South Carolina – FY 2018-2019 Behavioral Health Assessment and Plan Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

The South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) is the Single State Authority for the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) that is administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), and Center for Substance Abuse Prevention (CSAP).

DAODAS is organized into 32 county alcohol and drug abuse authorities that have incorporated themselves as Behavioral Health Services Association of South Carolina Inc. (BHSA). The 32 county authorities have offices in each of the state's 46 counties, thereby ensuring the availability of core substance use services to all South Carolina residents. These services include traditional group, individual, and family outpatient counseling, post-discharge; Alcohol and Drug Safety Action Program (ADSAP), the state's DUI program; youth and adolescent services; and primary prevention/education programs. Service delivery emphasizes evidence-based practices and is supported by DAODAS quality assurance efforts. DAODAS has recently embraced implementation science frameworks for service-quality improvement efforts designed to encourage the provider system to measure clinician fidelity to evidence-based models.

Each county authority is licensed by the S.C. Department of Health and Environmental Control and accredited by CARF International or the Joint Commission. Licensing and credentialing of substance abuse counselors is regulated by State statute. This includes the requirement for certification of treatment counselors by the S.C. Association of Alcoholism and Drug Abuse Counselors (SCAADAC) and of prevention professionals by the S.C. Association of Prevention Professionals and Advocates (SCAPPA). There are no financial intermediaries between DAODAS and the county authorities, nor are there separate child and adult systems. DAODAS and the leadership of BHSA have a strong relationship and work closely to optimize the efficiency and effectiveness of services.

DAODAS reviews and approves the county authorities' yearly priorities through the submission of county plans, which aid in the collection of information able to describe county-level need and local provider efforts. These plans are structured in the SPF framework and focus on communicating county-level initiatives that influence priorities included in the State's Block Grant Application. The county authorities develop their priorities with input from local surveys, focus groups, advisory councils, and/or political entities that oversee them (either county governments or specially appointed commissions). All county authorities are required to develop and submit to DAODAS for approval at least one Primary Prevention Strategic Work Plan for each of the six CSAP-established primary prevention strategy areas. Development of the prevention work plan occurs through incorporation of the SPF model. The local county needs assessment process reflects gathering the data to demonstrate the needs of various populations to include diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations and military populations that encompass the fabric of the county. Cultural competency is also a step that is addressed in the development of the local prevention work plans to ensure prevention programs, policies and practices are appropriate

and effective for the populations served throughout the county. A county planning team reviews the plans for identification of statewide priorities. Approval is granted by the DAODAS Director.

DAODAS has been providing Medicaid services since 1993 and will continue collaborative efforts designed to increase access to quality substance use services. In State Fiscal Year 2012, DAODAS and the S.C. Department of Health and Human Services (DHHS), the state's Medicaid authority, began moving the state's public substance abuse treatment services to a managed care model, which was implemented in February 2013. This process highlights the Single State Authority's efforts to begin constructing a framework that encompasses changes produced by implementation of the Affordable Care Act (ACA) in State Fiscal Year 2014.

In 2013, per the recommendation of the S.C. Health Planning Committee convened by Gubernatorial Executive Order, South Carolina informed the federal government that it will not be establishing its own health exchange, nor will it be accepting the expansion of Medicaid. In place of the health exchange, DHHS developed the Healthy Outcomes Plan (HOP), which is intended to support uninsured South Carolina citizens by implementing service-delivery models to coordinate care for chronically ill, uninsured, high utilizers of emergency department (ED) services. The purpose of the HOP is to improve coordination of care, lower healthcare costs, and enhance the current healthcare systems in South Carolina.

The General Assembly of South Carolina granted $2 million to be allocated directly to the state's 33 county alcohol and drug abuse authorities using a HOP framework for healthcare integration and enhanced care coordination. The allocation is to be used for the support of uninsured and underinsured clients by covering costs associated with treatment services, removing barriers to accessing treatment services, and enhancing partnerships in communities across the state.

The Continuum of Care in South Carolina Using an ASAM Level Framework:

The 32 county authorities provide the following core services in each of the 46 counties: traditional group, individual, and family outpatient counseling, to include the post-discharge period; Alcohol and Drug Safety Action Program (ADSAP), which is the state's DUI program; youth and adolescent services; and, primary prevention/education programs; and, gambling addiction services.

Many county authorities provide specialized levels of care, such as intensive outpatient services (nine or more hours per week), day treatment, medically monitored withdrawal, adolescent inpatient treatment, and/or other residential services. Local providers that do not offer all levels of care are required by the DAODAS Block Grant Governing Terms to refer clients to appropriate levels of care at other county authorities. The following treatment services offered by the local providers are categorized according to the American Society of Addiction Medicine (ASAM)'s Levels of Care:

ASAM Level 0.5. Early Intervention Services

- Alcohol and Drug Safety Action Program (ADSAP, South Carolina's DUI program)

- Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Offender-based intervention
- Screening, Brief Intervention and Referral to Treatment (SBIRT)

ASAM Level 1. Outpatient Services

- The Bridge Program
- Gambling addiction services
- Educational individual and group counseling
- Youth and adolescent services
- Intensive family services

ASAM Level 2: Intensive Outpatient Services

- Intensive outpatient group treatment
- Day treatment

ASAM Level 3. Inpatient Services:

- Withdrawal management (social and medical)
- Halfway housing
- Inpatient treatment
- Residential treatment

Prevention:

Prevention is a priority for South Carolina and DAODAS, as demonstrated by the comprehensive nature of the state's prevention infrastructure and the diverse funding streams for prevention, including both state and federal funding. DAODAS will continue to spend a minimum of 20% set aside from the SABG to ensure that alcohol, tobacco, and other drug (ATOD) primary prevention services are available throughout the state's 46 counties. DAODAS also receives general State revenue that is earmarked for prevention. This funding has ranged from $500,000 to $1.6 million (as available) in previous budget years.

In 2010, South Carolina received approximately $10.6 million over a five-year period to implement the Strategic Prevention Framework State Incentive Grant (SPF SIG) awarded by SAMHSA/CSAP. The SPF SIG in South Carolina ended implementation funding to the 18 community sites as of September 30, 2014, and the grant ended in June 2015. The State has begun to infuse the SPF planning model into the SABG primary prevention set-aside by offering training and technical assistance to the other 28 counties that were not funded with the SPF SIG to increase training opportunities for community needs-assessment activities. DAODAS is continuing the implementation of the SPF process and will focus on the second step (Capacity), building upon needs assessment trainings conducted during State Fiscal Year 2015. There is tremendous value in these capacity-building activities. The process will be guided by DAODAS and Regional Capacity Coaches to provide guidance, technical assistance, training, materials, and resources.

Additionally, South Carolina applied for and received in September, 2015 the Partnership for Success (PFS) grant from CSAP/SAMHSA. Empowering Communities for Healthy Outcomes (ECHO) is a multi-layered approach to bolstering prevention infrastructure for data-driven decision-making. ECHO is specifically addressing prescription drug abuse/misuse of youth ages 12 to 25 and impaired driving across the lifespan in 10 high need counties across the state (5 impaired driving sites and 5 prescription drug sites). The data-driven approach is helping increase capacity in those counties to address a wide range of local concerns through the implementation of evidence-based programs and strategies.

Other Behavioral Health Services in South Carolina:

S.C. Department of Mental Health

- The Earle E. Morris Jr. Alcohol and Drug Addiction Treatment Center ("Morris Village") is licensed by the State of South Carolina and is accredited by CARF. Morris Village has 96 operational beds and provides inpatient treatment for adults affected by substance abuse or addiction and – when indicated – addiction accompanied by psychiatric illness.
- William S. Hall Psychiatric Institute / Child & Adolescent is licensed by the State of South Carolina for 89 beds as a specialized hospital, with a separately licensed 37-bed residential treatment facility for children and adolescents. Hall Institute provides inpatient psychiatric services and residential treatment for adolescents. As part of its inpatient psychiatric services, Hall Institute includes an 18-bed dual-diagnosis unit for adolescents with substance use disorders.

S.C. Vocational Rehabilitation Department:

- Holmesview Center in Greenville and Palmetto Center in Florence are voluntary residential treatment centers for clients who need inpatient therapy for substance use disorders. Both facilities provide a full range of vocational and treatment services for people whose employment is jeopardized by substance use. Referred to the centers by their vocational rehabilitation counselors, clients receive follow-up services once they return to their communities.

Opioid Treatment Programs

The number of certified Opioid Treatment Programs (OTPs), their location by county, and their reported number of patients are depicted in Table 1 (next page). Their average patient capacity will be determined in collaboration with the South Carolina Association for the Treatment of Opioid Dependence (SCATOD), the organization that represents the South Carolina OTPs.

Office-based Opioid Treatment Providers

The number, location and other details about the Office-based Opioid Treatment (OBOT) certified providers are at the SAMHSA Buprenorphine Treatment Practitioner Locator, South Carolina. Many of the DATA-2000 certified providers reportedly are not active. Their status will

be determined in collaboration with the Medical University of South Carolina (MUSC) and other relevant organizations as part of the Opioid STR Project.

Table 1

PROGRAM	City	County	Methadone Census	Buprenorphine (OTP}	OBOT
BHG – Aiken Treatment Center	Aiken	Aiken	180	0	60
BHG – Spartanburg Treatment Center	Spartanburg	Spartanburg			Y
Center for Behavioral Health South Carolina	N. Charleston	Charleston	392	26	21
Center of Hope of Myrtle Beach	Myrtle Beach	Horry			
Charleston Center	Charleston	Charleston	296	5	4
Columbia Metro Treatment Center	W. Columbia	Lexington			
Crossroads Treatment Center of Charleston	N. Charleston	Charleston	230	0	N
Crossroads Treatment Center of Columbia	Columbia	Richland	310	0	N
Crossroads Treatment Center of Greenville	Greenville	Greenville	341	y	y
Crossroads Treatment Center of Seneca	Seneca	Oconee	265	0	N
Greenville Metro Treatment Center	Greenville	Greenville	313	12	N
Greenwood Treatment Specialists	Greenwood	Greenwood			
Palmetto Carolina Treatment Center	Duncan	Spartanburg	300	17	N
Recovery Concepts - Ridgeland	Ridgeland	Jasper			
Recovery Concepts of the Carolina - Upstate	Easley	Pickens	305	98	160
Rock Hill Treatment Center	Rock Hill	York			
Southwest Carolina Treatment Center	Anderson	Anderson	325	39	N
Starting Point of Darlington	Hartsville	Darlington	306	N	N
Starting Point of Florence	Florence	Florence	803	N	N
York County Treatment Center	Fort Mill	York	635	38	N

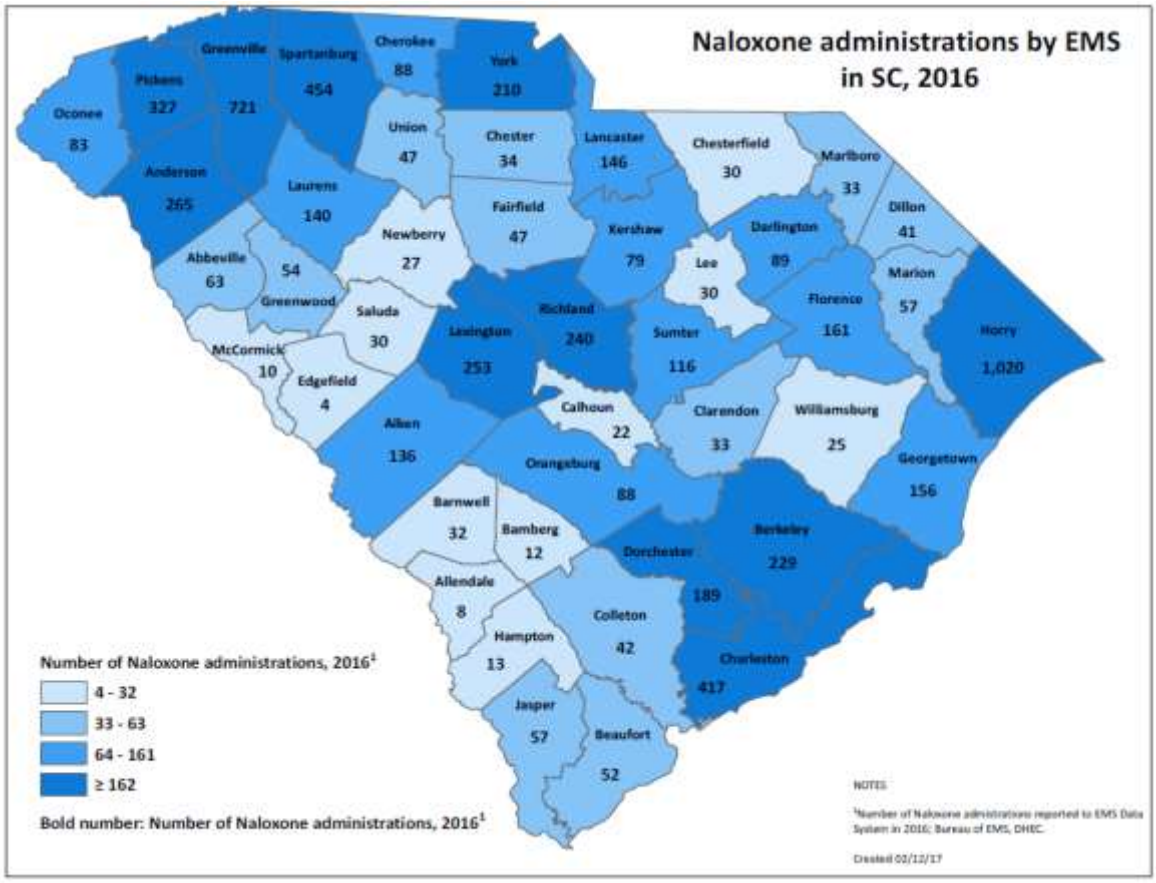
Opioid Overdose Prevention-Naloxone

Pursuant to a Joint Protocol signed by the Boards of Pharmacy and Medical Examiners on November 17, 2016, persons who are at risk of an opioid overdose or their caregivers may obtain Naloxone at pharmacies across the state *without a prescription*.

The South Carolina Overdose Prevention Project, (a 5-year SAMHSA funded grant), Narcan® (Naloxone HCI) nasal spray 4mg is offered free of charge to trained law enforcement officers through the Law Enforcement Officer Narcan (LEON) program; and, trained patients and/or caregivers in the county SUD services agencies across South Carolina.

As part of the *Crisis Naloxone Program* sponsored by DAODAS, individuals whom, after an assessment by staff at county SUD services agencies, are deemed at high risk of an opioid overdose, may be provided a voucher to obtain Narcan® free of charge at participating pharmacies. To be eligible for a voucher a patient must be unable to pay for naloxone and be either waiting to get into a state-funded (301 system) treatment program or leaves a current treatment program against staff advice. Figure 1 (next page) depicts Naloxone administration by EMS across the state. The total number and type of entities/individuals trained in overdose education and Naloxone administration will be determined in collaboration with DHEC.

Figure 1



Recovery Support

The main recovery community in South Carolina is South Carolina Faces and Voices of Recovery (SC FAVOR), which is organized state-wide, with a number of regional organizations in the various regions of the state. There is a full-blown Recovery Community Organization in the Upstate: FAVOR Greenville that has a full-time staff and a large number of volunteers functioning in various capacities, mainly as Recovery Coaches. In addition, there are five other Recovery Community Organizations that are active. The STR grant is providing start-up funding to two more RCO's: FAVOR Grand Strand (Horry County) and FAVOR Tri-County (York, Lancaster, Chester and recently, Chesterfield Counties).

According to FAVOR SC[1], there are approximately 140 Peer Support Specialists who have been trained and are deployed across the state, with a third employed by County Authorities, another third are working as health care paraprofessionals in private and faith-based providers, and the rest are working independently or as volunteers in recovery community organizations. In addition, the STR Project will fund:

a. Two additional Peer Support Specialists in Greenville and Horry County hospital emergency departments to assist opioid overdose patients who are revived and admitted to ER, to include follow-up after release.
b. Nine additional Peer Support Specialists, particularly in high need counties. The decision matrix used for determining the need for Peer Support Specialists is at Table 2 (page 9). The counties were divided into the following four bands:
    - Those who have severe opioid issues are grouped in the Orange Band. Within this band, those counties with no or low capacity are prioritized over those who have some capacity.
    - Those who are not designated as having "severe" opioid issues are grouped in three subsets, determined by the average of Mortality and ED Discharge Rates. Those who score "3" are in the Green Band and are ranked by increasing capacity. Those who score "2.5" are grouped in the Blue Band and are similarly ranked. Finally, those counties who scored less than "2.5," are in White Band, ranked by increasing capacity.
c. Four Peer Support Specialists in the Withdrawal Management Centers in Greenville, Richland, Charleston and York Counties that are operated by the County Authorities.

The STR Project is also assisting the re-integration of persons released from incarceration. Two such positions will be funded at the S.C. Department of Corrections, and additional three positions will be deployed at high need county jails.

Faith-Based and 12-Step Services. There are 35 faith-based programs based in 21 counties; 1,229 Alcoholics Anonymous meetings as of March 2017, held by 358 groups in 70 cities; and, 392 Narcotics Anonymous meetings as of April 2017, held by 133 groups in 77 cities.

Statewide Initiatives:

Governor's Prescription Drug Abuse Prevention Council

In May 2013, the Inspector General in South Carolina published a report outlining South Carolina's recent experiences with the non-medical use of prescription drugs. In March 2014, an executive order was issued by Governor Nikki R. Haley citing the Inspector General's report. The executive order led to the creation of the Governor's Prescription Drug Abuse Prevention Council, tasked with creating a statewide plan to prevent and treat the non-medical use of prescription drugs. This council was initially co-chaired by DAODAS Director Robert C. Toomey and Chief Surgeon of Southeastern Facial Plastic/Cosmetics Louis E. Costa II, D.M.D., The plan was written by the council, a statewide multi-agency collaboration. It was published in December 2014 with recommendations for multiple system-level changes. Accomplishments since the plan was published include:

- The S.C. Board of Medical Examiners amended licensure renewal statements to include continuing medical education on prescribing and monitoring controlled substances.
- The S.C. Department of Labor, Licensing and Regulation (LLR) now requires 2 online CME credit hours on "Responsible Opioid Prescribing" with training focusing on use of the state's prescription drug monitoring program for prescribers renewing licenses. More

than 7,500 prescribers have completed the requirement so far.

- DAODAS, Blue Cross Blue Shield of South Carolina, S.C. Medical Association, LLR, S.C. Drug Enforcement Administration, and the S.C. Department of Health Human Services are collaborating to create a statewide public education campaign / provider toolkit that will include the Council's recommendations. This communication effort will reach all prescribers with messaging and education regarding best practices for prescribing of opioids and pain management, with information on identifying substance use disorders, and referral options and resources for opioid dependence treatment.
- DAODAS is completing an assessment of current prescription drug drop-box sites at law enforcement agencies statewide for potential expansion and improvements. Pharmacy manufacturers have been contacted for drop-box funding and take-back participation. DAODAS has offered coordination between health systems that qualify as drop-box sites and local law enforcement for safe disposal strategies.
- Substance use disorder education emphasizing non-medical use of prescription drugs has expanded within the S.C. Criminal Justice Academy and will reach all law enforcement agencies within one year.
- A guide created by DAODAS that includes best practices for community-level prevention programs and strategies targeting non-medical use of prescription drugs will be published in early 2016. Berkeley, Dorchester, and Darlington counties have been awarded funding to implement community-based prevention strategies.
- Prescriber registration and monthly patient queries with the state's prescription drug monitoring program (SCRIPTS) are up: 4,994 prescribers and 3,011 pharmacists have registered as of August 2015.
- A contract agreement for integration of SCRIPTS and the state's health information exchange network (SCHIEx) is in place.
- The South Carolina Overdose Prevention Act passed in May 2015, allowing wider access to naloxone to first responders and to the general public by prescription.
- The Fifth Judicial Circuit Solicitor's Office and the S.C. Department of Health and Environmental Control are coordinating a phased-in pilot for law enforcement officers to carry and use naloxone in Richland, Lexington, and Kershaw counties.

Governor's Domestic Violence Task Force

In 2014, the Charleston, S.C.-based Post and Courier newspaper began an eight-month investigation leading to a seven-part Pulitzer Prize-winning series focusing on domestic violence in South Carolina titled "Till Death Do Us Part." In January 2015, Governor Nikki R. Haley filed an executive order establishing the Domestic Violence Task Force (DVTF). DAODAS has been a key participant in task force and subcommittee efforts.

The DVTF was broken into four work groups to address criminal justice; services for victims and offenders; community awareness, education, and outreach; and government resources. Over the summer of 2015, the work groups met to collect data and information from counties and regions of the state, identifying problems and developing a list of recommendations for the state.

DAODAS participated in all work groups and has developed a collaborative relationship with the Coalition Against Domestic Violence and Sexual Assault (SCCADVASA). In August 2015, the recommendations for the DVTF were published, and DAODAS has participated in moving these recommendations forward with multiple state agencies.

Modified Interpersonal Group Psychotherapy

Another initiative to improve quality of services involves a statewide training on Modified Interpersonal Group Psychotherapy (MIGP) and Rational Behavior Therapy (RBT) led by Jeff Georgi, senior clinician with the Private Diagnostic Clinic of Duke University Medical Center. In conjunction with training on the two treatment models, participants are directly challenged to transcend traditional monolithic visions of addictions treatment, develop a deeper understanding of the disease of addiction, and apply the latest scientific knowledge to direct practice through understanding the bio-psycho-social-spiritual-experiential model (BPSSEM). The first cohort consisted of 33 participants from the county alcohol and drug abuse authorities completing a one-year training. Regional Learning Teams (RLTs) supporting clinical supervision and ensuring fidelity to the model have also been a key component of the initiative. The cohort was expanded in State Fiscal Year 2014 with 30 more participants, adding and strengthening the structure of the RLTs. Regional MIGP training started at Charleston Center in 2015, where a regional cohort of 30 participants will complete the training and engage in a community of practice similar to the RLTs. This demonstrates a statewide shift toward adopting a consistent, unified, evidence-based treatment model.

Recovery-Oriented System of Care (ROSC)

ROSC is a paradigm shift in the provision of intervention and treatment services in South Carolina, as it focuses on prevention and intervention before a traditional treatment episode, as well as recovery support during and after the treatment episode. The central focus of a ROSC is to create an infrastructure or "system of care" with the resources to effectively address the full range of substance use problems within communities. A ROSC encompasses a menu of individualized, person-centered and strength-based services within a self-defined network.

After strategic planning in 2013, the ROSC moved into a transitional period. In November 2014, a new project coordinator, Julie Cole, joined DAODAS to oversee the development of the ROSC. Ms. Cole, along with the co-chairs of the ROSC Collaborative Committee, attended the ROSC Systems Transformation Institute with Dr. Ijeoma Achara in March 2015. The mission of the ROSC is "to develop and mobilize formal and informal networks of services to build on and sustain long-term recovery for individuals and families impacted by substance use disorder." A Request for Proposals has been developed to engage in consultation specific to the planning and implementation of three demonstration projects/sites for a system transformation initiative.

These demonstration sites/projects will serve as a learning collaborative for ROSC system transformation. These efforts will be utilized to develop further systems transformation projects throughout the state.

Table 2. Capacity and Need in the 46 SC Counties—Peer Support Specialists

(Sorted by Severity, Capacity and average of ED Discharge Rate and Mortality Rate)

County	No. of Providers[a]	Population Density	Capacity[b]	Severity[c]	ED Discharge Rate	Mortality Rate	Average
Marion	0	65.6	0	High	4	4	4
Colleton	0	33.7	0	High	4	4	4
Darlington	0	120.3	0	High	4	3	3.5
Oconee	0	110.8	0	High	2	4	3
Union	0	54.9	0	High	3	3	3
Lancaster	0	143.2	0	High	3	2	2.5
Laurens	0	91.7	0	High	2	3	2.5
Dorchester	1	248	4	High	4	4	4
Florence	1	171.8	6	High	4	3	3.5
Pickens	5	233.5	21	High	3	4	3.5
Spartanburg	8	352.4	23	High	4	4	4
Anderson	7	250.5	28	High	3	4	3.5
Horry	7	225.7	31	High	4	4	4
Greenville	27	587.6	46	High	3	4	3.5
Georgetown	3	58.4	51	High	4	4	4
Charleston	46	269.3	171	High	4	3	3.5
Williamsburg	0	35.8	0		4	2	3
Lexington	2	356.7	6		3	3	3
Aiken	1	150.8	7		2	4	3
Greenwood	2	150.6	13		4	2	3
Barnwell	0	40	0		2	3	2.5
Berkeley	1	153.6	7		3	2	2.5
York	4	338.1	12		2	3	2.5
Kershaw	3	84.2	36		3	2	2.5
Dillon	0	77.5	0		3	1	2
Newberry	0	58.1	0		3	1	2
Edgefield	0	52.4	0		1	3	2
Clarendon	0	49.5	0		2	2	2
Bamberg	0	39.6	0		1	3	2
Jasper	0	37.2	0		1	3	2
Hampton	0	36.7	0		3	1	2
Cherokee	0	140.3	0		1	2	1.5
Marlboro	0	58.3	0		2	1	1.5
Chesterfield	0	57.5	0		1	2	1.5
Abbeville	0	49.1	0		1	2	1.5
Lee	0	45.5	0		2	1	1.5
McCormick	0	25.4	0		2	1	1.5
Chester	0	55.8	0		1	1	1
Saluda	0	43.2	0		1	1	1
Calhoun	0	38.3	0		1	1	1
Allendale	0	24.3	0		1	1	1
Sumter	1	158	6		2	2	2
Orangeburg	1	80.9	12		2	2	2
Beaufort	7	182.4	38		1	2	1.5
Richland	22	510.2	43		2	2	2
Fairfield	3	32.9	91		1	1	1

a. Total number of OTPs and OBOTs.
b. Capacity represents the availability of OUD providers in a given county. It is calculated by dividing the total number of OUD providers into the population density and multiplying the result by 1,000.
c. Severity was determined by considering the mortality, naloxone administration and ER discharge rates

DAODAS, in cooperation with Faces and Voices of Recovery South Carolina (FAVOR SC) has continued peer support training and certification. Several local agencies have hired Peer Support Specialists and are seeing improved client outcomes. Several more agencies have continued

assessing need and building capacity for Medication-Assisted Treatment. Trainings on the Science of Addiction and Recovery, ROSC, and Language of Recovery occur on an ongoing basis on a statewide and local level, and this will continue.

Collaboration with Community Partners:

Recovery Program Transformation and Innovation Fund (RPTIF)
Starting in 2014, DAODAS and the S.C. Department of Health and Human Services (DHHS), with guidance from the University of South Carolina (USC) College of Social Work, allocated $1.8 million from South Carolina lawsuits against pharmaceutical firms to be used for substance use treatment and recovery. DHHS contracted with the College of Social Work to announce a request for proposals around multiple topics to include technology enhancements, community partnerships/healthcare integration, increased service delivery, workforce development, tele-medicine, and infrastructure. The College of Social Work provided technical support to awardees through close communication during the implementation of their projects and performing a process evaluation. These efforts led to multiple publications adding to data resources for our system. The third allocation of the RPTIF is set for 2016, with continued technical assistance in grant writing, project structure and implementation. The request for proposals was distributed to the state's county alcohol and drug abuse authorities, and proposals are due October 26, 2015.

State Prevention Partnerships

South Carolina continues to support a collaborative substance abuse prevention system that ensures the use of evidence-based programs, policies, and practices, as well as emphasizes cultural competency and demonstrates accountability among partners.

The Governor's Council on Substance Abuse Prevention and Treatment – with its varied membership of state agencies and community and youth service organizations – provides an ideal mix of perspectives to effectively guide youth-focused substance use prevention services in South Carolina. Currently, the Council fulfills the following roles:

- serves as an advisory body to Governor Nikki Haley on substance use disorder prevention and treatment;
- tracks substance use disorder funding streams and seeks to identify opportunities to coordinate, leverage, or redirect funding;
- promotes effective prevention strategies and processes and encourages their implementation in key organizations;
- addresses important issues through standing or ad hoc committees (Underage Drinking Action Group, Fetal Alcohol Spectrum Disorder Group, State Epidemiological Outcomes Workgroup (SEOW), Workgroup on Evidence-Based Programs, Policies and Practices);
- oversees major initiatives (e.g., SPF SIG, Partnership for Success); and
- informs Council members of ATOD information and important agency developments.

The Council continues translating the findings and recommendations of the SEOW into actionable policies. The Governor's Council has proven to be an effectively diverse group in

terms of its concern for the state's various populations, its state and local perspectives, and its cross-agency input.

State priorities identified by the SOEW and affirmed by the Governor's Council are underage alcohol use, impaired driving, non-medical use of prescription drugs, marijuana use, and tobacco use. The SEOW split into subgroups based on interest in a specified profile topic to discuss: (1) which data indicators should be used; (2) which data indicators are not appropriate for use, with the reason(s) for the exclusions; and (3) how much weight each indicator should hold in the profile. Since SEOW members are the gatekeepers to the specific indicators measured across the state, DAODAS collaborated with the SEOW to obtain the most current data available for each indicator. Data analysis was conducted by DAODAS staff with input from SEOW members. Following the analysis, county-level indicators were compared across the state to determine a rank for each county in respect to the need for prevention services around underage drinking, non-medical use of prescription drugs, impaired driving, tobacco use, and marijuana use.

Based on the process described above, the Governor's Council voted in January 2015 to add non-medical use of prescription drugs and marijuana to the previously identified priorities for the state.

South Carolina submitted an application in March 2015 for the Partnership for Success (PFS) grant from SAMHSA/CSAP, and the new grant began September 29, 2015. Empowering Communities for Healthy Outcomes (ECHO) is a multi-layered approach to bolstering prevention infrastructure for data-driven decision-making. ECHO will specifically address non-medical use of prescription drugs for youth ages 12-25 and impaired driving across the lifespan. The resulting increase in capacity will benefit communities' ability to address a wide range of local concerns. ECHO will address the two priorities mentioned above by identifying and funding high-need counties through data analysis generated by SEOW efforts.

ECHO will also strengthen local and state capacity to address substance use issues through a well-planned, data-driven approach. The Governor's Council on Substance Abuse Prevention and Treatment, led by the DAODAS Director and including all key state agencies, will continue as a strong advisory group providing guidance and assistance. At the state level, ECHO will create a clear vision for prevention that will drive the development of multi-agency strategic planning, unite prevention systems across the state, and set a measurable course for state and local efforts. At the local level, ECHO will impact thousands of citizens by funding nine counties to implement evidence-based policies and practices through the SPF process. This will ensure true collaboration is achieved at all levels so that community-level change is realized and the capacity to address local concerns is strengthened.

Joint Council on Children and Adolescents

In 2007, DAODAS and the S.C. Department of Mental Health (DMH) proposed and formed the S.C. Joint Council on Children and Adolescents in collaboration with the state Departments of Juvenile Justice (DJJ), Education (DOE), and Social Services (DSS); Behavioral Health Services Association of South Carolina Inc. (BHSA); S.C. Primary Health Care Association; Faces and Voices of Recovery South Carolina (FAVOR SC); S.C. Federation of Families; and parent advocates. The Council's mission is "to develop a coordinated system of care that promotes the efficient provision of effective services for children, adolescents, and their family." Currently,

the Council is a 27-member organizations, including nine state agencies and such non-governmental entities as The Duke Endowment, American Academy of Pediatrics, and Blue Cross Blue Shield of South Carolina. This year, the Council has added a youth representative, along with continued parent representation.

In January 2015, DAODAS Director Robert C. Toomey began his appointment as chairman, succeeding the 2013 appointment of Anthony "Tony" Keck, Director of the S.C. Department of Health and Human Services (DHHS). Upon his appointment, Mr. Toomey called for restructuring of the Joint Council to make the goals focused and fresh, while honoring the previous accomplishments of the group. Mr. Toomey has conducted a survey of the partnership regarding priorities of the group as well as reviewed the by-laws. Strategic planning is currently underway and will be completed by 2016.

The Joint Council, through its subcommittees and work groups, has accomplished multiple initiatives since its inception in 2012. Past accomplishments include increased screening and referral practices across systems, cross-agency workforce development, promotion of culturally competent services, adoption of core competencies for the child and adolescent professional workforce, adoption of the "Trauma-Informed System of Care" concept, recommendations and support of a cognitive behavioral treatment model for youth, and implementation of a Systems of Care grant in October 2014.

The Palmetto Coordinated System of Care. The Palmetto Coordinated System of Care (PCSC) received a four-year System of Care (SOC) grant from SAMHSA in October 2014. The PCSC has established several workgroups, to include:

- Service Array Workgroup – To expand the current service array, this workgroup has recommended that new services begin with mobile crisis, intensive family services, respite, and peer support services.
- Communications Workgroup – Youth, family, and provider focus groups were conducted to inform them about the PCSC and to get participants' thoughts on services and ways that the project can best communicate with youth, families, and providers.
- Social Marketing – Youth and family focus groups were held to obtain input on the PCSC logo design and for the PCSC web site.
- The PCSC implemented "wrap-around" services though a case management agency.

Statewide Trauma-Informed Care Initiative

The Trauma-Informed Subcommittee of the Joint Council on Children and Adolescents has been involved in collaboration and strategic planning with a number of community and state organizations to implement trauma-informed services within those organizations. The trauma-informed initiative's main purpose is to promote an organizational culture change toward reflecting five core principles: safety, trustworthiness, choice, collaboration, and empowerment in all services delivered. Trauma is pervasive and touches many aspects of life; between 55% and 90% of individuals have experienced at least one traumatic event in a lifetime. Many

individuals who have experienced trauma in the past experience mental health disorders, problems associated with substance use, suicidal ideations, and other interpersonal struggles not always connected to trauma.

Along with offering evidence-based trauma models, this state-level initiative is encouraging a change in the culture and environment of behavioral health facilities so that they treat patients in a manner that reduces trauma. For example, front-line and administration staff will be trained to handle the daily client population with a trauma-informed understanding and skill set. DAODAS has received federal technical assistance on Trauma-Informed Care and currently is engaged in planning that resulted from this assistance. DAODAS will continue to be a leader in this paradigm shift at the state level and will promote trauma- informed training and implementation in the behavioral health system.

Collaboration for Success

The most recent responsibility of the Joint Council is oversight of the "Collaboration for Success" project (funded by a State Adolescent Treatment Enhancement and Dissemination grant), which will design, implement, and evaluate activities to enhance adolescent treatment and disseminate successful initiatives statewide.

Collaboration for Success II will expand the provision of a proven evidence-based practice, ACRA/ACC, from four counties to eight counties in South Carolina over the next three years, reaching approximately 880 adolescents (ages 12 to 18). The focus of the grant will be on improving the infrastructure for providing direct treatment services and increasing youth access to care, especially for traditionally underserved groups (e.g., youth from low-income, single-parent homes; those living in remote rural areas; ethnic/cultural groups with little exposure to treatment programs for substance use disorders and co-occurring disorders). Outcomes resulting from improved access to treatment will include reductions in substance use, improvements in education and social connectedness, and reduced juvenile justice referrals.

Under the oversight of the Joint Council on Children and Adolescents, Collaboration for Success II will double the number of counties participating in Collaboration for Success, the SAMHSA-funded grant project that piloted the AACR/ACC model. Past successes will be spread further across the state and will include: continued use of electronic screening to determine youths' needs for service referrals, extensive statewide training on core competencies for clinicians working with adolescents and their families, active inclusion of families and adolescents on the Joint Council, intra-agency collaboration on system of care planning, expanded use of an online learning management system and its training modules, and continuing work from the multi-agency Workforce Training Collaborative and the Multi-Cultural Council to guide cultural competency practices.

DAODAS/DMH Collaborations

The S.C. Department of Mental Health (DMH) and DAODAS have a longstanding relationship, as the two departments serve similar populations. DMH and DAODAS continue to work toward multiple collaborations in efforts to more consistently serve South Carolina residents.

The strongest point of collaboration between the two agencies is the institution of recovery-support services in the behavioral health system. Through the Recovery-Oriented System of Care initiative, DAODAS developed the peer support training *(see above)* that aligns with DMH's peer support programming. DAODAS wishes to work closely with DMH in readying Peer Support Specialists to care for the co-occurring population.
The challenge in the collaboration between DMH and DAODAS continues to be aligning value systems, approaches, and perspectives, as well as improving communication at all levels of service delivery. DAODAS recognizes the importance of decreasing gaps in services and making transitions easier for partnering behavioral health providers such as DMH. DAODAS is committed to nurturing its established relationship with DMH to ensure consistent treatment for our target populations.

DAODAS/DHHS Collaboration

In November 2011, the S.C. Department of Health and Human Services (DHHS) launched an initiative encouraging OB/GYN providers to provide screening, brief intervention, and referral to treatment (SBIRT) services to patients who are pregnant or during 12 months postpartum to address alcohol, tobacco, and other drug use, as well as depression and domestic violence.

DAODAS providers have collaborated with OB/GYN providers in their local communities to provide substance use disorder treatment to patients when the need for treatment has been identified through the provision of SBIRT services.

DAODAS is an involved partner in the S.C. DHHS Birth Outcomes Initiative (BOI). Additional partners include the S.C. Hospital Association, S.C. Department of Health and Environmental Control, S.C. Department of Mental Health, S.C. Office of Research and Statistics, University of South Carolina's Institute on Families in Society, and the S.C. March of Dimes. Launched in July 2011, the BOI seeks to improve birth outcomes for newborns in South Carolina who are Medicaid beneficiaries. DAODAS, in conjunction with the BOI, is currently working to reduce the length of stay in neonatal intensive care units for infants exposed to opioids during pregnancy as well as to create a link for referral to local behavioral health services for the mothers.

In August 2013, DAODAS was awarded a five-year CSAT cooperative agreement to implement SBIRT in six counties located in diverse areas of the state, to include Allendale, Barnwell, Georgetown, Greenville, Horry, and York counties. The goals of the S.C. SBIRT initiative are:

- to increase access to SBIRT services for adults in primary care and community health settings;
- to ensure that SBIRT is utilized as the standard of care in South Carolina's healthcare settings through state-level system and policy changes; and
- to improve physical and behavioral health outcomes for adults with substance use disorders and co-occurring mental illness.

Formal SBIRT protocols have been implemented in 14 healthcare sites in five counties, to include a Rural Health Clinic (RHC), hospital clinic, and emergency department in Barnwell County; three Federally Qualified Health Care (FQHC) sites in Georgetown County; an internal medicine clinic and an FQHC site in Greenville County; five FQHC sites in Horry County; and an FQHC site in York County. Addiction counselors are co-located at the healthcare sites to provide SBIRT and brief treatment services. The S.C. SBIRT initiative has collectively

provided more than 129,000 screenings for alcohol, tobacco, and other drug use to over 45,000 adult male and female patients. S.C. SBIRT was implemented collaboratively between the county alcohol and drug abuse authorities and healthcare providers in the five participating counties.

DAODAS/Criminal Justice System (S.C. Department of Juvenile Justice and S.C. Department of Corrections)

DAODAS continues to nurture its nationally recognized Bridge program to successfully transition individuals with substance use disorders who are being released by the S.C. Department of Juvenile Justice and returning to their communities. The Bridge also refers juveniles to adolescent treatment services when appropriate.

DAODAS and the S.C. Department of Corrections have continued to work on developing a seamless transition for offenders into outpatient treatment services in hopes of reflecting the outcomes of the Bridge program for young adult offenders. In the past, there has been collaboration on grant writing and other initiatives; however, agencies were unable to sustain these efforts. The current effort requires no additional resources for referral connections and training opportunities offered by the DAODAS system. We are currently in development of a cross-training for both systems to support networking, education, and improved collaboration.

DAODAS/DSS Collaboration

Through the Partners in Achieving Independence through Recovery and Self-Sufficiency Strategies (PAIRS) Program, DAODAS is assisting the S.C. Department of Social Services (DSS) in achieving its goal of strengthening family units through the development of the Midlands Family Care Center (MFCC). The MFCC offers mothers at risk of losing custody of their children to DSS due to a substance use disorder a chance to engage in treatment services with their children onsite in a residential setting. Both mother and child receive therapeutic intervention and transitional services.

In support of the ongoing collaborative effort, DAODAS and DSS signed a contract for services on April 1, 2015. The contract addresses drug testing and having a substance use counselor on site or available to the DSS process as needed. Currently, 31 such counselors have been hired by the 33 SABG-funded providers. Staff began orientation training in July 2015. The curriculum continues to focus on their role as liaisons between DSS and DAODAS, which includes referral, staffing, and case management of clients accessing both systems. This program was recently changed to fund one counselor/case manager per DSS region, that is, it was reduced to five counselors in total.

DAODAS is working with the National Center on Substance Abuse and Child Welfare to use their Collaborative Values Survey to see what areas of cross-training will be needed, as well as working to develop an RFP for evaluation of the project. DAODAS will create a statewide conference in conjunction with DSS to address the cross-training efforts.

Service to Diverse Racial and Ethnic Groups

DAODAS has as a core principle to serve the residents of South Carolina regardless of their race, ethnic background, or sexual orientation. The department also understands the importance of cultural competence and offers training to all employees in its system on this topic to best serve

individuals seeking help for substance use disorders. DAODAS' local providers strive to practice in accordance with ROSC principles that encourage the individual to chart his/her own journey in treatment. Each individual's cultural, racial, sexual orientation, and ethnic attributes are attended to in the treatment process. Since the needs of sexual-gender minorities may not be addressed adequately, the department is planning to include trainings as part of the core competencies common to DAODAS, the S.C. Department of Social Services, S.C. Department of Juvenile Justice, and other agencies serving the citizens of the South Carolina. DAODAS will continue to strengthen its service structure to accommodate all South Carolina residents seeking treatment services.

SABG Priority Populations

Pregnant Women and Women with Dependent Children

South Carolina, through the DAODAS Block Grant Governing Terms, requires sub-grantees to comply with Section 109:

"109. Women (45 CFR § 96.131). Subgrantee shall ensure that services awarded by DAODAS are made available to pregnant women.

a. Pregnant women will be given priority for admission to all program components funded wholly or in part by federal block grant funds.

b. SUBGRANTEE shall actively publicize the availability of such services and the priority status of pregnant women through such means as ongoing public service announcements, regular advertisements in local/regional print media, posters placed in targeted areas, and communications to other community-based organizations, healthcare providers, and social service agencies.

c. SUBGRANTEE shall notify DAODAS when it is unable to admit a pregnant woman to treatment because of insufficient treatment capacity.

d. SUBGRANTEE shall make available interim services to any pregnant woman who cannot be admitted to treatment within 48 hours of having applied. Interim services are those defined in the Intravenous Substance Abusers section under subparagraph (e.)

e. For pregnant women, interim services shall also include counseling on the effects of alcohol and drug abuse on the fetus, as well as referral for prenatal care.

f. Programs providing services to pregnant opiate using women shall receive at least 6 hours of training on opiates and pregnant women every year."

Each SUD service providing sub-grantee also sends DAODAS its capacity management protocol yearly. In order to monitor capacity and compliance with the above Section (as well as other requirements that apply to priority populations). DAODAS requires each sub-grantee to submit the attached Capacity Monitoring Form. Of note are the following provisions:

Frequency of submission. Submit form monthly. However, submit the form weekly if

- Under Capacity, 90% or more of capacity is reached.

- Under Priority Populations—IVDU. The answer to the first question is "No," or the answer to the second question is "Yes."
- Under Priority Populations—Pregnant Women, the answer to any of the questions is "No." (as seen below)

Question	*Yes*	*No*
Was each pregnant women given priority admission?		
If the immediate previous answer is "no," was each such client either referred to DAODAS or to another facility?		
If the immediate previous answer is "no," was such a client provided with appropriate interim services?		
Was each pregnant client referred for pre-natal care?		

DAODAS also monitors compliance with this requirement during yearly on site visits and through the data provided by local agencies. Sub-grantees are to contact DAODAS if they are not able to place a pregnant woman. They also must provide a lower level of care until the client is able to access the level of care needed.

If agencies are not able to admit pregnant women they are to call DAODAS and the Treatment Coordinator should be able to help them access services for that client. Our local providers work together well and they refer clients to each other if they are not able to serve them, and call DAODAS as a last resort. DAODAS has just received SAMHSA-provided technical assistance on capacity management and is actively considering the adoption of a centralized automated database.

A sample of client files are reviewed during yearly on site reviews to be sure agencies are in compliance with the DAODAS Block Grant Governing Terms. The Treatment Coordinator is responsible for this requirement. In addition, the planning staff monitor compliance with Section 109 during site visits.

There are presently three ASAM PPC II Level 3.5 and 3.7 residential treatment programs where a woman can go and take up to two of her children with her to services. They are operated by:

- Charleston Center--16-bed New Life program in Charleston County that allows two children (ages 5 and under);
- Circle Park Behavioral Health Services--16-bed Chrysalis Center in Florence County that allows the women to bring up to two children (ages 10 and under) with them to treatment;
- The Phoenix Center--16-bed Serenity Place in Greenville County that allows women to bring up to two children (ages 5 and under) with them to treatment.

There are also two other residential treatment programs for pregnant and parenting women: Keystone Substance Abuse Services in York County accepts up to 6 women in level 3.5 and 3.7 and Shoreline Behavioral Health Services in Horry County accepts 10 women.

There are eleven women's intensive outpatient (IOP) treatment programs in South Carolina, ten of which are funded by the department and one of which is funded by another source. These programs are designed for women who are in need of more than traditional outpatient counseling

but, who for a variety of reasons, are unable to receive inpatient care. Because the lack of child care has historically been a barrier to treatment for many women with children, all eleven of the women's IOPs provide on-site day care or have arrangements with local child-care facilities to provide these services for the children of women in treatment. These programs are available in Aiken, Anderson/Oconee, Berkeley, Charleston, Dorchester, Horry, Lexington/Richland, Pickens, Spartanburg, Sumter and York counties.

DAODAS also has two Family Care Centers where women and their children can access day treatment services and live at a children's home. These programs are located in Columbia (served by LRADAC) and Charleston (served by Charleston Center).

In addition to these programs all of our 33 local providers serve pregnant women in outpatient treatment and give priority to them in accessing services.

Four of these programs offer medication assisted treatment services or contract with a methadone clinic for these services. They are Charleston Center, Phoenix Center (Serenity Place), Behavioral Health Services of Pickens County, and Keystone Behavioral Health Services in York County. One of our providers, Tri-County Commission serves its three counties (Orangeburg, Calhoun and Bamberg) and also provides services through a hub and spoke model for Clarendon and Barnwell Counties also.

All of our residential facilities are available to all areas of the state and clients can access services from a program in their region or statewide. If one of or programs is not able to provide the MAT services or refer to a methadone clinic, they will refer the clients to Charleston Center or a program in their region.

Persons Who Inject Drugs

South Carolina, through the DAODAS Block Grant Governing Terms, requires sub-grantees to comply with Section 108:

"108. Intravenous Substance Users (45 CFR § 96.126)

Subgrantee shall ensure that services funded by DAODAS are provided to persons identified as intravenous users of illicit drugs. SUBGRANTEE further agrees to:

a. Provide DAODAS with a statement of capacity for each service or level of care funded in part with federal block grant funds;

b. Notify DAODAS within seven days of having reached 90 percent of its capacity to admit individuals to a particular service or level of care; refer to Capacity Monitoring Report Form (incorporated by reference and accessible at www.daodas.state.sc.us/countysc.asp).

c. Maintain a formal waiting list that shall include a unique patient identifier for each intravenous drug user seeking treatment;

d. Notify DAODAS when any intravenous drug user is placed on a waiting list; refer to Capacity Monitoring Report Form (incorporated by reference and accessible at www.daodas.state.sc.us/countysc.asp).

e. Provide interim services to those persons who cannot be admitted to treatment within 14 days of making a request. Interim services shall be made available not more than 48 hours after the request for treatment and shall include at a minimum:

   1) Counseling and education about HIV and tuberculosis;

   2) Counseling and education about the risk of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and tuberculosis transmission does not occur;

   3) Referral for HIV or tuberculosis treatment services if necessary; and

f. Conduct outreach efforts to encourage individuals in need of treatment services for intravenous drug abuse to undergo such treatment. Subgrantee shall actively publicize the availability of such services and the priority status of intravenous drug users through such means as ongoing public service announcements, regular advertisements in local/regional print media, posters placed in targeted areas, and communications to other community-based organizations, healthcare providers, and social service agencies. Subgrantee shall develop collaborative relationships with Methadone maintenance clinics for the purpose of coordination of treatment services to intravenous drug users.

g. All staff who have contact with a client should have training on the Governing Terms sections 108 and 109 annually (see section 117 for details). Training documentation will be reviewed on DAODAS compliance review visits.

Subgrantee shall ensure that no funds provided by DAODAS be used to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug or distributing bleach for the purpose of cleaning needles for such hypodermic injection 45 CFR § 96.135 (a) (6)."

In order to monitor capacity and compliance with the above Section (as well as other requirements that apply to priority populations). DAODAS requires each sub-grantee to submit the attached Capacity Monitoring Form.

DAODAS also monitors compliance with this requirement during yearly on site visits and through the data provided by local agencies. Sub-grantees are to contact DAODAS if they are not able to place a PWID. They also must provide a lower level of care until the client is able to access the level of care needed.

If agencies are not able to admit PWID they are to call DAODAS and the Treatment Coordinator should be able to help them access services for that client. Our local providers work together well and they refer clients to each other if they are not able to serve them, and call DAODAS as a last resort. DAODAS has just received SAMHSA-provided technical assistance on capacity management and is actively considering the adoption of a centralized automated database.

A sample of client files are reviewed during yearly on site reviews to be sure agencies are in compliance with the DAODAS Block Grant Governing Terms. The Treatment Coordinator is

responsible for this requirement. In addition, the planning staff monitor compliance with Section 109 during site visits.

Persons at Risk for Tuberculosis

South Carolina, through the DAODAS Block Grant Governing Terms, requires sub-grantees to comply with Section 112:

> **"112. Tuberculosis (TB) Services (45 CFR § 96.127)**
>
> Subgrantee will routinely make available, directly or through arrangements with other public or non-profit entities, tuberculosis services to each individual receiving treatment for alcohol and other drug abuse after being found to be high risk by the assessment. Tuberculosis services means:
>
> a. Counseling individuals with respect to tuberculosis;
>
> b. Making available necessary testing to determine whether individuals have been infected with mycobacterium tuberculosis to determine the appropriate form of treatment for each individual; and
>
> c. Providing for or referring individuals infected by mycobacterium tuberculosis for appropriate medical evaluation and treatment.
>
> In the case of an individual in need of such treatment who is denied admission to the program based on lack of the capacity of the program to admit the individual, Subgrantee will refer the individual to another provider of tuberculosis service.
>
> Subgrantee will implement infection control procedures established by DAODAS, in cooperation with DHEC's Tuberculosis Control Officer, which are designed to prevent the transmission of tuberculosis, including the following:
>
> a. Screening of patients;
>
> b. Identification of those individuals who are at high risk of becoming infected; and
>
> c. Conduction of case management activities to ensure those individuals receive such services.
>
> d. All individuals identified with active tuberculosis shall be reported by the testing organization to the appropriate state officials.
>
> Subgrantee shall comply with reporting instructions promulgated by DAODAS to ensure that all recipients of tuberculosis services are appropriately identified and all services documented."

DAODAS monitors program compliance related to tuberculosis services by desk reviews and onsite visits.

In addition, the Department has a state-wide policy, County Assistance Program (CAP), which is designed to identify issues and implement a mandatory "technical assistance" and guided corrective action plan before the problem worsens. The program applies to subgrantee compliance with the Federal and state requirements regarding the special populations listed above. If a provider does not participate in the CAP or does not make progress, then a Mandatory Improvement Program (MIP) is imposed. If the MIP is not successful, the Department may take a number of measures, ranging from withholding reimbursements to assigning the county's catchment area to another county authority.

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

Overview:

Data contained in the following section will provide a brief overview of the needs and critical gaps impacting the state's public substance use disorder (SUD) prevention, intervention, treatment and recovery system.

In the section, the gap between treatment need and service utilization will be described by substance. A discussion of youth risk perception regarding substance use will be offered to illustrate the need for primary prevention services focused on reducing initiation of youth substance use.

The needs assessment takes into account the work of the South Carolina State Epidemiological Outcomes Workgroup (SEOW). The South Carolina SEOW, established in May 2006 through a grant from the Center for Substance Abuse Prevention (CSAP), is responsible for reviewing existing data on alcohol, tobacco, and other drugs to identify related problems or issues. The workgroup is also responsible for monitoring data to identify trends in substance use or misuse. The current composition of the SEOW is shown at Table 1 (next page).

The mission of the SEOW is to create a highly effective substance misuse prevention data system that will support and enhance efforts to reduce alcohol, tobacco, and other drug (ATOD) use across the lifespan of people in South Carolina communities through the development and implementation of a comprehensive statewide prevention strategy. The goal of the SEOW is to develop a data-driven planning and resource-allocation model – a deliberate strategy for interpreting, comparing, and synthesizing multiple health-related indicators in order to translate information into good planning around the identified needs of the state.

The SEOW's tasks include producing a Statewide Epidemiological Profile as a document that organizes, summarizes, and presents archival data for use in prevention planning and decision making for the state. These data include measures – or "indicators" – of ATOD consumption and consequences, primarily from periodic national surveys, which allow the state to report trends over multiple years and to compare South Carolina to national rates. The indicators included in the profile were carefully selected (most are from the State Epidemiological Data System [SEDS] developed by SAMHSA/CSAP) and met criteria for availability. In addition,

national sources were supplemented with state data sources, all the while keeping in mind these selective criteria. The report includes graphs and tables that depict the use of alcohol, tobacco, and other drugs in South Carolina during recent years, along with the associated consequences of that use. Updates of the state profile have been completed in subsequent years by the SEOW.

Table 1. South Carolina SEOW Composition, July 2017

Andrew Fogner (Manager)	SC Department of Alcohol and Other Drug Abuse Services
Dan Walker	SC Department of Alcohol and Other Drug Abuse Services
Michelle Nienhius	SC Department of Alcohol and Other Drug Abuse Services
Khosrow Heidari	SC Department of Health and Environmental Control
Chelsea Lynes	SC Department of Health and Environmental Control
Abdoulaye Diedhiou	SC Department of Health and Environmental Control
Ian Hamilton	SC Tobacco Free Collaborative
Aunyika Moonan	SC Hospital Association
Kartikay Kaushik	SC Hospital Association
Sarah Crawford	SC Revenue of Fiscal Affairs
Virginia Andrews	SC Department of Public Safety
Andrea Bickley	SC Department of Health Human Services
Sarah Needler	SC Department of Health Human Services
Sarah Osborne	SC Department of Mental Health
Leigh Ann Chmura	SC Department of Mental Health
Katelyn Cheek	SC Pharmacy Association
Melissa Mull	University of South Carolina
Casey Childers	University of South Carolina
Amber Watson	SC Campaign to Prevent Teen Pregnancy
Steven Burritt	SC Mothers Against Drunk Driving
Michael George	Pacific Institute of Research and Evaluation
Barbara Brown	Citizens Center
Charles Bradberry	SC Department of Corrections
Kennard Dubose	SC Department of Corrections
Melissa Strompolis	SC Children's Trust
Brad Leake	SC Department of Social Services
Craig Wheatley	SC Department of Juvenile Justice

South Carolina

South Carolina is a small, rural state. The Census Bureau estimates the 2016 population of South Carolina to be 4,961,119. According to data available through the State's Office of Revenue and Fiscal Affairs, approximately 34% of the state's inhabitants reside in a rural area.

South Carolina – FY 2018-2019 Behavioral Health Assessment and Plan Planning Steps

Ensuring access to quality substance use disorder (SUD) treatment and prevention services in each of the state's 46 counties represents a great challenge for the Single State Authority (the Department of Alcohol and Other Drug Abuse Services [DAODAS]), the designated state agency responsible for administering federal block grant SUD treatment and prevention funds.

The agency has identified a critical need associated with allocating limited block grant funds in a manner that adequately addresses the requirements of a sustainable provider network. Efforts to address this need will be discussed further in the section identifying state and local provider needs.

Pulling from the National Survey on Drug Use and Health, NSDUH, the national substance use disorder prevalence estimate is overall 10.3%, 11.9% within the Medicaid population and 13.6% for adults aged 18-64 who are uninsured and whose family income is less than 139% of FPL. For South Carolina, 11% of the population has a substance use disorder, but higher than the national average, 19.1% of adults who are uninsured and with a family income less than 139% of FPL have a substance use disorder.

DAODAS is also working towards reducing financial barriers associated with access to high quality substance use disorder treatment services by focusing federal and state block grant dollars on service delivery for uninsured populations.

Primary Substance Misuse Prevention:

Local providers utilize the Strategic Prevention Framework (SPF) to ensure the greatest impact on their communities. This framework implies that communities should assess their needs, build capacity, plan programs/strategies, implement programs/strategies, and evaluate their programs/strategies to reduce the prevalence of substance use across our state. Through technical assistance and training, South Carolina's Regional Capacity Coaches and DAODAS staff have been able to help local providers navigate the SPF with their communities rather successfully over the past few years.

Service providers are also encouraged to: 1) deliver programs/strategies that touch on one of the six CSAP strategies; and 2) select approved evidence-based programs and strategies to reduce alcohol, tobacco, and other drug use among all South Carolinians. In Fiscal Year 2016, 96% of all participants served in primary prevention education programs were served using evidence-based universal, selected, and indicated programs.

It is South Carolina's hope that, with continued efforts to utilize SPF, community input, CSAP strategies, and evidence-based strategies/programs, the state can demonstrate success in reducing substance use among its residents.

Adolescents with Substance Use Disorders:

In South Carolina, according to the National Surveys on Drug Use and Health, about 102,000 individuals aged 12 or older per year in 2013-2015 were dependent on or abused illicit drugs within the year prior to being surveyed. However, 18,000 individuals aged 12 or older per year from 2007 to 2014 received treatment for their illicit drug use within the year prior of being surveyed.

The state's public SUD treatment system provides services to a fraction of those likely in need of treatment. Approximately 4,500 youth ages 12 to 17 entered treatment services during the past

fiscal year. This represents about 13% of all treatment admissions occurring during fiscal year 2017.

Approximately half of all adolescent admissions originate from the criminal justice system. School systems represent the second largest referral source, providing about one-fourth of all admissions to treatment. Efforts to target these referral sources include close collaboration with the state's juvenile justice and public education systems.

South Carolina will ensure that high quality substance use disorder treatment services targeting adolescent populations including individuals involved in the criminal or juvenile justice systems are available within each community. The SSA will implement strategies that include service location expansion, outreach to community partners and continued workforce development efforts designed to enhance competencies for professionals working with adolescent populations.

Following this discussion, this section will transition to information that addresses needs and system gaps relevant to identified priority populations at the state and local levels broken out by substance type.

Alcohol:

Figure One (below) provides state and national estimates on the prevalence of alcohol use disorders. These data, collected through NSDUH, indicate that around 235,000 individuals in South Carolina were dependent on or misused alcohol during the year prior to being surveyed. Estimates indicate that the state's alcohol dependence prevalence rate mirrors national trends, falling yet not changing significantly from 6.5% in 2010 to 5.9% in 2014.

Figure Two (next page) indicates that fewer than 10% of South Carolinians in need of treatment for problems related to alcohol use receive care through a DAODAS-funded provider during any given calendar year.

Looking at FY17, 57.9% of patients mentioned an alcohol problem (either primary, secondary or tertiary).

Figure One: Alcohol dependence among individuals aged 12 or older

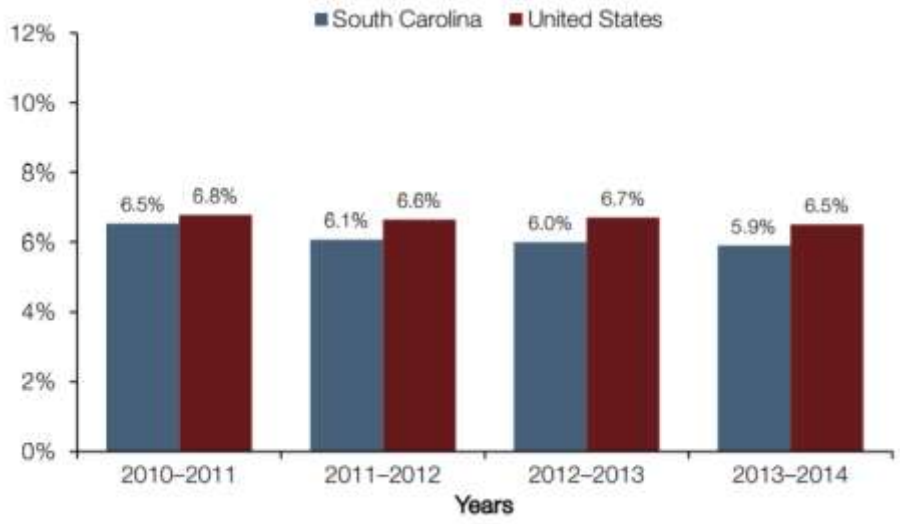
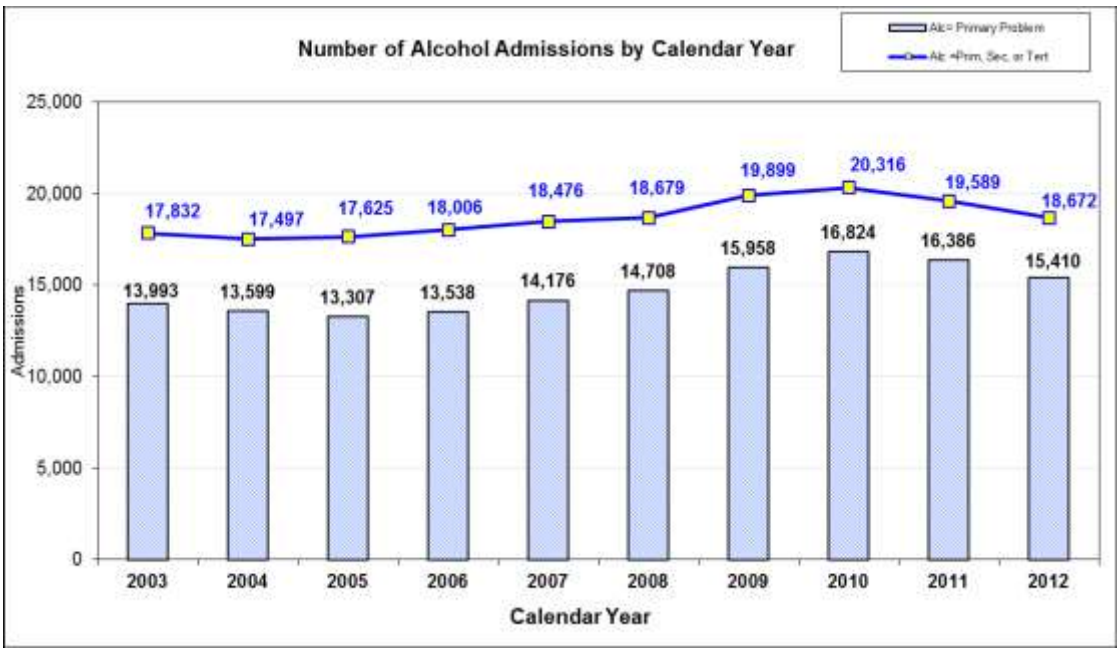


Figure Two: Alcohol admissions by calendar year



Adolescences and Alcohol Related Prevention:

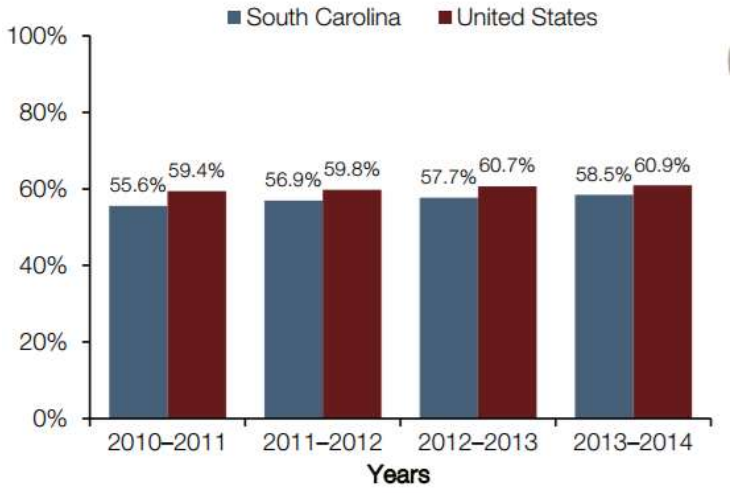
Substance use typically begins to emerge during adolescence. South Carolina's prevention efforts acknowledge the age distribution of substance use initiation by prioritizing prevention efforts aimed at reducing substance use during adolescence.

Rates of binge alcohol use for individuals 12 to 20 years old have consistently hovered around the 15% mark during the past five years according to the NSDUH. This rate has remained below the national average. South Carolina's percentage of binge alcohol use among individuals aged 12-20 was similar to the national percentage. In 2013-2014, 67,000 individuals reported binge alcohol use within the month prior to being surveyed.

Youth survey respondents are asked about the risks associated with substance use. Figure Three (next page) below provides trends regarding youth risk perceptions for binge drinking (defined as having five or more drinks on any one occasion). Estimates mirror national trends, indicating that more than half of adolescents discount risks associated with binge drinking. In South Carolina, roughly 58.5% of adolescents aged 12-17 in 2013-2014 perceived no great risk from having five or more drinks once or twice a week.

Aligning with our priorities, prevention of underage alcohol use is a high priority. Research has shown that early age of onset for using alcohol leads to an increased risk of developing a substance use disorder later in life (Hingson, 2006). The Centers for Disease Control and Prevention (CDC)'s 2015 Youth Behavior Risk Survey (YRBS) indicates that 17.8% of South Carolina high school students reported using alcohol before age 13 and 55.8% reported they had at least one drink of alcohol during their lifetime.

Figure Three



According to the 2016 Communities That Care (CTC) Survey, 48.1% of South Carolina high school students have used alcohol in their lifetimes. This begs the question of how so many youth manage to acquire alcohol. Also on the CTC Survey, 30.7% of South Carolina high school students reported that someone gave it to them at a party. Therefore, South Carolina plans to utilize environmental strategies such as high-visibility law enforcement to decrease accessibility of alcohol for youth, and eventually to decrease the prevalence of underage drinking in South Carolina.

However, it is the State's hope that continued utilization of evidence-based education curricula designed to inform youth about the dangers of early alcohol use will decrease youth use, particularly early in adolescence.

The Fatality Analysis Reporting System (FARS) reports the percentage of traffic fatalities that involved a driver with a blood alcohol concentration of 0.08% or higher. In 2014, South Carolina reported that 353 out of 809 fatalities (44%) met these criteria for an alcohol-involved fatality. This is 10% higher than the nation's average of 31% (10,136 out of 32,999 fatalities).

South Carolina will continue its partnership with Mothers Against Drunk Driving (MADD), the S.C. Highway Patrol, S.C. Law Enforcement Division, and other agencies and organizations to reduce alcohol-related car crashes.

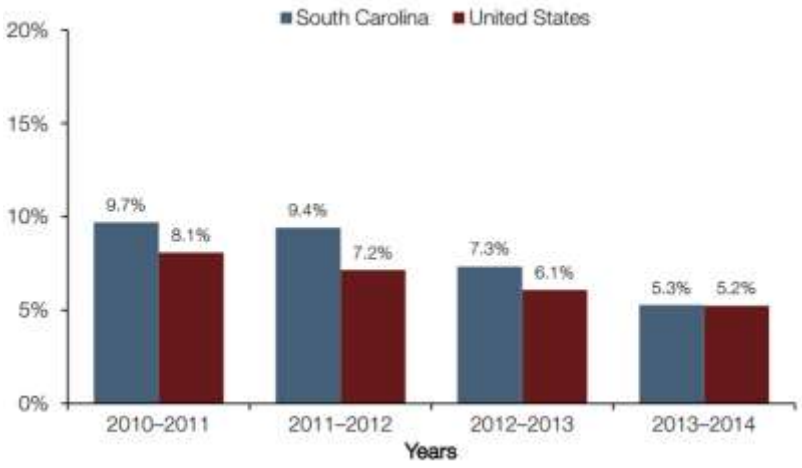
County prevention providers in South Carolina will work in collaboration with local law enforcement through the South Carolina Alcohol Enforcement Team (AET) program. The AETs will focus on environmental prevention activities to reduce youth access to alcohol through both social and retails sources. Specific environmental prevention activities could include alcohol compliance checks, merchant education, controlled party dispersals, and shoulder taps. County prevention providers will also work in collaboration with community coalitions to create and/or revise local policies that may positively impact underage drinking while training key stakeholders on evidence-based practices to reduce underage drinking.

Tobacco Use:

Figure Four below provides state and national estimates on the prevalence of cigarette use. These data, collected through NSDUH, indicate that around 19,000 individuals in South Carolina were using cigarettes during the past month prior to being surveyed.

However, approximately 60% of patients mentioned they were current smokers when entering treatment in FY17.

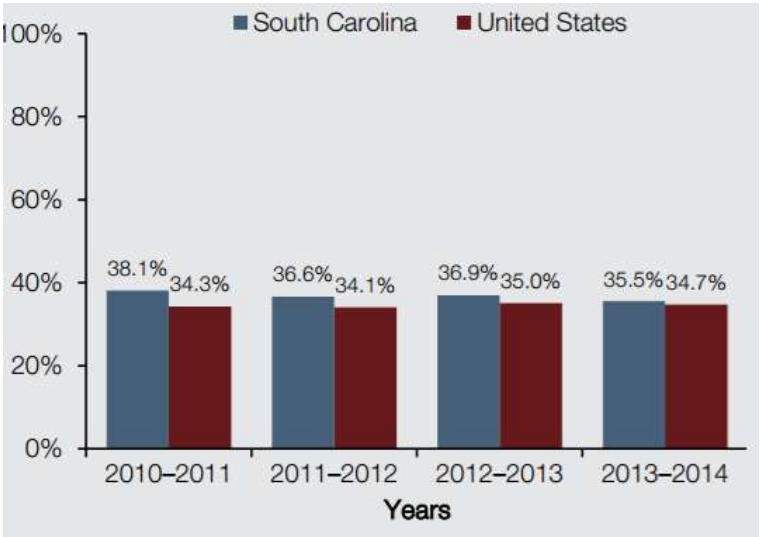
Figure Four: Past Month Cigarette Use among Adolescents Aged 12-17



Adolescents and Tobacco Related Prevention:

Youth survey respondents were asked about the risks associated with substance use. Figure Five below provides trends regarding youth risk perceptions for tobacco use. Estimates mirror national trends, indicating that 35.5% of adolescents aged 12-17 in 2013-2014 perceived no great risk from smoking one or more packs of cigarettes a day.

Figure Five. Adolescents Aged 12-17 Who Perceived No Great Risk from Smoking One or More Packs of Cigarettes a Day



While South Carolina is still working on reducing the prevalence of youth use of traditionally known forms of tobacco, there are other forms of tobacco emerging as threats to public health across the state. These forms of tobacco include roll-your-own cigarettes, flavored cigarettes, clove cigars, flavored "little cigarettes," smoking from a hookah or water pipe, snus, dissolvable products, and e-cigarettes. On the 2013 YTS, 36.5% of respondents reported using one of these tobacco products.

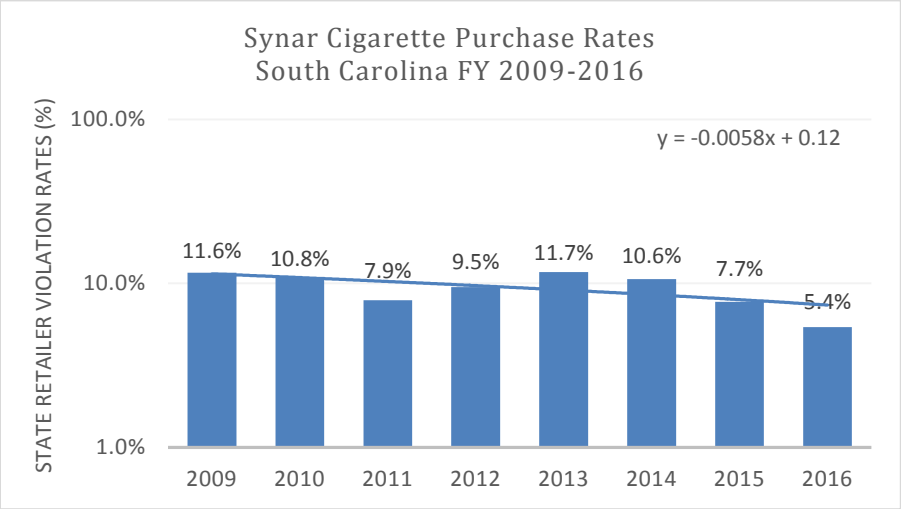
According to the 2015 YRBS, 29.1% of respondents currently use tobacco products in the past 30 days while 19.7% reported they currently use electronic vapor products. However, 42.9% reported that have used electronic vapor products in their lifetime.

Looking at the 2016 CTC, 63.3% of respondents reported that it was very easy or sort or easy to obtain cigarettes.

In 2013, a sample of 1,609 high school students answered the South Carolina Youth Tobacco Survey (YTS). Of these students, 23.7% reported that they currently smoked cigarettes. To measure access and accessibility, students under the age of 18 were asked where they got their cigarettes. The results were as follows: 22.9% reported that they purchased their cigarettes in stores, and 81.2% reported that they got their cigarettes from social sources such as friends, families, or others.

Despite this accessibility issue, the Synar study results from 2009 to 2016 demonstrate a small but steady decrease in the retailer violation rate. Figure Six below demonstrates the decrease over this period with only 5.4% buy rate in 2016.

Figure Seven



South Carolina will also continue to utilize its prevention staff to coordinate with local law enforcement and implement assorted evidence-based strategies to reduce youth-access to tobacco. Specific environmental prevention activities could include tobacco compliance checks and merchant education.

County prevention providers will provide information to youth and adults in South Carolina about the dangers, laws, consequences and harmfulness of underage tobacco use through the dissemination of information and deliver the South Carolina Tobacco Education Program (TEP)

for youth identified as having violated South Carolina law prohibiting youth under 18 from attempting to possess or purchase tobacco products.

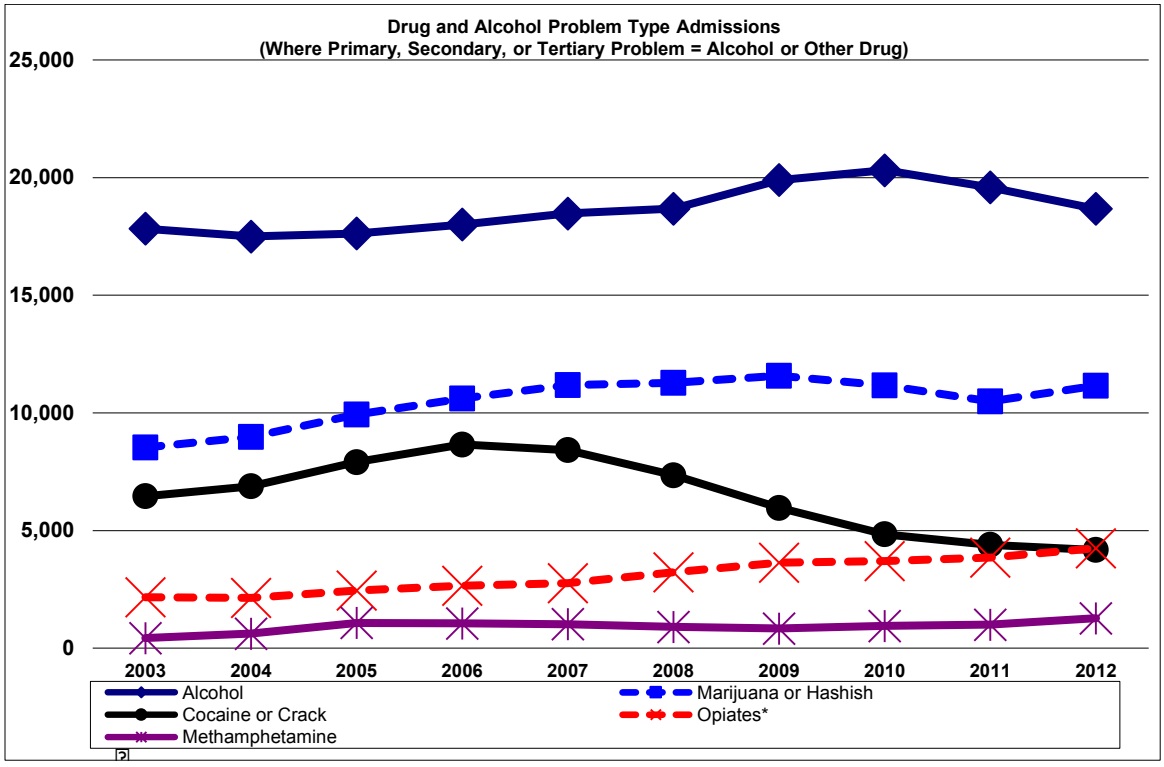
There are fewer federal, state, and local policies focused on regulating these emerging tobacco products, and South Carolina will look to dedicate additional resources toward better understanding youth use, access, and perceptions of these products.

Cannabis Use:

Figure Eight below indicates that historically South Carolinians in need of treatment for a primary problem related to cannabis use who received care through a DAODAS-funded provider have been on a rise since 2003.

Looking into FY17, 46.1% of patients mentioned a cannabis problem either primary, secondary or tertiary.

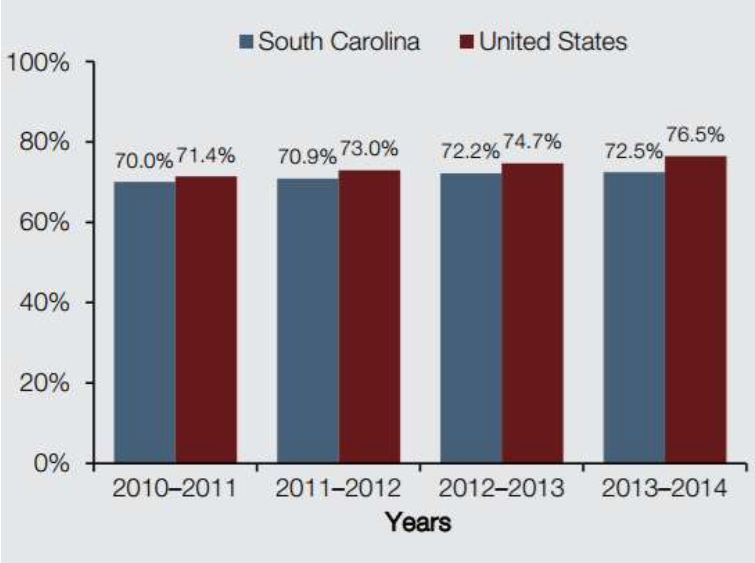
Figure Eight: Historical 2003 – 2012 Drug and Alcohol Admissions



Adolescents and Cannabis Related Prevention:

In South Carolina, about 7 in 10, 72.5%, of adolescents aged 12-17 in 2013-2014 perceived no great risk from smoking marijuana once a month (Figure Nine, next page). This percentage is slightly lower than the national average, but did not change significantly from 2010-2011 to 2013-2014.

Figure Nine: Adolescents Aged 12-17 Who Perceived No Great Risk from Smoking Marijuana Once a Month



According to the Youth Risk Behavior Surveillance System, 34.5 percent of adolescents have ever used marijuana. Also, 8.4% of adolescents tried marijuana before the age of 13, which is up from 8.0% in 2013.

According to the CTC Survey, 29.6% of South Carolina high school students have used marijuana in their lifetimes. 58.4% of respondents reported that it was very easy or sort of easy to obtain marijuana and almost half, 48.6%, saw no risk or slight risk in marijuana use.

It is South Carolina's hope that, with continued efforts to utilize SPF, community input, CSAP strategies, and evidence-based strategies/programs, the state can demonstrate success in reducing cannabis use among its residents.

Opiate Use:

Figure Eleven (next page) indicates that the State's rate of treatment need for problems related to opioid misuse has dramatically risen during the past decade. The number of admissions have been on a steady climb over the past decade, nearly by 300% from 2003 to 2013.

However, looking at FY17, 17% of South Carolinians in our treatment network had opioid related admission (Figure Twelve). 52% of those patients were male, 88% were white and 44% were between the ages of 25-34. Of patients with an opioid related admission, 30% had a primary problem with heroin (Figure Thirteen).

Looking at the distribution of patients, as expected, the counties with the highest rates of naloxone administration and mortality also held high rates of opiate related admissions (Figure Fourteen).

Figure Eleven

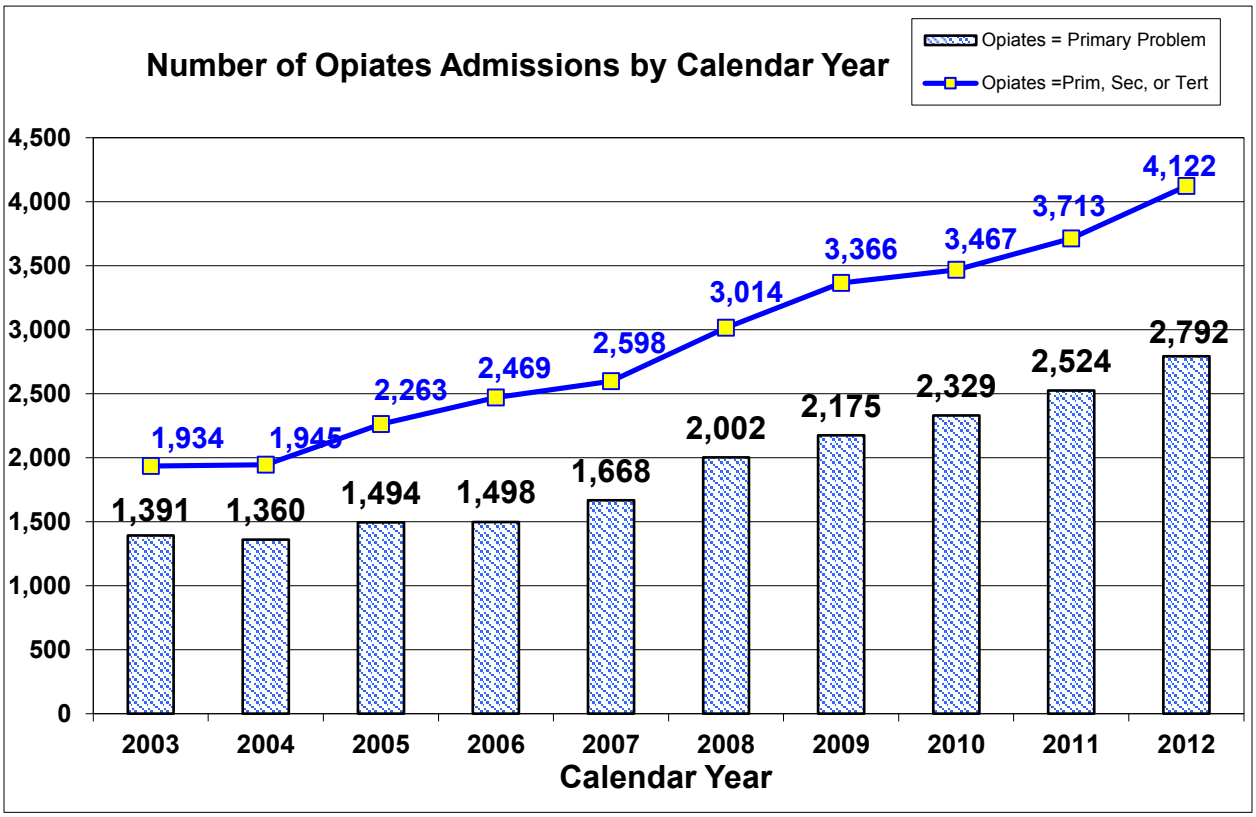


Figure Twelve

% of Total Unduplicated Patient Count

Substance Use Category	2016-07	2016-08	2016-09	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	SFY Total
Any Opiate Problem Type*	17%	16%	17%	15%	17%	18%	18%	16%	15%	18%	17%	19%	**17%**
Primary Problem Type = Heroin	6%	5%	5%	4%	5%	5%	5%	4%	5%	5%	6%	6%	**5%**
Any Problem Type = Heroin	7%	6%	7%	6%	7%	7%	7%	6%	6%	7%	8%	8%	**7%**
Primary Problem Type = Other Opiates	6%	6%	6%	5%	6%	6%	7%	7%	5%	7%	6%	7%	**6%**
Any Problem Type = Other Opiates	12%	12%	12%	11%	12%	13%	14%	13%	11%	13%	12%	14%	**12%**
Any Injection Use Mentioned**	3%	2%	3%	3%	3%	2%	3%	3%	2%	3%	3%	3%	**3%**
Past 30 Day Injection Use Mentioned	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	**2%**

* Any Opiate Problem = Heroin, Methadone, and Other Opiates and Synthetics
** Any Injection use and past 30 day injection use includes injection of non-opiate substances

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Figure Thirteen

% of Total of Unduplicated Patients Reporting Opiate Problem Types

Substance Use Category	2016-07	2016-08	2016-09	2016-10	2016-11	2016-12	2017-01	2017-02	2017-03	2017-04	2017-05	2017-06	SFY Total
Primary Problem Type = Heroin	33%	29%	29%	28%	29%	31%	28%	27%	31%	29%	36%	31%	**30%**
Any Problem Type = Heroin	44%	38%	40%	39%	38%	41%	39%	37%	40%	41%	47%	43%	**40%**
Primary Problem Type = Other Opiates	35%	36%	36%	34%	37%	34%	38%	41%	35%	37%	33%	37%	**36%**
Any Problem Type = Other Opiates	71%	74%	73%	72%	72%	74%	75%	78%	76%	73%	71%	73%	**74%**
Any Injection Use Mentioned**	16%	16%	16%	17%	18%	14%	18%	16%	15%	18%	16%	17%	**16%**
Past 30 Day Injection Use Mentioned	12%	10%	12%	10%	13%	9%	11%	9%	10%	11%	11%	10%	**11%**

* Any Opiate Problem = Heroin, Methadone, and Other Opiates and Synthetics
** Any Injection use and past 30 day injection use includes injection of non-opiate substances

Figure Fourteen

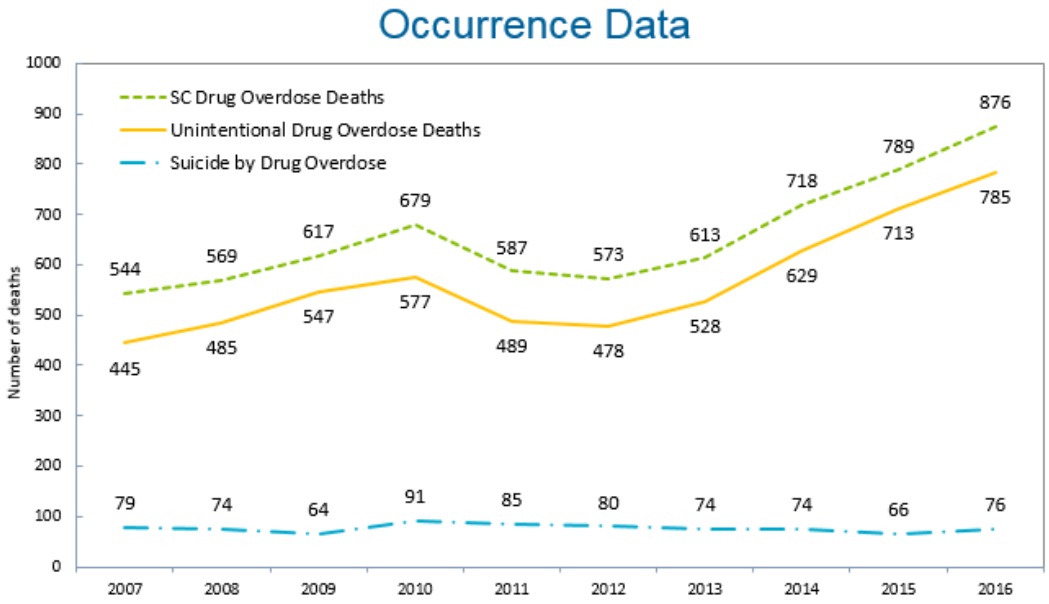
Agency	Total Unduplicated Admissions	% Opiate Related Admissions
York	2,026	28.1%
Charleston	2,652	28.0%
Colleton	360	24.7%
Greenville	4,286	23.9%
Florence	1,300	20.2%
Horry	2,044	19.5%
Georgetown	352	18.5%
Williamsburg	301	18.3%
LRADAC	4,213	18.1%
Lancaster	437	17.6%
Spartanburg	1,803	16.9%
State Average	**35,028**	**16.8%**

Additional data from the State's Health Agency – the Department of Health and Environmental Control (DHEC) – provide some indication of the consequences related to opiates associated with injection drug use. Between 1999 and 2013, unintentional drug poisoning (overdose) deaths for heroin increased from three to 27. When combining all opiates, those figures jump from 21 in 1999 to 154 in 2013. DHEC representatives suspect these data actually underrepresent the true volume of overdose deaths.

There was an 11% increase in drug overdose deaths in South Carolina, up from 789 deaths in 2015 to 876 deaths in 2016. In 2016, 70.3% of all drug overdose deaths involved opioids. There was a 9% increase in deaths involving opioids, up from 565 in 2015 to 616 in 2016. Deaths due to opioid overdose in SC by occurrence has been on a steady rise since 2007 (Figure Sixteen).

The largest percent change in the past two years were deaths related to fentanyl, with a 46% increase (130 in 2015 to 190 in 2016).

Figure Fifteen

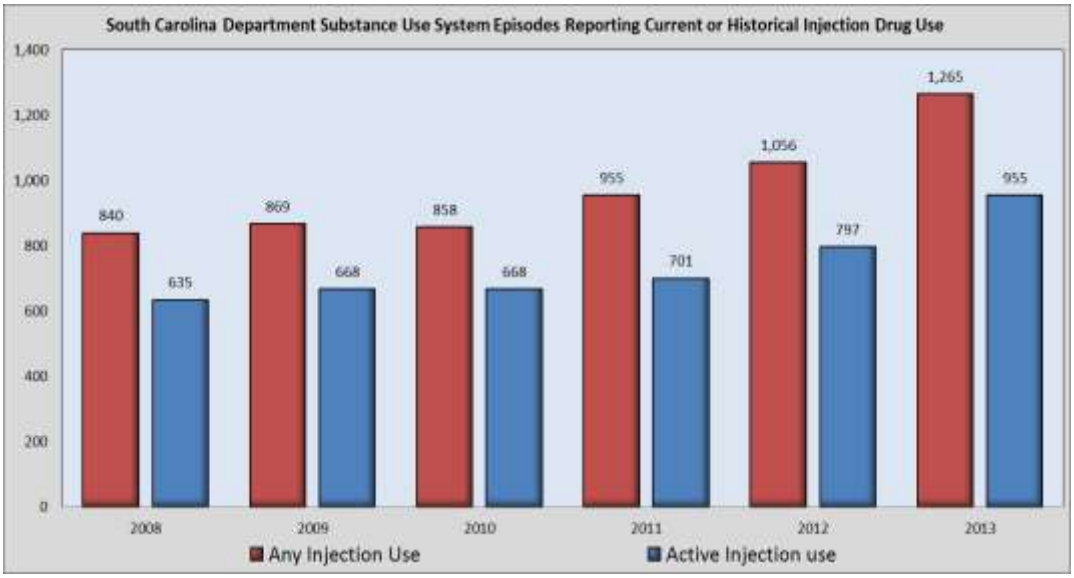


Persons who are intravenous drug users:

Figure Sixteen on the following page provides a brief description of the volume of clients entering treatment services. The chart indicates that clients reporting active injection use at admission increased 50% from 2008 to 2013. Slightly more than two-thirds of active intravenous drug users reported their primary problem was related to opiate use. Approximately 30% reported having a mental health problem in addition to a substance use disorder.

Despite limitations, these figures help to illustrate the dramatic increase and risk associated with opiate use and its relationship to injection-related methods of administration.

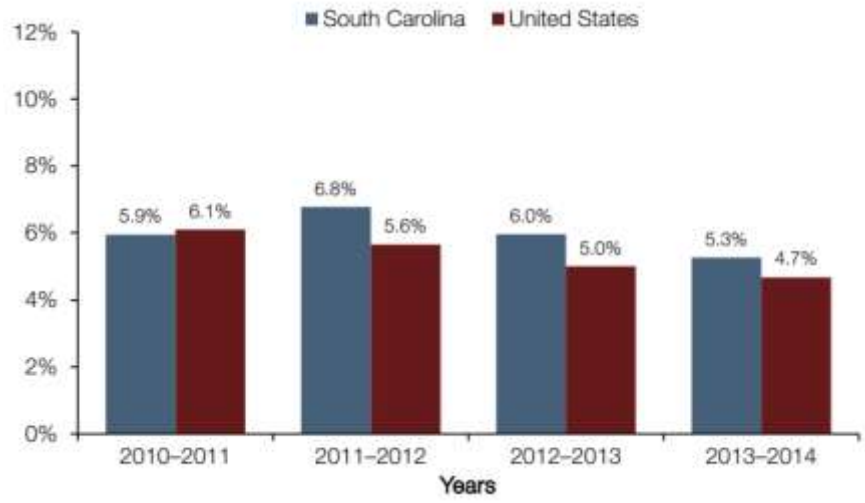
Figure Sixteen: Episodes Reporting Current or Historical Injection Drug Use



Adolescents and Opioid Related Prevention

South Carolina's percentage of nonmedical use of pain relievers among adolescents aged 12-17 was similar to the national percentage in 2013-2014 from the NSDUH. Roughly 19,000 adolescents aged 12017, 5.3%, per year reported nonmedical use of pain relievers within the year prior to being surveyed (Figure Seventeen).

Figure Seventeen: Past Year Nonmedical Use of Pain Relievers Among Adolescents Aged 12-17



According to the 2015 YRBS, 16.4% of respondents have took prescription drugs without a doctor's prescription in their lifetime and 2.1% have used heroin.

Similar to the YRBS, 2.2% of respondents from the 2016 CTC reported ever using heroin. However, only 7.7% of respondents currently misuse prescription drugs. 47.2% of CTC

respondents reported the source of their prescription drug use was from a family member without asking or from a friend for free.

DAODAS is focused on the potential risk associated with this population initiating injection-use practices and has created state and local priority areas that focus prevention and treatment services around both patients currently reporting Intravenous drug use, as well as those at risk of transitioning to intravenous drug use. Associated strategies include treatment efforts to expand medication-assisted therapies able to reduce the symptoms of opiate dependence, as well as prevention efforts designed to reduce access to unused prescription pain medications. Through a SAMHSA Partnerships for Success 2015 (PFS 2015) award, DAODAS implements the Empowering Communities for Healthy Outcomes (ECHO) project to prevent the onset and reduce the progression of prescription drug misuse. Implementation communities will work towards reducing past-30-day use of non-prescribed prescription drugs by youth and implement evidence-based programs and/or promising practices in response to local strategic plans.

Federally Identified Priority Populations and Services:

The Substance Abuse Prevention and Treatment Block Grant requires that states address several priority populations and services. A comprehensive listing of these priority areas is provided below.

1) Persons who are intravenous drug users
2) Women who are pregnant and have a substance use disorder
3) Parents with substance use disorders who have dependent children
4) Individuals with tuberculosis
5) Persons living with or at risk for HIV/AIDS who are in need of substance misuse intervention, treatment, or prevention services
6) Individuals in need of primary substance misuse prevention

A discussion of these remaining priorities immediately follows the list.

Women who are pregnant and have a substance use disorder:

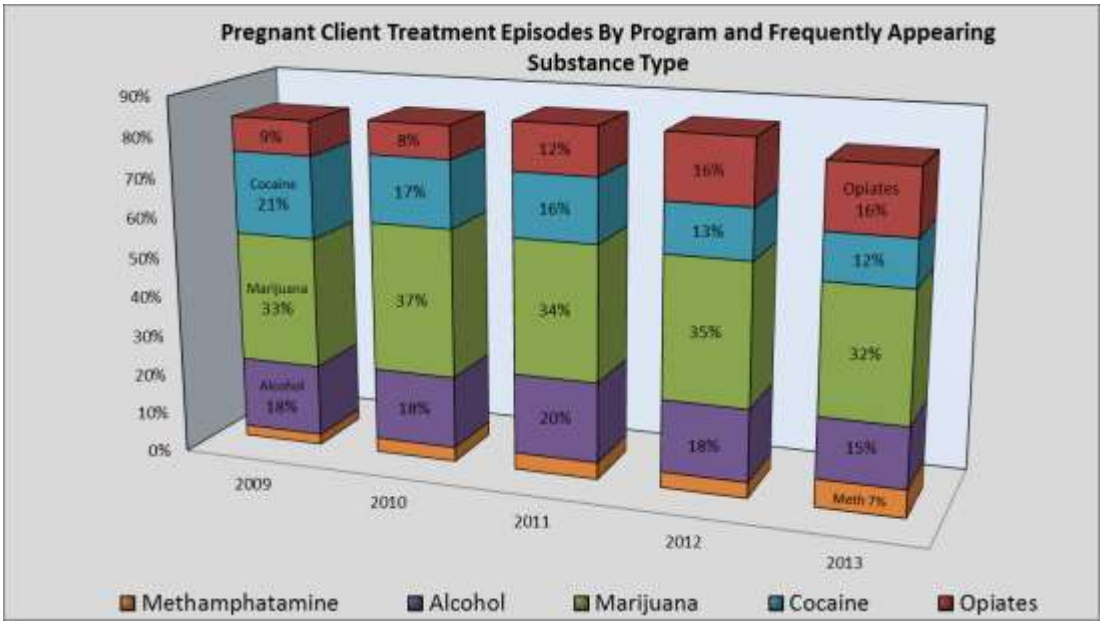
Pregnant women are given priority access to treatment services available through the DAODAS-funded provider network. Residential, day treatment, and intensive outpatient services are available in every region of the state. Figure Seventeen (next page)provides trends for frequently reported primary substance use types for pregnant clients in previous fiscal years.

However, there were 709 pregnant clients accessing care during fiscal year 2017. Similar to previous years, approximately half of pregnant patients were treated for marijuana misuse, followed by 34% for alcohol misuse and 25% for opiate misuse.

DAODAS will ensure that high quality substance use disorder treatment services for pregnant females are available within each community. The SSA will implement strategies to include expansion of primary and specialty health care substance use screenings for pregnant females, increase collaboration with the State's Social Services Agency responsible for child welfare through co-location of staff and improved screening/referral service delivery coordination and

continue collaboration with the State's Medicaid Agency to engage OBGYN service providers in screening, intervention, and referral to treatment service models.

Figure Seventeen



Parents with substance use disorders (SUDs) who have dependent children:

DAODAS and its local provider network ensure that a continuum of quality treatment services for parents with dependent children is accessible throughout the state. Residential and intensive outpatient care focusing on the family unit is available in every region of the state. Over the past eight years, approximately 35% of adult clients reported living with one or more dependent children. Figure Eighteen (next page) provides an illustration contrasting clients with and without dependent children who are entering care. Service provision and child care targeting young family members are offered in addition to traditional SUD treatment in order to meet the needs of the entire family

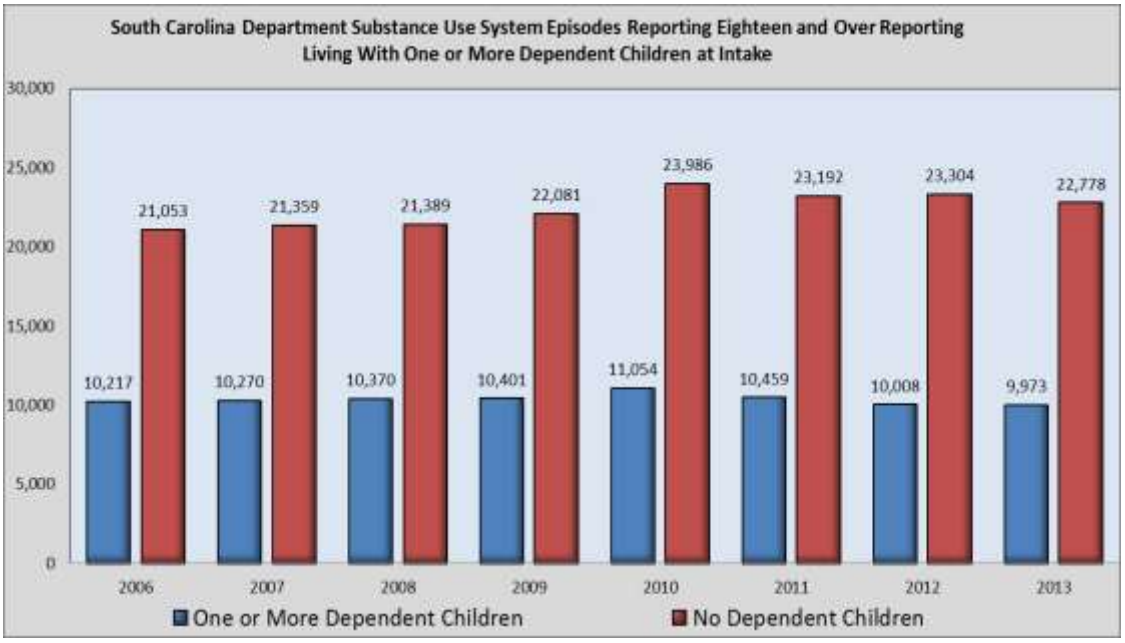
After the criminal justice system, social services represent the largest referral source for DAODAS and its local provider network. The majority of these clients (approximately 4,500 admissions a year) are involved with the S.C. Department of Social Services (DSS) Child Protective Services Unit. Figure Ten provides information from DSS regarding the volume of services associated with child welfare (DSS, 2015). The graphic indicates that approximately 30,000 cases of child abuse or neglect were made during the most recently completed fiscal year. Of those, one-fifth (6,000) were screened as having no risk. The remaining 24,000 calls indicated some level of risk requiring additional assessment and service delivery. Unknown by DSS is the proportion of calls prompting further service delivery associated with parent or guardian substance use.

During the past few years, DAODAS has strengthened its collaboration with DSS by funding full-time SUD counselors who are collocated in local DSS offices. These positions strengthen the assessment and service-delivery process for DSS, which is the state's Child Protective

Service agency, by conducting screenings, assessments, and coordinated treatment referrals for parents or guardians with active abuse or neglect investigations.

South Carolina will ensure that high quality family focused substance use disorder treatment services are available within each community. Strategies for working with parents with substance uses disorder who have dependent children include increasing collaboration with the state's social services agency responsible for child welfare through co-location of staff and improved screening/referral service delivery coordination and expanding opportunities for family participation across the service menu.

.**Figure Eighteen**



Individuals with tuberculosis and persons living with or at risk for HIV/AIDS who are in need of substance misuse intervention, treatment, or prevention services:

Assessment processes for all clients entering SUD treatment and intervention services include a screening for behavioral risks and symptoms associated with communicable diseases such as HIV/AIDS, hepatitis, sexually transmitted diseases (STDs), and tuberculosis. Education, prevention, and testing services for HIV/AIDS and tuberculosis are emphasized throughout the continuum of services offered by DOADAS-funded providers. Expanded efforts to include similar services designed to address risks for hepatitis and other STDs represent critical gaps that will continue to be explored with DHEC, the State's public health department, during the planning period.

Healthcare providers in South Carolina are required to report detected cases of HIV/AIDS to DHEC. This data-collection standard has provided the state with a useful trend measure that can be used to track the incidence of HIV/AIDS. There were 742 newly reported cases of HIV infection in the state in 2015. The same report indicates that there were 18,420 individuals living in South Carolina who were HIV/AIDS positive as of December 2015, up from 16,312.

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Nationally, South Carolina ranks 17th among all states and territories for both HIV/AIDS incidence and prevalence rates (DHEC, 2015).

Of the 742 newly reported cases in 2015, 21 (2.8%) were linked to HIV/AIDS exposure due to injection drug use. Similar to previous years, half of all newly reported cases were under the age of 39. New cases were predominately black (69.1%) and male (71%). Approximately 27% of newly reported cases originated from the Low Country region of the state. The three largest counties – Charleston, Richland, and Greenville – made up slightly more than one-third of the newly reported cases in calendar year 2015.

DAODAS funds 18 providers across the state to provide HIV early intervention services. Ten of the funded sites are classified as rural. Within these sites, 1,200 HIV tests were administered to clients receiving SUD treatment and intervention services during the most recent reporting time frame. Four tests (<1%) were determined to be HIV positive.

Healthcare providers in South Carolina are also required to report detected cases of tuberculosis (TB) to DHEC. This data-collection standard has provided the state with a useful measure that can be used to track the incidence of TB. During 2015, there were 104 newly reported cases of TB infection in the state, up from 79 reported in 2014 (13% increase). Similarly from the CDC, the United States experienced a small but significant increase between 2014 and 2015 in the case rate.

All clients receiving SUD treatment and intervention services are screened for symptoms associated with tuberculosis and other communicable diseases. Detoxification and residential treatment settings have additional screening and testing protocols due to program structure and shared living arrangements. Data-collection protocols for communicable diseases have improved through the DAODAS provider network's continuing efforts toward implementation of a uniform electronic clinical record.

Information gathered at initial assessment within DAODAS' 301 system indicates that one-third of patients reported having unprotected sex within the past six months (with single or multiple partners). Approximately 2.5% reported having sex with someone who was positive for HIV or hepatitis C. Slightly below 5% of assessed clients reported sharing needles and related paraphernalia to inject drugs.

For HIV, DAODAS will work towards increasing the number of clients screened for high-risk behaviors associated with HIV infection, the number of Oraquick HIV rapid tests among clients who were found – through universal screening protocols – to be at high risk for behaviors associated with HIV infection. DAODAS and its funded provider network will also continue to implement a method of data collection that relies on the provider's electronic health record to gather and store data associated with screening and provision of the Oraquick HIV rapid tests.

For individuals with tuberculosis, DAODAS will enhance the availability of routine TB services for individuals receiving substance use disorder treatment services. THE SSA will monitor the protocol and support local training efforts and utilize the AOD provider electronic health record capability to track data associated with the provision of client focused routine TB screening.

Conclusion:

The preceding section provides information that supports each of the State's identified priority areas. Where appropriate, plans to explore or implement strategies for eliminating identified information or service gaps were highlighted. The following list provides a brief review of plans to address identified data gaps highlighted in each priority area. More information linking identified service and system gaps to strategies designed to address deficits for each priority area will be offered in Section III.

Overview of Plans to Address Data and System Gaps

1. Increase the SEOW's contribution to both the prevention and treatment needs-assessment process.
2. Explore opportunities to partner and increase collaboration with key community and state partners through data analysis efforts associated with the S.C. Revenue and Fiscal Affairs Office's Data Warehouse.
3. Explore the availability and quality of data associated with SUD treatment services occurring outside of the state's network of public providers. Assess the potential to use available data for improved collaboration between public and private providers of behavioral health care.
4. Monitor access, utilization, and outcomes associated with SUD treatment and intervention services for highlighted referral sources and demographic groups in order to evaluate outreach efforts designed to foster collaboration with partner agencies.
5. Continue to work with the state's Electronic Health Record Implementation Team to explore potential strategies for addressing data gaps in needs-assessment and service-planning activities.
6. Expand the use of Health Information Exchange systems for improved collaboration and integration between behavioral and physical healthcare providers.

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Step 3. Quality and Data Collection Readiness

1. *Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).*

The Department of Alcohol and Other Drug Abuse Services (DAODAS) has financially supported its provider network's implementation of a uniform electronic clinical record for the provision of public substance use disorder treatment services. Implementation for all 32 providers began in February 2013. Full transition of all client-level data collection activities began in December 2013. Data collected within the clinical record includes client demographics, service utilization, and client functioning throughout an episode of care. Data access features allow for reporting at the agency, program, provider, and client levels. The software vendor continues to develop a data warehouse for its entire customer base that provides access to additional data not currently captured in the TEDS data set. These continued efforts should provide DAODAS and its local network with access to an expanded set of client and service-utilization data for reporting purposes.

South Carolina collects all of the required data for the primary prevention forms to report on the usage of the SABG primary prevention set-aside through the IMPACT system developed by Mosaix Software. Data collected on each prevention service provided throughout the state includes: number served, demographics, time spent preparing for and conducting the service activity, etc. The state collects additional information on evidence-based curriculum programs and environmental strategies for the statewide prevention evaluation report. South Carolina has been contracting with the Pacific Institute for Research and Evaluation (PIRE) to evaluate prevention services in South Carolina since 2005.

DAODAS uses multiple methods of outcome evaluation, with each method suited to the particular type of prevention services being evaluated and commensurate with anticipated level of impact of those strategies. In other words, we put the most effort into the evaluation of strategies that promise to have the greatest impact on risk factors, levels of use, or consequences. Each year since 2005, PIRE has produced a prevention outcomes report for South Carolina. These reports summarize prevention outcomes generated by the state's substance abuse prevention system. A large portion of the content of these reports focuses on the outcomes generated through pre- and post-testing of multi-session youth prevention curricula because those evaluation methods are the most standardized across state. In addition, other sections of the report focus on the outcomes that can be assessed across the state in the implementation of environmental strategies and the Youth Access to Tobacco Study (Synar). Copies of the reports can be assessed by visiting the following website: http://ncweb.pire.org/scdocuments/

For education services, since 2005 DAODAS has been requiring the use of a standardized pre- and post-test for curricula. This questionnaire addresses five common risk factors for youth initiation, measures past-30-day use of eight substances, and includes several other questions related to issues like age of first use and parental communication about ATOD use. Counties administer the surveys locally under guidance developed by PIRE and send them to DAODAS for PIRE to scan, analyze, and prepare local and state outcome reports.

For environmental strategies, DAODAS has forms developed for the following law enforcement operations: compliance checks, public safety checkpoints, fake ID checks, saturation patrols, controlled party dispersals, and "shoulder taps." These are completed locally, typically by law enforcement, and sent to DAODAS via the 16 judicial circuit Alcohol Enforcement Team Coordinators. PIRE scans and analyzes these data. Data are handled different based on the operation. For some, total ticket counts primarily are tracked. For compliance checks, multiple analyses are done with the provided data, primarily calculating changes in retailer violation rates for underage sales over time.

The state also has standardized evaluation tools for the Palmetto Retailer Education Program (PREP) and the Tobacco Education Program (TEP) for youth who violate the laws against underage tobacco possession.

For the rest of the funded programs, some are evaluated locally, with consultation available from PIRE, because they are unique local efforts that fall outside the established standardized evaluation protocols. Others are determined to be unlikely to generate true risk factor/behavioral outcomes – information dissemination, community-based processes, and alternatives – and are primarily evaluated only by tracking process measures like the number of materials disseminated or number of people reached.

The annual outcomes report serves as a companion document to the *South Carolina Profile on Alcohol, Tobacco, and Other Substance-Related Indicators* (the "SEOW Profile"). The report provides an overview of data indicators related to youth and adult drug use, consequences and risk factors, and is an important measuring stick for the overall direction of the state in addressing its ATOD issues. In particular, the report provides updates on progress for the four state ATOD priorities determined by the Governor's Council on Substance Abuse Prevention and Treatment:

- Underage drinking
- Alcohol-related car crashes (including youth crashes)
- Youth tobacco use (including smokeless tobacco use)
- Substance use during pregnancy

The report focuses more on efforts with clearly attributable outcomes or in-depth analyses of process data to inform South Carolina's prevention efforts. Understanding and building upon our measurable efforts while working toward the goal of "moving the needle" on state indicators is a positive complementary approach.

2. *Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).*

The department's data collection activities are limited to the provision of public substance use disorder treatment services. Data included in the system, however, includes claims submitted to Medicaid and other third-party payers.

3. *Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?*

The state resumed submission of client-level data collection during Federal Fiscal Year 2016. The state is currently submitting approximately 3,000 patient records to SAMHSA's Treatment Episode Data Set Vendor each month

4. *If not, what changes will the state need to make to be able to collect and report on these measures?*

No changes are required at this time.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Underage Alcohol Use

Priority Type: SAP

Population(s): PP

Goal of the priority area:

To reduce underage alcohol use in South Carolina.

Objective:

i. Decrease past month alcohol use (30 day use) among South Carolina high school students to 30% or less.
ii. To reduce the underage alcohol buy rate for the state of South Carolina to 12% or less.

Strategies to attain the objective:

i. County prevention providers will provide information to youth and adults in South Carolina about the dangers, laws, consequences and harmfulness of underage alcohol use through the dissemination of information.
ii. County prevention providers in South Carolina will work in collaboration with local law enforcement through the South Carolina Alcohol Enforcement Team (AET) program. The AETs will focus on environmental prevention activities to reduce youth access to alcohol through both social and retails sources. Specific environmental prevention activities could include alcohol compliance checks, merchant education, controlled party dispersals, and shoulder taps.
iii. County prevention provides will work in collaboration with community coalitions to create and/or revise local policies that may positively impact underage drinking.
iv. Training will be provided to all key stakeholders on evidence-based practices to reduce underage drinking.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Self-reported past month (30 day) alcohol use among South Carolina high school students

Baseline Measurement: 24.6% (2015)

First-year target/outcome measurement: 24% or less

Second-year target/outcome measurement: 23% or less

Data Source:

Youth Behavior Risk Survey (YRBS)

Description of Data:

The YRBS is conducted every two years in South Carolina with a sample of high school students from public high schools throughout the state.

Data issues/caveats that affect outcome measures::

None.

Indicator #: 2

Indicator: Underage alcohol buy rate for the state of South Carolina

Baseline Measurement: 11.1% (2016)

First-year target/outcome measurement: 11% or less

Second-year target/outcome measurement: 11% or less

Data Source:

Local law enforcement data reported via the AET Alcohol Compliance Check Form.

Description of Data:

Local law enforcement reported via the AET Alcohol Compliance Check Form. The information on each form is aggregated to the county level and the state level.

Data issues/caveats that affect outcome measures::

Local law enforcement choose the frequency and targets of their compliance check efforts. Therefore, there may be some inconsistency from year to year in what areas receive compliance checks and to what intensity. This may have some influence on the buy rate, particularly if an area not traditionally enforced begins to receive compliance checks. These areas often begin with higher buy rates.

Priority #: 2

Priority Area: Alcohol-related car crashes

Priority Type: SAP

Population(s): PP

Goal of the priority area:

To reduce alcohol-related car crashes across South Carolina

Objective:

Decrease the percentage of motor vehicle fatalities in which one or more drivers had a BAC of 0.08 or higher to 40% or less

Strategies to attain the objective:

i. Local prevention providers in South Carolina will disseminate information to driving-age youth and adults about the dangers, law, and consequences of impaired driving through presentation, health fairs, media campaigns, distribution of printed materials, newspaper articles, and other media outreach.
ii. Prevention providers in South Carolina will work in collaboration with local law enforcement through the South Carolina Alcohol Enforcement Team (AET) program. The AETs will focus on environmental prevention activities to reduce alcohol-related car crashes through public safety checkpoints, saturation patrols, and merchant education to prevent over-service and intoxicated driving.
iii. Six Strategic Prevention Framework Partnerships for Success (SPF-PFS) counties will be funded in the FY2016 year to address impaired driving in their communities. The funded sites will implement selected evidence-based environmental strategies to address the root causes of impaired driving, including alcohol-related car crashes, as identified through the Strategic Prevention Framework. The funds will likely remain in place until September 30, 2020.
iv. Key stakeholders will be trained on evidence-based practices reducing alcohol-related car crashes.
v. In collaboration with community coalitions, prevention providers will work to create and/or revise local policies that may help reduce the number of alcohol-related crashes in communities

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percentage of motor vehicle fatalities attributable to alcohol in South Carolina

Baseline Measurement: 31% (2015)

First-year target/outcome measurement: 31% or less

Second-year target/outcome measurement: 31% or less

Data Source:

South Carolina Department of Public Safety Office of Highway Safety and Justice Programs 2015 Impaired Driving Countermeasures Plan.

Description of Data:

Using FARS data (Fatal Accident Reporting System. Financial Accounting and Reporting System), the indicator measures the percentage of deaths in motor vehicle crashes that involve a driver with a BAC of .08% or greater.

Data issues/caveats that affect outcome measures::

Time lag associated with determining cause of motor vehicle fatalities associated with excessive alcohol consumption.

Priority #: 3

Priority Area: Youth Tobacco Use

Priority Type: SAP

Population(s): PP

Goal of the priority area:

To reduce tobacco use among youth in South Carolina

Objective:

i. To reduce the state Retailer Violation Rate (RVR) to 10% or less.
ii. To reduce past-month tobacco use (30 day use) among South Carolina high school students to 15% or less

Strategies to attain the objective:

i. County prevention providers will provide information to youth and adults in South Carolina about the dangers, laws, consequences and harmfulness of underage tobacco use through the dissemination of information.
ii. County prevention providers in South Carolina will work in collaboration with local law enforcement to implement environmental prevention activities to reduce youth access to tobacco through retails sources. Specific environmental prevention activities could include tobacco compliance checks and merchant education.
iii. County prevention providers will work in collaboration with community coalitions to create and/or revise local policies that may positively impact youth tobacco use.
iv. Training will be provided to all key stakeholders on evidence-based practices to reduce youth tobacco use.
v. Local prevention providers will continue to assist the State in implementing the annual Youth Access to Tobacco Study to measure the retailer violation rate (RVR) in South Carolina.
vi. Local prevention providers will deliver the South Carolina Tobacco Education Program (TEP) for youth identified as having violated South Carolina law prohibiting youth under 18 from attempting to possess or purchase tobacco products. The referral of youth to this program can come from the courts, schools, parents/guardians, and/or from the youth themselves.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Self-reported past month (30 day) tobacco use (cigarettes) among South Carolina high school students

Baseline Measurement: 9.6% (2015)

First-year target/outcome measurement: At or below 9.6%

Second-year target/outcome measurement: Below 9%

Data Source:

Youth Behavior Risk Survey (YRBS).

Description of Data:

The YRBS is conducted every two years in South Carolina with a sample of high school students from public high schools throughout the state.

Data issues/caveats that affect outcome measures::

None.

Indicator #: 2

Indicator: The state Retailer Violation Rate (RVR) as measured by the Youth Access to Tobacco Study

Baseline Measurement: 5.3%

First-year target/outcome measurement: At or below 5%

Second-year target/outcome measurement: At oe below 5%

Data Source:

The state Retailer Violation Rate (RVR) as measured by the Youth Access to Tobacco Study.

Description of Data:

Youth Access to Tobacco Study measures the percentage of retailers that sold cigarettes to an underage buyer.

Data issues/caveats that affect outcome measures::

The study has up to a 3% margin of error. The study universe is compromised by the lack of a comprehensive listing of all outlets selling tobacco within the state.

Priority #: 4

Priority Area: Women who are pregnant and Women with Dependent Children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Ensure that high quality substance use disorder treatment services for pregnant women and women with dependent children are available within each community.

Objective:

1. Increase the number of pregnant females who complete treatment services by 5% by the end of the planning period (from baseline SFY 2017)
2. Increase the number of pregnant opioid users who are able to access MAT service by 5% by the end of the planning period (from baseline SFY 2017)

Strategies to attain the objective:

i. Increase the use of Trauma specific and other evidence based treatment services that increase good outcomes for this population.
ii. Increase collaboration with waiver 2000 physicians and Methadone Clinics through co-location of staff and/or improved screening/referral service delivery coordination.
iii. Continue collaboration with the State's Medicaid Agency to engage OBGYN service providers in screening, intervention, and referral to treatment service models.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Successful completion of treatment episod of patients who are pregnant.

Baseline Measurement: 41% of patients who are pregnant successfully complete their treatment episode.

First-year target/outcome measurement: 42% of patients who are pregnant successfully complete their treatment episode (increase of 2.5%)

Second-year target/outcome measurement: 43% of patients who are pregnant successfully complete their treatment episode (increase of 5%)

Data Source:

Provider clinical record data extract.

Description of Data:

All DAODAS funded providers across the state currently use the same vendor for their electronic clinical record. Data stored in the record includes client demographics, referral source, clinically relevant information used for treatment planning, as well as service utilization information.

Data issues/caveats that affect outcome measures::

None.

Indicator #: 2

Indicator: Number of pregnant women who are diagnosed with Opioid Use Disorder and begin using MAT services.

Baseline Measurement: 68 pregnant women were diagnosed with (OUD) and began to use MAT services.

First-year target/outcome measurement: At least 70 pregnant women who are diagnosed with Opioid Use Disorder and will begin using MAT services (increase of 2.5%)

Second-year target/outcome measurement: At least 72 pregnant women who are diagnosed with Opioid Use Disorder and will begin using MAT services (increase of 2.5%)

Data Source:

DAODAS funded provider electronic clinical record data extract.

Description of Data:

All DAODAS funded providers across the state currently use the same vendor for their electronic clinical record. Data stored in the record includes client demographics, referral source, clinically relevant information used for treatment planning, as well as service utilization information.

Data issues/caveats that affect outcome measures::

None.

Indicator #: 3

Indicator: Broken appointments (no-show rate) from assessment to first clinical service.

Baseline Measurement: The rate will be based on state-wide data collected 10/01/2017 to 12/31/2017.

First-year target/outcome measurement: The no show rate from assessment to first clinical service will be reduced by at least 25%.

Second-year target/outcome measurement: The no show rate from assessment to first clinical service will be reduced by at least 33%.

Data Source:

Provider clinical record data extract.

Description of Data:

All DAODAS funded providers across the state currently use the same vendor for their electronic clinical record. Data stored in the record includes client demographics, referral source, clinically relevant information used for treatment planning, as well as service utilization information.

Data issues/caveats that affect outcome measures::

None.

Priority #: 5

Priority Area: Primary Substance Abuse Prevention—Community Populations for Environmental Prevention Activities and Community Settings for Universal, Selective, and Indicated Prevention Interventions

Priority Type: SAP

Population(s): PP

Goal of the priority area:

To provide primary prevention programs and practices to prevent substance abuse and improve the well-being of youth and families in South Carolina

Objective:

i. 95% or more of individuals participating in primary prevention educational programs will be served using evidence-based universal, selected and indicated programs.

ii. To reduce the percentage of South Carolina high school students reporting the use of any substance in the past 30 days to 45% or less.

Strategies to attain the objective:

i. County prevention providers will provide information to youth and adults in South Carolina about the dangers, laws, consequences and harmfulness of substance use and substance abuse through the dissemination of information.
ii. County prevention providers in South Carolina will deliver evidence-based universal, selected, and/or indicated educational primary prevention programs to youth, adults, and/or families throughout the state based on the needs of individual communities.
iii. DAODAS prevention consultants and regional capacity coaches will provide technical assistance and training to local prevention professionals throughout the state to develop and implement strategic plans to address substance abuse in South Carolina.
iv. DAODAS will train local prevention providers in South Carolina on evidence-based primary prevention programs and practices to reduce substance use and abuse and to promote healthier communities throughout the state.
v. In collaboration with community coalitions, local prevention providers will work to create and/or revise local policies that may positively impact communities and reduce substance use in South Carolina's counties.
vi. In collaboration with community coalitions and partner agencies, local prevention providers will work to provide substance-free alternative events and services for youth in their communities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of the participants served by primary prevention evidence-based universal, selected, and indicated educational programs

Baseline Measurement: 99.5% (2016)

First-year target/outcome measurement: At or above 99%

Second-year target/outcome measurement: At or above 99%

Data Source:

DAODAS funded provider electronic data collection and management software: MOSAIX IMPACT.

Description of Data:

An annual prevention evaluation report has been provided for South Carolina by the Pacific Institute for Research and Evaluation (PIRE) since 2005. The report summarizes prevention outcomes generated by implementation of prevention activities throughout the year by South Carolina's system of county alcohol and drug abuse authorities. The report focuses on outcomes generated through pre- and post-testing of middle and high school youth as well as outcomes that can be assessed across sites for environmental strategies for alcohol and tobacco and the Youth Access to Tobacco Study (i.e., "Synar"). For additional information, please visit: http://ncweb.pire.org/scdocuments/

Data issues/caveats that affect outcome measures::

Due to the high percentage of participants already being served in evidence-based programming, there is an evident ceiling effect and little room for improvement.

Priority #: 6

Priority Area: Service Delivery to Uninsured Populations

Priority Type: SAT

Population(s):

Goal of the priority area:

Reduce financial barriers associated with access to high quality substance use disorder treatment services by focusing federal and state block grant dollars on service delivery for uninsured populations

Objective:

Transition federal block grant dollars to cover the direct cost of care for uninsured patients

Strategies to attain the objective:

i. Continue to expand fee for service block grant reimbursement strategy
ii. Work with provider network to expand service menu eligible for reimbursement

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of unrestricted block grant allocated for fee for service reimbursement covering uninsured populations

Baseline Measurement: 20% of unrestricted block grant funds allocated to fee for service reimbursement covering uninsured populations

First-year target/outcome measurement: 25% of unrestricted block grant funds allocated to fee for service reimbursement covering uninsured populations

Second-year target/outcome measurement: 30% of unrestricted block grant funds allocated to fee for service reimbursement covering uninsured populations

Data Source:

DAODAS block grant financial monitoring system

Description of Data:

DAODAS tracks federal block grant expenditure funds for each funded provider.

Data issues/caveats that affect outcome measures::

None

Priority #: 7

Priority Area: Adolescents with Substance Use Disorders

Priority Type: SAT

Population(s): Other (Adolescents w/SA and/or MH)

Goal of the priority area:

Ensure that high quality substance use disorder treatment services targeting adolescent populations are available within each community

Objective:

– Increase adolescent admissions to treatment services by 10% or more

Strategies to attain the objective:

i. Service location expansion addressing adolescent treatment needs through school based counseling service delivery
ii. Outreach to community partners for improved collaboration efforts targeting screening and referral to treatment services
iii. Continued workforce development efforts designed to enhance competencies for professionals working with adolescent populations

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of adolescents admitted to treatment services.

Baseline Measurement: FY 17 = 4,425

First-year target/outcome measurement: Increase adolescent admissions to treatment services by 5% over FY 17 Baseline

Second-year target/outcome measurement: Increase adolescent admissions to treatment services by 10% over FY 17 Baseline

Data Source:

DAODAS funded provider electronic clinical record data extract.

Description of Data:

All DAODAS funded providers across the state currently use the same vendor for their electronic clinical record. Data stored in the record includes client demographics, referral source, clinically relevant information used for treatment planning, as well as service utilization information.

Data issues/caveats that affect outcome measures::

None.

Priority #: 8

Priority Area: Individuals with substance use disorders involved in the criminal or juvenile justice systems

Priority Type: SAT

Population(s): Other (Criminal/Juvenile Justice)

Goal of the priority area:

Ensure that high quality substance use disorder treatment services for individuals involved in the criminal or juvenile justice systems are available within each community

Objective:

Increase criminal justice system referred admissions to treatment services 5% by the end of the planning period

Strategies to attain the objective:

i. Increase collaboration with the State's Department of Corrections Agency to incorporate community based substance use disorder treatment services for offender re-entry programming.
ii. Continue to coordinate treatment planning and service provision efforts for youth clients involved with the state's juvenile justice agency.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Criminal justice system referred treatment admission totals.

Baseline Measurement: 13,704 admissions

First-year target/outcome measurement: 2.5% or more over baseline admission volume.

Second-year target/outcome measurement: 5% or more over baseline admission volume.

Data Source:

DAODAS funded provider electronic clinical record data extract

Description of Data:

All DAODAS funded providers across the state currently use the same vendor for their electronic clinical record. Data stored in the record includes client demographics, referral source, clinically relevant information used for treatment planning, as well as service utilization information

Data issues/caveats that affect outcome measures::

Priority #: 9

Priority Area: Individuals with Tuberculosis and Other Communicable Diseases

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Ensure the availability of routine TB services for individuals receiving substance use disorder treatment services

Objective:

100% of patient assessments will include evidence of TB screening.

Strategies to attain the objective:

i. DAODAS will monitor the protocol and support local training efforts for providing routine TB services.
ii. DAODAS and its provider network will increase the number of treatment patients participating in TB screening services.
iii. DAODAS will utilize the AOD provider electronic health record capability to track data associated with the provision of client focused routine TB screening.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Patient clinical assessments that contain evidence of TB risk screenings.

Baseline Measurement: 100%

First-year target/outcome measurement: 100%

Second-year target/outcome measurement: 100%

Data Source:

DAODAS funded provider electronic clinical record data extract

Description of Data:

All DAODAS funded providers across the state currently use the same vendor for their electronic clinical record. Data stored in the record includes client demographics, referral source, clinically relevant information used for treatment planning, as well as service utilization information

Data issues/caveats that affect outcome measures::

Priority #: 10

Priority Area: HIV Early Intervention Services

Priority Type: SAT

Population(s): EIS/HIV

Goal of the priority area:

Provide HIV early intervention services to individuals participating in substance use disorder treatment programs.

Objective:

100% of adult and young adult/teen assessments administered across the provider network will include a HIV infection risk behavior/exposure screening by the end of the planning period (SFY 2018).

Strategies to attain the objective:

i. Increase the number of clients screened for high-risk behaviors/exposures associated with HIV infection acquisition.
ii. Increase the number of Rapid HIV tests conducted on clients assessed (through universal screening protocols) to be at high-risk for HIV acquisition.
iii. Utilize the provider electronic health record to gather and store data associated with risk screening and the provision of rapid HIV tests conducted.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Patient clinical assessments that contain evidence of HIV risk screenings

Baseline Measurement: 100%

First-year target/outcome measurement: 100%

Second-year target/outcome measurement: 100%

Data Source:

DAODAS funded provider electronic clinical record data extract

Description of Data:

All DAODAS funded providers across the state currently use the same vendor for their electronic clinical record. Data stored in the record includes client demographics, referral source, clinically relevant information used for treatment planning, as well as service utilization information.

Data issues/caveats that affect outcome measures::

Priority #: 11

Priority Area: Persons Who Inject Drugs

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

Ensure that high quality substance use disorder (SUD) and Opioid Use Disorder (OUD) services for persons who inject drugs are available within each community.

Objective:

Increase the number of persons who report injecting drugs who are admitted to services.

Strategies to attain the objective:

Follow federal block grant priority population requirements for persons who inject drugs by giving this population priority access to treatment.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of persons who report injecting drugs who are admitted to services.

Baseline Measurement: 2,360 persons.

First-year target/outcome measurement: 2,420 persons (increase of 2.5%).

Second-year target/outcome measurement: 2,478 persons (increase of 5%)

Data Source:

DAODAS-funded

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 12

Priority Area: State's response to the opioid crisis.

Priority Type: SAP, SAT

Population(s): PWWDC, PP, PWID, Other (Adolescents w/SA and/or MH, Rural, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder,)

Goal of the priority area:

To address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD) (including prescription opioids as well as illicit drugs such as heroin).

Objective:

1. Develop a statewide Medication-Assisted Treatment (MAT) system that will be based on a comprehensive state strategic plan that, in turn, will be based on a thorough needs assessment.

2. Design, implement, enhance, and evaluate primary and secondary prevention using evidence-based methods defined by SAMHSA or the CDC that are proven to reduce the number of persons with OUDs and OUD-associated deaths.

3. Implement or expand access to clinically appropriate evidence-based practices for OUD treatment.

4. Provide assistance to patients with treatment costs.

5. Provide treatment transition and coverage for patients reentering communities from criminal justice settings.

6. Enhance or support the provision of peer and other recovery support services to improve treatment access and retention and to support long-term recovery.

Strategies to attain the objective:

1.1. Conduct a thorough needs assessment that will identify areas where opioid misuse and related harms are most prevalent; the number and location of opioid treatment providers in the state, including providers that offer opioid use disorder (OUD) services; and all existing activities and their funding sources in the state that address opioid use prevention, treatment, and recovery activities and remaining gaps in these activities.
1.2. Develop a comprehensive state strategic plan with input from patients and families, and in collaboration with relevant state agencies, community organizations, and substance use disorder (SUD)/OUD providers.
1.3. Develop a diffusion plan that is based on the state's successful STAR-SI project, using NIATx system-level change principles and toolkit.
1.4. Develop a sustainability plan.

2.1. Ensure that STR activities are coordinated with and complement existing prevention initiatives, such as Drug Free Communities, ECHO, and Overdose Prevention.
2.2. Expand the current multimedia prescription drug misuse/abuse campaign to construct and implement additional tools for the campaign.
2.3. Expand the DHEC Opioid Overdose Prevention Program by funding a Naloxone Coordinator.
2.4. Expand and enhance the DHEC PDMP by removing barriers to its use by hospitals and prescribers.

3.1. Expand use of Modified Interpersonal Group Psychotherapy (MIGP), informed by the Biological Psychological Social Spiritual Experiential Model (BPSSEM).
3.2. Expand the A-CRA/ACC adolescent treatment project.
3.3. Expand trauma-informed care to all providers.
3.4. Partner with the Medical University of South Carolina (MUSC) to implement a comprehensive approach to expanding MAT/OUD services across the state. The initiative will include developing a resource web site, expanding the use of the MUSC Center for Telehealth, academic detailing, expansion of the SBIRT program, and implementation of the national Project ECHO model.

4.1. Ensure that STR expenditures are coordinated with and complement existing funding streams, such as Medicaid and Medicare, SABG, Federal discretionary grants, and state allocations.
4.2. Provide financial support for medications prescribed for patients who are indigent.
4.3. Provide financial support for talk therapy for patients who are indigent.

5.1. Provide peer support specialists to help effect seamless transitions from state prisons to the community.
5.2. Provide peer support specialists to help effect seamless transitions from selected county jails to the community.

6.1. Provide peer support in selected hospital emergency departments.
6.2. Support DHEC proposal to deploy community paramedicine follow-up visits.
6.3. Expand Community Recovery Centers.
6.4. Help establish a Recovery High School.
6.5. Expand peer support capabilities in high-need, mostly rural counties and provide peer support training to clinical supervisors of peer support specialists.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of overdose deaths involving opioids.

Baseline Measurement: 616 in 2016.

First-year target/outcome measurement: At or below 616 overdose deaths involving aoioids

Second-year target/outcome measurement: At or below 616 overdose deaths involving aoioids

Data Source:

South Carolina Department of Health and Environmental Control – Vital Statistics.

http://www.dhec.sc.gov/Health/Opioids/OpioidStatistics/

Description of Data:

Occurence rate. Cases are non-mutually exclusive. Deaths can have more than one drug listed.

Opioid-Involved Overdose Deaths: South Carolina county level death data from 2015 and 2016 broken down by heroin and prescription opioids is available here: http://www.dhec.sc.gov/Health/Opioids/images/Overdose%20Deaths%20Involving%20Opioids%202015%20and%202016.pdf. The data from 2014 and 2015 is available here: http://www.dhec.sc.gov/Health/Opioids/images/Overdose%20Deaths%20Involving%20Opioids%202014%20and%202015.pdf.

Opioid-Involved Overdose Deaths by County of Occurrence, 2015: The map for 2015 is available here.

Additional contextual information:
- Prescription Opioid Overdose Deaths: In 2016, 550 deaths occurred in South Carolina from a drug overdose with prescription opioid drugs listed on the death certificate, up 7% from 512 in 2015 and up 18% from 464 in 2014.

- Heroin Overdose Deaths: Fatal overdoses involving heroin increased by 14% from 2015 to 2016. By comparison, fatal overdoses involving heroin increased by 67% from 2014 to 2015.

- Opioid Overdose Deaths Surpass Homicides: In 2015, the number of deaths from heroin and opioid overdoses in South Carolina surpassed the number of homicides.

Data issues/caveats that affect outcome measures::

None.

Indicator #: 2

Indicator: Number of patients who receive MAT treatment for OUD.

Baseline Measurement: SFY 2017 (will be available by January 1, 2018.

First-year target/outcome measurement: Increase by 5% over SFY 2017.

Second-year target/outcome measurement: Increase by 10% over SFY 2017

Data Source:

CareLogic database that is used by each county SUD authority. In addition, periodic reporting by Opioid Treatment Centers will augment the CareLogic reporting.

Description of Data:

CareLogic is a database of electronic health records of each SUD/OUD patient served by the state's public provider system (the 32 county authorities that served each one of the state's 46 counties). The periodic reporting by the Opioid Treatment Centers is expected to cover at least pegnant and parenting women.

Data issues/caveats that affect outcome measures::

None.

Indicator #: 3

Indicator: Number of patients reentering communities from criminal justice settings.

Baseline Measurement: New project (the first and second year results will inform baseline measurement for the outyears)

First-year target/outcome measurement: At least 10 patients from state prisons and 40 patients from county jails.

Second-year target/outcome measurement: At least 15 patients from state prisons and 60 patients from county jails.

Data Source:

Reporting from Peer Support Specialists who are assigned to the state prisons and county jails.

Description of Data:

Demographic data; dates and descriptions of services provided; discharge data; and recovery support data.

Data issues/caveats that affect outcome measures::

None.

Indicator #:	4
Indicator:	Number of OUD patients in the public system who receive recovery services
Baseline Measurement:	New project (the first and second year results will inform baseline measurement for the outyears)
First-year target/outcome measurement:	At least 30 patients in hospital emergency rooms and 45 patients in the high need counties.
Second-year target/outcome measurement:	At least 45 patients in hospital emergency rooms and 73 patients in the high need counties.

Data Source:

Periodic reporting from the public providers who are providing services.

Description of Data:

Demographic data; dates and descriptions of services provided; discharge data; and recovery support data.

Data issues/caveats that affect outcome measures::

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[25] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[26] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[27]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[28] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[29] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[30]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[31] SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[32] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[33] Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[34] and ACOs[35] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[36] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[37]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[38] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[39] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.[40] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[41] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[42] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states? Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[43] SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[44] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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[28] Social Determinants of Health, Healthy People 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39; http://www.cdc.gov/socialdeterminants/Index.html

[29] http://www.samhsa.gov/health-disparities/strategic-initiatives

[30] http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/

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[43] About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm; National Behavioral Health Quality Framework, Draft, August 2013, http://samhsa.gov/data/NBHQF

[44] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

The South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) works closely with the South Carolina Department of Mental Health to coordinate care to patients who present with co-occurring disorders. DAODAS contracts with 32 local substance use disorder (SUD) providers which work with the 17 mental health clinics (and satellite) offices to coordinate care for such individuals. Since the agencies are independent of each other, DAODAS is working to integrate SUD care with various primary care physicians and FQHCs in response to the opioid epidemic and under the auspices of the STR Grant provided to reach state. The department has also embarked on expanding Telehealth initiatives through its SUD provider network with a range of health care providers, and will be able to be reimbursed by Medicaid for physician and physician assistance care in January 2018. In addition, DAODAS is working in 3 large hospitals to implement SBIRT in order to increase referrals into the SUD system, while tying the individual to a primary care home.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

The South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) works closely with the South Carolina Department of Mental Health to coordinate care to patients who present with co-occurring disorders. DAODAS contracts with 32 local substance use disorder (SUD) providers which work with the 17 mental health clinics (and satellite) offices to coordinate care for such individuals. Since the agencies are independent of each other, DAODAS is working to integrate SUD care with various primary care physicians and FQHCs in response to the opioid epidemic and under the auspices of the STR Grant provided to reach state. The department has also embarked on expanding Telehealth initiatives through its SUD provider network with a range of health care providers, and will be able to be reimbursed by Medicaid for physician and physician assistance care in January 2018. In addition, DAODAS is working in 3 large hospitals to implement SBIRT in order to increase referrals into the SUD system, while

tying the individual to a primary care home.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ○ Yes ◉ No

and Medicaid? ○ Yes ◉ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

Not applicable.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ◉ Yes ○ No

6. Do the behavioral health providers screen and refer for:

a) Prevention and wellness education ◉ Yes ○ No

b) Health risks such as

i) heart disease ○ Yes ◉ No

ii) hypertension ○ Yes ◉ No

viii) high cholesterol ○ Yes ◉ No

ix) diabetes ○ Yes ◉ No

c) Recovery supports ◉ Yes ○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ○ Yes ◉ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ○ Yes ◉ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

Parity is essentially not enforced in South Carolina.

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

No.

Please indicate areas of technical assistance needed related to this section

The SSA/SMHA would appreciate TA on enforcement efforts that work in other states.

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[45], **Healthy People, 2020**[46], **National Stakeholder Strategy for Achieving Health Equity**[47], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[48].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[49]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[50]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[51]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

[45] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[46] **http://www.healthypeople.gov/2020/default.aspx**

[47] **http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf**

[48] **http://www.thinkculturalhealth.hhs.gov**

[49] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[50] **http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208**

[51] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please respond to the following items:

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

a) Race	(•) Yes ( ) No
b) Ethnicity	(•) Yes ( ) No
c) Gender	(•) Yes ( ) No
d) Sexual orientation	( ) Yes (•) No
e) Gender identity	( ) Yes (•) No
f) Age	(•) Yes ( ) No

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

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

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

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

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? (•) Yes ( ) No

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

The state through the South Carolina Joint Council for Youth and Adolescents hosts an annual cultural and linguistic conference for parents, youth professionals, and law-enforcement and medical personnel. Additionally, four regional training opportunities are offered during each year. Recently covered topics include CLAS standards, LBGTQ populations, suicide prevention , health disparities, and the impact of poverty.

Please indicate areas of technical assistance needed related to this section

Not at this time.

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

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

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[52], The New Freedom Commission on Mental Health[53], the IOM[54], and the NQF[55]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[56] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[57] are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[58] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

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

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

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

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

[54] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

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

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

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

[58] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

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

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

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

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

DAODAS just recently received SAMHSA-provided technical assistance on the subject. We expect to address the subject during State Fiscal Year 2018.

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

Not at this time.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? (●) Yes ( ) No

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

The DAODAS Block Grant Governing Terms convey to the sub-grantees all of the federal Block Grant terms, conditions, assurances, funding agreements, and certifications. Compliance is checked annually through site vists and desk-side reviews.

Please indicate areas of technical assistance needed to this section

Not at tis time.

Footnotes:

Environmental Factors and Plan

9. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- [x] Data on consequences of substance using behaviors
- [x] Substance-using behaviors
- [x] Intervening variables (including risk and protective factors)
- [ ] Others (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- [ ] Children (under age 12)
- [x] Youth (ages 12-17)
- [x] Young adults/college age (ages 18-26)
- [x] Adults (ages 27-54)
- [x] Older adults (age 55 and above)
- [ ] Cultural/ethnic minorities
- [ ] Sexual/gender minorities
- [ ] Rural communities
- [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- [x] Archival indicators (Please list)

SC Revenue and Fiscal Affairs Office ; CDC Wonder and Fatality Analysis Reporting System

- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [ ] Monitoring the Future
- [ ] Communities that Care
- [x] State - developed survey instrument
- [ ] Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? ○ Yes ◉ No

If yes, (please explain)

If no, (please explain) how SABG funds are allocated:

A funding allocation formula was established by DAODAS in July, 2013. DAODAS provides SAPT BG primary prevention set aside dollars to the 32 county agencies that provide primary prevention services for the citizens of South Carolina that reside in the 46 counties across the state. The funding formula is made up of three components-funding for base service implenentation, funding based on county population levels and additional discretionary funding that is determined by DAODAS based on need and availablilty of funds from year to year.
Base implemenation funds: Each agency recieves $40,000 to support primary prevention service implementation. If an agency serves two or more counties, the agency recevies an additional $10,000 to support service implemeation in each county they serve. For example Low Country serves three counties-Allendale, Hampton and Jasper, so there total base funds for primary prevention service implemenation is $70,000.

Population Funds: Each county has been placed in a tier- small, medium or large- based on census data on the total population for the county. Multi-county agenices- populations are added together and then the agency is placed in the appropriate level- small, medium or large-based on the total population for the counties served by the agency. Additional funds are provided in incremental amounts ($4,846 for the smallest popluation agency up to $158,039 for the largest population agency.

Discretionary funding based on need- DAODAS may provide additional primary prevention funds (if available) based on the needs of the agency outlined in the county plan.

In addition, each judicial circuit (16 that cover the 46 counties) in South Carolina are provided with funding to address the coordination of environmental strategies to reduce underage alcohol use. The AETs are intended to implement evidence-based environmental strategies to reduce underage alcohol use and its harmful consequences coupled with an active public education and prevention strategy. These teams impact the goal established by South Carolina to reduce underage alcohol use on the state and local level.The Alcohol education/Enforcement Teams are funded at $35,000; $40,000; or $50,000, based on the total population of the counties contained in the judicial circuits. AS described above, the funding levels correspond to the population tiers- small=$35,000; mediun= $40,000 and large=$50,000. These funds can be used to support salary of a coordinator, supplies and materials for data reporting and cost related ti the implemantation of strategies such as Information Dissemination: Community Events/Presentations on Underage Drinking (e.g. MADD Power of Youth/Parents); Education: Underage Drinking Education/Alive at 25; Alternative Events: Events hosted in the community to provide alcohol-free events to those under 21 in the community (e.g. Prom Promise); and Community-Based Process: Participation in community groups/meetings to plan prevention activities to reduce underage drinking (coalition meetings, key officer meetings, AET Circuit meetings, state & national level AET meetings/conferences that focus on underage drinking prevention)

Each county agency submits a county plan at the begin of the state fiscal year for DAODAS approval. The county plan incapsulates the Strategic Prevention Framework (SPF) approach and primary prevention services are included in the county plans. To assist the State in fulfilling federal expectations and mandates, counties should demonstrate by utlizing the SPF how primary prevention service outcome focused activities that are planned to be implemented incorporate activities that fall under each of the strategies designated by the Center for Substance Abuse Prevention (CSAP) and as indicated by local needs assessment.

Through the utilization of the SPF model, South Carolina identified the following priority areas being addressed throughout the state utilizing the SAPT BG Primary Prevention Funding:
• Reducing underage alcohol use and the consequences of use;
• Reducing alcohol-related car crashes (including youth crashes);
• Reducing youth tobacco use (including smokeless tobacco use);
• Preventing substance abuse and improve the well-being of youth and families in South Carolina.

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

The SEOW produdces an annual report

Please indicate areas of technical assistance needed related to this section

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe

South Carolina Association of Prevention Professionals and Advocates (SCAPPA) certifies the substance use disorder workforce in South Carolina. The SCAPPA certification system is designed to certify the competency of two (2) classifications of prevention professionals: 1. Certified Prevention Specialist, and, 2. Certified Senior Prevention Specialist). The SCAPPA standards for certification meet or exceed those set by the International Certification & Reciprocity Consortium (IC&RC) as the minimum qualifications of an entry-level Prevention Specialist.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe mechanism used

Regional Capacity Coaches were added to the South Carolina prevention infrastructure during FY2010, to provide training and technical assistance to Strategic Prevention Framework State Incentive Grant (SPF SIG) grant sub-recipients. The Coaches' role has expanded over the years to also provide prevention training and technical assistance through the SABG primary prevention set aside to all 32 local agencies throughout the state that provide primary prevention services utilizing the SPF.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

If yes, please describe mechanism used

Since FY16, DAODAS has coordinated an annual training survey to help determine capacity needs of the prevention workforce in South Carolina. Subsequently, an annual training plan is completed by the coaches in coordination with DAODAS and SCAPPA to coordinate training provided throughout the year.

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

DAODAS created a capacity deliverable in FY16 and a planning deliverable in FY 17, which allowed the prevention workforce to consider its needs related to capacity. The prevention workforce was provided with funds to support increase capacity from the SAPT BG primary prevention set aside. This was part of the process of infusing the SPF into the SAPT BG. For example, several local prevention agencies used these funds to attend national conferences or to purchase and receive training for evidence-based curriculum programs and/or environmental strategies.

Please indicate areas of technical assistance needed related to this section

Narratve Question

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Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) ○ Yes ○ No ◉ N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** ☐ Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** ☐ Timelines
- **c)** ☐ Roles and responsibilities
- **d)** ☐ Process indicators
- **e)** ☐ Outcome indicators
- **f)** ☐ Cultural competence component
- **g)** ☐ Sustainability component
- **h)** ☐ Other (please list):
- **i)** ☑ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? ◉ Yes ○ No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? ○ Yes ◉ No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

South Carolina is in the process of revitalizing the evidence-based workgroup. The group was active during the SPF SIG and has been dormant over the past two years.

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

Although the state does not have a separate strategic plan, South Carolina utilizes the information that is documented in the SAPT BG plan to guide primary prevention services and funding throughout the state as previously described in the needs

assessment section.

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

Narratve Question

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Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☐ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☐ The SSA funds community coalitions to provide prevention services.
- **h)** ☐ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☑ The SSA directly funds other state agency prevention programs.
- **j)** ☑ Other (please describe)

South Carolina has a provider network that was established through legislation in 1973 (Act 301). Currently there are 32 local agencies-some are county government and some are local non-profits- that provide prevention, intervention, treatment and recovery services for the citizens of the 46 counties throughout the state. South Carolina DAODAS akso has contracts with PIRE for preventuon evlaution services and SEOW-related work, South Carolina Assocuation of Prevention Professionals and Advocates (SCAPPA) for workforce development/certification and with the SC chapter of Mother's Against Drunk Driving (MADD) to provide the Power of Parents and the Power of Youth curriculums across the state.

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

County prevention staff provide informational presentations to children, adolescents, and adults throughout their respective counties, and they work with various community partners to reach these audiences. Schools, faith communities, job sites, community civic clubs, law enforcement agencies, non-profit service organizations, and other local agencies such as social services, court systems, and health departments are just some of the partners that a county agency may work with to provide information on alcohol, tobacco, and other drugs to the general public.

Data collected through the IMPACT system indicates these services reached approximately 566,378 people throughout the state in FY'16 and accounted for 21.5% of the total service activities recorded by the counties in the IMPACT system.

b) Education:

South Carolina's county alcohol and drug abuse authorities work with partner agencies within the counties to provide prevention services for children, adolescents, and adults. For example, many of the counties work with their school districts (many counties have more than one) to implement evidence-based prevention curriculum programs in the schools for elementary, middle and high school students. County prevention staff are encouraged to consider the cultural needs of the population when selecting the program that they plan to implement. In addition to working with local schools to reach youth, some of our counties also partner with faith-based groups, community groups, and after-school programs to reach young people with these educational prevention services. County agencies may also provide programs to adults through various partners as well. Education programs funded in 2016 were as follows:

Alcohol-Drug True Stories (hosted by Matt Damon) is a movie with testimonials by real people about their experiences with alcohol and drugs. Used together with its accompanying discussion guide, this is considered an evidenced-based practice. The program was implemented with 271 matched youth at one site. There was a statistically significant change in perceived risk.

All Stars is a comprehensive evidence-based ATOD prevention curriculum. This program was used by two sites with a total of 84 matched participants. There were no statistically significant changes in risk factors or substances.

Keepin' It Real, an evidence-based, video-enhanced intervention for youth 10 to 17 that uses a culturally-grounded resiliency model that incorporates traditional ethnic values and practices that protect against drug use, was used by one site with a total of 142 matched participants. There were no statistically significant changes in risk factors or substances.

Life Skills Training, a skill-based, evidence-based ATOD prevention curriculum, was the most commonly implemented program with seven sites and 1009 matched participants. There were desired changes on four of the five risk factors (perceived risk, decision making, disapproval of use, and perceived peer norms). There was a significant decrease in alcohol use and marginally significant decreases in cigarettes, marijuana, and inhalant use.

Project Alert, a comprehensive evidence-based ATOD prevention curriculum for middle school students, was delivered at one site to 20 matched participants. There were no statistically significant changes in risk factors or substances.

Project TND, a prevention curriculum intended for high school students, was used by one site with 27 total matched participants. There were desired changes on four of the five risk factors (perceived risk, decision making, disapproval of use, and perceived peer norms). There was also a significant decrease in the use of marijuana.

Too Good for Drugs is an evidence-based program with specific lessons for each middle and high school grade. One site, with a total of 57 matched participants, used this program. There were no statistically significant changes in risk factors or substances.

Why Try is a comprehensive evidence-based ATOD prevention curriculum, which was implemented at one site with 32 participants. There were no statistically significant changes in risk factors or substances.

County authorities are not required to use evidence-based interventions exclusively, though most do. In FY '16, 99.5% (all but 8 of matched pre- and post-tests) of participants were served in evidence-based programs.

Data collected through the IMPACT system indicates these services reached approximately1,354 people throughout the state in FY'16 and accounted for 4.6% of the total service activities recorded by the counties in the IMPACT system.

c) Alternatives:

Some of the county providers work with organizations in their communities to plan and host events such as awareness runs/walks, after-prom parties, safe Halloween events, and ropes courses.

Data collected through the IMPACT system indicates these services reached approximately 9,470 people throughout the state in FY'16 and accounted for 3.2% of the total service activities recorded by the counties in the IMPACT system.

d) Problem Identification and Referral:

Local prevention providers offer approved tobacco and alcohol education (diversionary) programs for youth who are ticketed in South Carolina for breaking either the tobacco or alcohol laws. More than 700 youth were in diversion programs for youth alcohol and tobacco offenses (510 served in the Alcohol Education Program and 228 served in the Tobacco Education Program). A few counties also work with local colleges to provide a disversion program to students who may have an infraction cited by campus law enforcement and/or student life related to subtsnace use.

Data collected through the IMPACT system indicates these services reached approximately 819 people throughout the state in FY'16 and accounted for 2.2% of the total service activities recorded by the counties in the IMPACT system.

e) Community-Based Processes:

Some of the county prevention agencies work in collaboration with community coalitions to create and/or revise local policies that may positively impact underage drinking.

In collaboration with community coalitions, some of the prevention providers work to create and/or revise local policies that may help reduce the number of alcohol-related crashes in communities.

Some of the county prevention agencies work in collaboration with community coalitions to create and/or revise local policies that may positively impact youth tobacco use.

In collaboration with community coalitions, local prevention providers work to create and/or revise local policies that may positively impact communities and reduce substance use in South Carolina's counties.

In collaboration with community coalitions and partner agencies, local prevention providers work to provide substance-free alternative events and services for youth in their communities.

All of the county prevention agencies work in collaboration with state and local law enforcement partners to implement environmental strategies to address underage alcohol and tobacco use.

Data collected through the IMPACT system indicates these services reached approximately 37,887 people throughout the state in FY'16 and accounted for 44.5% of the total service activities recorded by the counties in the IMPACT system.

f) Environmental:

County prevention providers in South Carolina work in collaboration with local law enforcement through the South Carolina Alcohol Enforcement Team (AET) program. Primary prevention SAPT block grant dollars are not allocated or spent for enforcement operations conducted by law enforcement. The AETs focus on environmental prevention activities to reduce youth access to alcohol through both social and retails sources. Specific environmental prevention activities could include alcohol compliance checks, merchant education, controlled party dispersals, and "shoulder tap" operations.

Prevention providers in South Carolina will also work in collaboration the AETs to focus on environmental prevention activities to reduce alcohol-related car crashes through public safety checkpoints, saturation patrols, and merchant education to prevent over-service and intoxicated driving.

County prevention providers in South Carolina will work in collaboration with local law enforcement to implement environmental prevention activities to reduce youth access to tobacco through retail sources. Specific environmental prevention activities could include tobacco compliance checks and merchant education.

Environmental strategies implemented throughout the state in 2016 include:
Alcohol compliance checks, tobacco compliance checks. 8,176 alcohol compliance checks and 1,167 tobacco compliance checks. Sales were completed for 11.1% of alcohol attempts and 5.9% of tobacco attempts.

Merchant Education-: The counties served 1,809 merchants in the Palmetto Retailers Education Program (PREP) in FY '16.

Most merchants asked to see the buyers' IDs (90.6% and 92.6% for alcohol and tobacco, respectively) and most merchants studied the IDs (71.4% and 68.3% for alcohol and tobacco,respectively). Buyer and clerk race were significant predictors of alcohol sales, while buyer race and clerk gender were significant predictors of tobacco sales. Not surprisingly, clerks estimated to be young (ages 15-17) were more likely to sell alcohol and tobacco.

Public Safety Checkpoints and Sturation Patrols: AETs reported a total of 715 public safety checkpoints. Among the violations, there were 214 DUIs. In addition, there were 232 saturation patrols reported. This operation generated another 7,837 tickets, among them 530 DUIs.

Controlled Party Dispersals and party prevention AETs dispersed 66 parties attended by 2,065 persons. Together, 383 tickets (170 for underage drinking) were written during those dispersals. Another 121 parties were reported as having been prevented due to proactive use of advanced information.

Shoulder Taps: A total of 254 individuals were approached by the cooperating youth to purchase alcohol as part of Shoulder Tap operations,with 15 purchasing (20.8% sales).

Fake ID/Bar Checks: In FY '16, there were 297 bar checks conducted, resulting in 232 fake ID violations and 344 other alcohol-related charges to patrons.

In addition, many counties are working on local policies to help create safer, healtier communities in schools, towns, workplaces and colleges.

Data collected through the IMPACT system indicates these services reached approximately 98,775 people throughout the

state in FY'16 and accounted for 21.6% of the total service activities recorded by the counties in the IMPACT system.

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

If yes, please describe

Prevention work plans submitted by the local agencies to DAODAS must address sources used for funding the strategies implemented by each agency. DAODAS reviews the submitted work plans to ensure that the primary prevention services funded through the SAPT BG primary prevention set aside are services that are not funded through other means. DAODAS also conducts annual site visits of the local providers to review the prevention program/services provided throughout the state to ensure adherence to all state and federal guidelines.

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

N/A

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

Based on the CSAP 2016 site visit recommendations contained in the South Carolina State Development Plan, DAODAS is currenlty wokring with JBS and CSAP to seek TA to:
1. assist DAODAS to assess current prevention program and financial reporting processes to improve accuracy of reported SABG 20% prevention set-aside expenditures and numbers served
2. develop consistent definitions and provider interpretations for assigning time/costs to CSAP's 6 prevention strategies
3. provide examples from other state substance abuse prevention data systems that providers can report to DOADAS financial data and program data in one data system. (This could possibly be addressed by a state to state call).

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? ○ Yes ◉ No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☐ Includes evaluation information from sub-recipients
- **c)** ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☐ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please list:)
- **g)** ☑ Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ Numbers served
- **b)** ☑ Implementation fidelity
- **c)** ☐ Participant satisfaction
- **d)** ☑ Number of evidence based programs/practices/policies implemented
- **e)** ☑ Attendance
- **f)** ☑ Demographic information
- **g)** ☐ Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy use
- ☑ Binge use

- [x] Perception of harm
- **c)** [x] Disapproval of use
- **d)** [x] Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **e)** [ ] Other (please describe):

Footnotes:

Although South Carolina does not have an evaluation plan, we do have a contract with the Pacific Institute for Research and Evaluation. The contract has been in place since 2005 to assist the state with evaluating general prevention services provided through the SAPT BG primary prevention set aside. All recurring programs (education services both evidence-based and non-evidence-based) that are implemented throughout the state for youth ages 10-20 are required to implement a standard pre/posttest with the students. All environmental enforcement strategies conducted by partner law enforcement agencies to reduce access and availability of alcohol and tobacco products in SC are required to enter data into the SC AET web platform. We have forms to capture data on compliance checks, public safety checkpoints, saturation patrols, control party dispersal operations, Fake ID/Bar checks and media that accompanies these strategies. PIRE produces an annual report for SC. The reports are posted on the following website: http://ncweb.pire.org/scdocuments/
The flies are under the Evaluation tab and prevention outcomes tab

Environmental Factors and Plan

11. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Are you considering any of the following:

	Targeted services for veterans	( ) Yes (•) No

c) Expansion of services for:

(1)	Adolescents	(•) Yes ( ) No
(2)	Other Adults	( ) Yes (•) No
(3)	Medication-Assisted Treatment (MAT)	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 9. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Either directly or through and arrangement with public or private non-profit entities make pernatal care available to PWWDC receiving services? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Are you considering any of the following:

a) Open assessment and intake scheduling (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, custody issue (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

DAODAS monitors program compliance related to activitiers and services for PWWDC by desk reviews and on site visits. The Federal requirements for PWWDC are incorporated into the DAODAS Block Grant Governing Terms (see attached). In addition, the dfepartment has a state-wide policy, County Assistance Program (CAP), which is designed to identify issues and implement a mandatory technical assistance and guided corrective action plan before the problerm worsens. If a provider does not participate in the CAP or does not make progress, then a Manadatory Assistance Program (MAP) is imposed. If the MAP is not successful, the Department may take a number of measures, ranging from witholding reimbursements to assigning the county's catchment area to another county authority.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(•) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(•) Yes ( ) No
c)	Outreach activities	(•) Yes ( ) No
d)	Syringe services programs	( ) Yes (•) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(•) Yes ( ) No

2. Are you considering any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	(•) Yes ( ) No
b)	Automatic reminder system associated with 14-120 day performance requirement	(•) Yes ( ) No
c)	Use of peer recovery supports to maintain contact and support	(•) Yes ( ) No
d)	Service expansion to specific populations (military families, veterans, adolescents, older adults)	( ) Yes (•) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

DAODAS monitors program compliance related to activities and services for PWID by desk reviews and on site visits. The Federal requirements for PWID are incorporated into the DAODAS Block Grant Governing Terms (see attached). In addition, the Department has a state-wide policy, County Assistance Program (CAP), which is designed to identify issues and implement a mandatory "technical assistance" and guided corrective action plan before the problerm worsens. If a provider does not participate in the CAP or does not make progress, then a Mandatory Assistance Program (MAP) is imposed. If the MAP is not successful, the Department may take a number of measures, ranging from witholding reimbursements to assigning the county's catchment area to another county authority. In addition, DAODAS is in the early stages of implementing a centralized and automated capacity moniring system. The present system was developed in response to a SAMHSA site visit, but is cumbersome as it relies on reports submitted by email (see the attached Report).

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (•) Yes ( ) No

2. Are you considering any of the following:

a)	Business agreement/MOU with primary healthcare providers	( ) Yes (•) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	( ) Yes (•) No
c)	Established co-located SUD professionals within FQHCs	( ) Yes (•) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

DAODAS monitors program compliance related to tuberculosis services by desk reviews and on site visits. The Federal requirements for PWWDC are incorporated into the DAODAS Block Grant Governing Terms (see attached). In addition, the dfepartment has a state-wide policy, County Assistance Program (CAP), which is designed to identify issues and implement a mandatory "technical assistance" and guided corrective action plan before the problerm worsens. If a provider does not participate in the CAP or does not make progress, then a Manadatory Assistance Program (MAP) is imposed. If the MAP is not successful, the Department may take a number of measures, ranging from witholding reimbursements to assigning the county's catchment area to another county authority.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery? (•) Yes ( ) No

2. Are you considering any of the following:

a)	Establishment of EIS-HIV service hubs in rural areas	(•) Yes ( ) No
b)	Establishment or expansion of tele-health and social media support services	( ) Yes (•) No
c)	Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS	( ) Yes (•) No

Syringe Service Programs

1.	Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)?	(•) Yes ( ) No
2.	Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?	( ) Yes (•) No
3.	Do any of the programs use SABG funds to support elements of a Syringe Services Program?	( ) Yes (•) No

If yes, plese provide a brief description of the elements and the arrangement

Not applicable.

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Are you considering any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (●) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (●) Yes ( ) No
- **f)** Explore expansion of service for:
  - **i)** MAT — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — (●) Yes ( ) No

2. Are you considering any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — (●) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449) — (●) Yes ( ) No

2. Are you considering any of the following:

- **a)** Notice to Program Beneficiaries — ( ) Yes (●) No
- **b)** Develop an organized referral system to identify alternative providers — (●) Yes ( ) No
- **a)** Develop a system to maintain a list of referrals made by religious organizations — (●) Yes ( ) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Are you considering any of the following:

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No
- **c)** Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Are you considering any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records — (●) Yes ( ) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure — (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

SFY2018: 19 providers
SFY2019: 7 providers

Note: Either number is far more than 5% of the sub-recipients, or 2 providers, that are required. The variance in the yearly numbers stem from the phased approach to strating the CARF accredidation process. Incidentally, South Carolina was the second state in the nation to have achieved national accreditation for the entire statewide public AOD service delivery system. However, South Carolina was the first state in which national accreditation was achieved by all service providers on their first attempt.

3. Are you considering any of the following:

a) Development of a quality improvement plan — ( ) Yes (●) No

b) Establishment of policies and procedures related to independent peer review — ( ) Yes (●) No

c) Develop long-term planning for service revision and expansion to meet the needs of specific populations — (●) Yes ( ) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — (●) Yes ( ) No

If YES, please identify the accreditation organization(s)

i) [x] Commission on the Accreditation of Rehabilitation Facilities

ii) [x] The Joint Commission

iii) [ ] Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? (●) Yes ( ) No

2. Are you considering any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service (●) Yes ( ) No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ( ) Yes (●) No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state (●) Yes ( ) No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services (●) Yes ( ) No

c) Preformance-based accountability ( ) Yes (●) No

d) Data collection and reporting requirements (●) Yes ( ) No

2. Are you considering any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs (●) Yes ( ) No

b) Addition of training sessions designed to increase employee understanding of recovery support services (●) Yes ( ) No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services (●) Yes ( ) No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort (●) Yes ( ) No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ( ) Yes (●) No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ( ) Yes (●) No

b) Early Intervention Services Regarding HIV ( ) Yes (●) No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ( ) Yes (●) No

b) Professional Development ( ) Yes (●) No

c) Coordination of Various Activities and Services ( ) Yes (●) No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

The state's regulations and statutes that govern SUD programs are:

Regulations regarding licensing of SUD facilities: http://www.scdhec.gov/Agency/docs/health-regs/61-93.pdf

Statute regarding DAODAS: http://www.scstatehouse.gov/code/t44c049.php

Statute regarding County Authorities: http://www.scstatehouse.gov/code/t61c012.php

Statute regarding Licensed Professional Counselors: http://www.scstatehouse.gov/code/t40c075.php

Footnotes:

Criterion 1. The South Carolina National Guard, and the federal military departments have targeted services for veterans, as does the Veteran's Administration. DAODAS and its network of SUD providers have been, and continue to be, ready to provide SUD services to veterans. Regarding expansion of services to other adults, the Department continues to emphasize serrvices for preganant and parenting women and has aplied for a CSAT Grant, State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (PPW-PLT).

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017? (●) Yes ( ) No

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

One of the major components of the CQI Plan, the Quality Assurance Standards is undergoing a significant revision to incorporate Medication Assisted Treatment, trauma-informed care, opioid overdose prevention, SBIRT, youth and adolescents, recovery supprt, and special populations (such as pregnant women and IVDUs).

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

Not at this time.

Footnotes:

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma [60] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[61] paper.

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

61 *Ibid*

Please respond to the following items

1.	Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues?	(•) Yes ( ) No
2.	Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers?	(•) Yes ( ) No
3.	Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care?	(•) Yes ( ) No
4.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	(•) Yes ( ) No

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

DAODAS has contracted with Community Connections from Washington D.C. to help us implement Trauma Informed Care (TIC). This began as a result of two things. First, the Legislative Committee on Children and Families asked The Joint Council on Children and Adolescents to implement a plan for all child serving agencies to become Trauma Informed. DAODAS requested technical assistance from SAMHSA to begin planning and implementation. Roger Fallot provided our technical assistance and at the time he worked for Community Connections. So we developed an implementation plan and he presented it to our Behavioral Health Services Association (Local agency directors). The plan was for five years and each year 5 to 7 of our local providers would be trained in TIC. The process began with a two day introductory training for teams of 1 to 10 people from each agency, depending on the size of the agency. Then each team would use the client and staff surveys to develop their implementation plan. They also attended two webinars with the trainers during the year and two Learning Collaboratives. Each agency was encouraged to have a

person with lived experience on their team. Each agency also got a visit from the trainer for a walk through and training of all agency staff on TIC. At the end of the year about three people from each of the agencies participated in a training of trainers. This was done so they could train new staff and other agencies in their area.

Most of our providers took advantage of this opportunity and we have now incorporated TIC into our contract. Mr. Fallot developed a fidelity scale and each agency is required to complete the fidelity scale and develop a plan for improvement or maintenance of their progress with implementing TIC. We have also contracted with a survivor to complete local visits to support and advise agencies on their progress.

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

Not at this time.

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[62]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[63]

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[62] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. **OJJDP Model Programs Guide**

[63] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? (●) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? (●) Yes ( ) No

3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? (●) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? (●) Yes ( ) No

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

DAODAS has long collaborated with the the Departments of Corrections and Juvenile Justice to provide transition or re-entry services for those who are incarcerated and have had SUD issues. the South Carolina Opioid STR program will greatly increasethese programs and expand them to hospital emergency departments.

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

Not at this time.

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? ( ) Yes (●) No

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☐ Naltrexone (oral, IM)
- **f)** ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? (●) Yes ( ) No

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

As the opioid crisis grew, South Carolina provided funds to DAODAS to use for Medication Assisted Treatment (MAT), to include assistance with medications. Subsequently, the Federal Opiod STR grant was received. In essence, the various state and federal funding sources were leveraged to optimize the state's approach to the crisis and MAT in general, without violating state and federal proscriptions.

Please indicate areas of technical assistance needed to this section.

Not at this time.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual?s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.
SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:
Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders**.
States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.
Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Block grant funding of recovery support services. ( ) Yes (●) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

A few years ago DAODAS was instrumental in forming Faces and Voices of Recovery South Carolina and regional FAVOR Chapters. They are represented on several of the committees that address planning implementation or evaluation. One good example is the Joint Council on Children and Adolescents. There are several family members and Family organizations represented on this committee.

The FAVOR Chapters are also a part of planning for peer certification training and are in the process of developing continuing education trainings for that population. They have also served in interview panels when hiring staff here at DAODAS.

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Not applicable. The South Carolina Department of Mental Health serves adults with SMI and children with SED.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

DAODAS uses SAMHSA's definition of recovery and has provided peer certification since around 2008. This is also a Medicaid reimbursable service since that time. This agency received technical assistance from SAMHSA around 2008 to introduce Recovery Oriented Systems of Care (ROSC) to the state. Since that time several state chapters of FAVOR have started with help from our Recovery liaison. One of the Chapters has gone as far as raising money to open a Recovery Center called FAVOR Greenville. They have been in operation for about five years now. To date a few of our larger agencies have hired peer specialists but one barrier to hiring has been lack of funding and the Medicaid reimbursement rate is not sufficient to support their salaries. State staff and members of the ROSC Committee attended ROSC Training with Dr. Achara in 2016. The committee which included FAVOR representatives and other agency and community members has been suspended until we are able to pilot ROSC in a few sites across the state. DAODAS has requested technical assistance for the pilots from SAMHSA and was approved but the ROSC staff here at DAODAS resigned and we are in the process of hiring. The Opioid STR grant has allowed us to hire peer specialists in four detox programs, the Department of Corrections to help inmates who are opioid users transition back into the community, and in rural areas that data shows are high need areas. With the opioid STR funds we will also begin to provide peer supervision training.

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

FAVOR Tri-county applied for a grant to provide telephone recovery check-ups for clients when they complete services with some of our local providers. They have also provide training to the faith community in a rural area of the state on recovery supports. As a result a church in the area is now holding recovery groups and providing support to families.

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

DAODAS has already requested technical assistance for ROSC.

Footnotes:

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community[66]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24[67]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death[68].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21[69]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs[70].

According to data from the 2015 Report to Congress[71] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[66]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[67]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593?602.

[68]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[69]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[70]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010**

[71] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult behavioral health system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Palmetto Coordinated System of Care is a program to help children stay at home; in school; when possible, out of the child welfare system; and, when possible, out of the juvenile justice system. This program serves children and youth with serious behavioral health challenges who are in or most at risk of out of home placements. Services that are convenient and more supportive of families help children and youth stay in their communities.

The collaboration is governed by a Leadership Team, comprising agency directors of Continuum of Care, SC Department of Alcohol and Other Drug Abuse Services, SC Department of Disabilities and Special Needs, SC Department of Health and Human Services, SC Department of Juvenile Justice, SC Department of Mental Health, SC Department of Social Services and three family members.

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

There are many providers and organizations in South Carolina that aim to address the challenges related to behavioral health problems and substance abuse in children and adolescents. When families are facing these problems, the Palmetto Coordinated System of Care (PCSC) believes the most successful path to healthy and happy homes rests on getting help with treatments that have been proven effective (evidence-based interventions). The Center of Excellence in Evidence-Based Intervention helps and supports providers to deliver these kinds of high quality treatments that research has shown to be effective.

The Center is newly established and supports the PCSC. Current activities include examining evidence-based intervention models. Future activities include facilitation of training and establishing systems for implementation support. The PCSC will also provide training and technical assistance for data collection efforts. These activities are designed to ensure delivery of high quality services to families in need.

The mission of the Center of Excellence is to support agencies and organizations in the selection and implementation of evidence-based interventions to promote youth and family well-being and to address challenges related to behavioral health problems and substance use.

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

Not at this time.

Footnotes: