in 2020 by BHDD. MCCC is operated by Charleston Dorchester Mental Health Center (CDMHC). MCCC answers all calls that are submitted through the state crisis number (833-364-2274), regardless of the time of day. However, during business hours, many law enforcement agencies directly call their local CMHCs instead of calling the state number. In these situations, the CMHCs will deploy their Mobile Crisis Teams without involving MCCC. During non-business hours, MCCC responds to all calls submitted through the state number as well as any calls directly from law enforcement agencies. MCCC acts as a bridge for communication between first responders and Mobile Crisis clinicians. First responders can contact the center 24/7 to triage calls, gather information, or request Mobile Crisis response.

MCCC assists individuals statewide and communicates with community mental health centers in all 46 counties to assist with triage and emergency assessment. MCCC's responsibility is to triage calls, attempt to de-escalate callers in crisis, and dispatch Mobile Crisis teams to mental health crises which are unable to be de-escalated and require after-hours response. If immediate response is needed, the call center will contact local emergency services dispatch for individuals across the state to request first responders to respond so individuals can be stabilized until Mobile Crisis teams are able to arrive on scene. In addition to those responsibilities, MCCC also provides callers with information regarding resources in their community, including local mental health centers, referrals to 211, and referrals to suicide prevention lifelines. Hospitals and ERs throughout the state are also able to contact MCCC and receive mental health history information about patients; this type of information includes medication information and the most recent appointments with patients' psychiatrists or counselors. This information is shared for continuity of care purposes, to ensure patients receive safe comprehensive, well-informed care.

Operations and administrative oversight, as well as supervision of the call center staff, are the responsibility of the Charleston Dorchester Mental Health Center (CDMHC).

2. 988 Suicide and Crisis Lifeline Centers:

There are two 988 Call Centers in South Carolina.

BHDD also operates a 988 Suicide and Crisis Lifeline Center. Originally, Mental Health America of Greenville County (MHAGC) operated the sole National Suicide Prevention Call Center in South Carolina. On June 1, 2023, BHDD launched a second 988 Suicide and Crisis Lifeline Center for South Carolina. This statewide call center is operated by Charleston Dorchester Mental Health Center (CDMHC). Callers with SC area codes who are experiencing mental health or suicide crises are assisted by this center. Callers are provided with telephonic crisis intervention services. Third-party callers can also reach out to 988 when they are concerned about people who may need mental health or substance abuse resources in their area.

Currently, the 988 center at CDMHC provides telephonic, chat, and text services. 988 callers are given the opportunity to participate in a follow-up care program; if they choose this service, the 988 center will schedule follow-up calls with the callers. The follow-up calls will connect the participants to care and secondary referrals, as well as address any barriers to care through referral sources.

B. "Someone to Respond": Mobile Crisis Teams

The Mobile Crisis Team program provides an extension of BHDD community mental health center services; during business hours, BHDD community mental health centers serve patients by appointment, during walk-in hours, and via phone. Mobile Crisis provides mobile response to patients in the community who cannot, or are unable to, access services; the program is able to provide a mobile response in the community for individuals in crisis who are in need of crisis intervention services when mental health centers are closed. Mobile Crisis teams are able to provide assessment, intervention, and referral for people who are at imminent risk and need to be involuntarily committed to protect themselves or other people. After hours, weekends, and on holidays, teams of two respond in person, remotely via telehealth, or by phone to those experiencing psychiatric emergencies. Mobile Crisis teams, working collaboratively with the detention centers, may provide assessment and crisis intervention services in the jails.

For an on-site response, two-person teams comprised of at least one master's level clinician co-respond with local law enforcement. The team of two may also include a bachelor's level staff person or a peer with lived expertise. Mobile Crisis teams are dispatched by the BHDD Call Center, which is operated by the Charleston Dorchester Mental Health Center (CDMHC). Referral calls are received from individuals in crisis, law enforcement and other first responders, and third-party callers including family or community providers and the 988 Suicide and Crisis Lifeline Network.

Other "Someone To Respond" Initiatives: Alliance Program and FRST Program

Two other programs provide services for people who may be in crisis. These two programs are separate from Mobile Crisis Teams.

Alliance Program:

Alliance provides opportunities for first responders to collaborate with BHDD and better serve community members who are experiencing mental health or behavioral health issues, including crises. Through Alliance, Mental Health Professionals (MHPs) are embedded in law enforcement agencies, fire and rescue departments, 911 dispatch centers, and hospital emergency departments. The MHPs work collaboratively with first responders to identify and support children, adolescents, and families experiencing mental health issues. The MHPs also collaborate with other

community agencies to provide information and resources to people in need. They provide mental health screenings, assessments, and crisis interventions, determine the need for inpatient admissions, and make appropriate referrals. MHPs working in hospital emergency departments support the mental health needs of patients, including referrals to community treatment and determining the need for inpatient admission. MHPs who are embedded in law enforcement agencies serve victims of crime, and respond alongside uniformed officers to calls that involve mental health situations; they help provide crisis response and de-escalation. Some Alliance staff are embedded or work closely in detention centers, which are a type of law enforcement agency. MHPs who are embedded at 911 dispatch centers respond to calls that are mental health related; they support dispatchers in determining the appropriate response to calls that may involve mental health crises.

First Responder Support Team (FRST):

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

C. "Somewhere to Go": Crisis Receiving and Stabilization Facilities

CRSFs reduce hospitalization by helping people receive services in their communities. CRSFs are generally viewed as a more appropriate and less expensive alternative to hospital emergency departments or inpatient psychiatric hospital units.

While BHDD has successfully implemented two statewide crisis call centers and a statewide mobile crisis team program, there are still many opportunities for improvement related to Crisis Receiving and Stabilization Facilities (CRSFs). Currently, BHDD operates two CRSFs. SC's two CRSFs are operated by the BHDD Charleston Dorchester Mental Health Center (CDMHC) on SC's east coast, and the BHDD Columbia Area Mental Health Center (CAMHC) in the central part of the state.

1. Tri-County Crisis Stabilization Center at Charleston Dorchester Mental Health Center (CDMHC):

The Tri-County Crisis Stabilization Center (TCSC) is operated by the Charleston Dorchester Mental Health Center (CDMHC). Established in 2017, TCSC is a 10 bed, voluntary, short-term facility for adults, with the primary focus of stabilizing psychiatric symptoms. The target population is people who are experiencing symptoms significant enough that they need more than outpatient services can provide, but not quite to the level of inpatient treatment. Many of these individuals have historically ended up in the local EDs, and this program is designed to route them to a more appropriate level of care, when possible. For someone to be admitted to the unit, they must be experiencing psychiatric symptoms, willing for admission and participation in treatment, medically stable, and able to perform ADLs. Patients can have co-occurring substance use disorders, but can't currently be under the influence of substances or in need of medical detox. The staff consists of masters prepared clinicians, bachelor's level clinicians, a nurse on each shift, and a psychiatrist who rounds on the facility each morning and is available by phone 24/7. The treatment services consist of group therapy, individual therapy, nursing services, assessment for medications by a psychiatrist, and psychosocial rehabilitation services. Since the average length of stay is 3-5 days, the clinical programming is intensive and requires patient participation throughout the day. We focus on what led to their current crisis, how to stabilize their symptoms, and how to set up skills and support systems to prevent this sort of crisis in the future. A part of this support system includes linking them to follow-up with the appropriate outpatient treatment when they are discharged.

2. Midlands Crisis Stabilization Unit:

The Midlands Crisis Stabilization Unit (MCSU) is operated by the Columbia Area Mental Health Center (CAMHC). Opening its doors in August 2025, MCSU is a 9-bed, voluntary, short-term facility for adults, with the primary focus of stabilizing psychiatric symptoms. The target population is people who are experiencing symptoms significant enough that they need more than outpatient services can provide, but not quite to the level of inpatient treatment. Many of these individuals have historically ended up in the local EDs, and this program is designed to route them to a more appropriate level of care, when possible. For someone to be admitted to the unit, they must be experiencing psychiatric symptoms, willing for admission and participation in treatment, medically stable, and able to perform ADLs. Patients can have co-occurring substance use disorders, but cannot currently be under the influence of substances or in need of medical detox. The staff consists of masters prepared clinicians, bachelors level clinicians, a nurse on each shift, and a psychiatrist who makes rounds in the facility each morning and is available by phone 24/7.

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

Facilities Similar to CRSFs:

BHDD also operates three programs that meet many, but not all, of the criteria for CRSFs. Because these programs do not provide 24/7 services, they are not categorized as CRSFs.

1. The Eubanks Center at Spartanburg Area Mental Health Center (SAMHC):

Named after the late Judge Ray C. Eubanks Jr., this program presents a supportive "living room" drop-in center where individuals experiencing heightened mental health symptoms can receive immediate peer support assistance. Established in 2019, the center is staffed and operated by BHDD OMH's Spartanburg Area Mental Health Center (SAMHC) in space donated by the Spartanburg Regional Healthcare System. The program has shown to be an effective alternative to emergency department visits for mental health crises. The Eubanks Center: provides individuals with mental illnesses an additional support system outside of clinical settings, and includes Peer Support Specialists, a clinician, and a care coordinator who works in conjunction with SAMHC's CCBHC pilot program. The Peer Living Room is uniquely designed to reduce the stigma of getting support for mental health symptoms by providing services in a home-like setting for anyone in the community, age 16 and older. Services are provided by certified peer support specialists. These specialists are active in their own mental health recovery and certified to provide support through strength-based approach. Hope, empathy, and respect are some of the guiding principles modeled at the Peer Living Room. These peer-to-peer interactions provide a safe place in times of mental health crisis. The program offers relapse prevention through individual and group appointments.

2. The CAFÉ through Project FOCUS (Family Options in Cherokee, Union, and Spartanburg Counties) at Spartanburg Area Mental Health Center (SAMHC):

Project FOCUS is a program that serves children and youth, ages 0-21, who have a serious emotional disturbance (SED). Their families are also served by this program. Project FOCUS provides services in three contiguous counties: Cherokee, Union, and Spartanburg. The Child and Family Engagement Center (CAFÉ), located in Spartanburg County, serves as a crisis diversion location for Project FOCUS. This location was where the greatest need was identified, based on the numbers of children that were often waiting in the hospital due to behavioral health crises. Along with crisis intervention services, the CAFÉ provides screenings, assessments, individual and group therapy, intensive in-home services, respite services, peer support and family/parental peer support services for children and youth ages 0-21 along with their families. The CAFÉ (Child, Adolescent, and Family Engagement Center) promotes the FOCUS project mission to provide culturally competent, evidence-based practices while ensuring meaningful participation from patients and their families. FOCUS aims to serve children, youth, and their families from diverse backgrounds and improve overall behavioral health outcomes for patients with SED who are experiencing crises. FOCUS clinicians are trained in a variety of Evidence Based Practices (EBPs) such as Motivational Interviewing, Cognitive Behavioral Therapy (CBT), Trauma-Focused CBT, Attachment Bio-Behavioral Catchup (ABC) and Multidimensional Family Therapy (MDFT) and Parent-Child Interaction Therapy (PCIT). These services are also accessible in the Cherokee and Union locations. The first floor of the CAFÉ, referred to as the Eubanks Center, is where nursing services are provided for those who may walk in. Telehealth services are also available for those in the Cherokee and Union areas. Services provided on the first floor include a comprehensive assessment, initial medication regime, and regular monitoring visits for medication. The array of services provided via the FOCUS project positively impact the lives of children, adolescents, and their families in the upstate region in South Carolina.

3. The Living Room program (LRP) at Aiken Barnwell MHC (ABMHC):

This program is designed as a response to community needs for mental health services outside of emergency room settings. The LRP will be for individuals in need of a crisis respite program with services and support designed to proactively divert crises and break the cycle of psychiatric hospitalization. The LRP will provide a safe, inviting, home-like atmosphere where individuals can calmly process crisis events as well as learn and apply wellness strategies to help prevent future crisis events. Hope, empathy and respect are some of the guiding principles modeled at the Peer Living Room. Staffing for this program includes a mental health professional, a peer support specialist, and a care coordinator.

2025 Block Grant Crisis Services set-aside funding was allocated to support this program. ABMHC began serving patients in July 2026.

Additional "Somewhere to Go" Initiatives:

In addition to the three non-CRSF facilities discussed above, South Carolina also has several emergency options for people who are experiencing crises.

Emergency Department Specialized Behavioral Health Units:

In June 2023, the South Carolina Department of Health and Human Services (SCDHHS) announced that it was awarding one-time infrastructure grants worth more than $45 million to 13 hospitals throughout the state. These grants resulted in the establishment of specialized behavioral

health units to respond to individuals who experience behavioral health crises. These units are based on a “no exclusion” philosophy and will be designed to have environments that feel calm and safe. The units must adhere to an Emergency Psychiatric Assessment, Treatment & Healing (EmPATH) philosophy. The units provide 24/7 services and are staffed by multi-disciplinary teams. Twelve of the hospitals below have operational EmPath units:

• AnMed Health Medical Center
• Beaufort Memorial Hospital
• Leatherman Center
• Hampton Regional Medical Center (to open later)
• 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

BHDD already partners with 11 of these 13 hospitals, and looks forward to collaborating with the hospitals when their EmPath units are launched.

Hospital Transportation Program:

Several years ago, the South Carolina General Assembly directed BHDD to create a program using a private contractor as an alternative to law enforcement for the transport of non-violent adult patients who have been determined by a licensed physician to need an involuntary emergency psychiatric hospitalization. The program covers the entire state of South Carolina, and patient transports are available 24/7. Since the inception of the program in September of 2022, more than 6,000 patients have been successfully transported.
Patients who meet the following criteria can be transported:
• The patient is being hospitalized for initial emergency psychiatric treatment.
• The patient is an adult (18 years of age or older)
• The patient has been medically cleared
• The patient is non-violent (drivers do not restrain the patients like law enforcement)
• The patient is not an elopement risk
• The patient is ambulatory and able to get into and out of a vehicle on their own
• The patient is not oversized (excessive height/weight may impact patient comfort and safety)

Unmarked vehicles are designed for safe and secure transports of adult patients. These vehicles have secure patient compartments that allow patients to be transported without restraints. Camera systems allow drivers to monitor the patients during the transports. The cameras record both patients and drivers during transport. The vehicles are also equipped with secure storage area for patients’ belongings. All of the drivers have received extensive trainings on mental health topics, including de-escalation strategies. The drivers are hand-selected to work on this program; they understand their role is to provide transportation safely and respectfully for people who are experiencing crises.

Patients who do not meet the above requirements may require law enforcement or non-emergency ambulance transport. The program reduces the use of law enforcement’s limited resources and time unless unequivocally required.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to	☐	☐	☐	☐	☐	☑

contact						
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to be	☐	☐	☑	☐	☐	☐

3. Briefly explain your stages of implementation selections here.

Stage 1: Someone to Talk To:

This stage is at the "program sustainment" level. Individuals, families, and first responders throughout the state, in every county, are able to quickly and easily reach out for support during crises.

From July 2025 through April 3, 2026, the Mobile Crisis Call Center received 9,102 crisis calls. The center received an additional 16,974 calls that were not related to mental health crises. Due to an upgrade of the electronic health record, data for April 4- June 30, 2026 was not available at the time of the report.

Between July 2025 and June 2026, the state 988 Centers received 59,812 routed calls, and answered 50,771 calls, with an average answer rate of 84.88%.

Stage 2: Someone to Respond:

This stage is at the "program sustainment" level.

Throughout the state, in every county, BHDD OMH Mobile Crisis teams are ready to be deployed to respond to a variety of crises. The program has achieved sustainment as it has been fully operational and implemented statewide since summer 2019. Quality assurance protocols are in place for auditing purposes. A four-year SAMHSA for Community Crisis Response Partnerships supports the participation of Certified Peer Support Specialists on Mobile Crisis teams in ten counties: Aiken, Anderson, Chesterfield, Laurens, Newberry, Greenwood, Edgefield, McCormick, Abbeville, and Saluda. These counties were chosen due to high suicide rates in the counties, as well as other health disparities.

From July 2025 through June 2026, Alliance staff members worked with 35 first responder agencies, responded to 8,143 calls for service, and assisted 4,655 people in crisis (unduplicated).

From July 2025 through June 2026, FRST clinicians provided 4,815 services to 3,253 first responders, many of whom were in crisis, at risk of crisis, or at risk of developing PTSD or other serious mental illnesses. This includes therapy sessions, critical incident stress debriefings, crisis support and post critical incident seminars.

Stage 3: Somewhere to Go:

This stage is still at the "early implementation" level, with fewer than 25% of counties benefiting from the services provided through Crisis Receiving and Stabilization Facilities (CRSFs). However, there are other places for people in crisis to seek assistance.

Tri-County Crisis Stabilization Center (TCSC) at Charleston Dorchester Mental Health Center (CDMHC): From July 2025 through March 2026, 546 people (unduplicated) sought help or were referred to the program. 270 patients (unduplicated) were admitted and received services from the program. 98 patients received emergency assessments and then were referred to other services at CDMHC. 268 admitted patients were diverted from emergency departments. Due to an upgrade of the electronic health record, data for April-June 2026 was not available at the time of the report.

Midlands Crisis Stabilization Unit at Columbia Area Mental Health Center (CAMHC): CAMHC began serving patients in August 2025. There were 27 patients referred and 8 unduplicated patients served from August 2025-July 2026. 7 patients were able to receive services after discharge at CAMHC.

The Living Room program (LRP) at Aiken Barnwell MHC (ABMHC): ABMHC opened the doors to this program to begin serving patients in July 2026. This is not a CRSF.
From October 2024 – September 2025, emergency departments responded to 78,721 visits from patients diagnosed with mental, behavioral, and neurodevelopmental disorders. The number of duplicated or unduplicated patients is unknown. This data was provided by the SC Revenue and Fiscal Affairs Office.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

SAMHSA's National Guidelines for Behavioral Health Crisis Care outline minimum expectations to ensure that crisis services will be provided for "anyone, anywhere and anytime." BHDD 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 recommended by SAMHSA:
A. Regional Crisis Call Center
B. Crisis Mobile Team Response
C. Crisis Receiving and Stabilization Facilities

A. Regional Crisis Call Center:

SAMHSA recommends that regional crisis call centers should be staffed 24/7, provide telephonic, text, and chat services, offer quality coordination of crisis care in real time, and meet the National Suicide Prevention Lifeline standards for risk assessment and engagement with people who are at risk of suicide.

The South Carolina Mobile Crisis Call Center (MCCC), which is operated by the BHDD Charleston Dorchester Mental Health Center (CDMHC). First implemented in 2020, MCCC assists individuals statewide and communicates with community mental health centers in all 46 counties to assist with triage and emergency assessment. The call center's responsibility is to triage calls, attempt to de-escalate callers in crisis, and dispatch MC teams to mental health crises which are unable to be de-escalated and require after-hours response. If immediate response is needed, the call center will also call local emergency services dispatch for individuals across the state to request first responders to respond so individuals can be stabilized until Mobile Crisis teams are able to arrive on scene. In addition to those responsibilities, MCCC also assists with providing callers with information regarding resources in their community including alcohol and drug assistance programs, local mental health centers, referrals to 211, and referrals to suicide prevention lifelines. Hospitals and ERs throughout the state are also able to call and receive mental health history information, such as medication information and most recent appointments with a patient's psychiatrist or therapist for continuity of care purposes.

MCCC assists BHDD's MC teams by triaging calls, developing safety plans, diverting emergencies, and providing resources to individuals not needing immediate Mobile Crisis or emergency response. MCCC also acts as a bridge for communication between first responders and Mobile Crisis clinicians. First responders can contact the center 24/7 to triage calls, gather information, or request Mobile Crisis response.

In 2023, BHDD significantly expanded its services for crisis calls through the launch of a second 24/7 988 Suicide and Crisis Lifeline Center in South Carolina. Originally, there was only one 988 Center in the state; that center was operated by Mental Health America of Greenville County (MHAGC). The addition of BHDD's new 988 center, which is operated by operated by Charleston Dorchester Mental Health Center (CDMHC), means that significantly more South Carolinians were given the opportunity to communicate directly with 988 staff members and volunteers who live in South Carolina; this shared residency can provide emotional relief for some callers, because they know that the people they are communicating with are familiar with South Carolina's culture. Callers with SC area codes who are experiencing mental health or suicide crises are assisted by this center. Callers are provided with telephonic crisis intervention services. Third-party callers can also reach out to 988 when they are concerned about people who may need mental health or substance abuse resources in their area. The 988 center at CDMHC provides telephonic, chat, and text services. 988 callers are given the opportunity to participate in a 988-follow-up care program; if they choose this service, the 988 center will schedule follow-up calls with the callers. The follow-up calls will connect the participants to care and secondary referrals, as well as address any barriers to care through referral sources.

B. Crisis Mobile Team Response:

SAMHSA recommends that mobile crisis teams be available to reach people in a timely manner in their homes, workplaces, and other community-based locations. Minimum expectations for these teams include the provision of a credentialed clinician capable of assessing needs of the individual; the capability of a team to respond at any time and to where the person in crisis is (home, work, etc.); and the ability to connect individuals in need of a higher level of care through warm hand-offs and transportation coordination.

BHDD Mobile Crisis (MC) teams currently meet all three of these expectations. The two-person MC teams operate 24/7/365 in all 46 counties. They provide services in the community, and partner with local emergency departments, inpatient hospitals, and other community partners. In terms of the National Guidelines proposed best practices, the MC teams have begun to incorporate peers as team members. Due to the centralized nature of South Carolina's mental health system, the teams are able to offer next-day walk-in screenings for individuals who are stabilized in the community; these screenings help people get connected to outpatient services very quickly. The MC program also provides the following essential functions outlined in SAMHSA's National Guidelines: Triage/screening, assessment, de-escalation, peer support, coordination with additional medical providers or other resources, crisis safety planning, and follow-up services.

The MC teams work with the Mobile Crisis Call Center, as discussed in Section A above.

C. Crisis Receiving and Stabilization Facilities

SAMHSA has nine minimum expectations for Crisis Receiving and Stabilization Facilities (CRSFs): accept all referrals; provide assessment and support rather than requiring medical clearances; design services to address mental health and substance use issues; assess physical health needs; provide 24/7 services through a multi-disciplinary team; allow both walk-in and first responder drop-offs; have the capacity to accept all

referrals with few exceptions and a no-rejection policy for first responders; screen for suicide risks; and screen for violence risks.

The CRSF portion of BHDD's statewide crisis program still has many opportunities for improvement. Currently, BHDD OMH operates only two CRSFs, and the second one just opened its doors in July 2025. The Tri-County Crisis Stabilization Center is operated by Charleston Dorchester Mental Health Center (CDMHC) on the east coast of the state, and the Midlands Crisis Stabilization Facility, operated by the Columbia Area Mental Health Center (CAMHC), is located in the middle of the state.
Several other BHDD Community Mental Health Centers (CMHCs) are interested in establishing these types of facilities, but establishing new CRSFs depends on future funding opportunities.
The Eubanks Center and the Project FOCUS CAFÉ, which are operated by the Spartanburg Area Mental Health Center (SAMHC), are both located in the northwest corner of the state. These facilities meet almost all CRSF requirements, but they do not provide 24/7 services. Therefore, they are not categorized as CRSFs. The Living Room program (LRP) at Aiken Barnwell MHC (ABMHC), located in the southwest part of the state, is designed as a response to community needs for mental health services outside of emergency room settings. ABMHC began serving patients in July 2026.

South Carolina has 79 emergency departments spread across the state. Currently, there are twelve emergency departments that operate EmPATH units, which are behavioral health units to provide services to individuals experiencing behavioral health crises. One additional EmPATH unit is planned to open in the near future.
BHDD recognizes that the state's current CRSF services are limited, and it also recognizes the importance of providing these facilities to redirect people in crisis from emergency departments. In the future, BHDD OMH hopes to develop significantly more CRSF programs throughout the state. Ideally, every CMHC would have a CRSF. However, there are numerous logistical and financial challenges related to the development of these specialized programs. BHDD is experiencing an ongoing challenge related to workforce retention and expansion, and the development of new CRSFs is certainly affected by these workforce challenges. Nevertheless, BHDD leadership is actively involved in exploring the best possible ways to increase CRSFs, as well as other services designed to help individuals who are experiencing behavioral health crises. BHDD committed the majority of its 2024 Crisis Services Set-Aside funding to establish a new CRSF at the Columbia Area Mental Health Center (CAMHC) and to support ongoing operations for the CRSF at the Charleston Dorchester Mental Health Center (CDMHC). BHDD OMH plans to commit a large portion of its 2027 Crisis Services Set-Aside funding to support the new CRSF at CAMHC.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 2
   ii. Not in the suicide lifeline network: 1
b. Number of Crisis Call Centers with follow up protocols in place
   i. In the 988 Suicide and Crisis lifeline network: 2
   ii. Not in the suicide lifeline network: 1
c. Estimated percent of 911 calls that are coded out as BH related: 0

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 0
b. Integrated with public safety first responder structures (police, paramedic, fire): 0
c. Number that utilizes peer recovery services as a core component of the model: 0

Safe place to be

a. Number of Emergency Departments: 79
b. Number of Emergency Departments that operate a specialized behavioral health component: 12
c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 2

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

CCBHC Connections:
Two of the 16 CMHCs are using a CCBHC model. These two CMHCs (like all CMHCs) have 24/7 Mobile Crisis response teams. They also coordinate closely with the 988 Call Centers. The two CMHCs that use a CCBHC model are the Beckman Center for Mental Health Services (BCMHS) and the Spartanburg Area Mental Health Center (SAMHC).

Allocations:
The 2027 Crisis Services Set-Aside will fund the following BHDD OMH programs located throughout the state.
Crisis Receiving and Stabilization Facility (Columbia Area MHC): $445,694
Mobile Crisis Team (Greater Greenville MHC): $25,000
Justice-Involved Program Manager: $154,511
FOCUS CAFÉ (Spartanburg Area MHC): $415,594
Mobile Crisis Team (all CMHCs): unknown
Alliance Program (all CMHCs): unknown

Total Planned Allocations: $1,040,799

Program Descriptions for the Above Allocations:

Crisis Receiving and Stabilization Facility – at Columbia Area MHC
Funding for this program will include personnel expenses, training/professional development, and/or program supplies for CRSF staff members, as well as contracted providers.

Mobile Crisis Team – at Greater Greenville MHC:
Funding for this program will include personnel expenses, training/professional development, and/or program supplies for Mobile Crisis Team staff.

Justice-Involved Program Manager – FRST Program at Central Administration Office:
Funding for this program will include personnel expenses, training/professional development, and/or program supplies for the Justice-Involved Program Manager.

FOCUS CAFÉ – at Spartanburg Area MHC:
Funding for this program will include personnel expenses, training/professional development, and/or program supplies for FOCUS CAFÉ staff.

Mobile Crisis Teams – at Multiple CMHCs:
Funding for this program will include personnel expenses, training/professional development, and/or program supplies for Mobile Crisis team members at a variety of CMHCs. BHDD OMH does not yet know exactly which CMHCs will use block grant funding for its Mobile Crisis teams, or how much will be used.

Alliance Program – at Multiple CMHCs:
Funding for this program will include personnel expenses, training/professional development, and/or program supplies for Alliance staff members at a variety of CMHCs. BHDD OMH does not yet know exactly which CMHCs will use block grant funding for its Alliance program, or how much will be used.

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

No technical assistance is requested.

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

Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in **42 U.S.C. §300x-3** for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)

The draft FFY27 Mental Health Block Grant Application was made available to BHDD OMH leadership and the Planning Council chairperson for review. The draft application was then provided to all Planning Council members for a one-week comment period, prior to a one-week public comment period that began on August 24, 2026. See attached 2 comments received from Planning Council members by the end of their comment period. The draft 2026 Mental Health Block Grant Report was provided to all Planning Council members for review and comment in November 2025. No substantive comments were received during the comment period.

The Planning Council Chairperson submitted the attached letter of support for the FFY27 Mental Health Block Grant Application on behalf of the Council.

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan ○ Yes ○ No

b. State Report ○ Yes ● No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

Prior to April 2025, the state's designated mental health authority was the SC Department of Mental Health (SCDMH). The SCDMH leadership team planned and implemented community health treatment and recovery support services for people with SMI/SED.

In April 2025, the Governor of South Carolina signed Bill S.2 into law. This bill formed the SC Department of Behavioral Health and Developmental Disabilities (SCDBHDD). This new department is comprised of three offices: the Office of Mental Health (BHDD OMH), the Office of Substance Use Services (BHDD OSUS), and the Office of Intellectual and Developmental Disabilities (BHDD OIDD). The restructuring was designed as a system to promote more collaborative care for patients with multiple health challenges, including mental illnesses and serious emotional disturbances, substance use disorders, and/or intellectual or developmental disabilities. Over the next few years, this restructuring will undoubtedly change some of the ways that community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services are planned and implemented.

Following any new guidance from BHDD leadership, BHDD OMH leadership will continue to plan and implement community health treatment and recovery support services for people with SMI/SED.

See also the attached support letter from the South Carolina Mental Health State Planning Council Chairperson.

The Office of Substance Use Services (BHDD OSUS) is responsible for planning and implementing substance misuse prevention, SUD treatment, and recovery support services.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) (●) Yes ( ) No

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The primary duties of the South Carolina Mental Health State Planning Council are to review the state's Mental Health Block Grant application and report and make recommendations to BHDD; serve as advocates for people with mental illness, including adults with serious mental illness (SMI) and children and adolescents with serious emotional disturbance (SED); and monitor, review, and evaluate the allocation and adequacy of mental health services in the state (see attached South Carolina Mental Health State Planning Council Bylaws, specifically Article II).

Bimonthly Planning Council meetings provide a forum for members, including people in recovery, families, and other stakeholders, to engage with BHDD leadership and offer input on agency initiatives. Council meeting agendas include reports from BHDD leadership, including the BHDD OMH Director, Deputy Director of Community Mental Health Services, Deputy Director of Long Term Care, or their designees. Council members receive agency reports, including legislative updates and budget requests, and are provided the opportunity to ask questions and provide input. Council meetings also typically include presentations on programs serving individuals with SMI or SED that highlight agency partnerships and best practices. These presentations inform the Council of a variety of mental health services being provided and offer another opportunity for input.

Council members have advocated for individuals with SMI or SED on legislative issues related to mental health services in South Carolina, including participating in committee hearings.

See also the attached support letter from the South Carolina Mental Health State Planning Council Chairperson.

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

No technical assistance is requested.

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

Footnotes:

SOUTH CAROLINA MENTAL HEALTH STATE PLANNING COUNCIL

May 20, 2026

Minutes

Members Present

Amy Jolly	Eileen Schell	Aaron Brown
Carol Rudder	Ryan Chitwood	Candy True
Janie Simpson	Chief Michelle Mitchum	Nakeila Johnson
Chris Kunkle	Tray Stone	Angela Carroll
Beth Franco	Joan Herbert	Robert Bank
Deborah Blalock	Bill Lindsey	Teri Browne

Guests

Lauri Hammond	Troy Pharis	Janet Bell
Ana Garcia	David Burleson	Elysia Cochran
Tracy LaPointe	Melanie Gambrell	

Staff

Michele Murff
Megan Woodham

Documents Distributed

March 11, 2026 Minutes

May 20, 2026 Agenda

Approval of Agenda

Aaron Brown called the meeting to order at 10:04am.

On the motion of Beth Franco and seconded by Eileen Schell, the agenda was approved.

Approval of Minutes

On the motion of Beth Franco and seconded by Tray Stone, the minutes for March 11 were approved.

Welcome and Introductions

Everyone in attendance introduced themselves.

A Moment with Aaron Brown on Behalf of Mandy Halloran

Aaron Brown shared Mandy's message on the importance of people with lived experience sharing their perspective and expertise during these meetings.

Nomination for Vice Chair

Aaron Brown asked that members send nominations for Vice Chair to Stuart Shields.

Update from the Director of Office of Mental Health, Robert Bank

Dr. Robert Bank announced that this will be his last Planning Council meeting, as his retirement will be on June 1. The interim Office Director will be announced on Tuesday, May 26. Dr. Bank will be meeting with the Governor's

Office on Friday, May 29. The position has been posted as of May 19, 2026. Dr. Bank shared words of gratitude to the Planning Council members for their role in supporting Block Grant spending, as well as to the Executive Committee and Michele Murff and consumers for sharing their experience.

An Agency Director for BHDD has not been named as of May 20. The new Governor taking office in 2027 may lead to some changes in who will be director, as it is a cabinet position.

The House and Senate gave the three offices approximately $21 million total. Deborah Blalock shared that the House recommended $21 million while the Senate recommended $23 million. Neither recommendation funded 988. About $4.7 million was requested for 988 to replace the grant money that is ending September 2026 and to increase staffing towards answering at least 90% of calls in SC. The call volume has increased by 20% and chat/text is currently available at the Greenville call center but not at the Charleston call center. The House partially funded efforts related to the DOJ settlement such as increasing Mobile Crisis teams and Peer Support Services, but the Senate did not fund these efforts in their recommendation. Conference Committee are currently meeting to come to an agreement. The Sine Die resolution to work past the closing hour of the legislative session includes work on the budget. Money cannot be added but can be moved around from original recommendations. Ms. Blalock shared uncertainty about what will happen if 988 funding does not come from SAMHSA or the state.

Janie Simpson shared an idea to write a letter from the State Planning Council about 988 funding. Joan Herbert motioned that Aaron Brown write a letter to clearly state support and rationale to fund 988. Janie Simpson seconded. All in favor, none opposed.

Dr. Bank praised OMH staff's ability to continue offering services in the face of change.

Aaron Brown shared appreciation for Dr. Bank and his experience working with him. There was time for comments and questions. Joan Herbert praised Dr. Bank's contributions as Acting Director and his focus on the people who are served by the agency. Janie Simpson thanked Dr. Bank for his compassion and commitment to people with mental illness. Bill Lindsey thanked Dr. Bank for his role as a partner and friend of the National Alliance on Mental Illness (NAMI) and of Mr. Lindsey. Eileen Schell shared appreciation for Dr. Bank.

Community Mental Health Services Update, Deborah Blalock

Deborah Blalock gave an update on Assertive Community Treatment (ACT) teams at 13/16 centers with current recruitment efforts to meet requirements for team sizes and staffing. Coastal Empire, Anderson Oconee Pickens, and Tri-County do not have enough patients that meet the requirements to participate in ACT. These centers are constantly monitoring the number of patients who would need ACT level of care. ACT is second highest community-based level of care. Crisis Stabilization Units (CSU) are the highest. ACT teams meet a variety of serious mental health needs. To meet fidelity of the model, small teams can support a maximum of 50 participants. Large teams can support 111. There is an internal minimum of 30 participants before OMH will sanction the creation of a team to account for costs. There was discussion of the requirements to join ACT, which includes that consumers must agree to participate because the treatment is rigorous.

Ms. Blalock shared that the Charleston 988 call center has answered over 52,000 calls since June 2024 and shared a graph that shows suicide deaths by youth are dropping since the launch of 988. The referenced article is in Journal of the American Medical Association.

Every mental health center (MHC) is hiring a masters prepared clinician to work with individuals with intellectual and developmental disabilities (IDD) as a result of the merger. Some centers have already identified individuals for hire. Four MHCs are hiring individuals to work with all detention centers in their region. There will be four regions based in Charleston, Horry, Spartanburg, and Catawba. The staff will work from the center but will work with the OMH Forensics team. CMHS is working with county authorities for alcohol and drug services to better treat

individuals with both substance use and mental health disorders. Fairfield may be embedding across the authority and MHC, co-location is already happening in some other counties to bolster the “No Wrong Door” system. OMH is submitting 16 grants to SC Department of Health and Human Services (DHHS) for rural health transformation. The applications are related to expanding community knowledge and use of Mobile Crisis. Two centers are also submitting to expand Highway to Hope and ACT team. Grant submissions are due June 1.

Deborah Blalock shared kind words about Dr. Bank and his steadiness and reminder that the patients matter more than a name or a physical office location during this time of change. CMHS is grateful for Dr. Bank and excited for him to start this new journey. Dr. Bank praised Ms. Blalock’s enthusiasm for meeting patients where they are by creating and expanding programs, which has helped people put their worries aside while working on these projects.

There was time for questions. Ms. Blalock gave more information about the Highway to Hope program. There was discussion of options to fund 988, which include a grant Notice of Funding Opportunity (NOFO) projected to be posted on May 29 or using agency reserves to cover for one fiscal year, but the final decision would not be made by Dr. Bank or Ms. Blalock. Dr. Bank shared that there seems to be support from the Governor’s Office to use agency reserves to maintain current operation of 988.

Inpatient Services Update and Longterm Care, Robert Bank

Dr. Bank shared an update on funding strategies to work towards a balanced budget. Expansion of inpatient services will likely be needed in the future, especially in Forensics. There are current efforts, as mentioned by Ms. Blalock, to get people out of detention centers and into community treatment, which supports Forensics’ efforts. Forensics staff are providing public education and working to expedite low level charges. Facilities at Bryan are aging and will need physical plant investments going forward. Harris Hospital is an option for expanding, as it is in fair shape, but Harris has smaller workforce because Anderson is more rural.

Dr. Bank gave an update on transition efforts from Bryan to the Nursing Home. A majority of the patients have a significant psychiatric or neurological disorder that lead to behavioral concerns that may require medication, which many nursing homes are not capable of providing.

The youth Psychiatric Residential Treatment Facility (PRTF) is a 24-bed unit run by a contractor. Patients have been admitted. There have been difficulties due to intensive staffing and security needs, so census has been about 6-8 patients with efforts to fine-tune staffing. OMH will continue working with the Department of Juvenile Justice (DJJ) to support youth with mental health disorders and behavioral challenges.

The Transitions team has worked to get support in place for patients prior to discharge, so the length of stay after patients have been identified for discharge has been 3-6 months as opposed to 2.5 years with very few patients returning to inpatient because they have supports in the community when they leave the facility.

There was time for questions.

Assertive Community Treatment (ACT), Troy Pharis, DHSc, LPCS, LACS

Troy Pharis is the ACT Team Lead for Columbia Area Mental Health Center (CAMHC), the largest team with about 84 participants. Mr. Pharis gave an overview of ACT and discussed the parameters for participants. Their primary focus is on high-need factors like food and housing and on engagement with participants. He discussed funding challenges and requirements. Mr. Pharis also went over criteria for discharge.

There was time for questions following Mr. Pharis’s presentation. Topics included substance use and dual diagnosis, discharge to inpatient services, crisis situations, and billing.

Announcements

Tray Stone with NAMI Mid-Carolina shared that their walk is 9am-1pm on June 6 at Moore Park in Irmo. They've raised about $36,140 with 229 walkers.

Carol Rudder has a team called Chris's Champs for the NAMI Mid-Carolina walk.

Eileen Schell with Mental Health America of South Carolina (MHASC) shared that the Thriving in Recovery Peer Support conference will be Friday, September 18.

Bill Lindsey with NAMI shared that their state conference is September 3 at R2I2 in Columbia. One of their Keynote Speakers is the NAMI National Head of Policy.

Chief Michelle Mitchum shared that Pine Hill went to Washington D.C. for a community-based workforce congressional briefing to support mental health services for First Responders and last week did a presentation for region 4 Public Health Institute.

David Burleson introduced himself as the incoming Executive Director for MHASC. Janie Simpson noted that non-profits on the Council are usually represented by their Executive Director.

Old Business/New Business

There was no old business.

There was no new business.

Public Comment

There was no public comment.

Adjournment

On the motion of Tray Stone and seconded by Bill Lindsey, the meeting was adjourned at 11:49am

The next meeting of the State Planning Council will be held virtually on Wednesday, July 15, 2026 from 10:00AM – 12:00PM.

South Carolina Mental Health State Planning Council

August 14, 2026

Christopher D. Carroll, MSc
Principal Deputy Assistant Secretary
for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, MD 20857

Dear Christopher Carroll,

The South Carolina Mental Health State Planning Council has reviewed this application. We have been monitoring and evaluating Community Mental Health Services this past year.

At every meeting, we are given updates by the Director of the Office of Mental Health (OMH) and the Deputy Director of Community Mental Health Services (CMHS). They share an overview of what has been happening throughout the Office. We ask questions and request specific information at every meeting. If a question is asked that a member of senior management does not know, that information is later emailed to the entire council.

At our meetings we have presentations about different community mental health programs. We are able to ask about metrics used in these programs and outcomes. We are impressed by their effectiveness. Many times, the council members have specific data questions that are later sent out in email.

This past year we had the following presentations:

- Certified Community Behavioral Health Clinics (CCBHC)
  Tacey Perillo, Executive Director of Beckman Center for Mental Health, gave a presentation on the purpose of the CCBHC, which integrates primary care services, and the mental health staff involved in the clinic, as well as community partnerships. Madeline Birk, the CCBHC Program Coordinator, reviewed warm handoffs, primary care, and program data. Tacey noted that Beckman had 146 primary care referrals and 405 follow-up visits. Patients are coming back to the clinic and utilizing this model of care as evidenced by the number of follow-up visits. Spartanburg is also a test pilot for CCBHC. Beckman and Spartanburg are

collaborating to share resources. This program is open to anyone at the Mental Health Center regardless of their ability to pay.

- Assertive Community Treatment (ACT)

  Troy Pharis is the ACT Team Lead for Columbia Area Mental Health Center (CAMHC), the largest team with about 84 participants. Mr. Pharis gave an overview of ACT and discussed the parameters for participants. Their primary focus is on high-need factors like food and housing and on engagement with participants. He discussed funding challenges and requirements. Mr. Pharis also went over criteria for discharge. Further topics included substance use and dual diagnosis, discharge to inpatient services, crisis situations, and billing services.

- Patient Affairs and Family Peer Support

  Jeffrey Gage gave an overview of his role as the Patient Affairs Coordinator with OMH and the Family Peer Support Initiative. Mr. Gage participates in center Patient Advisory Board meetings to share feedback with the centers, supports peer support staff, and manage additional special projects. Projects include the CIT card initiative being used by 9 of 16 OMH Mental Health Centers. People with Mental Illness can keep the cards on hand to give to law enforcement if they are in crisis. Family Peer Support focuses on the caregiver to support them in navigating new diagnoses. South Carolina will be the first state in the country to offer a certification for Family Peer Support Services – Adult Caregiver (FPSS – AC), and OMH is developing the curriculum with SC SHARE. OMH will serve as the certifying body and will conduct train-the -trainer sessions approximately one year after the initial training. OMH is also engaging with Medicare/Medicaid to explore reimbursement for services. Family Peer Support Services – Youth Caregiver (FPSS – YC) currently has other agencies engaging in this practice, but there are not any statewide certifications. OMH is reviewing several curricula to determine qualification for certification. OMH will be the sole certifying body for the state.

- Family Testimony

  The Council had a heartfelt testimony from a family member on the Council, Carol Rudder. Carol Rudder gave a moving testimony about her son Chris to the Council. Ms. Rudder shared her experience as a mom and some key moments in her son's life and mental health journey. She talked about being kept out of the loop in her son's care and doctors dismissing him when they learned about his diagnosis of Paranoid Schizophrenia. Ms. Rudder found support with the National Alliance on Mental Illness (NAMI) after her husband's passing and became a teacher with Family for Family. With the knowledge she gained from NAMI, Ms. Rudder advocated for her son's needs to help him find consistent care and helped Chris navigate his appointments. Chris passed away in 2000 from physical side effects of

his medications, which all caused dry mouth and constipation, and Ms. Rudder now advocates for physical health monitoring to be a part of the treatment plan for mental health patients

Our September 2026 presentation will be by the Program Director for Justice Involved Services. We are excited to learn how individuals with mental illness are being helped with their criminal justice issues.

We are a passionate council and are grateful for all the support we are given by the Office of Mental Health. We will continue to monitor and evaluate services, advocate for children and adults with mental illness, and evaluate the Block Grant application.

Council members participated on the Request for Proposals (RFP) committee to decide what nonprofits would receive funding from the Block Grant. That process is still ongoing.

Thank you,

Aaron M. Brown, LMSW

Chairperson
SC Mental Health State Planning Council

From: Megan Woodham
To: Liza Watson
Cc: Michele Murff
Subject: FW: [EXTERNAL] Re: Feedback for 2027-2028 CMHS Block Grant Application
Date: Tuesday, August 18, 2026 1:19:43 PM

Good afternoon Liza,

Please see the below comments from Candace True, a member of the State Planning Council.

Thank you,
Megan Woodham, M.T.
Suicide Prevention Program Coordinator I
Office of Mental Health

South Carolina Department *of* Behavioral Health and Developmental Disabilities
State of South Carolina Health Campus
400 Otarre Parkway, Cayce, SC 29033
Office: 803-898-2461
megan.woodham@omh.bhdd.sc.gov

Visit BHDD online at bhdd.sc.gov. Our email address has also changed. Please update your bookmarks and contact information.

From: janie simpson <janebsimpson@yahoo.com>
Sent: Tuesday, August 18, 2026 1:12 PM
To: Candace True <cltrue613@yahoo.com>
Cc: Megan Woodham <megan.woodham@omh.bhdd.sc.gov>
Subject: [EXTERNAL] Re: Feedback for 2027-2028 CMHS Block Grant Application

You're funny! You have a doctorate. Lol.

I'm copying Megan on your comments so she can send them to Liza.

Thank you for reading through it, Candy!

On Tue, Aug 18, 2026 at 1:09 PM, Candace True <cltrue613@yahoo.com> wrote:

> Janie,
>
> I have read through a lot of this in small 'chunks'. It all looks good. Sometimes it gets like reading legal documents- I figure if it is above my reading level it is correct.
>
> Dr. Candace True, DMA,
> Executive Manager, Armed Services Veterans Band
> Manager, Die Lustigen Musikanten
>
> > On Aug 18, 2026, at 10:56, janie simpson <janebsimpson@yahoo.com> wrote:
> >
> > Hi, All!
> >
> > I hope everyone is having a good day!
> >
> > It is very very important that we, as a Council, give feedback on this application. I know it can seem long and overwhelming, but it is broken down into parts.
> >
> > There is an index that tells you what each section is about. Lots of the pages are graphs and tables - so it's not a whole lot of thick blocks of texts.
> >
> > Please take time to look through the application this week and give feedback
> >
> > Thanks!
> > Janie
> >
> > On Mon, Aug 17, 2026 at 3:46 PM, Megan Woodham <megan.woodham@omh.bhdd.sc.gov> wrote:
> >
> > > Good afternoon,

The application has been updated. Please use the following link: https://bhdd.sc.gov/sites/bhdd/files/2026-08/2027%20Block%20Grant%20Application%20-%20DRAFT%20FOR%20REVIEW%208.17.26.pdf in place of the one sent out this morning.

Thank you!

Megan Woodham, M.T.

Suicide Prevention Program Coordinator I

Office of Mental Health

South Carolina Department *of* Behavioral Health and Developmental Disabilities

State of South Carolina Health Campus

400 Otarre Parkway, Cayce, SC 29033

Office: 803-898-2461

megan.woodham@omh.bhdd.sc.gov

Visit BHDD online at bhdd.sc.gov. Our email address has also changed. Please update your bookmarks and contact information.

From: Megan Woodham
Sent: Monday, August 17, 2026 8:56 AM
To: Aaron Brown <abrown@scshare.com>; Alicia Day (amday@email.sc.edu) <amday@email.sc.edu>; Amy Jolly

<Ajolly@workinprogresscolumbia.com>; Ana Garcia <Ana.Garcia@schousing.com>; Angela Anderson <angela.anderson2@omh.bhdd.sc.gov>; Beth Franco <Franco@disabilityrightssc.org>; Beverly Griffin <beverly.griffin@fedfamsc.org>; Bill Lindsey <bill.lindsey@namisc.org>; Bonita Shropshire <bonita.shropshire@omh.bhdd.sc.gov>; Candy True <Cltrue613@yahoo.com>; Carol Rudder <crudder@sc.rr.com>; Carol Rudder <carolrudder7@gmail.com>; Carroll, Angela; Charity Williams <devotedarts1@gmail.com>; Chief Michelle Mitchum <mmitchum@phhn.org>; Chris Allen <Cjallen123@gmail.com>; Chris Allen <Christopher.j.allen2.civ@army.mil>; Chris Kunkle <Kunkle.chris@doc.state.sc.us>; Cindy Smith <Cndysmth57@gmail.com>; David Burleson (dburleson@mha-sc.org) <dburleson@mha-sc.org>; Deborah Blalock <deborah.blalock@omh.bhdd.sc.gov>; Donna M Strickland <donna.strickland@omh.bhdd.sc.gov>; Elyisa Cochran (elyisa@email.sc.edu) <elyisa@email.sc.edu>; Erin Bramlitt <erin.bramlitt@omh.bhdd.sc.gov>; Erin Laughter <erin.laughter@omh.bhdd.sc.gov>; Ernest Lathrop <ELathrop@scvrd.net>; Hannah Bonsu <hbonsu@daodas.sc.gov>; Hariett Abner <habner@scvrd.net>; Jamie Chrisman <Jamie.Chrisman@favorpiedmont.org>; Janie Simpson <janebsimpson@yahoo.com>; Jeffrey Gage <jeffrey.gage@omh.bhdd.sc.gov>; Jessica Suber <jessica.suber@omh.bhdd.sc.gov>; Joan Herbert <herbertj1112@hotmail.com>; John Kendall <Jkendall8810@gmail.com>; Kate Brunnelson (kateb@namipiedmont.org) <kateb@namipiedmont.org>; Kim Ballentine <kim.ballentine@omh.bhdd.sc.gov>; Kimberly Rudd <kimberly.rudd@omh.bhdd.sc.gov>; Krystle Gay <Krystle.Gay@prismahealth.org>; Latoya Abney <LABNEY@SCVRD.NET>; Lauri Hammond <lauri.hammond@scdhhs.gov>; lgpearce2@gmail.com; Lisa McCliment <lmccliment@ed.sc.gov>; Mandy Halloran (ahalloran.carolina@gmail.com) <ahalloran.carolina@gmail.com>; Maria Beth Smith <mbs29485@yahoo.com>; Marilla Copeland <marillacopeland31@yahoo.com>; Mattie Wolff (mkfuqua@email.sc.edu) <mkfuqua@email.sc.edu>; Melanie Gambrell <melanie.gambrell@omh.bhdd.sc.gov>; Melanie Hendricks; Michele Murff <michele.murff@omh.bhdd.sc.gov>; Nakeila Johnson <njohnson@scshare.com>; Nichole Lowder <lowder.nichole@doc.sc.gov>; Nikeya Chavous <Chavous.Nikeya@doc.sc.gov>; Renaye Long <renaye.long@schousing.com>; Robert White <rdwhite@namipiedmont.org>; Robin Crawford <robin.crawford@omh.bhdd.sc.gov>; Rochelle Caton <rochelle.caton@omh.bhdd.sc.gov>; Ryan Chitwood <jrc227843@gmail.com>; Samntka Miller (samantka@email.sc.edu) <samantka@email.sc.edu>; Shelina Flarisee <theskysurlimit@gmail.com>; Stuart Shields

<sjshields525@outlook.com>; Teri Brown <BROWNETM@mailbox.sc.edu>; Theresa Bishop <theresa.bishop@omh.bhdd.sc.gov>; Tracy LaPointe <tracy.lapointe@omh.bhdd.sc.gov>; Tray Stone <traystone@gmail.com>; Versie Bellamy <versie.bellamy@omh.bhdd.sc.gov>
Cc: Liza Watson <liza.watson@omh.bhdd.sc.gov>
Subject: 2027-2028 CMHS Block Grant Application
Importance: High

Good morning Planning Council members and guests,

Please see the below message from our Director of Grants Administration, Liza Watson. Please submit any comments to Liza by **noon on Sunday, August 23.** Let us know if you have any questions.

SC Mental Health State Planning Council Members and Guests –

The BHDD federal fiscal year 2027-2028 Community Mental Health Services Block Grant Application is now available for review and public comment on the agency web site: Home | BHDD | South Carolina Department of Behavioral Health & Developmental Disabilities.

Please note that this application serves as the Agency's Community Mental Health Services Block Grant State Plan, required by Public Law 102-321, for providing comprehensive community mental health services to adults with a serious mental illness and to children with a serious emotional disturbance. The completed application will also include the governor's designation letter and a letter of support from the planning council chair.

The report is available for review at this link: https://bhdd.sc.gov/sites/bhdd/files/2026-08/2027%20Block%20Grant%20Application%20-%208.13.26%20DRAFT%20FOR%20REVIEW.pdf.

Please send questions and comments to:

- Liza Watson, Director of Grants Administration
- Phone: (803) 898-8457
- E-mail: liza.watson@omh.bhdd.sc.gov
- Postal Mail: PO Box 485, Columbia, SC, 29202, Attn: Liza Watson

Comments on the application should be submitted by noon, Sunday, August 23, 2026.

Our Council Chair, Aaron Brown, received the application ahead of time to review.

Please let us know if you have any questions or need more information.

Thank you,

Megan Woodham, M.T.

Suicide Prevention Program Coordinator I

Office of Mental Health

South Carolina Department *of* Behavioral Health and Developmental Disabilities

State of South Carolina Health Campus

400 Otarre Parkway, Cayce, SC 29033

Office: 803-898-2461

megan.woodham@omh.bhdd.sc.gov

Visit BHDD online at bhdd.sc.gov. Our email address has also changed. Please update your bookmarks and contact information.

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From: Michelle Mitchum
To: Liza Watson
Subject: [EXTERNAL] Review Comments and Requested Corrections – FFY 2027–2028 Community Mental Health Services Block Grant Application
Date: Wednesday, August 19, 2026 12:04:32 PM

Good morning,

Thank you for the opportunity to review the draft FFY 2027–2028 Community Mental Health Services Block Grant application. After reviewing the application and comparing it with prior Block Grant materials, Planning Council records, and information previously presented to the Council, I identified several items that should be corrected, clarified, or documented before final submission.

I am currently attending a tribal health conference and am reviewing this application while participating in conference activities. Given the number and seriousness of the issues identified, I wanted to ensure these concerns were submitted within the Council's review period rather than delay them. I may provide additional comments if further issues are identified during my continued review.

1. Incorrect Planning Council classification and removal of original Native American/Indigenous representative role. I am currently identified solely as an "Individual in recovery." That classification is inaccurate and should be removed. I specifically provide Native American/Indigenous community representation, and prior Block Grant materials identified Pine Hill Indian Community Development Initiative as the organization represented. The current application should restore the original identification reflected in the earlier Block Grant rather than substitute an inaccurate lived-experience classification.

2. PHICDI/Pine Hill Health Network is omitted from the membership roster. The roster includes a field for "Agency or Organization Represented," yet my entry does not identify Pine Hill Indian Community Development Initiative or Pine Hill Health Network. That omission should be corrected.

3. Native American and Indigenous community representation is not accurately reflected. The application should distinguish between the federal category for representatives of federally recognized tribes and the Council's actual Native American/Indigenous community representation.

4. Pine Hill Health Network is omitted from the service-system narrative. PHHN's community-health and crisis-response programs, some funded entirely by SAMHSA, have been disclosed through my Council participation and through the Orangeburg Sequential Intercept Mapping process. These services should be considered when the State describes available community-based and rural behavioral-health capacity.

5. Indigenous community behavioral-health capacity is omitted. PHHN serves Indigenous communities as well as rural communities experiencing behavioral-health and emergency-

service access barriers. This capacity is relevant to statewide planning, representation, access, and system adequacy.

6. PHHN's first-responder mental and behavioral-health programming is omitted. PHHN has first-responder mental and behavioral-health programming supported through SAMHSA, including rural EMS and first-responder behavioral-health activities. These programs are relevant to the State's description of crisis response, rural mental-health services, workforce support, and first-responder behavioral-health capacity. Whether or not the State has directly supported these activities is irrelevant to whether they constitute existing behavioral-health capacity within South Carolina. The purpose of the application is to accurately describe the State's mental-health system and available resources, not only programs funded or operated by the State. For a SAMHSA Mental Health Block Grant application to fail to identify relevant SAMHSA-funded activities already operating within South Carolina creates an incomplete picture of available capacity and reflects negatively on the accuracy and coordination of the overall submission. That omission should be corrected before the application is finalized.

7. PHHN crisis resources are omitted. PHHN maintains mobile crisis response capability, text-based access, and a toll-free 800-number hotline. These resources should be reviewed for inclusion wherever the application describes crisis contact, mobile response, rural access, or community-based crisis capacity.

8. Community-based organization capacity appears underrepresented more broadly. The application primarily describes BHDD and CMHC resources. If the application is intended to describe the adequacy of the statewide mental-health system, known CBO capacity should also be reflected or the scope of the description should be clearly limited.

9. The Orangeburg SIM omission raises a related planning concern. PHHN was not appropriately included and is not reflected in the Orangeburg SIM resource description despite its service capacity being disclosed. I brought these concerns to Debbie's attention; however, our current Council bylaws do not appear to provide a defined process for bringing this type of system-level concern before the full Planning Council for review, discussion, and disposition. As I understand the Council's purpose, concerns regarding gaps in mental-health planning, service availability, and adequacy should be matters the Planning Council is able to formally consider. The same type of omission now appears to be carrying forward into the Block Grant narrative.

10. The application contains indications that prior-year grant language was carried forward without complete current-year validation. The incorrect SFY 2027 planning-period end date is one clear example, but it does not appear to be isolated. This and other sections of the application seem to simply regurgitate language, dates, classifications, program descriptions, and other information from past Block Grant applications without sufficient review to determine whether the information remains accurate for the current grant period. Given the number of discrepancies identified throughout the draft, I recommend a section-by-section review of all carried-forward material before final submission.

11. Table 6 contains a conflicting planning period. The table describes SFY 2027 as July 1, 2026 through June 30, 2027, but the populated dates are 1/1/2026 through 1/1/2027. These dates should be reconciled.

12. Table 6 reports $0 for Planning Council Activities, Partnerships/Community

Outreach/Needs Assessment, Quality Assurance and Improvement, and Research/Evaluation. If these activities are supported through other funding sources, the application should clarify that so the budget does not appear inconsistent with activities described elsewhere. Likewise, if any nonprofit subawards were made with Planning Council member involvement through an RFP or other review process, those activities and the related funding should be clearly identified in the appropriate section of the application. This is especially important where the Chair's letter references Council member participation in deciding which nonprofits would receive Block Grant funding.

13. ESMI funding amounts should be reconciled throughout the application. The final submission should use one consistent figure in all applicable sections.

14. PREP fidelity language appears inconsistent. The narrative says PREP hopes to add formal continuous fidelity monitoring this year, while another response indicates that fidelity is monitored. This should be clarified by program.

15. First-episode psychosis incidence remains unknown. The application acknowledges that the State has not calculated or tracked statewide FEP incidence. This is an important planning-data gap and should remain clearly disclosed.

16. The crisis-capacity narrative conflicts with the quantitative crisis table. The application states that all CMHCs have 24/7 mobile crisis response teams, while the quantitative section reports zero communities with independent mobile behavioral-health crisis capacity, zero integrated with public-safety first responders, and zero using peer recovery services as a core component. These entries require reconciliation.

17. The EmPATH counts are internally inconsistent. The narrative says 12 hospitals have operational EmPATH units, lists 13 hospitals including one described as opening later, and then states that BHDD partners with 11 of the 13. Operational, planned, and partnered sites should be separately and accurately counted.

18. The specialized behavioral-health emergency department count does not appear to align with the EmPATH narrative. One section reports nine emergency departments with specialized behavioral-health components while another describes a larger number of EmPATH sites. The definitions and counts should be reconciled.

19. The Aiken-Barnwell Living Room language appears outdated. The application says the program hoped to open in fall 2025 or January 2026. Those dates have passed. The application should state the program's actual current operational status.

20. The crisis set-aside allocation needs clarification. The four specified dollar amounts total the full crisis set-aside, yet Mobile Crisis at multiple CMHCs and the Alliance Program are also listed with "unknown" amounts. The funding source for those additional activities should be identified.

21. The application states that BHDD does not yet know which CMHCs will use Block Grant funding for Mobile Crisis and Alliance or how much will be used. This should be reconciled with the exact total planned allocation.

22. The application should distinguish statewide availability from local accessibility and

capacity. Statements describing a statewide system should not imply uniform local access where actual service availability varies by county or region.

23. The application acknowledges limited Crisis Receiving and Stabilization Facility capacity while other language may suggest a more mature statewide crisis system. These descriptions should be harmonized.

24. The full Council review chronology needs clarification. The Chair's letter is dated August 14, 2026 and states that the Planning Council "has reviewed this application," yet the current application was subsequently circulated to the broader Council for individual review and comments. Please identify the basis for the August 14 representation that the Council had already reviewed the application.

25. Email circulation for comments should not be treated as the same thing as formal Council deliberation or adoption. Providing members an opportunity to submit individual comments does not itself establish that the Council collectively approved every factual statement, conclusion, or representation contained in the Chair's letter.

26. The Chair's letter states that it was submitted on behalf of the Council. Please identify the Council authorization supporting substantive statements made on behalf of the full Council.

27. Placeholder text remains in the application. The draft still states, "See attached xxxx comments received…" This should be corrected before final submission. This response, including the corrections, concerns, and requests for clarification identified here, should be included in that section as part of the Planning Council comments received during the review period. In addition, if the application is materially updated or edited in response to Council comments or other review, we, the Planning Council, should be afforded a new opportunity to review the revised grant package before it is submitted to SAMHSA.

28. The public-comment chronology is written as though the August 24 public-comment period had already begun, although the draft was generated before that date. The tense and timing should be corrected and then updated after the public-comment period actually begins.

29. The application describes the Council as monitoring, reviewing, and evaluating the allocation and adequacy of mental-health services statewide, but the supporting description largely consists of presentations, agency updates, and opportunities to ask questions. The application should identify the actual methodology used by the Council to conduct an annual statewide adequacy evaluation.

30. No defined Council methodology for statewide adequacy review is identified. The application does not identify a clear assessment framework, metrics, geographic gap analysis, findings process, recommendation tracker, or annual adequacy determination.

31. No formal pathway is identified for a Council member to submit a specific system-level concern for Council review. There should be a mechanism for referral, evidence review, recommendations, agency response, and documented disposition.

32. The Orangeburg SIM issue demonstrates this governance gap. Administrative correspondence with BHDD staff concerning a system-level issue should not be treated as Planning Council review, evaluation, or disposition of that concern.

33. The statement that the Council has been monitoring and evaluating Community Mental Health Services during the past year should be supported by documented Council evaluation activity. Receiving presentations and asking questions is not automatically the same as conducting and documenting the Council's statutory evaluation function.

34. The Chair's statement that the Council is "impressed by" program effectiveness is a broad evaluative conclusion. The application should identify the metrics, outcomes, or Council action supporting that conclusion if it is to be attributed to the full Council.

35. The Family Peer Support certification discussion requires documentation. The Chair's letter describes the proposed Adult Caregiver certification, curriculum development, OMH certification authority, and reimbursement discussions, but the Planning Council records available to me do not clearly document the presentation or Council discussion supporting all of these representations.

36. The statement that South Carolina will be the first state in the country to offer this certification should be independently verified before submission.

37. The RFP/nonprofit funding statement requires substantial clarification. The Chair's letter states that Council members participated on an RFP committee "to decide what nonprofits would receive funding from the Block Grant."

38. Please identify the specific RFP committee and the Planning Council members who served on it. The March 11, 2026 minutes indicate that OMH Procurement planned to issue a Mental Health Block Grant RFP, and Council members were later asked to volunteer. I have not been provided a final committee roster.

39. Please identify the actual authority of that RFP committee. Participation by individual Council members in a review or scoring panel is not the same as the Planning Council as a body making final nonprofit funding decisions.

40. Please identify the scoring process, conflict-of-interest requirements, recusals, recommendation authority, and final award authority for the RFP process. This is particularly important because Council membership includes nonprofit providers, advocates, and organizational representatives.

41. The roster's "Agency or Organization Represented" field is incomplete for multiple members. The application should accurately identify represented organizations so that Council composition and required representation can be meaningfully evaluated.

42. The application answers "Yes" to whether Council membership is representative of the service-area population, but the current roster does not accurately reflect the Council's Native American/Indigenous representative role and does not clearly identify all organizational affiliations. That response should be reviewed.

43. Youth/adolescent representation should be reviewed. The current Council composition should be evaluated against prior recommendations concerning representation and youth-serving organizations.

44. SUD representation should also be reviewed in light of the BHDD structure and the

application's assertion that substance-use prevention, treatment, recovery, and co-occurring issues are successfully integrated into Council work.

45. Public-comment URLs are blank. The application says the plan is posted on the web for public comment but does not provide the requested URL or the prior-year final-plan URL.

46. The one-week public-comment period is very compressed. At minimum, the timeline should be accurately disclosed, and all comments should be preserved and addressed as required.

47. Planning Council comments and recommendations should be transmitted with the application regardless of whether BHDD accepts them. Please ensure these comments are included in the formal review record and are not omitted merely because the agency disagrees with any requested correction.

48. Several state-information and signature fields remain incomplete in the draft. These should be completed before final submission.

49. If the Acting Office Director signs as an authorized designee, the required designation documentation should be attached where applicable.

50. Minor statutory and editorial errors remain. Examples include "Substance Abuse and Mental Health Services Administrations" and "Tile 42." These should be corrected if the federal system permits editing.

51. The overall application should receive a complete current-year factual review before submission. Taken together, the outdated information, conflicting data, membership errors, unsupported Council-attributed statements, incomplete descriptions of community-based capacity, and other discrepancies raise concerns about whether all portions of the application have been independently reviewed and validated for the current grant period.

I appreciate the opportunity to review the application. Given the number of factual, technical, representation, and governance issues identified, I respectfully request that these matters be reviewed and corrected before the application is finalized.

Please treat this email as my formal Planning Council review comments and requested corrections. Where a statement is retained despite a concern identified above, I request that the supporting record, authority, or source be identified so that the Council record accurately reflects the basis for the representation being made to SAMHSA.

I also request that this response be included with the Planning Council comments submitted as part of the Block Grant application. If substantive changes are made to the application following this review, the Planning Council should receive the updated application and be afforded an opportunity to review the revised package before final submission to SAMHSA.

Because I am currently attending a tribal health conference and conducting this review around conference obligations, I reserve the opportunity to submit additional comments if further discrepancies are identified before the close of the review period.

Thank you,

Chief Michelle Mitchum, DrPH, MSCJ/Law, CMA, CHW, CBHS, CPSS, CPT, LC/CDC, CTPS in Native American Communities
EMT-B candidate, Lowcountry Regional EMS
Certified Rural Health Clinic Professional (National Association of Rural Health Clinics)
Indigenous Public Health Leadership, National Network of Public Health Institutes
Region IV Public Health Leadership, PHLI, Univ. of Georgia/Emory University
Ambassador of UofSC Center for Community Health Alignment
Indigenous Representative, SC Department of Mental Health Planning Committee
Executive Director,
Pine Hill Health Network
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O: (803) 247-2534
EFax: (833) 536-1811
C: (803) 662-3377
www.phhn.org

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2027 End Year: 2028

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
LaToya Abney	State Employees		1410 Boston Avenue West Columbia , 29172 PH: 803-896-4250	
Chris Allen	Advocates/representatives who are not state employees or providers		1225 Bluff Road Columbia SC, 29201 PH: 803-447-5094	christopher.j.allen2.mil@army.mil
Versie Bellamy	State Employees		220 Faison Drive Columbia , 29203 PH: 803-935-5761	versie.bellamy@omh.bhdd.sc.gov
Deborah Blalock	State Employees		400 Otarre Parkway Cayce SC, 29033 PH: 803-898-8348	deborah.blalock@omh.bhdd.sc.gov
Nakeila Bonner	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			njohnson@scshare.com
Hannah Bonsu	State Employees		400 Otarre Parkway Cayce , 29033 PH: 803-896-4198	hbonsu@osus.bhdd.sc.gov
Aaron Brown	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			abrown@scshare.com
Teri Browne	Advocates/representatives who are not state employees or providers		1512 Pendleton Street Columbia SC, 29208 PH: 803-777-6528	brownetm@mailbox.sc.edu
David Burleson	Advocates/representatives who are not state employees or providers		2201 Commerce Drive Cayce SC, 29033 PH: 803-920-1487	dburleson@mha-sc.org
Angela Carrol	State Employees		1535 Confederate Avenue Columbia , 29202 PH: 803-727-2935	
Ryan Chitwood	Individuals in recovery (including adults with SMI who are receiving or have			rchitwood@yourturnhealth.com

	received mental health services)			
Marilla Copeland	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			marillacopeland31@yahoo.com
Shelina Flarisee	Parents of children with SED			theskysurlimit@gmail.com
Beth Franco	Advocates/representatives who are not state employees or providers		3710 Landmark Drive Columbia SC, 29204 PH: 803-782-0639	franco@disabilityrightssc.org
Beverly Griffin	Parents of children with SED			beverly.griffin@fedfamsc.org
Mandy Halloran	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			mhalloran@able-sc.org
Melanie Hendricks	State Employees		1801 Main Street Columbia SC, 29201 PH: 803-898-1891	melanie.hendricks@scddhs.gov
Joan Herbert	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			herbertj1112@hotmail.com
Amy Jolly	Providers		2331 Devine Street Columbia SC, 29205 PH: 803-758-0066	ajolly@workinprogresscolumbia.com
John Kendall	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			jkendall8810@gmail.com
Chris Kunkle	State Employees		4444 Broad River Road Columbia SC, 29210 PH: 803-896-1238	kunkle.chris@doc.sc.gov
Erin Laughter	State Employees		400 Otarre Parkway Cayce SC, 29033	
Bill Lindsey	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			billlindsey@namisc.org
Renaye Long	State Employees		300-C Outlet Pointe Blvd Columbia SC, 29210 PH: 803-896-9292	renaye.long@schousing.com
Nichole Lowder	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			lowder.nichole@doc.sc.gov
Lisa McCliment	State Employees		428 Wholesale Lane West Columbia , 29172 PH: 803-734-4074	Lmccliment@ed.sc.gov
Michelle Mitchum	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			mmitchum@phhn.org
Kimberly Rudd	State Employees		400 Otarre Parkway Cayce , 29033	kimberly.rudd@omh.bhdd.sc.gov

			PH: 803-898-8319	
Carol Rudder	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			crudder@sc.rr.com
Stuart Shields	Advocates/representatives who are not state employees or providers		1099 Took Place Florence SC, 29505 PH: 843-992-8031	sjshields525@outlook.com
Janie Simpson	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			janebsimpson@yahoo.com
Cindy Smith	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			Cndysmth57@gmail.com
Maria Beth Smith	Parents of children with SED			mbs29485@yahoo.com
Tray Stone	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			traystone@gmail.com
Candy True	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			cltrue613@yahoo.com

*Council members should be listed only once by type of membership and Agency/organization represented.
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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2027 End Year: 2028

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	12	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	3	
3. Parents of children with SED	3	
4. Vacancies (individuals and family members)	0	
5. Total individuals in recovery, family members, and parents of children with SED	**18**	**51.43%**
6. State Employees	11	
7. Providers	1	
8. Vacancies (state employees and providers)	0	
9. Total State Employees & Providers	**12**	**34.29%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	0	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	5	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	**5**	**14.29%**
16. Total membership (all members of the council)	**35**	

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Footnotes:

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. §300x-51) requires, as a condition of the funding agreement for the grant, that states will provide an opportunity for the public to comment on the state Block Grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the federal government.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ● No

b) Posting of the plan on the web for public comment? ● Yes ○ No

If yes, provide URL:

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

d) Please indicate areas of technical assistance needs related to this section.

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Footnotes: