Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$32,236,077		$310,000	$21,864,441	$17,767,428	$0	$200,000
a. Pregnant Women and Women with Dependent Children**	$5,254,146		$210,000	$3,514,852	$0	$0	$0
b. All Other	$26,981,931		$100,000	$18,349,589	$17,767,428	$0	$200,000
2. Primary Prevention	$0		$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention	$10,464,745		$0	$10,602,135	$168,658	$0	$40,000
b. Mental Health Primary Prevention							
3. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)							
4. Tuberculosis Services	$0		$0	$0	$0	$0	$0
5. Early Intervention Services for HIV	$2,371,492		$0	$0	$0	$0	$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	$2,357,528		$280,000	$1,190,582	$2,252,572	$0	$207,844
10. Total	**$47,429,842**	**$0**	**$590,000**	**$33,657,158**	**$20,188,658**	**$0**	**$447,844**

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

South Carolina is a designated HIV state for FY20 with 5% of the total block grant amount spent on HIV services.

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	4817	906
2. Women with Dependent Children	0	7203
3. Individuals with a co-occurring M/SUD	135177	3000
4. Persons who inject drugs	64000	3249
5. Persons experiencing homelessness	3933	881

Please provide an explanation for any data cells for which the state does not have a data source.

1) Pregnant women estimate comes from NDUH estimate of past month illicit drug use for 2017 (8.5% of pregnant females reported past month use of illicit drugs). 2) The state could not locate an estimate of treatment need for women with dependent children. Similarly, the state does not have an exact count of the number of women participating in treatment who have dependent children currently living with them. Aggregate number in treatment provided reflects referrals from the state's child protective services system which refers families involved in abuse/neglect cases related to substance use. 3) Co-Occurring estimate comes from 2017 National Survey on Drug Use and Health: Detailed Tables (3.4% of individuals 18 and over estimated to have both a mental health and a substance use disorder). State's estimated population of 18 and over for latest census = 3.97 million 4) Persons who inject drugs estimates comes from 2017 National Survey on Drug Use and Health: Detailed Tables(1.6% of individuals 18 and over estimated to have any lifetime injection drug use). State's estimated population of 18 and over for latest census = 3.97 million 5) Homeless treatment need estimate comes from 2018 South Carolina Point in Time Count Report.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment*	$16,268,957
2 . Primary Substance Abuse Prevention	$5,081,587
3 . Early Intervention Services for HIV**	$1,185,746
4 . Tuberculosis Services	$0
5 . Administration (SSA Level Only)	$1,178,631
6. Total	**$23,714,921**

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered ?designated states? as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a ?designated state? in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state?s AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

0930-0169 Approved: 07/17/2017 Expires: 07/30/2020

Footnotes:

South Carolina is still considered a HIV designated state.

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

A		B
Strategy	**IOM Target**	**FFY 2020 SA Block Grant Award**
1. Information Dissemination	Universal	$1,239,742
	Selective	
	Indicated	
	Unspecified	
	Total	**$1,239,742**
2. Education	Universal	$275,087
	Selective	$36,678
	Indicated	$55,017
	Unspecified	
	Total	**$366,782**
3. Alternatives	Universal	$183,392
	Selective	
	Indicated	
	Unspecified	
	Total	**$183,392**
4. Problem Identification and Referral	Universal	
	Selective	$27,509
	Indicated	$155,883
	Unspecified	
	Total	**$183,392**
	Universal	$1,237,894

5. Community-Based Process	Selective	
	Indicated	
	Unspecified	
	Total	**$1,237,894**
6. Environmental	Universal	$1,237,894
	Selective	
	Indicated	
	Unspecified	
	Total	**$1,237,894**
7. Section 1926 Tobacco	Universal	$50,000
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$50,000**
8. Other	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$0**
Total Prevention Expenditures		**$4,499,096**
Total SABG Award*		**$23,714,921**
Planned Primary Prevention Percentage		**18.97 %**

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

0930-0169 Approved: 07/17/2017 Expires: 07/30/2020

Footnotes:

A total of $582,491.00 of the prevention funds are accounted for in the resource table 6

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award
Universal Direct	$275,087
Universal Indirect	$3,948,922
Selective	$64,187
Indicated	$210,900
Column Total	**$4,499,096**
Total SABG Award*	**$23,714,921**
Planned Primary Prevention Percentage	**18.97 %**

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

0930-0169 Approved: 07/17/2017 Expires: 07/30/2020

Footnotes:

A total of $582,491.00 of the prevention funds are accounted for in the resource table 6

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Targeted Substances	
Alcohol	☑
Tobacco	☑
Marijuana	☑
Prescription Drugs	☑
Cocaine	☐
Heroin	☐
Inhalants	☐
Methamphetamine	☐
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☐
Targeted Populations	
Students in College	☑
Military Families	☑
LGBTQ	☐
American Indians/Alaska Natives	☐
African American	☑
Hispanic	☑
Homeless	☐
Native Hawaiian/Other Pacific Islanders	☐
Asian	☐
Rural	☑
Underserved Racial and Ethnic Minorities	☑

Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FY 2020 A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems	$25,000	$103,759	$25,000
2. Infrastructure Support			$45,000
3. Partnerships, community outreach, and needs assessment	$84,346	$155,258	
4. Planning Council Activities (MHBG required, SABG optional)	$0	$0	$0
5. Quality Assurance and Improvement	$50,500	$13,400	
6. Research and Evaluation		$125,770	
7. Training and Education	$34,500	$184,304	$10,000
8. Total	**$194,346**	**$582,491**	**$80,000**

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.
0930-0169 Approved: 07/17/2017 Expires: 07/30/2020

Footnotes:

Environmental Factors and Plan

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

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] 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.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

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.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] 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.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD 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.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] 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 M/SUD include: developing models for inclusion of M/SUD 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.[30] 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 M/SUD 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[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD 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.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] 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.[36] 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.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD 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.[39] 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 M/SUD 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.[40]
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.[41] 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.

[22] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102-123 **http://www.who.int/bulletin/volumes/91/2/12-108282.pdf**; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52-77

[23] Research Review of Health Promotion Programs for People with SMI, 2012, **http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper**; About SAMHSA's Wellness Efforts, **https://www.samhsa.gov/wellness-initiative**; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Hearts, **https://www.samhsa.gov/health-care-health-systems-integration**; Schizophrenia as a health disparity, **http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml**

[24] Comorbidity: Addiction and other mental illnesses, **http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses** Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, JAMA Psychiatry. 2014; 71 (3):248-254. doi:10.1001/jamapsychiatry.2013.3726; **http://www.samhsa.gov/co-occurring/**

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

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

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

[28] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. **https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf**; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, **https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf**; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. **http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf**; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, **http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf**; American Psychiatric Association, **http://www.psych.org/practice/professional-interests/integrated-care**; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, **http://books.nap.edu/openbook.php?record_id=11470&page=210**; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, **http://nasadad.org/nasadad-reports**

[29] Health Care Integration, **http://samhsa.gov/health-reform/health-care-integration**; SAMHSA-HRSA Center for Integrated Health Solutions, (**http://www.integration.samhsa.gov/**)

[30] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, **https://www.integration.samhsa.gov/operations-administration/telebehavioral-health**; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, **http://www.americantelemed.org/home**; National Telehealth Policy Resource Center, **http://telehealthpolicy.us/medicaid**;

[31] Health Homes, **http://www.integration.samhsa.gov/integrated-care-models/health-homes**

[32] New financing models, **https://www.integration.samhsa.gov/financing**

[33] Waivers, **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html**; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, **http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf**

[34] What are my preventive care benefits? **https://www.healthcare.gov/what-are-my-preventive-care-benefits/**; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); **http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html**

[35] Medicare-Medicaid Enrollee State Profiles, **http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html**; About the Compact of Free Association, **http://uscompact.org/about/cofa.php**

[36] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, **http://www.cbo.gov/publication/44308**

[37] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

[38] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

[39] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, **http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf**; Creating jobs by addressing primary care workforce needs, **https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n**

[40] 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**

[41] 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) continues to contractually and financially incentivize the integration of addiction treatment and primary care, particularly as work has been done to expand access to medically assisted treatment. The contracts, communications, and reimbursement mechanisms in place for the medical treatment of addiction emphasize and incentivize development of health home models of care, and of partnerships between local FQHCs and local alcohol and drug treatment providers with SABG resources. The coordination of services across these providers includes use of telehealth technology, and the state's Health Information Exchange which allows transfer of information across electronic health records. Because DAODAS has a strong working relationship with the state's Medicaid agency, staff in our Quality Assurance department work with Medicaid and the Managed Care Organizations nearly every day to ensure local providers are practicing targeted case management with those Medicaid and MCO beneficiaries and coordinating patients across primary care and specialty treatment. The Department of Alcohol and Other Drug Abuse Services also very recently completed training over 170 employees working in the state's public health clinics on SBIRT. As DAODAS continues to work closely with the Department of Public Health, both agencies will enforce SBIRT as a standard practice for all women of child bearing age who seek public health services such as family planning services or family vaccinations. Finally, the SSA leads and participates in multiple coalitions and advisory boards that look at system level support for integrated care deliver and overall healthcare workforce needs. This allows for the awareness of programming and services supported by other federal funds as state leaders look to braid and leverage subsidies and opportunities for care and system evolution.

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) and the South Carolina Department of Mental Health (DMH) have developed a dually employed Program Manager position to report to both state agencies. This role is to support the movement toward integrated systems of care for individuals and families with co-occurring mental health and subsistence use disorders. Functionally, this manager is to develop relationships and referral models for coordinated care across the 17 local Community Mental Health Centers that are supported by MHBG and State safety net resources, and the 32 local County Alcohol and Drug treatment centers that have SABG and State safety net resources. These 49 centers provide services for any citizen in need in all 46 counties of the state. The dually employed manager attends leadership meetings of both state agencies to improve communication and collaboration, and assesses local needs and then delivers evidence-based practices cross-training for staff to screen and treat co-occurring disorders. Establishing this role helps the state move toward better coordination of care for patients, and a "no wrong door" emphasis for citizens who enter the public treatment systems.

Additionally, DAODAS and DMH will be working together with local stakeholders where mobile crisis stabilization, and crisis stabilization units are being established locally. As development has been underway in some places in the state for several years, DAODAS has been absent from the work. The Department of Mental Health has recently agreed that addiction screenings are important to integrate in these crisis services, and will become increasingly important as the prevalence of stimulant use disorder is on the rise.

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

b) 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 M/SUD providers screen and refer for:

a) Prevention and wellness education ◉ Yes ○ No

b) Health risks such as

ii) heart disease ○ Yes ◉ No

iii) hypertension ○ Yes ◉ No

iv) high cholesterol ○ Yes ◉ No

v) 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

Not at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/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)[45].

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."[46]

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[47]. 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[48]. 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, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. 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.

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

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

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

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

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

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

Please respond to the following items:

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

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

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

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

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

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

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

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

Through the South Carolina Joint Council for Youth and Adolescents, the State 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 included CLAS standards, LBGTQ populations, suicide prevention, and health disparities, and the impact of poverty.

Please indicate areas of technical assistance needed related to this section

Not at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

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

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

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence 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. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions 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,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. 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."[53] 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 M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many 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)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, 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.

[49] 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

[50] 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.

[51] 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.

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

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

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

[55] **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.

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

In the recent past, DAODAS received SAMHSA-provided technical assistance on the subject, We began addressing the subject during state fiscal year 2018 and have continued to do so. South Carolina has found that without a fee-for-service model of reimbursement, providers are not incentivised to see patients.

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

Not at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

6. 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 M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and 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 M/SUD 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 M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

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

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

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

The DAODAS Annual Funding and Compliance Contract conveys to the sub-grantees all of the federal Block Grant terms, conditions, assurances, funding agreements, and certifications. Compliance is checked annually through desk reviews and site visits.

Please indicate areas of technical assistance needed related to this section

Recently, DAODAS was the recipient of technical assistance regarding this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

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

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

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

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

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

Please respond to the following items:

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

None that involved the SSA.

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

Unknown.

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

According to the State Historic Preservation Office, whose purpose is to encourage and facilitate the responsible stewardship of South Carolina’s irreplaceable historic and prehistoric places, and which operates as a program of the S.C. Department of Archives and History, recognition of Native American Indian tribes acknowledges the right of sovereignty and self-government. There are two levels of recognition: federal and state. At the federal level, recognition puts tribal governments at the same level as state governments with their rights to tax, make and enforce laws, and regulate activities. At the state level of recognition, tribal governments are equal to county governments. Recognition, at either level, allows tribes to determine requirements for membership.

The State Historic Preservation Office has identified one federally recognized Indian tribe with historic affiliation to the State of South Carolina. The Catawba Indian Nation is the only resident federally recognized Indian tribe in the state.

The promulgation of regulations regarding State Recognition of Native American Indian entities in South Carolina falls under the purview of the S.C. Commission for Minority Affairs (SC Code of Laws Section 1-31-40(A)(10)). The purpose of the Commission is “to study the causes and effects of the socio-economic deprivation of minorities in the State and to implement programs necessary to address inequities confronting minorities in the State.”

Pursuant to SC Code of Laws Section 1-31-40(A)(10) and SC Code of Regulations 139, which also fall under the purview of the Commission for Minority Affairs, the State of South Carolina recognizes three categories of Native American Indian entities in South Carolina: Native American Indian Tribes, Native American Indian Groups, and Native American Indian Special Interest Organizations. The categories are defined as:

• "Tribe" means an assembly of Indian people comprising numerous families, clans, or generations together with their descendents, who have a common character, interest, and behavior denoting a separate ethnic and cultural heritage, and who have existed as a separate community, on a substantially continuous basis throughout the past 100 years. In general, core members of the tribe are related to each other by blood. A tribal council and governmental authority unique to Native American Indians govern them.

• "Group" means a number of individuals assembled together, which have different characteristics, interests, and behaviors that do not denote a separate ethnic and cultural heritage today, as they once did. The group is composed of both Native American Indians and other ethnic races. They are not all related to one another by blood. A tribal council and governmental authority unique to Native American Indians govern them.

• "Special Interest Organization" means an assembly of people who have united for the common purpose of promoting Native American culture and addressing socio-economic deprivation among people of Indian origin. The organization is made up of Native American Indians and other ethnic races. A tribal council or other form of governing body provides oversight and management. Membership is not required. They may be organized as a private nonprofit corporation under the laws of South Carolina.

According to state law, the following entities meet the appropriate definitions as cited above:

• State-Recognized Native American Indian Tribes
o Beaver Creek Indians
o Edisto Natchez Kusso Tribe of South Carolina
o Pee Dee Nation of Upper South Carolina
o Pee Dee Indian Tribe of South Carolina
o Santee Indian Organization
o The Waccamaw Indian People
o Wassamasaw Tribe of Varnertown Indians

• State-Recognized Native American Indian Groups
o Chaloklowa Chickasaw Indian People
o Eastern Cherokee, Southern Iroquois and United Tribes of SC
o Natchez Tribe of South Carolina
o Pee Dee Indian Tribe of Beaver Creek
o Piedmont American Indian Association – Lower Eastern Cherokee Nation of South Carolina

• State-Recognized Native American Indian Special Interest Organizations
o American Indian Chamber of Commerce SC
o Little Horse Creek American Indian Cultural Center

As a part of SC Code of Regulations 139, there is established a Native American Indian Advisory Committee whose purpose is "to preserve the true aboriginal culture of the Americas in the State of South Carolina and to advance the Native American Indian culture." The Committee advises the Commission for Minority Affairs by apprising it of matters regarding Native American Indian Affairs, identifying the needs and concerns of the Native American Indian people of South Carolina by bringing such needs and concerns to the attention of the Commission, making recommendations to the Commission to address the needs and concerns of Native American Indian people, and inviting individuals recognized as specialists in Native American Indian Affairs and representatives of state and federal agencies to present information to members of the Advisory Committee.

It continues to be the intent of DAODAS to engage with Native Americans in South Carolina by establishing direct consultative relationships with the elected officials of the Catawba Nation (or their designees).

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

Not at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

8. 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:

1. ***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;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***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;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***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

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [ ] Other (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 formula was established by DAODAS in July, 2013 and updated this year in July, 2019. DAODAS provides SAPT BG primary prevention set aside dollars to 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 two components-funding for base service implementation and funding based on county population levels.
Base implementation funds: Each agency receives $60,000 to support primary prevention service implementation. If an agency serves two or more counties, the agency receives an additional $15,000 to support service implementation 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 implementation is $90,000.

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 agencies- 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. The population-based estimates were set by the US Census Bureau on April 18, 2019. Additional funds are provided in incremental amounts ($6,300 for the smallest population agency up to $209,700 for the largest population agency. At a minimum, population adjustments will be revised every five years.

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; median= $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 to the implementation 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 encapsulates 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 utilizing 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.

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:

1. ***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;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***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;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***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.

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. http://www.scappaonline.org/

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.

The regional capacity coaches are required through their contract with DAODAS to provide the following:

The Regional Capacity Coach will create the annual budget, and is responsible for providing timely and useful training and technical assistance (TTA) within the region. The Coaches' priority responsibility is to build the capacity of county 301 authorities (organizations) within the region to utilize the Strategic Planning Framework (SPF), also known as the Strategic Prevention Framework. Coaches are expected to provide guidance, training, and technical assistance for block grant and discretionary grant related staff, programs, practices, and services.

As related to capacity of prevention professionals in particular, the Regional Capacity Coach is available to help strengthen the workforce's capacity to use the SPF on a continuous basis. In sum, areas of technical assistance and training may include, but are not limited to: 1. SPF; 2.
Planning and Evaluation, 3. Prevention Education and Service Delivery, 4. Communication, 5. Community Organization, 6. Public Policy and Environmental Change, and 7. Professional Growth and Responsibility. The Regional Capacity Coach will meet other needs as identified by DAODAS or the counties served within the region, such as increasing the capacity of other local level staff (i.e. Agency Directors) to utilize the SPF. The Regional Capacity Coach also has administrative responsibilities, include, but may not be limited to: a quarterly report of training and technical assistance provided and, bi-monthly team meetings/conference calls.

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

strategies?

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.

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:

1. ***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;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***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;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***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.

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

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.

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:

1. ***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;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***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;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***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.

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 also has contracts with PIRE for prevention evaluation services and SEOW-related work, South Carolina Association 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 curriculum 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 will continue in FFY20 to 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. Public awareness through education campaigns is also another avenue that local providers use to get information out to the public through traditional and social media outlets.

Data collected through the IMPACT system indicates these services reached approximately 6,091,862 people throughout the state in FY'18 and accounted for approximately 30% of the total service activities recorded by the counties in the

IMPACT system.

b) Education:

South Carolina's county alcohol and drug abuse authorities will continue to work with partner agencies within the counties to provide prevention services for children, adolescents, and adults in FFY20. 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 fiscal year 2018 were as follows and due to the successfully implementation of these programs, several of these will be implemented across the state in FFY20:

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 417 matched youth at one site. There was a statistically significant change in perceived risk and perceived peer norms. There was also a significant decrease in alcohol use.

All Stars is a comprehensive evidence-based ATOD prevention curriculum. This program was used by one site with a total of 183 matched participants. There was a statistically significant change in perceived risk, decision-making and favorable attitudes. There was also a significant decrease in alcohol users.

Class Action is a comprehensive evidence-based ATOD prevention curriculum. This program was used by two sites with a total of 92 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 60 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 eight sites and 2730 matched participants. There were desired changes on two of the five risk factors (perceived risk and decision making). There were statistically significant changes in cigarette and alcohol use.

Operation Prevention Rx is an evidence-based program with the mission to educate students about the true impacts of opioids and kick-start lifesaving conversations in the home and classroom. It was used by one site with 249 matched participants. There were statistically significant changes on three of the five risk factors (perceived risk, decision-making and perceived peer norms).

Prime for Life: Exploring is an evidence-based motivational prevention and intervention program designed for people who might be making high-risk choices. This program was used by one site with 61 matched participants. There were statistically-significant changes on two of the five risk factors (perceived risk and favorable attitudes).

Project Alert, a comprehensive evidence-based ATOD prevention curriculum for middle school students, was delivered at two sites with a total of 57 matched participants. There were no statistically significant changes in risk factors or substances.

Project Northland is an evidence-based ATOD prevention curriculum with a strong focus on alcohol and influencing the environment. The program was used by one site with 16 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 56 total matched participants. There was also a significant decrease in the use of alcohol.

Too Good for Drugs is an evidence-based program with specific lessons for each middle and high school grade. Three sites, with a total of 207 matched participants, used this program. There were statistically significant changes in four risk factors.

Why Try is a comprehensive evidence-based ATOD prevention curriculum, which was implemented at two sites with 25 participants. There were statistically significant improvement in perceived risk, decision-making, favorable attitudes and peer norms, as well as a statistically significant decrease in marijuana use.

County authorities are not required to use evidence-based interventions exclusively, though most do. In FY '18 100% of participants were served in evidence-based programs.

In addition to the youth programs, providers also implemented programs geared towards families and adults (such as parenting programs, Strengthening Families, etc.)

Data collected through the IMPACT system indicates these services reached approximately 8,640 people throughout the state in FY'18 and accounted for 10% 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. This will continue in FFY20.

Data collected through the IMPACT system indicates these services reached approximately 4,668 people throughout the state in FY'18 and accounted for 4% 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. This will continue in FFY20. More than 600 youth were in diversion programs for youth alcohol and tobacco offenses (334 served in the Alcohol Education Program and 287 served in the Tobacco Education Program). A few counties also work with local colleges to provide a diversion program to students who may have an infraction cited by campus law enforcement and/or student life related to substance use.

Data collected through the IMPACT system indicates these services reached approximately 648 people throughout the state in FY'18 and accounted for 3% 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. These services are planned to continue in FFY20.

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 38,318 people throughout the state in FY'18 and accounted for 27% 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. These services are planned to continue in FFY20. 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.

Lead by the South Carolina Department of Alcohol & Other Drug Abuse Services (DAODAS), the SCAET Training Team is comprised of personnel from state and local AET partners. The courses are derived from training offered throughout the country by the Underage Drinking Enforcement Training Center (UDETC). Since late 2007, the SCAET Training Team has trained hundreds of law enforcement officers and prevention specialists across South Carolina. The Team works with the 16 AETs, 32 Alcohol & Drug Commissions that cover the 46 South Carolina counties, state and local law enforcement agencies, and other partners to offer the various training classes free of charge in South Carolina. A downloadable training brochure and more information on the training classes can be found here: http://scoutoftheirhands.org/scaet-training.html Trainings are offrered free of charge and participants receive professional credits from the SC Criminal Justice Academy for law enforcement and from the SC Association of Prevention Professionals and Advocates (SCAPPA) for prevention professionals.

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 FY 2018 include:

Alcohol compliance checks, tobacco compliance checks. 6,287 alcohol compliance checks and 746 tobacco compliance checks. Sales were completed for 6.9% of alcohol attempts and 3.9% of tobacco attempts.

Merchant Education-: The counties served 1,411 merchants in the Palmetto Retailers Education Program (PREP) in FY '18.

Most merchants asked to see the buyers' IDs (94.5% and 94.1% for alcohol and tobacco, respectively) and most merchants studied the IDs (79.2% and 67.4% for alcohol and tobacco, respectively). For alcohol sales, clerk age and race and buyer age, sex and race were statistically significant predictors of sales. For tobacco sales, clerk age was the only significant predictor of sales.

Public Safety Checkpoints and Saturation Patrols: AETs reported a total of 530 public safety checkpoints. Among the violations, there were 94 DUIs. In addition, there were 190 saturation patrols reported. This operation generated another 1,490 tickets, among them 28 DUIs.

Controlled Party Dispersals and party prevention AETs dispersed 129 parties attended by 3,253 persons. Together, 175 tickets were written during those dispersals.

Shoulder Taps: A total of 77 individuals were approached by the cooperating youth to purchase alcohol as part of Shoulder Tap operations, with 1 purchasing (1.3% sales).

Fake ID/Bar Checks: In FY '18, there were 207 bar checks conducted, resulting in 158 fake ID violations and 9 other retailer and patron charges.

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

Data collected through the IMPACT system indicates these services reached approximately 28,236 people throughout the state in FY'18 and accounted for 26% 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.

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:

1. ***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;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***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;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***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
- ☑ Perception of harm
- **c)** ☑ Disapproval of use

d) ☑ 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 files are under the Evaluation tab and prevention outcomes tab

Environmental Factors and Plan

10. 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) Services for special populations:

Targeted services for veterans?	( ) Yes (•) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. 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. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) 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 Has your state identified a need for 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, and custody issues? (●) 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 activities and services for PWWDC by desk reviews and on site visits. The Federal requirements for PWWDC are incorporated into the DAODAS Annual Funding and Compliance Contract (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 problem 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, DAODAS may take a number of measures, ranging from with holding 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. Has your state identified a need for 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 (e.g., 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 Annual Funding and Compliance Contract (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 problem 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, DAODAS may take a number of measures, ranging from with holding reimbursements to assigning the county's catchment area to another county authority.

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. Has your state identified a need for 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 TB are incorporated into the DAODAS Annual Funding and Compliance Contract (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 problem 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, DAODAS may take a number of measures, ranging from with holding 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 have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? (•) Yes ( ) No

2. Has your state identified a need for 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

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. Has your state identified a need for 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 services 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. Has your state identified a need for 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, such as 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. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ( ) Yes (●) No
- **b)** An organized referral system to identify alternative providers? — (●) Yes ( ) No
- **c)** 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. Has your state identified a need for 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. Has your state identified a need for 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.

SFY2020: 16 providers
SFY2021: 16 providers

Note: Either number is far more than 5% of the sub-recipients, or 2 providers, that are required. 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. Has your state identified a need for 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) Development of 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, such as the 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. Has your state identified a need for 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. Has your state identified a need for 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

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ( ) Yes (●) No

b) Mental Health TTC? ( ) Yes (●) No

c) Addiction TTC? ( ) Yes (●) No

d) State Targeted Response TTC? ( ) 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 that 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:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? ○ Yes ◉ No

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

Not at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] 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 M/SUD 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 M/SUD services. 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 M/SUD 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 M/SUD 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[58] paper.

57 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.*
58 *Ibid*

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

1. Does the state have a plan or policy for M/SUD providers that 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 M/SUD providers? (●) Yes ( ) No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? (●) Yes ( ) No

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 received federal technical assistance on Trauma-Informed Care and continues to be engaged in planning that resulted from this assistance. DAODAS remains a leader in an ongoing paradigm shift at the state level promoting Trauma-Informed Care through training and technical assistance in the behavioral health system.

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

Not at this time.

Footnotes:

Environmental Factors and Plan

13. 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.[59]

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.[60]
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 the Health Insurance 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.

[59] 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 Ren?e L. Binder. **OJJDP Model Programs Guide**

[60] **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 M/SUD 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, M/SUD 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 M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD 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 M/SUD 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 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

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

Not at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

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?

Through the SOR funding, DAODAS has implemented the health home model that will continue to integrate MAT and behavioral health therapies with primary care for patients with OUD. In addition, DAODAS is working with Ohio Valley Physicians to ensure the availability and accessibility of appropriate services for patients affected by opioid in fifteen (15) rural counties in South Carolina. Aiken, Abbeville, Allendale, Barnwell, Calhoun, Chester, Chesterfield, Clarendon, Edgefield-McCormick, Hampton, Marion, Newberry-Saluda, Union and Williamsburg. Another highlight is that there are approximately 310 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

**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.*

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☐ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☐ Psychiatric Advance Directives
- **c)** ☐ Family Engagement
- **d)** ☐ Safety Planning
- **e)** ☐ Peer-Operated Warm Lines
- **f)** ☐ Peer-Run Crisis Respite Programs
- **g)** ☐ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☐ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☐ Crisis Residential/Respite
- **d)** ☐ Crisis Intervention Team/Law Enforcement
- **e)** ☐ Mobile Crisis Outreach
- **f)** ☐ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☐ Peer Support/Peer Bridgers
- **b)** ☐ Follow-up Outreach and Support
- **c)** ☐ Family-to-Family Engagement
- **d)** ☐ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☐ Follow-up crisis engagement with families and involved community members

f) ☐ Recovery community coaches/peer recovery coaches

g) ☐ Recovery community organization

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

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery 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 to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

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

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

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

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

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

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

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

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

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

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 six years now. Opioid STR/SOR grants have 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/SOR funds we are also providing peer supervision trainings.

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

The CPSS guide inmates and serve as a support system during the transition from the South Carolina Department of Corrections to a warm handoff to local SUD providers, recovery housing, and job opportunities. To date 645 inmates have participated in the project. We have trained and certified 43 inmates throughout 5 South Carolina Department of Corrections institutions as CPSS:

1. We have 2 cohorts schedule to be trained in September and December which will bring the total to 100 inmates. The plan is 30% of the CPSS (extended stay inmates) will work as CPSS in the correctional facilities for sustainability of the program.
2. 100 inmates received medication post release due to short release dates.
3. 34 received oral and/or intramuscular naltraxone prior to release.
4. 32 participants are employed and 2 are persons with disabilities
5. 30 of the 32 participants were placed in oxford houses.
6. 4 had stable housing at release.
7. SCDC through the contract with DAODAS will hire an evaluator to evaluate the program.

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

Not at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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

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

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

Please respond to the following items

1. Does the state's Olmstead plan include :

Housing services provided.	○ Yes ○ No
Home and community based services.	○ Yes ○ No
Peer support services.	○ Yes ○ No
Employment services.	○ Yes ○ No

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

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

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD 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.[63]. 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.[64]. 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.[65].

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.[66]. 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.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

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

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

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

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

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

[64]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.

[65]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.

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

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **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 M/SUD 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 M/SUD 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 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 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.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

Advisory Council Members

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

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
No Data Available				

*Council members should be listed only once by type of membership and Agency/organization represented.
OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**0**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	0	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED/SUD*	0	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**0**	**0.00%**
State Employees	0	
Providers	0	
Vacancies	0	
Total State Employees & Providers	**0**	**0.00%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

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

Please respond to the following items:

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

a)	Public meetings or hearings?	○ Yes ◉ No
b)	Posting of the plan on the web for public comment?	◉ Yes ○ No
	If yes, provide URL: https://www.daodas.sc.gov/	
c)	Other (e.g. public service announcements, print media)	○ Yes ◉ No

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes: